Summer Meeting 2019

Elder Law & Special Needs Section

July 18 – 20, 2019

Boston Marriott Long Wharf
Boston, MA

Thank You! This program is made possible by the generous donation of time and expertise by members and volunteers. Thank you to our volunteers—and to you, for choosing NYSBA Programs.

This program is offered for educational purposes. The views and opinions of the faculty expressed during this program are those of the presenters and authors of the materials, including all materials that may have been updated since the books were printed or distributed electronically. Further, the statements made by the faculty during this program do not constitute legal advice.

ACCESSING THE ONLINE ELECTRONIC COURSE MATERIALS

Program materials will be distributed exclusively online in PDF format. It is strongly recommended that you save the course materials in advance, in the event that you will be bringing a computer or tablet with you to the program.

Printing the complete materials is not required for attending the program.

The course materials may be accessed online at: www.nysba.org/ELDSU19Materials

A hard copy NotePad will be provided to attendees at the live program site, which contains lined pages for taking notes on each topic, speaker biographies, and presentation slides or outlines if available.

Please note:

- You must have Adobe Acrobat on your computer in order to view, save, and/or print the files. If you do not already have this software, you can download a free copy of Adobe Acrobat Reader at https://get.adobe.com/reader/
- If you are bringing a laptop, tablet or other mobile device with you to the program, please be sure that your batteries are fully charged in advance, as electrical outlets may not be available.
- NYSBA cannot guarantee that free or paid Wi-Fi access will be available for your use at the program location.

MCLE INFORMATION

Program Title: **Elder Law & Special Needs Section Summer Meeting 2019**
Date/s: July 18-20, 2019 Location: Boston, MA

Evaluation: <https://nysba.co1.qualtrics.com/jfe/form/SV_bK2twXCljR2wOhL>
This evaluation survey link will be emailed to registrants following the program.

Total NY Credits: 10.0

Credit Category:
6.0 Areas of Professional Practice
1.0 Ethics and Professionalism
1.0 Skills
1.0 Law Practice Management
1.0 Diversity, Inclusion and Elimination of Bias (Experienced Attorneys Only)

This course is approved for credit for **both** experienced attorneys and newly admitted attorneys (admitted to the New York Bar for less than two years). Newly admitted attorneys participating via recording or webcast should refer to www.nycourts.gov/attorneys/cle regarding permitted formats.

Attendance Verification for New York MCLE Credit

In order to receive MCLE credit, attendees must:

1) **Sign in** with registration staff
2) Complete and return a **Form for Verification of Presence** (included with course materials) at the end of the program or session. For multi-day programs, you will receive a separate form for each day of the program, to be returned each day.

Partial credit for program segments is not allowed. Under New York State Continuing Legal Education Regulations and Guidelines, credit shall be awarded only for attendance at an entire course or program, or for attendance at an entire session of a course or program. Persons who arrive late, depart early, or are absent for any portion of a segment will not receive credit for that segment. The Form for Verification of Presence certifies presence for the entire presentation. Any exceptions where full educational benefit of the presentation is not received should be indicated on the form and noted with registration personnel.

Program Evaluation

The New York State Bar Association is committed to providing high quality continuing legal education courses, and your feedback regarding speakers and program accommodations is important to us. Following the program, an email will be sent to registrants with a link to complete an online evaluation survey. The link is also provided above.

ADDITIONAL INFORMATION AND POLICIES

Recording of NYSBA seminars, meetings and events is not permitted.

Accredited Provider

The New York State Bar Association's **Section and Meeting Services Department** has been certified by the New York State Continuing Legal Education Board as an accredited provider of continuing legal education courses and programs.

Credit Application Outside of New York State

Attorneys who wish to apply for credit outside of New York State should contact the governing body for MCLE in the respective jurisdiction.

MCLE Certificates

MCLE Certificates will be emailed to attendees a few weeks after the program, or mailed to those without an email address on file. **To update your contact information with NYSBA**, visit www.nysba.org/MyProfile, or contact the Member Resource Center at (800) 582-2452 or MRC@nysba.org.

Newly Admitted Attorneys—Permitted Formats

Newly admitted attorneys (admitted to the New York Bar for less than two years) may not be eligible to receive credit for certain program credit categories or formats. For official New York State CLE Board rules, see www.nycourts.gov/attorneys/cle.

Tuition Assistance

New York State Bar Association members and non-members may apply for a discount or scholarship to attend MCLE programs, based on financial hardship. This discount applies to the educational portion of the program only. Application details can be found at www.nysba.org/SectionCLEAssistance.

Questions

For questions, contact the NYSBA Section and Meeting Services Department at SectionCLE@nysba.org, or the NYSBA Member Resource Center at (800) 582-2452 (or (518) 463-3724 in the Albany area).

Lawyer Assistance Program 800.255.0569

Q. What is LAP?

A. The Lawyer Assistance Program is a program of the New York State Bar Association established to help attorneys, judges, and law students in New York State (NYSBA members and non-members) who are affected by alcoholism, drug abuse, gambling, depression, other mental health issues, or debilitating stress.

Q. What services does LAP provide?

A. Services are **free** and include:

- Early identification of impairment
- Intervention and motivation to seek help
- Assessment, evaluation and development of an appropriate treatment plan
- Referral to community resources, self-help groups, inpatient treatment, outpatient counseling, and rehabilitation services
- Referral to a trained peer assistant – attorneys who have faced their own difficulties and volunteer to assist a struggling colleague by providing support, understanding, guidance, and good listening
- Information and consultation for those (family, firm, and judges) concerned about an attorney
- Training programs on recognizing, preventing, and dealing with addiction, stress, depression, and other mental health issues

Q. Are LAP services confidential?

A. Absolutely, this wouldn't work any other way. In fact your confidentiality is guaranteed and protected under Section 499 of the Judiciary Law. Confidentiality is the hallmark of the program and the reason it has remained viable for almost 20 years.

Judiciary Law Section 499 Lawyer Assistance Committees Chapter 327 of the Laws of 1993

Confidential information privileged. The confidential relations and communications between a member or authorized agent of a lawyer assistance committee sponsored by a state or local bar association and any person, firm or corporation communicating with such a committee, its members or authorized agents shall be deemed to be privileged on the same basis as those provided by law between attorney and client. Such privileges may be waived only by the person, firm or corporation who has furnished information to the committee.

Q. How do I access LAP services?

A. LAP services are accessed voluntarily by calling **800.255.0569** or connecting to our website **www.nysba.org/lap**

Q. What can I expect when I contact LAP?

A. You can expect to speak to a Lawyer Assistance professional who has extensive experience with the issues and with the lawyer population. You can expect the undivided attention you deserve to share what's on your mind and to explore options for addressing your concerns. You will receive referrals, suggestions, and support. The LAP professional will ask your permission to check in with you in the weeks following your initial call to the LAP office.

Q. Can I expect resolution of my problem?

A. The LAP instills hope through the peer assistant volunteers, many of whom have triumphed over their own significant personal problems. Also there is evidence that appropriate treatment and support is effective in most cases of mental health problems. For example, a combination of medication and therapy effectively treats depression in 85% of the cases.

Personal Inventory

Personal problems such as alcoholism, substance abuse, depression and stress affect one's ability to practice law. Take time to review the following questions and consider whether you or a colleague would benefit from the available Lawyer Assistance Program services. If you answer "yes" to any of these questions, you may need help.

1. **Are my associates, clients or family saying that my behavior has changed or that I don't seem myself?**
2. **Is it difficult for me to maintain a routine and stay on top of responsibilities?**
3. **Have I experienced memory problems or an inability to concentrate?**
4. **Am I having difficulty managing emotions such as anger and sadness?**
5. **Have I missed appointments or appearances or failed to return phone calls? Am I keeping up with correspondence?**
6. **Have my sleeping and eating habits changed?**
7. **Am I experiencing a pattern of relationship problems with significant people in my life (spouse/parent, children, partners/associates)?**
8. **Does my family have a history of alcoholism, substance abuse or depression?**
9. **Do I drink or take drugs to deal with my problems?**
10. **In the last few months, have I had more drinks or drugs than I intended, or felt that I should cut back or quit, but could not?**
11. **Is gambling making me careless of my financial responsibilities?**
12. **Do I feel so stressed, burned out and depressed that I have thoughts of suicide?**

There Is Hope

CONTACT LAP TODAY FOR FREE CONFIDENTIAL ASSISTANCE AND SUPPORT

The sooner the better!

1.800.255.0569

NEW YORK STATE BAR ASSOCIATION

JOIN OUR SECTION

☐ As a NYSBA member, **PLEASE BILL ME $30 for Elder Law & Special Needs Section dues.** (law student rate is $15)

☐ I wish to become a member of the NYSBA (please see Association membership dues categories) and the Elder Law & Special Needs Section. **PLEASE BILL ME for both.**

☐ I am a Section member — please consider me for appointment to committees marked.

Name _____

Address _____

_____

City _____ State _____ Zip _____

The above address is my ☐ Home ☐ Office ☐ Both

Please supply us with an additional address.

Name _____

Address _____

City _____ State _____ Zip _____

Office phone (_____) _____

Home phone (_____) _____

Fax number (_____) _____

E-mail address _____

Date of birth _____ /_____ /_____

Law school _____

Graduation date _____

States and dates of admission to Bar: _____

Please return this application to:

MEMBER RESOURCE CENTER,
New York State Bar Association, One Elk Street, Albany NY 12207
Phone 800.582.2452/518.463.3200 • FAX 518.463.5993
E-mail mrc@nysba.org • www.nysba.org

JOIN A ELDER LAW & SPECIAL NEEDS SECTION COMMITTEE(S)

Please designate in order of choice (1, 2, 3) from the list below, a maximum of three committees in which you are interested. You are assured of at least one committee appointment, however, all appointments are made as space availability permits.

___ Client and Consumer Issues (ELD4000)
___ Diversity (ELD6800)
___ Elder Abuse (ELD7600)
___ Estates, Trusts and Tax Issues (ELD1200)
___ Ethics (ELD7300)
___ Financial Planning and Investments (ELD4400)
___ Guardianship (ELD1600)
___ Health Care Issues (ELD3600)
___ Legal Education (ELD1900)
___ Legislation (ELD2300)
___ Liaison to Law Schools (ELD6300)
___ Mediation (ELD7400)
___ Medicaid (ELD2900)
___ Membership Services (ELD1040)
___ Mental Health Law (ELD6100)
___ Mentoring (ELD7500)
___ Practice Management (ELD3300)
___ Publications (ELD6600)
___ Real Estate and Housing (ELD3900)
___ Special Ed (ELD8000)
___ Special Needs Planning (ELD3800)
___ Sponsorship (ELD6500)
___ Task Force on Challenges to Medicaid Practice (ELD8010)
___ Task Force on Unauthorized Practice of Law (ELD7700)
___ Technology (ELD7800)
___ Veteran's Benefits (ELD6700)

2019 ANNUAL MEMBERSHIP DUES

Class based on first year of admission to bar of any state. Membership year runs January through December.

ACTIVE/ASSOCIATE IN-STATE ATTORNEY MEMBERSHIP

Attorneys admitted 2011 and prior	$275
Attorneys admitted 2012-2013	185
Attorneys admitted 2014-2015	125
Attorneys admitted 2016 - 3.31.2018	60

ACTIVE/ASSOCIATE OUT-OF-STATE ATTORNEY MEMBERSHIP

Attorneys admitted 2011 and prior	$180
Attorneys admitted 2012-2013	150
Attorneys admitted 2014-2015	120
Attorneys admitted 2016 - 3.31.2018	60

OTHER

Sustaining Member	$400
Affiliate Member	185
Newly Admitted Member*	FREE

DEFINITIONS

Active In-State = Attorneys admitted in NYS, who work and/or reside in NYS
Associate In-State = Attorneys not admitted in NYS, who work and/or reside in NYS
Active Out-of-State = Attorneys admitted in NYS, who neither work nor reside in NYS
Associate Out-of-State = Attorneys not admitted in NYS, who neither work nor reside in NYS
Sustaining = Attorney members who voluntarily provide additional funds to further support the work of the Association
Affiliate = Person(s) holding a JD, not admitted to practice, who work for a law school or bar association
*Newly admitted = Attorneys admitted on or after April 1, 2018

NYSBA

SCHEDULE OF EVENTS

Thursday, July 18

9:00 – 10:00 am	Executive Officer's Meeting: Quincy Room
9:00 am – 5:30 pm	Registration: Front Foyer
10:15 am – 12:30 pm	Executive Committee Luncheon Meeting: Salons G, H & I
12:00 – 5:30 pm	Meet our Exhibitors: Front Foyer
1:15 – 5:30 pm	**GENERAL SESSIONS: Salons A-F** ***Wifi Sponsor:*** **QUONTIC BANK**
1:15 – 1:45 pm	Welcoming Remarks**: Tara Anne Pleat, Esq.**, Wilcenski & Pleat PLLC, Section Chair NYSBA Welcome: **Henry M. Greenberg, Esq.**, President, NYSBA Program Introductions: **Jeffrey A. Asher, Esq.** and **Judith M. Nolfo, Esq.**, Program Co-Chairs
1:45 – 2:35 pm	**Executive Hour – Understanding Disability** (1.0 Diversity, Inclusion and Elimination of Bias) This session, designed to provide attendees with a Diversity credit, will focus on improving attorneys' understanding of the concerns and issues faced by individuals with disabilities as it relates to independence, decision-making and self-determination.
Panelists:	**Christopher R. Lyons, Esq.**, Executive Director, AIM Services, Inc., Saratoga Springs **June MacClelland**, Senior Director and Chief Compliance Officer (and Parent), AIM Services, Inc., Saratoga Springs
2:35 – 2:45 pm	Refreshment and Snack Break with Exhibitors: Front Foyer ***Break Co-Sponsors:*** **ARTHUR B. LEVINE COMPANY and PREFERRED HOME CARE OF NEW YORK**
2:45 – 3:35 pm	**THE OPWDD Service Delivery System** (1.0 Areas of Professional Practice) Discussion will focus on the future of service delivery for the ID/DD population. What is the Office for Developmental Disabilities (OPWDD)? What is the Medicaid Waiver and how is it implemented? What is life like interfacing within the OPWDD System from the parents' perspective and from an Executive Directors' perspective? What are the gaps practitioners advising families need to be aware of and plan for? What do the next ten years in the OPWDD system look like?
Speaker:	**Mary Ann Allen, Esq.**, Executive Director, Wildwood Programs Inc., Schenectady
3:35 – 4:00 pm	Refreshment Break with Exhibitors: Front Foyer ***Break Sponsor:*** **PREMIER HOME CARE**
4:00 – 5:30 pm	**Surrogates Session: Special Needs Trusts, Guardians Ad Litem, Article 17-A** (1.0 Areas of Professional Practice) Using a few common fact patterns, this panel will focus on issues related to guardianship, disability and supplemental needs trusts. Judges will be asked to explain their approach to procedural aspects of the practice, and to provide their insight into some of the broader challenges that arise in representing individuals with disabilities and the fiduciaries who serve them.
Moderators:	**Edward V. Wilcenski, Esq.**, Wilcenski & Pleat PLLC, Clifton Park **Ron M. Landsman, Esq.,** Landsman Law Group, Rockville, MD
Panelists:	**Honorable Peter J. Kelly**, Queen's County Surrogate's Court, Jamaica **Honorable Richard Kupferman**, Saratoga County Surrogate's Court, Ballston Spa **Honorable Acea M. Mosey**, Erie County Surrogate's Court, Buffalo **Honorable Brandon R. Sall**, Westchester County Surrogate's Court, White Plains
6:00 – 8:00 pm	**WELCOME COCKTAIL RECEPTION:** Harborview Ballroom ***Reception Sponsor:*** **RDM FINANCIAL GROUP AT HIGHTOWER** Dinner on your own this evening

SCHEDULE OF EVENTS

Friday, July 19

7:30 – 8:30 am	Friends of Bill W. Meeting
8:00 am	Registration and Continental Breakfast with Exhibitors: Front Foyer
8:00 – 9:00 am	Elder Law and Special Needs Section Committee and District Delegate Breakfast Meetings: Harborview Ballroom
9:00 am – 1:00 pm	**GENERAL SESSION: Salons A-G** ***Wifi Sponsor:*** **ORANGE BANK & TRUST COMPANY**
9:00 – 9:15 am	Opening Remarks: **Tara Anne Pleat, Esq.,** Wilcenski & Pleat PLLC, Section Chair Program Introductions: **Jeffrey A. Asher, Esq.**, Program Co-Chair
9:15 – 10:05 am	**The ABCs of the SSA** (1.0 Skills) Social Security programs can be very difficult to understand for parents of children with disabilities. This session will describe the Supplemental Security Income (SSI) program in more detail with examples of how it might apply to our clients, as well as provide some introductory information about Social Security Disability and Disabled Adult Child Benefits.
Speaker:	**Neal A. Winston, Esq.**, Winston Law Group, Boston, MA
10:05 – 10:15 am	Refreshment Break with Exhibitors: Front Foyer
10:15 – 11:05 am	**The Sole Benefit Trust – Whatever Happened to this Planning Tool?** (1.0 Areas of Professional Practice) This session will review the requirements that must be satisfied in order to create a valid "sole benefit trust", a type of third party supplemental needs trust that protects the assets contained in the trust from being countable resources for government benefits purposes for the beneficiary who is disabled. The session will review how the sole benefit trust achieves the further objective of avoiding the imposition of a penalty period for the grantor, who also may need to apply for government benefits in the near future.
Speaker:	**Howard S. Krooks., Esq.**, Elder Law Associates PA, Boca Raton, FL
11:05 – 11:20 am	Refreshment Break with Exhibitors: Front Foyer
11:30 am – 12:20 pm	**Family Law and Special Needs Issues** (1.0 Areas of Professional Practice) A survey of the intersection of special needs issues and matrimonial and family law. Topics of discussion will include the impact of child support on eligibility for benefits, covering future needs for advocacy and support, and issues that arise when individuals who receive means tested benefits decide to marry.
Panelists:	**Ellyn S. Kravitz, Esq.**, Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara, Wolf & Carone, LLP, Brooklyn **Cora A. Alsante, Esq.**, Hancock Estabrook, LLP, Syracuse
12:20 – 12:30 am	Refreshment Break with Exhibitors: Front Foyer
12:30 – 12:55 pm	**17-A Update** (1.0 Areas of Professional Practice) This program will provide a current update on legislative and judicial efforts to modify the law governing guardianship for individuals with intellectual and other developmental disabilities under SCPA Article 17-A. The program will also briefly cover the law's historical context and origins, recent pressures for change, and legislative efforts to date.
Speaker:	**Kathryn E. Jerian, Esq.**, NYSARC, Inc., Latham
2:00 – 3:30 pm	**HISTORIC PUB CRAWL** Join the Freedom Trail player guides and visit the real headquarters where the Revolution was brewed – Blackstone Block. Experience Boston's oldest taverns while sampling local brews. Tour will depart from ArtsBoston Booth located past Faneuil Hall Marketplace. Directions will be provided. **Preregistration required. Tickets: $43 each. Must be 21 and over.**

SCHEDULE OF EVENTS

2:30 – 5:00 pm

ISABELLA STEWART GARDNER MUSEUM TOUR, 25 Evans Way
Learn about the woman, her vision and collection. Built by Gardner in 1903 to emulate a 15th c. Venetian palace, "Fenway Court" houses her collection, mixing European paintings and sculptures with textiles, furniture and objects from various cultures and periods in an intimate manner. The art collection includes works by Raphael, Michelangelo, Titian, Rembrandt, Sargent, Degas, Manet, Whistler, Raphael and others. The museum's much photographed interior courtyard reflects Gardner's passion for horticulture and garden design. Meet at Museum for Tour (by Green Line Train, it take approximately 30 min. to reach Museum from hotel.) **Preregistration required. Tickets: $35 each.**

2:30 – 4:00 pm

BEHIND THE SCENES AT FENWAY PARK, 4 Jersey Street
Don't miss this chance to tour the Big Green Monster and learn its history**.**
Added to the National Register of Historic Places in 2012, it has been home to the Boston Red Sox since 1912. Fenway is the oldest ballpark in major league baseball. The "Lone Red Seat" in the right-field bleachers marks Ted William's longest home run at the park. Group should meet at Gate D for tour. Directions from the Kenmore "T" station will be provided. **Tickets: $22 each. Preregistration required.**

6:30 – 10:30 pm

COCKTAIL RECEPTION & DINNER: NEW ENGLAND AQUARIUM, 1 Central Wharf
Entertainment Sponsor: **NYSARC TRUST SERVICES**
Don't miss our Coastal Clambake on the shore of Boston Harbor!
Enjoy cocktails on the Harbor Terrace and dinner in the Main
Exhibition Gallery at the Aquarium. Venue is walking distance from hotel.
Preregistration required.

SCHEDULE OF EVENTS

Saturday, July 20

7:30 – 8:30 am	Friends of Bill W. Meeting
8:00 am	Registration and Continental Breakfast with Exhibitors: Front Foyer
9:00 am – 12:00 pm	**GENERAL SESSION: Salons A-G** ***Wifi Sponsor:* WELLS FARGO**
9:00 – 9:10 am	Opening Remarks: **Tara Anne Pleat, Esq.**, Wilcenski & Pleat PLLC, Section Chair Program Introductions: **Judith M. Nolfo, Esq.**, Program Co-Chair
9:10 – 10:00 am	**Case Law Update 2019** (1.0 Areas of Professional Practice) An update on important case law, legislation (both passed and pending), fair hearings, regulations and happenings throughout the state and nation on issues pertaining to elder law, estate planning and special needs planning.
Speaker:	**Matthew J. Nolfo, Esq.**, Matthew J. Nolfo & Associates, New York City
10:00 – 10:50 am	**Attorney Wellness: The Science of Stress and the Road to Well-Being** (1.0 Law Practice Management) From productivity and profitability to ethical responsibility and public trust, attorney wellbeing is coming to the forefront of practice and personal management. Attorneys face nearly a constant stream of information, increasing expectations on shorter and shorter deadlines. Self-care and personal wellness is a greater need than ever before. Mindfulness practices and a well- being focus are key to helping lawyers go from striving to thriving.
Speaker:	**M. Elizabeth Coreno, Esq.**, The Law Offices of M. Elizabeth Coreno, Esq. P.C., Saratoga Springs
10:50 – 11:10 am	Refreshment Break with Exhibitors: Front Foyer ***Break Sponsor:* WILCENSKI & PLEAT PLLC**
11:10 am – 12:00 pm	**Inter-Generational Family Representation Case Study in Ethics** (1.0 Ethics) The program will be a panel discussion among 4 attorneys who will examine ethical issues that apply to a fact pattern involving potential clients within an inter-generational family who need or seek representation. Relevant Rules of Professional Conduct will be applied to issues that include: who may become a client given past representation of some family members; conflicts among possible clients; clients with diminished capacity and informed consent; and confidentially with respect to former and potential new clients within the family.
Panelists:	**Joanne Seminara, Esq.**, Grimaldi & Yeung LLP, Brooklyn **Robert P. Mascali, Esq.**, The Centers, Clearwater, FL **Paul M. Ryther, Esq.**, Law Office of Paul M. Ryther, East Bloomfield **Richard A. Marchese, Jr., Esq.**, Woods Oviatt Gilman LLP, Rochester

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The Center for Special Needs Trust Administration, Inc.
Premier Home Health Care
LCG Community Trust
Life, Inc. Pooled Trust Services
SCS Pooled Trust
RDM Financial Group at High Tower
Life's WORC Trust Services

UPCOMING CLE PROGRAMS

Guardianship Practice in New York | Friday, September 27, 2019 | NYC

Elder Law & Special Needs Section
and Trusts & Estates Law Section Joint Fall Meeting
Thursday and Friday, October 23-25, 2019 | The Gideon Putnam | Saratoga Springs
Information: **www.nysba.org/ELD**

Elder Law & Special Needs Section 2020 Annual Meeting
Tuesday, January 28, 2020 | The New York Hilton Midtown | NYC

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Saturday, July 20

Executive Hour – Understanding Disability

Christopher R. Lyons, Esq.
Executive Director, AIM Services, Inc., Saratoga Springs, NY

June MacClelland
Senior Director/Chief Compliance Officer
AIM Services, Inc., Saratoga Springs, NY

STATE of PUBLIC OPINION
COUNTY of YOUR COMMUNITY

RISK AND LIABILITY,
Plaintiff,
vs.

RIGHTS AND RESPONSIBILITY,
Defendant.

Christopher R. Lyons
Senior Director and Counsel
AIM Services, Inc.

Argued: June l9, 2017
NYSARC Executive Directors

NYSARC Inc. Bstabllshall949

AIM SERVICES/ INC.
The power of potential

What is Negligence?

Negligence is the determining factor in all personal injury cases, and one of the most common sources of any civil litigation in New York. In order to achieve success in an injury claim, plaintiffs must prove that the responsible person or party's negligence or carelessness was the direct or indirect cause of the injury. Negligence laws define the term as a failure to behave or perform a task with the same level of care or attention that a reasonable person or party would provide under the same circumstances (or taking unreasonable action when a prudent person would not).

Proving negligence means establishing the following:

- **Duty** – This means that the responsible party owed the plaintiff a duty. Here are two examples: a doctor assumes duty by agreeing to treat a patient, and getting behind the wheel of a car is automatically assuming duty to all others on the road.
- **Breach of Duty** – This means that the responsible party breached his or her duty by failing to act as a reasonable or prudent individual would have acted.
- **Proximate Cause** – This means that the breach of duty resulted in injury or harm to the plaintiff.
- **Damages** – This means that the injury caused the plaintiff real measurable or immeasurable damages such as financial costs or mental anguish.

BREACH of DUTY In The Context of Standard of Care

Medical Malpractice –

A doctor must exercise the reasonable degree of learning and skill ordinarily possessed by physicians and surgeons in the locality where the doctor practices *(Pike* v. *Honsinger,* 49 N. E. 760 (1898)). A doctor must use due care, as measured against the conduct of his peers. Due care requires a doctor to use his best judgment in using his skill and knowledge. A doctor must use his best judgment and whatever superior knowledge and skill he has, even if it exceeds that of the average doctor or specialist in the community where he practices *(Nestrowich* v. *Ricotta,* 767 N. E. 2d 125 (N.Y. 2002)).

Other Professionals and Standard of Care:

- Architect
- Accountants
- Lawyers
- Human Service Professionals

Human Service Professionals – Standard of Care
Olmstead Decision

States are, indeed, moving to re-balance their Medicaid spending to reflect the values of the Olmstead decision; and the federal government is providing incentives for them to do so in provisions such as the Balancing Incentive Payment Program; Community First Choice; Money Follows the Person; and the Medicaid Infra-structure grants to states (MIG). We also see structural changes to federal rules in the new HCBS definition and DOL rules.

Current Status: The Olmstead decision requires states to provide services and supports in the most integrated setting appropriate to the needs of qualified individuals with disabilities. We have come to understand the most integrated setting as one enabling people with disabilities to interact with their nondisabled peers to the fullest extent possible.

(Latest Court interpretation of Olmsted in New York)- O'Toole v Cuomo
Eastern District of New York Civ. Action No.l3-CIV-4166

HCBS Regulations

42 CFR 441.301(c)-

A waiver request under this subpart must include the following-

(1) *Person-centered planning process.* The individual will lead the person-centered planning process where possible. The individual's representative should have a participatory role, as needed and as defined by the individual, unless State law confers decision-making authority to the legal representative. All references to individuals include the role of the individual's representative. In addition to being led by the individual receiving services and supports, the person-centered planning process:

(i) Includes people chosen by the individual.

(ii) Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.

(iii) Is timely and occurs at times and locations of convenience to the individual.

(iv) Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with §435.905(b) of this chapter.

(v) Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.

(vi) Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process.

(vii) Offers informed choices to the individual regarding the services and supports they receive and from whom.

(viii) Includes a method for the individual to request updates to the plan as needed.

(ix) Records the alternative home and community-based settings that were considered by the individual.

(2) *The Person-Centered Service Plan.* The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under the State's 1915(c) HCBS waiver, the written plan must:

(i) Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

(ii) Reflect the individual's strengths and preferences.

(iii) Reflect clinical and support needs as identified through an assessment of functional need.

(iv) Include individually identified goals and desired outcomes.

(v) Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports.

(vi) Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.

(vii) Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with §435.905(b) of this chapter.

(viii) Identify the individual and/or entity responsible for monitoring the plan.

(ix) Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.

(x) Be distributed to the individual and other people involved in the plan.

(xi) Include those services, the purpose or control of which the individual elects to self-direct.

(xii) Prevent the provision of unnecessary or inappropriate services and supports.

(xiii) Document that any modification of the additional conditions, under paragraph (c)(4)(vi)(A) through (D) of this section, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

(A) Identify a specific and individualized assessed need.

(B) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

(C) Document less intrusive methods of meeting the need that have been tried but did not work.

(D) Include a clear description of the condition that is directly proportionate to the specific assessed need.

(E) Include a regular collection and review of data to measure the ongoing effectiveness of the modification.

(F) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

(G) Include informed consent of the individual.

(H) Include an assurance that interventions and supports will cause no harm to the individual.

Need for Expert Testimony

In professional negligence cases, such as medical malpractice lawsuits filed against physicians, the specific duty owed by the physician to the patient is defined by the profession itself. A member of the profession is needed to tell the judge and jury what the defending physician should have done or not done under the particular circumstances, and whether such conduct constituted negligence by violating the standards of care of the profession. Therefore, in medical malpractice litigation, expert witness testimony is nearly always necessary.

Beauparlant v Helderberg House (Albany County, Keegan, J.)

The Individual "Plan" of a Person with a Developmental Disability

As Effecting the Legal Standard of Care in Personal Injury Lawsuits

Written by Christopher R. Lyons, Esq.

NYSACRA

AIM SERVICES, INC.
The power of potential

The Individual "Plan" of a Person with a Developmental Disability As Effecting the Legal Standard of Care in Personal Injury Lawsuits

Most if not all jurisdictions have now developed statutory and regulatory schemes calling for the establishment of individual program plans ("IPP") by service providers for individuals with developmental disabilities. These written individualized plans are based upon appropriate and reliable professional assessments formulated in accordance with professional standards and arrived at in conjunction with the person served and other interested individuals including guardians and representatives. Often the plan is part of case management services provided to persons with disabilities and includes a diagnosis, an assessment of the individual's service needs, and individual service plan, an individual habilitation plan and methods for providing, evaluating and monitoring the services identified in the plan.

Without any particular focus on IPP's, tort lawsuits against service providers have centered on whether the facility met a particular standard of care. The standard of care has been compared to that of a provider of health services. As such, in order to be successful has been argued that a tort lawsuit must evidence a breach of an applicable standard of care with the concurrent injury to the person served and a causal connection between the breach and the person's injury. In medical malpractice cases for example, liability has been found if a physician owes the patient a duty of care, fails to meet the standard of care established by the profession and pertinent case law and negligently injures the patient. With the emerging importance of the IPP, it may be argued that a fact finder assessing breach of a standard of care owed by a provider of services to those with developmental disabilities must first look to the person's individual program plan before arriving at the appropriate standard of care.

Where a service provider is exposed to tort liability, the courts may define the facility's duty in terms of proper establishment of an individual program plan and the assurance that the services identified in the recipient's individual service plan have been delivered in accordance with the laws, rules and regulations governing the provision of those services and the specific determination of what services are appropriate.

One case illustrative of the above is Reasons v. State of Tennessee (1987 Tenn. App. Lexis 2919). In that case the claimant was a thirty-four year old "profoundly retarded" male who alleged that certain employees of the defendant, an intermediate care facility, were negligent in the care rendered to claimant. Specifically, the claimant alleged while eating food prepared at this center, he swallowed a bone that lodged in his esophagus, resulting in a esophageal perforation and infection.

The facts of the case revealed that specific persons served were designated as "charges" for a particular caregiver who had the responsibility of supervising his or her consumers during their meal time. The claimant grabbed a handful of sliced roast beef from the plate of another resident and proceeded to stuff it in his mouth, as a result of which he choked. (The connection between the roast beef and the retrieved bone was never formally resolved!)

The court determined that the plaintiff failed to establish by any proof that the defendant breached the standard of care. The court focused on a requirement that the staff at the defendant's facility develop an individual habitation plan for each resident. This included the ascertainment and establishment of the dietary need of each resident followed by individual observations by the staff. As developed, this claimant's diet plan called for a regular diet with triple portions. A regular diet did not include in its process an active overt screening of each and every meal served to petitioner and any other resident receiving a regular diet to eliminate

absolutely the presence of any bones from it. The court held that the claimant failed to establish that the defendant needed to remove all bones "from all food served to every profoundly retarded patient or resident". Indeed, the court went on to opine that the individual program plan was in keeping with the applicable guidelines that "residents at the center were to be 'normalized' ..." encouraging the patients to develop the best rhythm of life possible, and to do so to allow them to: carry out the customs and routines that are normal...[entitling consumers] the 'dignity of risks' [and] that in order to allow mentally retarded patients to develop their fullest capacity, they should be permitted to run the risk of danger or harm in progressing up the ladder of development.. (i4.).

Another case emblematic of the importance of the IPP in establishing a standard of care is Hunter v. Evergreen Presbyterian Vocational School et al., (338 So.2d 164 [Ct.App. Louisiana]). In that case, the consumer/decedent, was a ..moderately to severely retarded young man" who drowned in a pond on the defendant's premises. The consumer worked on the yard maintenance crew as part of his vocational training. Each work group had a staff supervisor. The supervisors, as a rule, did not stay continuously with the crews. At the time of the accident, the supervisor was away from the area near the pond where the consumers were working. While he was gone, the decedent consumer went into the pond apparently to retrieve a yard tool and drowned.

The court identified the principal issue in the case as to whether the standard of care owed by the defendant facility to the decedent consumer required continuous supervision throughout the day. The court held that the facility's duty to use reasonable care in this instance did not dictate continuous supervision. This was based on the defendant's policy to allow its consumers a certain amount of freedom consistent with their "mental capacities" which was "reasonable and necessary to accomplish [the facility's purposes]".

Significantly, the court found that it was "not shown that [the consumer] received continuous supervision at any time during his stay ... and [and that] during those three and one-half years, [the consumer] had given no indication that he was dangerous to himself". Noting that the consumer's only mishap came when he cut himself on the foot with a yard tool, the court found specifically that "this was not sufficient to give [the facility] notice that continuous supervision was necessary for [the consumer/decedent's] safety." Accordingly, the individual program plan developed for this consumer was determined to be appropriate and, based on same, the facility was not liable for the unfortunate death of the consumer.

Often the IPP is pivotal in establishing the standard of care applicable in medical care cases. In Canning v. Lensink, (1993 Conn. Super. Lexis 353), the plaintiff claimed that the defendant's negligence resulted from a departure from the accepted standard of care in like conditions for "a retarded individual who was admitted to the defendant facility for the purpose of respite care". In the Canning case the consumer/decedent died as a consequent of dehydration. There was a great deal of expert testimony that the defendant's own policy required sufficient admission information which was to be current and pre-forwarded to the respite coordinator. That specific information (which was included in the consumer's individual program plan) included known fluid and electrolyte problems in the past and hyper-irritability resulting from dehydration. The court found that the defendant breached the standard "to follow a patient, their symptomatology [and] write notes that can be used to follow the patient [and] to call other medical care and to get the patient to facility where that medical care can be delivered and to know when it is warranted." Based on the health information contained in the decedent/consumer's individual program plan, the facility was further found negligent in that the "care and treatment of [the decedent/consumer] was inappropriate, and that [the facility] breached

the standard of care properly to assess any health medical issue which would warrant continuing nursing observation during the [respite care]". In Canning the consumer's symptoms were ignorea and basic assessment including taking a temperature was not implemented. Accordingly, it can be argued that medical information contained in an individual program plan may also contribute to defining a particular standard of care. which a plaintiff in a tort case must establish and prove breached in order to successfully recover for personal injury.

Individual Program Plan standards have been generally defined as the exercise of reasonable care toward a consumer as the consumer's known condition may require (See e.g., Shackleford v. State of Louisiana DOR 534 So.2d 38 [1989]). In Shackleford. the consumer was kept in a "cottage" with older and larger consumers despite knowledge of repeated injury. The plaintiffs condition (21 year-old severely MR.) and the facts and circumstances peculiar and applicable to plaintiff (history of self injury and violence) were the specific basis for finding liability. The case supports the proposition that all the circumstances known considering an individual's needs and propensities, as determined by the plan, will be considered in determining a breach or compliance with a particular standard of care.

This is not to say, however, that an individual program plan, nor rules, regulations or policies, in themselves establish a standard of care. (See. Darling v. Charleston Community Memorial Hospital, 33 lli.2d 326, 332, 211 N.E.2d 253 (1965), cert. denied, 383 U.S. 946, 86 S. Ct. 1204, 16 L. Ed. 2d 209 (1966); Williams v. St. Claire Medical Center. 657 S.W.2d 590, 594-95 (Ky. App. 1983); Bly v. Rhoads, 216 Va. 645, 653, 222 S.E.2d 783 (1976). In most jurisdictions, the failure to follow an IPP or such rules and regulations is merely evidence, of negligence not negligence per se. (See e.g., Ziegert v. South Chicago Community Hospital. 99 Til. App.3d 83, 97-99, 425 N.E.2d 450 {1981); Boland v. Garber. 257 N.W.2d 384; 385-87

(Minn. 1977); Foley v. Bishop Clarkson Memorial Hospital 185 Neb. 89, 93, 173 N.W.2d 881 (1970).

Nor does a spontaneous act, not specifically anticipated in a consumer's IPP," attach liability to a service provider. In Johnson v. Department of MR&DD, (35 Ohio Misc.2d 18), the consumer, through his guardian, alleged, that while the consumer was an in-patient at the defendant's disabilities facility, the consumer was "negligently caused, permitted or allowed to receive personal injury and great pain and suffering". The consumer was a sixty-six year old "profoundly retarded male" who resided at a cottage, part of the defendant's overall facility. One evening a caregiver was assisting another consumer in the cottage about thirty feet away from the plaintiff when he was summoned by one of the other consumers to the doorway. He found the plaintiff prostrate with a cut over both eyes and bleeding. It was later learned that the injury was caused by the "unsupervised violent actions of another client". The facility argued that they had not known the other consumer to be abusive and that, although they acknowledged that there were occasionally aggressive consumers on the premises, there were no known aggressive consumers then in the cottage.

The court found that the plaintiff failed to provide expert testimony that the facility should have foreseen the attack or that the plaintiff himself required twenty-four hour attention. A care giver was within thirty feet of the consumer when the accident happened, a sufficient showing that the facility provided the standard of care required.

The above cases illustrate the importance of both establishing and implementing an appropriate individual program plan for each individual consumer and reviewing the plan at the time that a potential loss occurs which may give rise to a lawsuit. As the courts lend credence to the proposition that the standard of care should focus on the individual program plan, the need to

assess the plan becomes more and more important in loss prevention and strategic tort defensive strategies.

Christopher R. Lyons, National Counsel
Developmental Disabilities Program
CNA Commercial Insurance

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The OPWDD Service Delivery System

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Building The Framework For IDD Quality Measures

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Institute on Public Policy for People with Disabilities

MOSAIC

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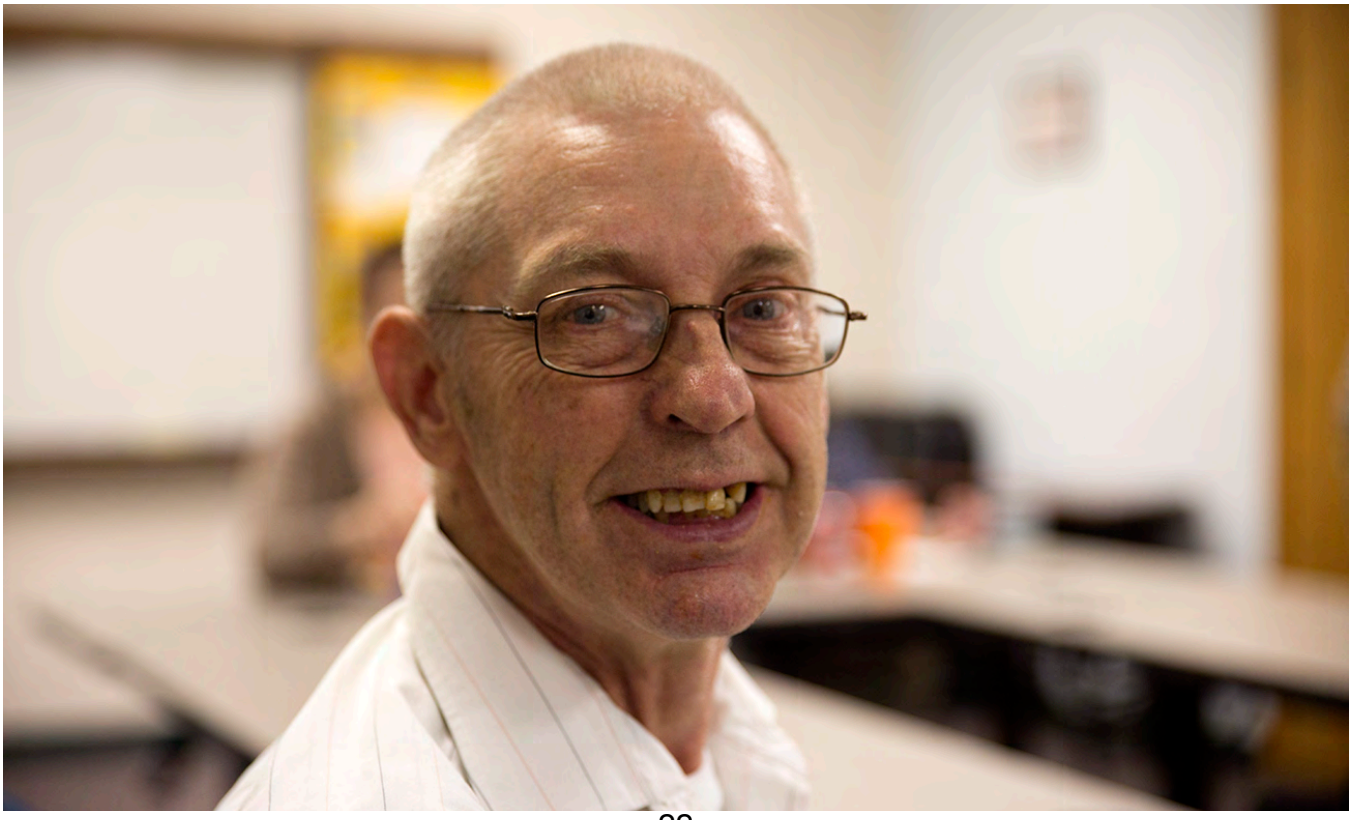

EXECUTIVE SUMMARY

Medicaid managed care is a rapidly growing service delivery model in the United States. The aim of Medicaid managed care is to reduce program costs and provide better utilization of health services through the contracting of managed care organizations (MCOs). While Medicaid managed care has existed for almost two decades, it has yet to be frequently used for long-term services and supports (LTSS) for people with intellectual and developmental disabilities (IDD). As utilization of managed care for people with IDD is low, there is little research about what standards should be used for traditional as well as alternative payment models such as value-based reimbursement models. For these reasons, and because there is beginning to be an expansion of Medicaid managed care into the IDD LTSS system, evidenced-based quality standards and guidelines about managed care provision for people with IDD are more critical than ever.

In October 2018, CQL | The Council on Quality and Leadership (CQL), The Institute on Public Policy for People with Disabilities, and Mosaic organized a symposium with approximately 25 thought leaders in the healthcare and LTSS industry – the stakeholders represented service providers, industry associations, managed care organizations, and other key leaders. The symposium was designed to develop a common understanding of value-based quality measures for people with IDD to ensure that as the industry moves to managed care, the quality metrics utilized are meaningful for people with IDD.

This report is a result of this symposium; what follows is a summary of those findings – a roadmap for the key measures which would support people with IDD to receive high quality services and supports. While we recognize much more work is necessary for evidenced-based standards and guidelines about managed care provision for people with IDD, this report serves as one of many first steps towards quality value-based service provision for people with IDD.

Findings from our data analysis of 28 service agencies who support approximately 3,000 people with IDD revealed that while traditional measures of health are important, many other factors play a role in quality services and supports, and quality of life. As indicated in the findings, respect, meaningful days, staff training, and many more social determinants have an impact on hospitalizations, injuries, medication errors, and behavioral issues.

Findings from our focus groups with thought leaders also indicated that although health and safety are foundational building blocks, they are not enough — it is important to ensure people with IDD have meaningful lives. Informed choice, person-centered practices, goals, community living, meaningful days, relationships, dignity and respect, continuity and security, and access to technology were all described as key components of quality. Building quality frameworks demands the creation of quality standards based on evidenced-based best practices. There also needs to be a recognition that quality is an investment. Finally, quality frameworks require a cultural change to person-centered services, not only in systems but in practice.

INTRODUCTION

For many providers and funders in human services, the lack of measurement and evaluative methods is top of mind. Also, as the transition to more managed care long-term services occurs, experts are identifying this gap as a top priority. This is a complex issue and as such, insight from a diverse set of stakeholders from a range of perspectives is critical.

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BACKGROUND



People with IDD have significantly poorer health and shorter life expectancies than the general population (O'Leary, Cooper, & Hughes-McCormack, 2017; Ouellette-Kuntz, 2005). This includes increased prevalence of cardiovascular disease, obesity, hypertension, osteoporosis, and poor oral health compared to nondisabled people (Haveman et al., 2010). People with IDD also tend to experience age related health conditions earlier and more rapidly than nondisabled people (Evenhuis, Hermans, Hilgenkamp, Bastiaanse, & Echteld, 2012; Glasson, Dye, & Bittles, 2014; Nochajski, 2000; World Health Organization, 2001). Their higher rates of chronic health conditions are due to genetics, social circumstances, environmental conditions, and access to health care services (Bittles et al., 2002; Krahn, Hammond, & Turner, 2006; Ouellette-Kuntz, 2005; Taggart & Cousins, 2014). Moreover, people with IDD's health disparities are often exacerbated by other key social determinants of health, such as poverty and social exclusion (Ouellette-Kuntz, 2005).

Research details, however, that commitment from stakeholders, especially service organizations and their staff, can serve as a significant facilitator (or barrier) to the success of health initiatives for people with IDD. In fact, research has found organizational supports can play a key role in promoting the health of people with IDD (Friedman, Rizzolo, & Spassiani, 2017a). People with IDD are approximately 13 times more likely to have best possible health outcomes present when organizational supports are in place (Friedman et al., 2017a). Moreover, when organizational supports are in place, people with IDD are not only more likely to have an active role in their health, but their health interventions are also more likely to be effective (Friedman et al., 2017a).

The quality of supports people with IDD receive, and by extension their health and quality of life, is also largely influenced by the government services they receive. Long-term services and supports (LTSS) are community or facility based services for people who need support to care for themselves because of disability, age, or functional limitations. The majority of government spending (federal, state, and local) for people with IDD is through Medicaid (e.g., $49.4 billion in fiscal year (FY) 2015) (Braddock, Hemp, Tanis, Wu, & Haffer, 2017). During the Great Recession (2007-2009) more people were relying on Medicaid because of unemployment, resulting in a drop in the proportion of total federal Medicaid spending going towards people with IDD (Braddock et al., 2015). In wake of

recovery from the Great Recession, states' allocation toward community supports and institutional care increased (Braddock et al., 2015; Friedman, 2017). However, there continues to be large waiting lists for services, as well as an unstable direct support professional (DSP) workforce (Bogenschutz, Hewitt, Nord, & Hepperlen, 2014; Hasan, 2013; Hewitt & Larson, 2007; Hewitt et al., 2008; Larson et al., 2016; Micke, 2015; Taylor, 2008). In 2013, approximately 233,000 people with IDD across the nation were waiting for Medicaid LTSS (Larson et al., 2016).

As states are grappling with a reduced fiscal landscape, Medicaid managed care is a rapidly growing service delivery model has become the United States (Williamson et al., 2017). The Centers for Medicare and Medicaid Services (CMS) explain, Medicaid "managed care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services" (Centers for Medicare and Medicaid, n.d.). The aim of Medicaid managed care is to reduce program costs and provide better utilization of health services through the contracting of MCOs.

As of July 2014, 55 million people in the United States were enrolled in managed care (Centers for Medicare and Medicaid, n.d.). Yet, there is conflicting research about the benefits of managed care for people with disabilities in the United States, particularly regarding the cost effectiveness and quality (Bindman, Chattopadhyay, Osmond, Huen, & Bacchetti, 2004; Burns, 2009a, 2009b; Caswell & Long, 2015; Coughlin, Long, & Graves, 2008; Duggan & Hayford, 2013; Premo, Kailes, Schwier, & Richards, 2003; Wegman et al., 2015; Williamson, Fitzgerald, Acosta, & Massey, 2013; Williamson, 2015; Williamson et al., 2017).

Moreover, while Medicaid managed care has existed for almost two decades, it has also yet to be frequently used for LTSS for people with IDD (Burns, 2009a). As utilization of managed care for people with IDD is low, there is little research about what quality standards should be used for value-based payments for the LTSS of people with IDD. The fact that such Medicaid managed care for people with IDD is understudied and, as a result, may be implemented without an appropriate evidence-base, is particularly concerning given "the health and quality of life of persons with disabilities is particularly sensitive to the accessibility of their health care" (Burns, 2009a, p. 1521).

For example, one study found people who receive support from MCOs are less likely to have opportunities to self-manage their health, which in turn results in less effective health interventions (Friedman, Rizzolo, & Spassiani, 2017b).

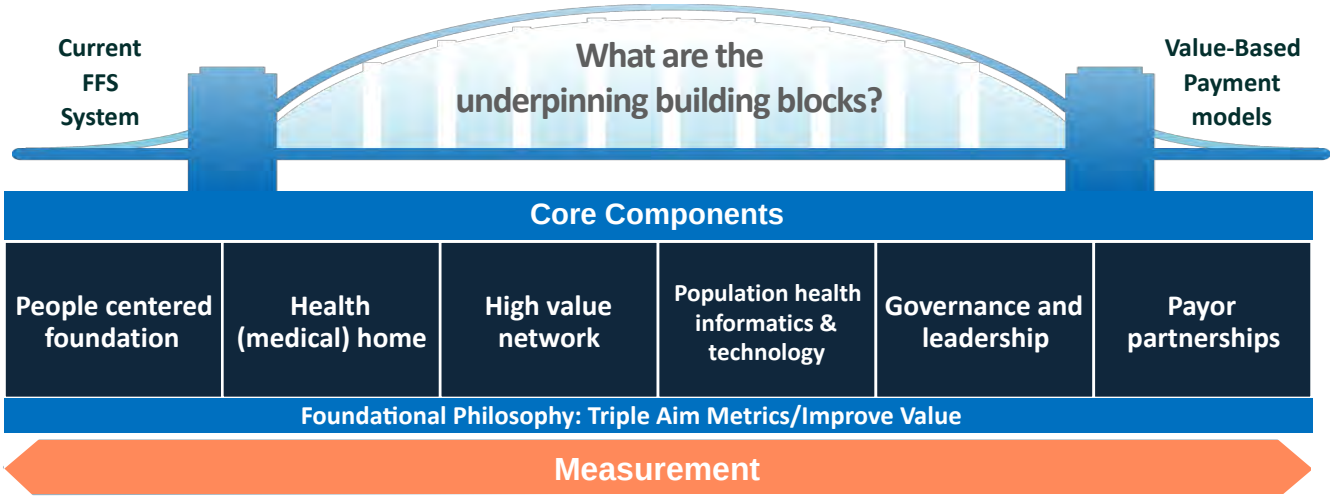
People with IDD are a unique population that, in many instances, require a different set of services and supports than nondisabled people or even people with other types of disabilities. For example, Medicaid LTSS for people with IDD frequently includes unique services such as residential habilitation, personal care, supported employment, and transportation (Braddock et al., 2015; Friedman, 2017; Friedman & Rizzolo, 2016, 2017; Rizzolo, Friedman, Lulinski-Norris, & Braddock, 2013). As such, "scholars caution against generalizing from such research to a population with a substantially different health profile" (Burns, 2009a, p. 1521; Currie & Fahr, 2005; Rowland, Rosenbaum, Simon, & Chait, 1995; Sisk et al., 1996). For these reasons, and because there is beginning to be an expansion of Medicaid managed care into the IDD LTSS system, evidenced-based standards and guidelines about managed care provision for people with IDD are more critical than ever.

THE BROAD PUSH FOR VALUE-BASED THINKING

Summary of a presentation by Andy Edeburn, Premier

Value-based services are an effort to shift away from traditional fee-for-service services, which are based on the *number* of services provided, to services that promote quality. Value-based thinking recognizes that emphasis on quality ultimately results in reduced health care costs.

The aim of healthcare today includes not only smarter spending (i.e., lower healthcare costs), but also better care – improved quality and satisfaction – and healthier people – improved health outcomes of populations (Institute for Healthcare Improvement, n.d.). As such, value-based thinking represents a cultural shift towards person-centered thinking.



Source: Premier.

While the majority of the current service system still functions under a fee-for-service model, there is bipartisan support to move away from fee-for-service, towards value. With these changes to Medicare and Medicaid, providers, not payers, will be increasingly held accountable for cost and outcomes. Moreover, commercial payers and managed care organizations are incentivized to follow Medicare's payment and quality models. As a result of these changes, there is an increased alignment between health systems, community resources, and "non-traditional" partners.

Value-based thinking incentivizes quality; leads opportunities to define what "quality" is and what it should mean. Yet, in the current system the majority of "health outcomes" are from traditional metrics, such as hospitalization rates or obesity rates. Successful quality metrics necessitate a shift toward inclusion of social determinants as well. As a result, data insights, analytics, exchange and innovation, are keys to future success and relevance.

LOOKING ACROSS THE INDUSTRY: WHAT STATES ARE THINKING

Summary of a presentation by Stacy DiStefano, *OPEN MINDS*

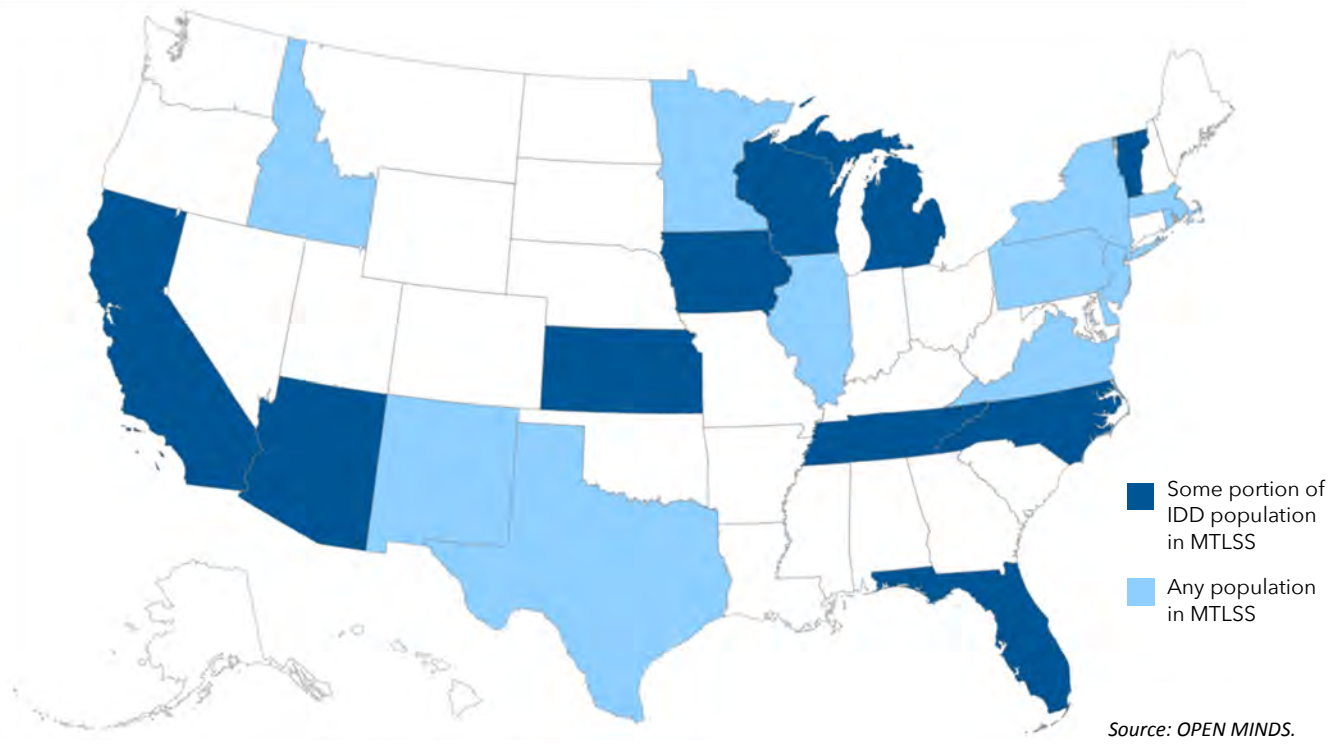
Approximately 1.5% of the United States population has IDD and public spending on people with IDD has increased (15% between 2006 and 2017 (Braddock et al., 2017)). More people with IDD than ever before are living in the community compared to institutional settings (Braddock et al., 2017), however, there is a shortage of home and community-based options due to long waiting lists, budgetary issues, a lack of housing, workforce issues, and caregiver stress.

The market for IDD services is also currently being shaped by a number of factors:

- "Pending 'block grant' and 'state discretion' models for use of federal funding;
- Increase in community-based care and changing CMS rules for home and community-based waivers;
- More long-term care services moving to managed care and competitive purchasing models—including IDD services;
- States struggling to address high service costs against budget constraints – leading to waiver waiting lists;
- New assistive technologies and remote monitoring for supporting people in the community; and,
- New organizations entering the market – both private equity-backed start-ups and extensions of multi-state non-profits."

As a result of all of these factors, reimbursement models are changing, with many provider organizations currently receiving value-based revenue.

Figure 1. States that include IDD in Medicaid Managed Long Term Services and Supports* (2017)



Source: OPEN MINDS.

Currently, 10 states include at least some portion of the IDD population in their Medicaid managed long term services and supports (MLTSS) (see Figure 1).

OPEN MINDS believes value-based reimbursement is here to stay because "of political and competitive pressure on payers, federal government, and employers, downward price pressure on health plans, the success of 'some' Accountable Care Organizations (ACOs), the early findings of the Medicare bundled rate initiative, and pressure on health plan medical loss ratios."

Managed care is likely to result in a number of changes, including "managing the Home and Community-Based Services (HCBS) program, 'service plans' created in conjunction with the managing entity, care coordination and service planning 'integration' (e.g., LTSS, medical, pharmacy, behavioral, social services), and value-based reimbursement models, which favor 'integration' across specialties and levels of care."

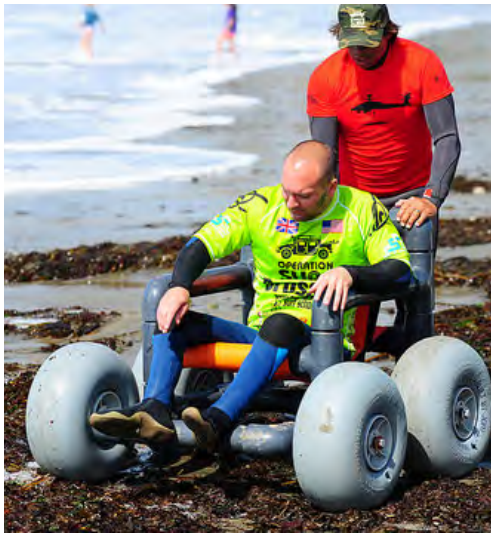
Moving from fee-for-service to managed value-based reimbursement, can result in a greater focus on outcomes, a greater data-driven culture, and a more effective implementation of technology.

Future sustainability of value-based reimbursement requires "understanding what consumers want, what payers (and their health plans) will pay for," what 'value' is, "how system restructuring will change competitive advantage, and how technology will change the 'value proposition'."

**States vary in MTLSS models and services included under managed care.*

SOCIAL DETERMINANTS OF HEALTH

Social determinants of health are conditions, environments, and settings that impact not only health but also overall quality of life. "By working to establish policies that positively influence social and economic conditions and those that support changes in individual behavior, we can improve health for large numbers of people in ways that can be sustained over time. Improving the conditions in which we live, learn, work, and play and the quality of our relationships will create a healthier population, society, and workforce" (United States Office of Disease Prevention and Health Promotion, n.d.). Social determinants of health are critical for health equity.



Social Determinants of Health Index

At CQL, we recently developed a new way of measuring social determinants of health. In order to create the measurement tool we cross-walked the *Healthy People 2020* Social Determinants of Health framework (United States Office of Disease Prevention and Health Promotion, n.d.) with the Personal Outcome Measures®.

The Personal Outcome Measures® was developed to comprehensively measure quality of life of people with disabilities while also paying attention to the key role organizational support can play in improving individual outcomes. Unlike other quality of life measures that are based on organizational standards, the Personal Outcome Measures® focuses on a person-centered definition of quality of life, including choice, self-advocacy, self-determination, and community inclusion. The Personal Outcome Measures® has been continually refined through initial pilot testing, 25 years of administration, research and content experts, a Delphi survey, and feedback from advisory groups. The current version of the Personal Outcome Measures® includes 21 indicators divided into five factors: my human security; my community; my relationships; my choice; and, my goals.

For the Social Determinants of Health Index, we selected

Personal Outcome Measures® indicators that conceptually fit into the following five *Healthy People 2020* Social Determinants of Health categories:

- Economic stability;
- Education;
- Social and community context;
- Health and health care; and,
- Neighborhood and built environment (United States Office of Disease Prevention and Health Promotion, n.d.)

We then ran an exploratory factor analysis (EFA) with promax rotation of Personal Outcome Measures® interviews with approximately 1,078 people with disabilities (conducted by certified reliable interviewers) from 2017 (Friedman, 2018). The findings of the EFA revealed the CQL Social Determinants of Health Index is comprised of three factors (see below).

The CQL Social Determinants of Health Index Factors

• People interact with other members of the community • People participate in the life of the community • People perform different social roles • People choose where to work • People choose where and with whom to live	• People exercise rights • People are treated fairly • People are respected • People experience continuity and security	• People have the best possible health • People are safe

Table 1 presents the means for each of the three factors. The average person had 50% of the social determinants present in their life. As indicated by the index, people with IDD frequently score higher on health and safety, compared to choice and engagement, or person-centeredness.

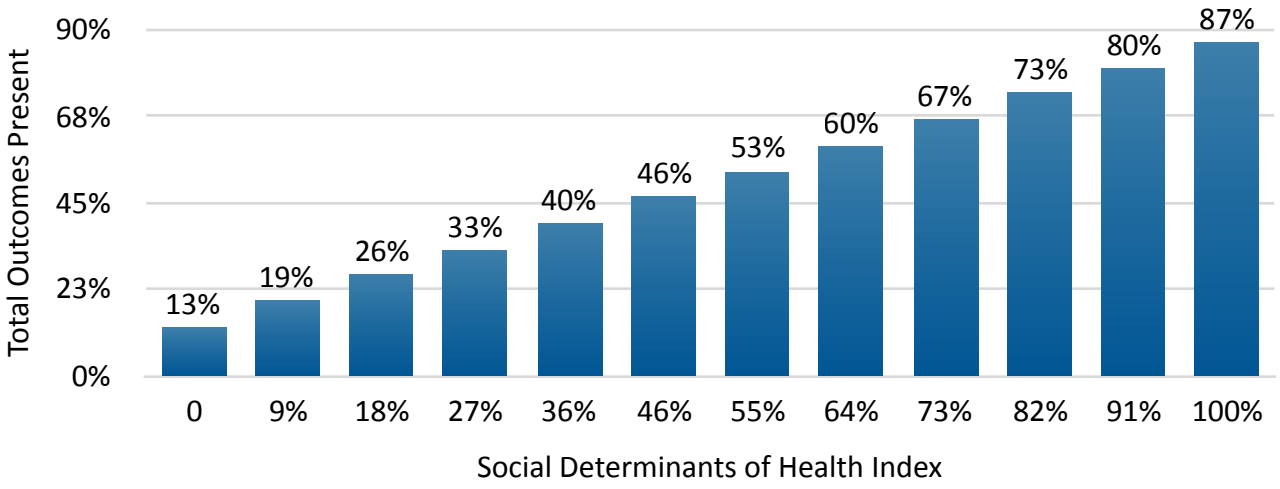
Table 1. Social Determinants of Health Index Factor Means (*n* = 1,078)

	M	SD
Factor 1: Choice and engagement	0.40	0.33
Factor 2: Person-centeredness	0.50	0.38
Factor 3: Health and safety	0.69	0.35
TOTAL	*0.50*	*0.28*

The Impact of Social Determinants of Health on Overall Quality of Life

We ran a linear regression model to explore the relationship between the social determinants of health and overall total personal quality of life outcomes and there was a significant relationship (F (1,1042) = 1781.43, p < .001, R^2 = .79), indicating the higher people scored on the social determinants of health index, the more quality of life outcomes they had present.

Figure 2. Relationship between Social Determinants of Health & Personal Outcomes

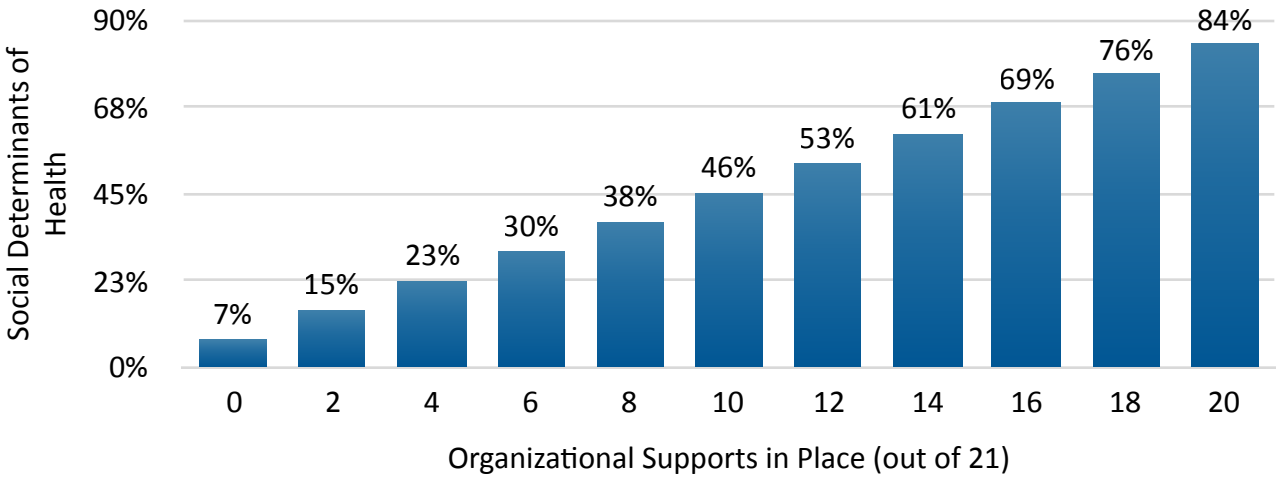


For example, a person that scores 50% on the Social Determinants of Health Index is expected to have half, or 50%, of their quality of life outcomes present. Whereas a person who scores 100% on the Social Determinants of Health Index is expected to have almost 90% of outcomes present – a significantly higher quality of life.

The Impact of Organizational Supports on Social Determinants of Health

As we found that social determinants of health are important to quality of life, we next explored how social determinants can be facilitated. To do so, we looked at the relationship between organizational supports and social determinants of health using a linear regression model. These include supports to facilitate personal outcomes around health, safety, choices, and many more. Findings revealed the more organizational supports people receive, the significantly higher their social determinants of health (F (1, 1029) = 2344.29, p < .001, R^2 = 0.83).

Figure 3. Impact of Organizational Support on Social Determinants of Health



For example, a person who has 8 out of the 21 organizational supports in place is expected to score 38% on the Social Determinants of Health Index, whereas a person who receives 16 out of the 21 organizational supports is expected to score 69% on the Social Determinants of Health Index.

Value Metrics

While the Social Determinants of Health Index examines social determinants at the individual level, as organizations play a key role in facilitating social determinants and quality of life, it is important to also examine metrics at the organizational level. To do so, we analyzed data from 28 organizations using the Basic Assurances® tool and their impact on other health metrics.

The Basic Assurances® tool is an organizational assessment that ensures accountabilities for health, safety, and human security within service provider organizations. The application of the Basic Assurances® involves two broad evaluation strategies – evaluation of both the system and the organizational practice. Policies and other systems are important for sustainability and consistency over time, but the actual practice of the policy at the organization level is critical to quality services. The *Basic Assurances®* contains 10 Factors, 46 Indicators, and over 300 quality probes (or sub-indicators).

This analysis is the result of a partnership with Mosaic, a faith-based organization with agencies across the United States. Mosaic provided CQL with de-identified data about the Basic Assurances®, health metrics, and incident reports from FY 2016 to 2018, and CQL independently conducted all analyses. This pilot is comprised of data from 28 service agencies who supported a total of 2,955 people with IDD.

The following variables were used as dependent variables (DVs) for the analyses:

- *Hospitalizations data*: every visit to the hospital, regardless of whether people were admitted or not.
- *Appointments*: any type of medical appointment, ranging from family medicine to specialists; this included psychiatric appointments as well.
- *Medication errors*: documentation of every time there was a medication error, regardless of the reason.
- *Injuries documented*: any type of injury event (e.g., redness, bruising, bleeding, lesions, unknown origin, etc.).
- *Behavioral issues*: all behavioral events or issues.

For all analyses, we controlled for agency size (the number of people the agency supported); because of collinearity, agency size was built into the DVs, resulting in the DVs all becoming 'rates' – the number of events per every one person the agency supported. For example, the hospitalization rate was the number of hospital visits for every one person the agency supported.

To examine differences in the DVs depending on each individual Basic Assurances® indicator, Mann-Whitney U was utilized. One-sided *p* values (exact) were utilized. Each model had a built-in control for organization size to minimize issues of collinearity. Below we present a snapshot of the significant findings. Statistics are presented in the Appendix.

Hospitalization Rates

Findings revealed, organizations that had systems in place around respecting people's concerns and responding accordingly, had significantly lower hospitalization rates (see Figure 4). When they did so, they had a hospitalization rate of 1.03 for every one person they served (over a three year period) versus 2.57 for when they did not have organizational systems in place promoting respect of people's concerns. For example, in an organization that supports 500 people, hospitalizations would be expected to drop from 1,285 (for a three year period) to 515 when organizations respect people's concerns.

Figure 4. The Organization Respects People's Concerns and Responds Accordingly (Systems)

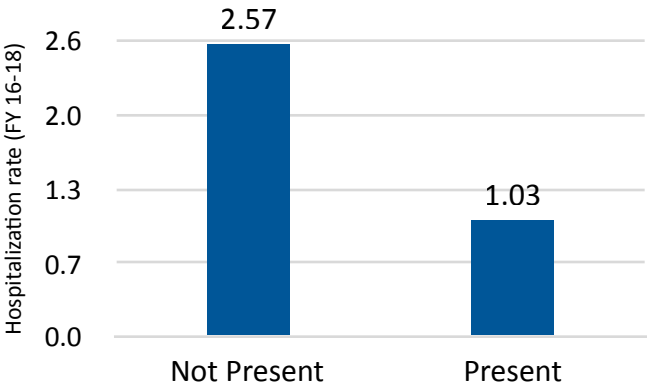
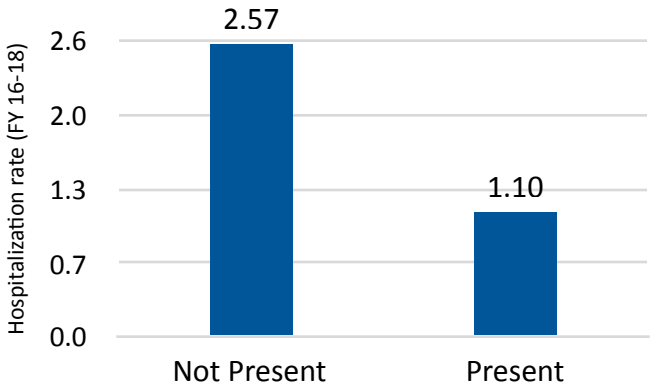


Figure 5. Supports and Services Enhance Dignity and Respect (Systems)



Respect was actually a common theme across these analyses. Figure 5 presents another example. When systems were in place to enhance services and supports that promote dignity and respect, agencies also had significantly lower hospitalization rates. When organizations put systems in place to ensure people had meaningful work and activity choices – they had a "meaningful day" – hospitalization rates were significantly lower, at 0.65 per person supported over a three year period versus 1.74 per person supported (Figure 6).

Natural supports also resulted in lower hospitalization rates (Figure 7). When organizations facilitated each person's desires for natural supports, there were lower hospitalization rates. When organizations had systems in place addressing individualized emergency plans, the hospitalization rate was 1.03 over a three year period, compared to 2.35 for when they did not have a system of individualized emergency plan in place (Figure 8).

Figure 6. People Have Meaningful Work And Activity Choices (Systems)

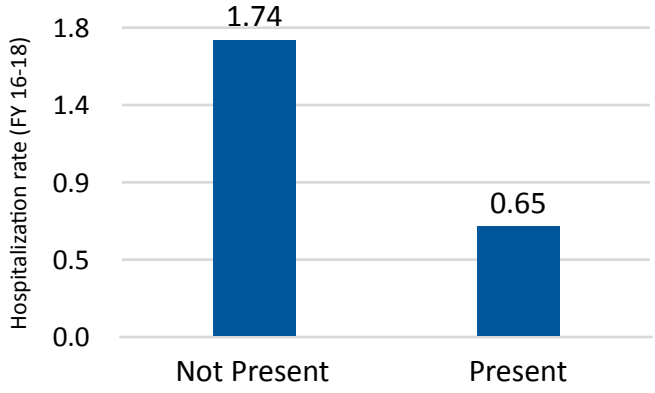
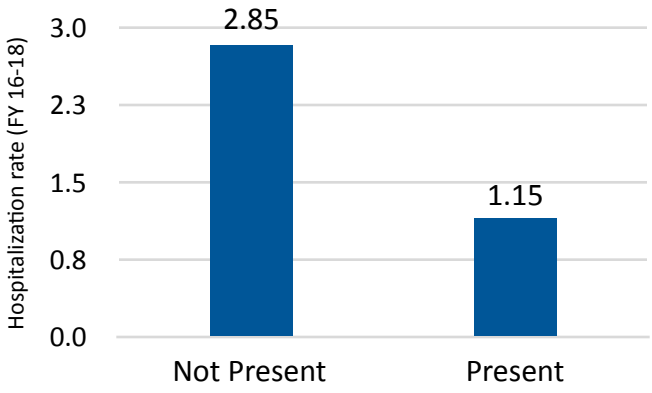


Figure 7. The Organization Facilitates Each Person's Desire For Natural Supports (Systems)



When organizations treated people with psychoactive medications for mental health needs *consistent with* national standards of care, hospitalization rates were lower (Figure 9).

Figure 8. The Organization Has Individualized Emergency Plans (Systems)

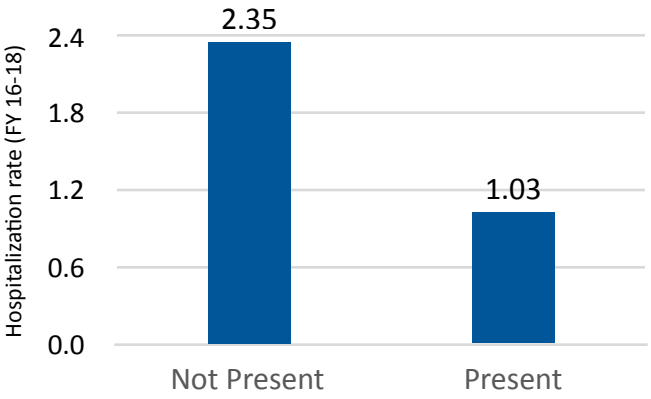
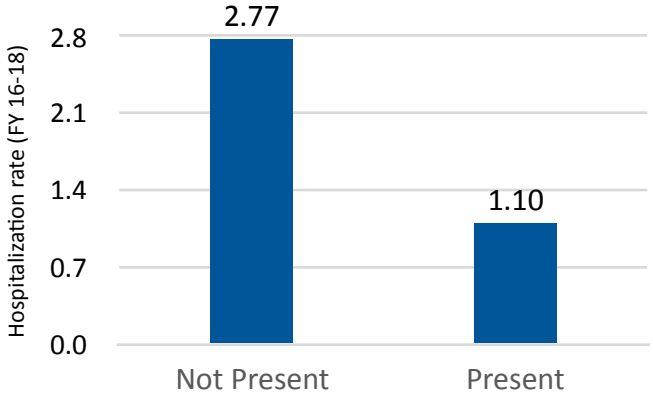


Figure 9. The Organization Treats People With Psychoactive Medications For Mental Health Needs Consistent With National Standards Of Care. (Practice)



Appointment Rates

We also examined differences in appointment rates. When organizations had systems in place to ensure people were free from abuse, neglect, mistreatment, and exploitation, the medical appointments rate was cut in half (Figure 10). But perhaps a bit less immediately obvious, when organizations had systems in place to implement ongoing staff development, there were also significantly fewer appointments (Figure 11).

Figure 10. People Are Free From Abuse, Neglect, Mistreatment And Exploitation (System)

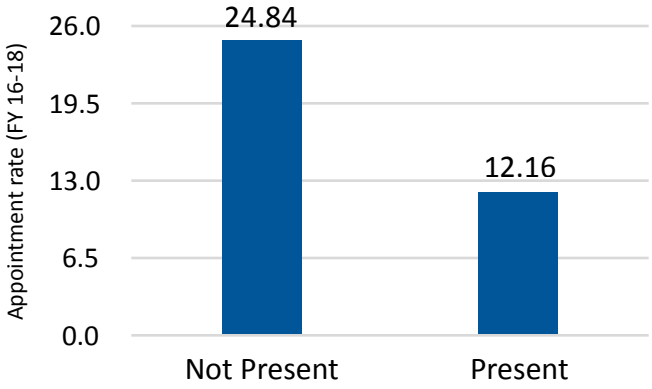
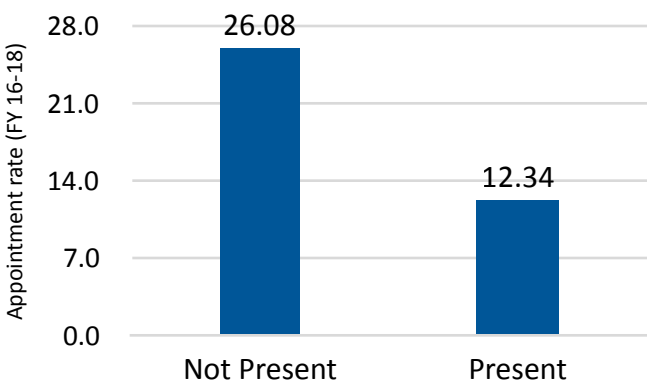


Figure 11. The Organization Implements An Ongoing Staff Development Program (System)



Medication Errors Rates

Medication errors are a significant concern for service organizations. When organizations treated people with psychoactive medications for mental health needs consistent with national standards of practice there were fewer medication errors (see Figure 12). When agencies treated people consistent with national standards of care, there were 3.13 medication errors for every one person they supported over the three year period, versus when they did not there were 14.92 for every one

person they supported. Also when people were free from unnecessary intrusive interventions, there were significantly fewer medication errors (Figure 13).

Figure 12. The Organization Treats People With Psychoactive Medications For Mental Health Needs Consistent With National Standards Of Care (Practice)

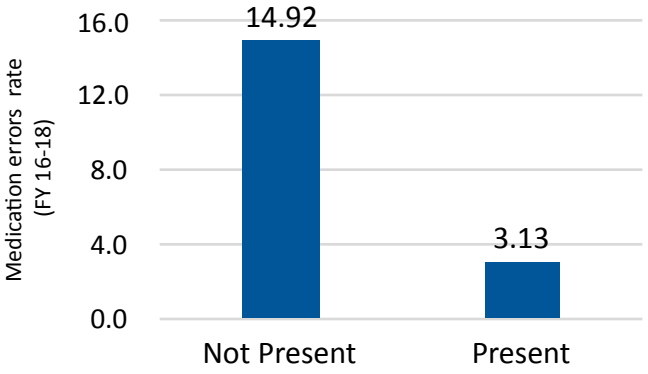
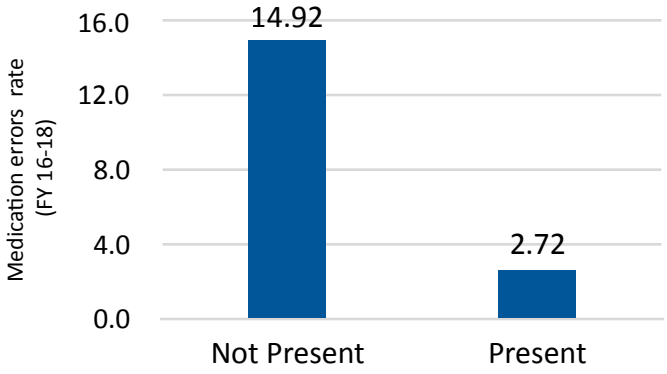


Figure 13. People Are Free From Unnecessary, Intrusive Interventions (Practice)



Injury Rates

Another variable we looked at was injuries. Analyses revealed dignity and respect was yet again a critical component. When organizations had practices in place to respect people's concerns and respond to them accordingly, the injuries rate of the people they supported was significantly lower (Figure 14). When agencies did not respect people's concerns, there was a rate of 12.61 injuries for every one person they supported over the 3 year period, whereas when they did respect people's concerns it dropped significantly to 5.85 injuries per person they supported. Similarly, when supports and services enhanced dignity and respect, the injury rate dropped from 12.77 to 5.98 (Figure 15).

Figure 14. The Organization Respects People's Concerns and Responds Accordingly (Practice)

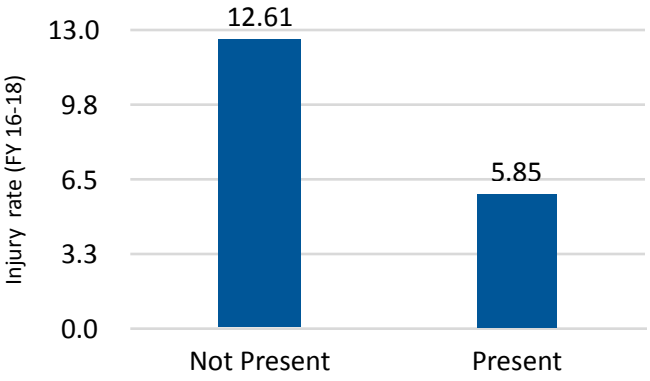
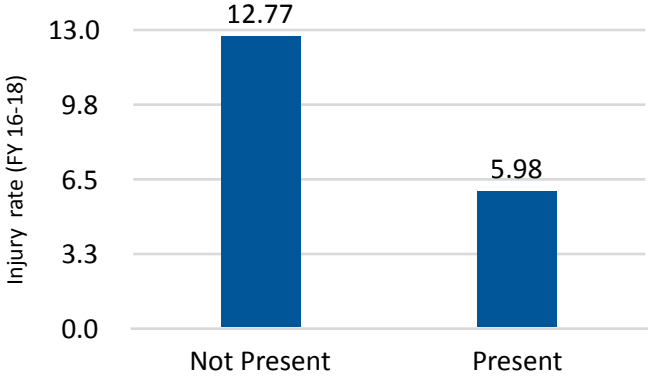


Figure 15. Supports and Services Enhance Dignity and Respect (Practice)



When systems were in place to ensure people have meaningful work and activity choices, the injury rate dropped from 9.38 for every one person over the three year period served to 3.02 (Figure 16).

When organizations had systems in place to facilitate each person's desire for natural supports, the injury rate was significantly lower (Figure 17). For example, for an organization that serves 500

people, the number of injuries is expected to goes down from 9,600 to 3,100 over a three year period when the organization facilitates each person's desires for natural supports.

Figure 16. People Have Meaningful Work And Activity Choices (System)

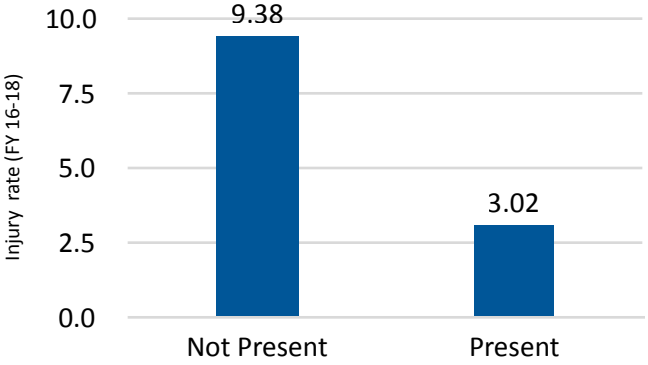
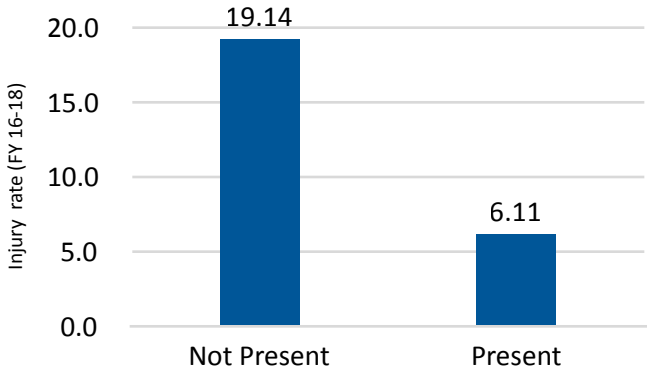


Figure 17. The Organization Facilitates Each Person's Desire For Natural Supports (Systems)



Behavioral Issues Rates

In terms of behavioral issues, when organizations respected people's concerns and responded accordingly, the behavioral issues rate dropped from 11.07 to 2.70 per person served for a three year period (Figure 18). Similar results were found when people had meaningful work and activity choices – when organizations ensured people had meaningful days – there were significantly fewer behavioral issues (Figure 19).

Figure 18. The Organization Respects People's Concerns and Responds Accordingly (Practice)

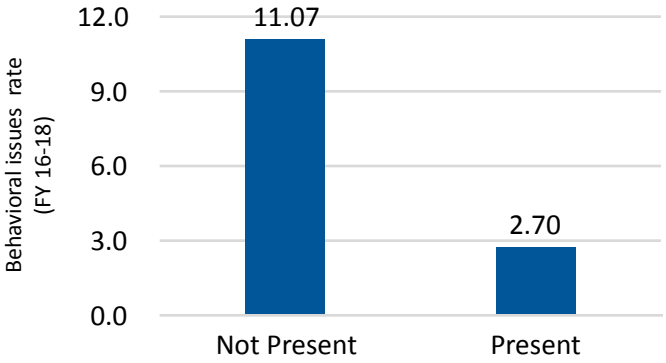


Figure 19. People Have Meaningful Work and Activity Choices (Practice)

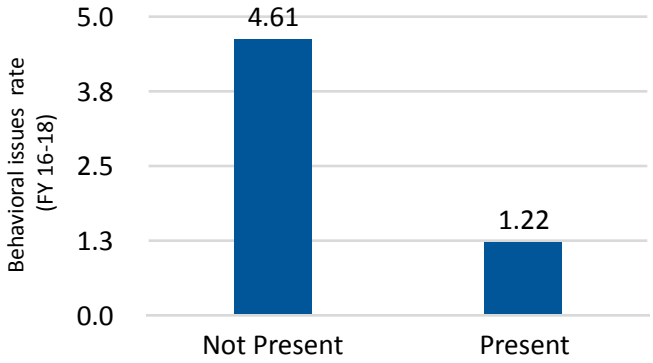
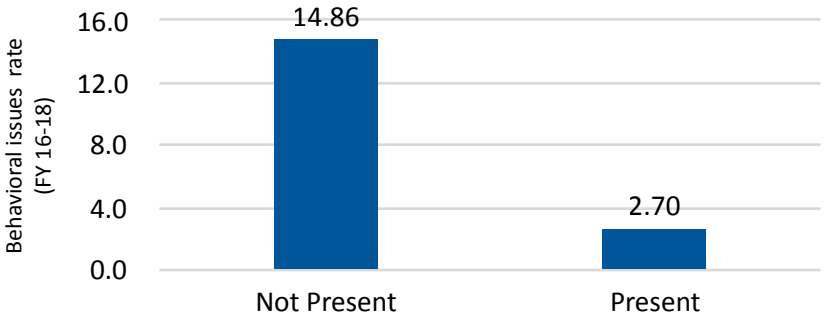


Figure 20. The Organization Ensures Thorough, Appropriate, & Prompt Responses To Substantiated Cases of Abuse, Neglect, Mistreatment and Exploitation (Practice)



When organizations ensured thorough, appropriate, and prompt responses to substantiated cases of abuse, neglect, mistreatment and exploitation, and to other associated issues identified in the investigation, the behavioral issues rate dropped from 14.86 for every 1 person served (over a three year period), to 2.70 for every 1 person served (Figure 20).

Most of the findings have examined how how different ways organizations support people with IDD can impact health, but there were additional findings related to the ways agencies treated their staff. When organizations implemented ongoing staff development programs, the behavioral issues rate amongst the people they supported dropped significantly from 14.86 to 1.97 over the three year period (Figure 21). Similarly, when organizations treated their employees with dignity, respect, and fairness, the behavioral issues rate dropped from 11.58 to 1.97 over the three year period (Figure 22). For example, an organization that serves 500 people which does not treat their employees with dignity and respect is expected to have 5,800 behavioral issues over a three year period, whereas if they do treat their employees with dignity and respect the number is projected to drop to less than 1,000 behavioral issues, indicating the way staff are trained and treated trickles down to the behaviors of the people supported.

Figure 21. The Organization Implements An Ongoing Staff Development Program (Practice)

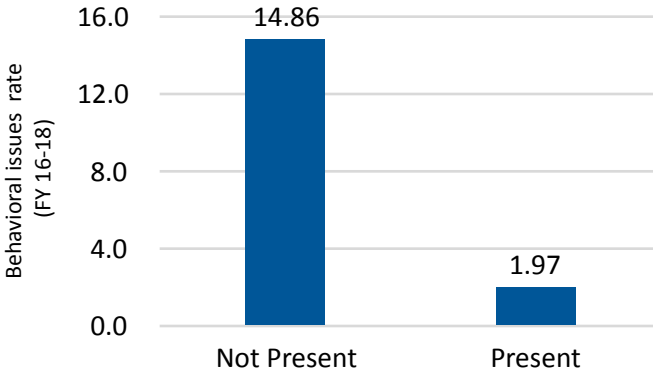
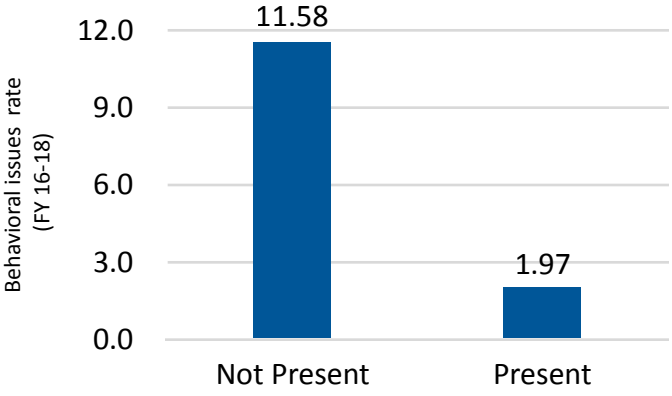


Figure 22. The Organization Treats Its Employees With Dignity, Respect And Fairness (Practice)



When organizations provided continuous and consistent services and supports for each person, the behavioral issues rate dropped from 18.61 to 2.46 per person served over the three year period (Figure 23).

Figure 23. The Organization Provides Continuous and Consistent Services and Supports For Each Person. (Practice)

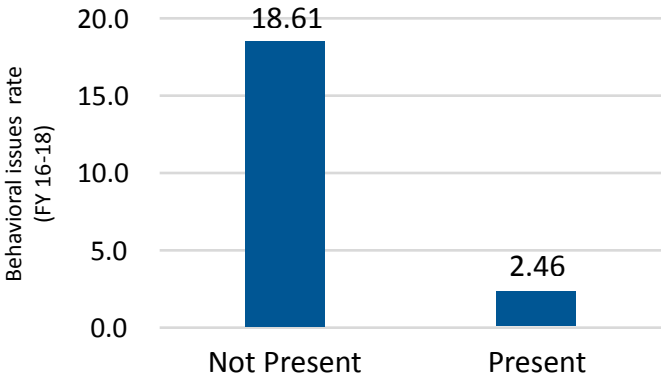
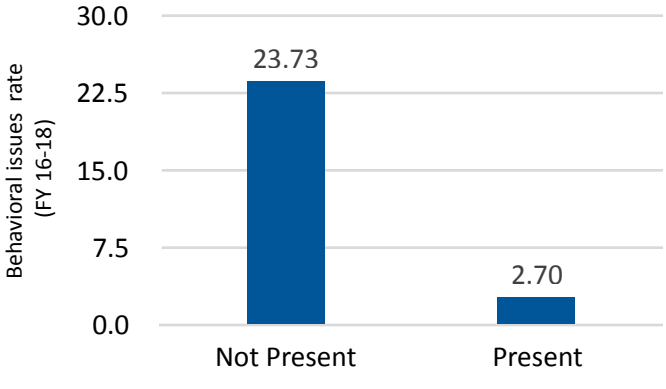


Figure 24. People Are Free From Unnecessary, Intrusive Interventions (System)



When organizations had systems in place and they were put into practice, to ensure people were free from unnecessary intrusive interventions, the behavioral issues rate dropped from 23.73 for every one person supported over the three year period to 2.70 (Figure 24). For example, for an organization that serves 500 people, the number of behavioral issues would be projected to go down from 12,000 to 1,400 for incidents over a three year period when people are free from unnecessary intrusive interventions.

Limitations and Directions For Future Study

When interpreting these findings, a few limitations should be noted. First, this study was a pilot with a relatively small sample size (28 agencies who supported 3,000 people with IDD). Moreover, it was a sample of convenience and the agencies in the sample represented one umbrella organization. It should also be noted we conducted a secondary analysis; as such, we do not know if hospitalizations were appropriate or used in lieu of primary care. We do not know if injuries were inflicted by others, or preventable. We also need more information about training - is there a particular training that leads to better results for people receiving supports? Future research should replicate this study with a larger and more diverse sample, adding additional variables and questions.

Conclusion

While traditional measures of health are important, many other factors play a role in quality services and supports, and quality of life. As indicated in the findings above, respect, meaningful days, staff training, and many more social determinants have an impact on hospitalizations, injuries, medication errors, and behavioral issues. We need to work to ensure measures of 'value' are holistic and ensure quality metrics are not only *value-based* but *valuable* to people with IDD.

BUILDING THE FRAMEWORK FOR VALUE BASED MEASURES

What Is Quality?

'Quality' is relative – what it means to different people and in different context can be open to interpretation. The aim of the symposium was to help determine what quality services and supports for people with IDD involves; key themes from discussions with the approximately 25 thought leaders are presented below. Although there were a variety of different themes that emerged over the course of the day, one consistent theme emerged — all attendees believed quality services go well beyond just health and safety metrics. Moreover, services and supports should not be driven by regulation alone, but rather by personal needs and preferences.

> "What *is* value? Is it in the eye of the beholder?"

Although health and safety in and of themselves do not wholly encompass quality, they were seen as the foundational building blocks upon which everything else is built. In fact, supporting people to be healthy and safe is an important aspect of supporting them to achieve valued life outcomes. People must feel safe in their environments and be free from abuse, neglect, mistreatment, and exploitation. It is also important that conceptualizations of health not focus solely on the person's impairments, but rather the health of the whole person. People with IDD must also have access to health and wellness supports, such as physical activity and nutrition.

Once these foundational building blocks are in place, it is important to ensure people have a meaningful life. People with IDD must be supported to reach their potential to live a life of quality. Quality necessitates a holistic approach, which includes a wrap-around robust service delivery model throughout the lifespan, especially during times of transition. In fact, attendees recognized the important role of family in determining quality as it is often not only the person with IDD being supported but the family as well; as a result, there are outcomes that are also relevant to family members.

For quality services and supports, attention should be paid towards social measures. Often called social determinants of health (SDOH), these social measures include those factors that contribute to health and quality of life (e.g., social support, access to opportunities, etc.), but are beyond traditional health metrics.

Informed Choice

One of the most commonly described aspects of quality was true informed choice. It was recognized that people with IDD must not only have choices, but these choices must be based on information regarding numerous options and opportunities. Examples of choice-making opportunities include people with IDD choosing their goals, what they do during the day (e.g., where they work and play), where and with whom they spend their time, and where they live and with whom they live. Furthermore, efforts must be made to provide opportunities to people who may not primarily use verbal communication to make choices; people who do not primarily use verbal communication need to have alternative mechanisms to express their wants and needs.

Person-Centered Practices and Meaningful Goals

Ultimately, informed choice is about control over ones' life – about services and supports truly being person-centered. People with IDD must be supported to find their voice and become empowered. People with IDD must also be centered in their own lives – and have a say in what is happening. As such, a vast array of services must be designed around the person to meet their interests and choices, rather than services and supports being limited by a set menu of services.

Although person-centeredness is a cornerstone of quality, it was recognized that person-centeredness is unfortunately often still a philosophy and not a practice. Person-centered plans must not only be developed in such a way that is relevant to the person's goals and desires, but monitored and adjusted regularly based on feedback and timeliness. Furthermore, the goals in these plans must be meaningful and chosen by the person with IDD. As all people grow and change, goals should be evolve and change over time, not become stagnant.

> "Regardless of mechanism, it should be **person-centered**."

Community Living

Community integration was also considered a critical aspect of quality. Community is not merely a place people with IDD go or have a presence, rather it is "a place people have a stake in, a place people feel they belong" (Hingsburger, 2017). Community integration is about engagement and being embedded into the community – it is a place where people have connections and meaningful

social roles. Are people spending time in their community, doing things they like and want to do, and experiencing new things? Are they spending time with non-paid people? Community integration means people with IDD not only develop social ties and relationships that result in natural supports, but also are integral community members themselves.

Meaningful Days

Another common theme regarding the meaning of quality was ensuring people with IDD have meaningful days, including community-based employment opportunities. People must be able to choose what they do during the day, and those activities must be meaningful. Community employment outcomes must always be prioritized. Moreover, although people should have community-based employment, having a job in the community is not enough; people must have a job that is based on their personal choice, work the amount they want to be working, and be satisfied with their job.

> "People need to have a meaningful day."

Relationships

Relationships were also frequently mentioned as a marker of quality services and supports, especially because people with IDD often face isolation and loneliness. Quality services and supports involve ensuring people with IDD have the relationships that are most important to them. Quality services and supports also help people with IDD build relationships beyond paid staff, including by extending into their communities. Services and supports should also facilitate creation of a network of natural supports and lifelong connections.

Dignity and Respect

Dignity and respect was recognized as a vital aspect of quality. People should not only feel respected and valued, but as part of dignity and respect, people should have control over their lives and have

real and meaningful choices. Services and supports should enhance dignity and respect in both systems and in practices. One central component of dignity and respect is the dignity of risk. Avoidance of risk is often foundational in built and social environments of people with IDD (Perske, 1972). However, "it is difficult to learn how to make decisions and handle risk if the chance to undertake either of these activities is denied… [providers are] keen to encourage decision-making in theory but unwilling to allow choices that result in very minimal risky behavior" (Hudson, 2003, p. 261). If people with disabilities are truly to have equal opportunities, this includes the opportunity to take risks. In alignment with dignity of risk, support should only be provided to the degree necessary. The best support involves balancing duty of care and dignity of risk.

Continuity and Security

Continuity and security was also described as an aspect of quality services and supports for people with IDD. Lack of continuity and security includes the disruptions in people with IDDs' lives due to factors such as a lack of personal decision making, economic insecurity, and most frequently, the services and supports they receive from organizations. The provision of services and supports from human service organizations often links people with IDDs' lives to organizational processes and change. As such, the stability, tenure, and retention of DSPs is a critical component to the continuity of services. While in the current service system, some DSP turnover is likely unavoidable, quality services and supports work to ensure a lack of continuity does not result in unmet needs. More attention is drawn to workforce issues later in the summary report.

Embracing Technology

Finally, attendees also believed quality involves creative uses of technology. Technology should not only be embraced for the sake of improving services and supports, but also utilized to reduce unmet needs.

Building Quality Frameworks

In addition to unearthing trends in what quality services and supports for people with IDD involve, the findings of this meeting also revealed potential ways to build quality frameworks.

Creating Quality Standards

One of the first steps in doing so is to create quality standards. There was a recognition that across the country states are doing different things and everyone was working from a different perspective. Often these experiences and perspectives were siloed and not shared outside of the state or network. As such, it was recommended that best practices in Medicaid managed care not only be established, but shared across networks and systems. There must be collaboration across groups and quality bodies.

It was also recommended that quality standards should be based on data and measures. Outcome measures often focus on the avoidance of negative outcomes – negative things that did not happen such as reduced incidents, hospitalizations, etc. – rather than measuring positive outcomes in people's lives. As one discussion group noted, "the key is how you measure it and consistency in how you measure." Most everyone agreed, regardless of the tool or tools that are used to measure quality outcomes, they should be person-centered, especially as there currently is a tension between person-centered services and funding wherein the expectations for person-centered services are high but the funding to support those services is low. Some participants felt it was necessary to have a data collection methodology that collects data at the individual level to be applicable to providers and MCOs for value-based payments. The tool/s should also be multidimensional and examine many perspectives (e.g., the person, their family).

> "Start with outcomes and *then* determine the methods to get to those outcomes."

Symposium discussion also emphasized the need for common baseline understandings and definitions of key concepts, particularly as values often differ depending on perspectives (e.g, payer, government, people with IDD, family, provider, etc.). It would be useful to have common definitions of value-based systems among all parties – a common language. For example, a common understanding of the purpose of the HCBS system would be fruitful since not all systems or players understand the uniqueness and nuances of the IDD HCBS LTSS system. Baseline understandings and standards would also make it easier to consistently execute value-based standards across the country because everyone would be speaking the same language.

One such way that was suggested to help set baseline standards was accreditation. Accreditation ensures consistency in quality standards across service and support providers. It was noted that "the absence of accreditation in this field is a real weakness." As it is based on consistent standards, accreditation is a useful foundation for value-based payments. Accreditation models must look at not only systems, but also practices from varying perspectives – as both are necessary to

> "Our values should be that people are treated with dignity and respect, and able to reach their potential. If these values aren't embedded in the system, it's just going to be about the cost. **The dignity of people is key**."

ensure the highest quality person-centered services and supports for people with IDD.

Producing Cultural Change

In order to create quality standards and build better frameworks, there must be cultural change. The current service system is very much entrenched in the culture and legacy of fee-for-service medical models. Fee-for-service models pay based on the number of services provided, rather than the quality of those supports. Older models are often frequently risk-averse. In contrast, quality value-based services should aim to build services around the person, and not the other way around. As such, there must be a vast array of services offered and available.

For this change to occur, there must be provider buy-in. Providers must not only be informed of the aims and philosophies of these changes, they must also be invested in making them happen. This organizational transformation is necessary at every level of the organization, from the people providing direct supports to organizational leadership.

While recently a shift has begun towards person-centered services and supports in regulations and policies, this shift is still more of an abstract philosophy rather than a practice. While the philosophical change regarding focusing on a person's whole life, such as the HCBS final settings rule, is commendable, funding is not there to support real change – funding does not align with these priorities, making this transformation unattainable for many people who receive Medicaid funded services. For example, work opportunities are often constrained by very low day service rates, which are based on congregate settings and not individual supports aligned with real work.

Investing in Quality

There can be no conversation about quality improvement without discussing cost and financing – the two are often intertwined. Participants recognized there needs to be a recognition that quality person-centered services and supports for people with IDD are an investment. Quality is often in conflict with funding, however. Truly committing to creating personalized services requires a robust and adequately funded service delivery system.

As such, there needs to be a focus on rates and rate structures. Rates need to reflect the desire to focus on a person's

whole life and be person-centered as is emphasized in regulations and policies. For example, funding is necessary to assuage the long waiting lists of people who are trying to get services, particularly as caregivers age and more people need services. Funding continues to lag significantly behind the commitment to create personalized services, and the quality of services and supports people receive, and their quality of life as a result, can be significantly hindered.

There is perhaps no better example of a need to invest in quality than DSP workforce issues. Staff turnover and the lack of a stable and reliable workforce is a chronic issue, and has a significant impact on quality. Providers need to have the ability to pay for talent, yet the ability to do so is often out of their control because of funding limitations and rates set by the state. In addition to an investment in staff funding, there should also be an investment in staff development and training. Staff credentialing could be a useful mechanism to expand staff development. Quality services and supports also require a cultural shift that treats DSPs themselves with dignity and respect, particularly as the impacts of doing so trickles down to people with IDD.

"If we could solve workforce issues, quality wouldn't be such a large issue - we'd have services with **unlimited potential**."

Quality frameworks demand we also look at the relationships between services and outcomes, and outcomes and healthcare. By doing so, there will be more evidence that by emphasizing quality, and the metrics described above, there will be more opportunities for returns on investments and cost savings. For example, reductions in hospitalizations, falls, incidents, emergency room use, and staff turnover can all result in cost savings for the system. These savings can then be shared and/or redistributed in order to increase the quality of services or supports provided. For example, cost savings could be utilized to increase DSP rates or increase staff development.

One such mechanism to encourage cultural change and facilitate quality is for States and MCOs to provide incentive payments. For example, as DSPs play a critical role in quality services, there could be incentive payments for adopting DSP hiring best practices, and/or development and training. There could also be incentive payments for customer satisfaction. Another way to create incentive payments would be to create a partial deemed status for accreditation. Providers could also be rewarded for innovation; doing so not only encourages dynamic services and supports, but also gives providers the flexibility to innovate.

"Is it ethical to assign a monetary value to quality of life?"

There also needs to be an alignment between what MCOs are incentivizing and what providers are doing, in order to ensure both groups are working towards and measuring the same thing. Moreover, if payments are incentivized, careful attention needs to be paid to the ethics of attaching money to quality and value. Is it ethical to place a specific monetary value on quality of life and outcomes? For example, how does one put a price tag on the cost of trusted relationships, which we know are an important part of creating quality and value? Careful attention to these ethical quandaries requires decisions based upon evidence-based best practices.

To build quality frameworks, payment systems also need to be structured so that MCOs can ensure the small boutique providers are able to survive and are not left behind in a changing landscape full of mergers and acquisitions. In fact, often these boutique providers are uniquely able to provide dynamic and personalized services and supports because of their size.

Moreover, attention also needs to be drawn to the business processes and skills of providers. In the managed care market, providers need to be able to develop business cases on the value of their services. Knowing how much services and support really cost is more important than ever in the shift away from traditional fee-for-service models.

Conclusion

Findings from our focus groups with thought leaders from across the country indicated that although health and safety are foundational building blocks of quality, they are not enough — it is important to ensure people with IDD have informed choice, community living, meaningful days, relationships, dignity and respect, and much more. Quality frameworks demand not only evidenced-based best practices but also a recognition that quality is an investment, both financially and philosophically.

MOVING FORWARD

This report represents a culmination of findings from a symposium attended by approximately 25 thought leaders in the healthcare and LTSS industry as well as data analysis from 28 agencies that support approximately 3,000 people with IDD. The symposium was designed to begin developing a common understanding of value-based quality measures for people with IDD as the industry moves to managed care. While the ultimate aim is to have a roadmap for the key measures which would support people with IDD to receive high quality services and supports, this report serves as but one of many first steps.

While the sample size of the pilot quantitative analysis was small, the findings point us in directions for future research. In terms of next steps, we will expand the sample size to see if the same findings hold true with larger numbers. We also plan to continue the conversation with these thought leaders and others about how we can define quality to make it meaningful for those we support. This is a new partnership and we can all learn from each other's experiences, positionalities, and knowledges.

Taken together, our findings imply that it may be possible to impact programmatic costs by shifting to focus on factors that impact quality, such as dignity and respect, and meaningful days. This report is the first step in bridging the existing social determinants of health and value-based payments literature with LTSS quality of life work. While it is preliminary, it is unique and promising, and should be pursued with vigor.

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APPENDIX

	Median				
	Not Present	Present	*U*	*p* (exact)	*r*
HOSPITALIZATION RATE					
The Organization Respects People's Concerns and Responds Accordingly. (System)	2.57	1.03	16	0.005	0.47
Supports and Services Enhance Dignity and Respect. (System)	2.57	1.10	6	0.007	0.44
People Have Meaningful Work and Activity Choices. (System)	1.74	0.65	36	0.003	0.51
The Organization Facilitates Each Person's Desire for Natural Supports. (System)	2.86	1.15	3	0.02	0.34
The Organization Has Individualized Emergency Plans. (System)	2.35	1.03	22	0.002	0.52
The Organization Treats People with Psychoactive Medications for Mental Health Needs Consistent with National Standards of Care. (Practice)	2.77	1.10	14	0.045	0.33
APPOINTMENT RATE					
People Are Free from Abuse, Neglect, Mistreatment and Exploitation. (System)	24.84	12.16	35	0.04	0.33
The Organization Implements an Ongoing Staff Development Program. (System)	26.08	12.34	27	0.04	0.35
MEDICATION ERROR RATE					
The Organization Treats People with Psychoactive Medications for Mental Health Needs Consistent with National Standards of Care. (Practice)	14.92	3.13	4	0.004	0.47
People Are Free from Unnecessary, Intrusive Interventions. (Practice)	14.92	2.72	13	0.003	0.50
INJURY RATE					
The Organization Respects People's Concerns and Responds Accordingly. (Practice)	12.61	5.84	29	0.009	0.45
Supports and Services Enhance Dignity and Respect. (Practice)	12.77	5.98	20	0.035	0.35
People Have Meaningful Work and Activity Choices. (System)	9.38	3.02	38	0.004	0.49
The Organization Facilitates Each Person's Desire for Natural Supports. (System)	19.14	6.11	5	0.032	0.35
BEHAVIORAL ISSUES RATE					
The Organization Respects People's Concerns and Responds Accordingly. (Practice)	11.07	2.70	35	0.02	0.39
People Have Meaningful Work and Activity Choices. (Practice)	4.61	1.22	14	0.045	0.33
The Organization Ensures Thorough, Appropriate and Prompt Responses to Substantiated Cases of Abuse, Neglect, Mistreatment and Exploitation, and to Other Associated Issues Identified In The Investigation. (Practice)	14.86	2.70	18	0.03	0.37
The Organization Implements an Ongoing Staff Development Program. (Practice)	14.86	1.97	34	0.003	0.51
The Organization Treats Its Employees with Dignity, Respect and Fairness. (Practice)	11.58	1.97	35	0.011	0.43
The Organization Provides Continuous and Consistent Services and Supports for Each Person. (Practice)	18.61	2.46	34	0.009	0.44
People Are Free from Unnecessary, Intrusive Interventions. (Practice)	23.73	2.70	11	0.002	0.53

Note. All rates control for agency size. Rates are per every 1 person with IDD supported.

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Surrogates Session: Special Needs Trusts, Guardians Ad Litem, Article 17-A

Honorable Peter J. Kelly
Queen's County Surrogate's Court, Jamaica, NY

Honorable Richard Kupferman
Saratoga County Surrogate's Court, Ballston Spa, NY

Honorable Acea M. Mosey
Erie County Surrogate's Court, Buffalo, NY

Honorable Brandon R. Sall
Westchester County Surrogate's Court, White Plains, NY

Moderators:
Edward V. Wilcenski, Esq.
Wilcenski & Pleat PLLC, Clifton Park, NY

Ron M. Landsman, Esq.
Landsman Law Group, Rockville, MD

NYSBA ELDER AND SPECIAL NEEDS LAW SECTION
SUMMER MEETING 2019
SURROGATE'S COURT JUDGES' PANEL

Panelists: **Hon. Peter Kelly (Queens County)**
Hon. Richard Kupferman (Saratoga County)
Hon. Acea Mosey (Erie County)
Hon. Brandon Sall (Westchester County)

Moderators: **Edward V. Wilcenski, Esq. (Clifton Park, NY)**
Ron M. Landsman, Esq. (Rockville, MD)

Fact Pattern: Michael

Michael is 17 years old and has a moderate developmental disability. He lives with his parents. Both work, and both are active and involved advocates for their son.

He reads at roughly a sixth-grade level. His math skills are more rudimentary, and he has difficulty understanding money and making change in simple cash transactions. He has difficulty navigating social situations and is easily manipulated. Luckily, he is in a small and supportive public school where he is well known and supported by staff and students alike.

Michael has an IEP (Individualized Education Plan), and also receives services through the Office of People With Developmental Disabilities (OPWDD) Waiver.[1] The Waiver provides him with a Care Manager (formerly known as a Service

[1] The OPWDD Waiver is a Medicaid funded program. Michael is Medicaid eligible even though he is under 18 years of age with working parents, because one of the rules that is "waived" for people in Waiver programs like this one is the rule that a parent's income and resources are countable in determining financial eligibility for Medicaid. The Supplemental Security Income (SSI) program does not have a similar rule, and so Michael is not yet eligible for SSI. When he reaches 18 years of age, the SSI program will look at him as an independent adult, and so long as he does not own more than $2,000 in countable resources, he can apply for and begin receiving an SSI check at that time.

Coordinator) and some staff who take him out in the community to recreate and to practice life skills.

He drives, he volunteers at a local fire department where he helps wash the trucks and maintain the equipment. He has an unpaid internship – arranged by his school - at a local insurance office where he makes copies, shreds documents, and does basic scanning. He has a job coach most days.

Michael has no independent property of his own. His parents pay all his bills.

He will turn 18 in three months. His parents understand that they will need legal authority to advocate for him once he becomes an adult, and they are considering an application to become his court appointed guardians under Article 17A of the SCPA.

Question:

1. Michael's parents obtain the required physician's affirmation and psychologist's affidavit required by the statute, both of which confirm that he has a developmental disability which meets the statutory criteria under SCPA 1750-a. Would you require or take any additional steps to investigate the nature and scope of the disability?

If you believe that Michael's disability does not warrant the plenary relief under Article 17A, how would you proceed? Would you dismiss the petition, or convert the matter to an Article 81 *sua sponte*?

2. Do you ask for any type of reporting for a personal needs (only) guardian?

Assume that the petition is denied in favor of having Michael execute a Durable Power of Attorney and Health Care Proxy. A few years later you hear that Michael has executed new documents appointing a "girlfriend" who is clearly taking advantage of him financially. His parents return to court to ask you to reconsider their appointment.

3. His disability has not changed. Do you entertain the petition? To what extent do you support Michael's right to make ***bad*** decisions?

4. Do you have any thoughts or comments on Supported Decision Making? See https://www.includenyc.org/resources/tip-sheet/supported-decision-making-an-alternative-to-guardianship

The Court appoints a Guardian of the Person and Property for Michael under Article 17A.

Fast forward 5 years: Michael is now 22 years old, has graduated from high school with an IEP diploma, and has moved out into an independent apartment, where he has a roommate – also with a moderate developmental disability. The apartment is close to his parents' home, and his parents continue to provide some financial and other support. In addition, Michael receives Medicaid funded support from a local disability service provider.

Staff visit his apartment to help him review and pay bills, grocery shop and provide other residential supports. Staff turnover is high and assigned staff are often young and inexperienced, and so his parents end up spending more time than they would like in overseeing and managing this residential arrangement.

Michael is now receiving SSI as his only source of income.

Later that year, Michael's grandfather dies. The grandfather named Michael as direct beneficiary on a life insurance policy with a $500,000 death benefit. In order to preserve Michael's eligibility for Medicaid, the Guardian seeks approval to establish a first party supplemental needs trust and to fund the trust with the policy proceeds. The request is filed as a petition to withdraw funds from the guardianship account and transfer them to the trustee of a first party supplemental needs trust (SNT). A local bank is proposed as trustee.

5. Would the Court appoint a Guardian *ad litem* (GAL) to represent Michael in this proceeding, and if so, what criteria does the Court use in identifying GALs in cases involving SNTs?

The proposed SNT meets the four basic statutory criteria for first party SNTs under federal and state law[2]: Michael is under 65 years of age, he has a qualifying disability, the trust names his parents as settlors (and will be established pursuant to court order), and the trust provides the Medicaid program with a right of recovery upon Michael's death.

6. Would the Court require any notice of the proceeding to establish the SNT on the local Department of Social Services? If so, on what legal basis?

7. Would the Court treat DSS as a party entitled only to notice pursuant to SCPA 1753(2), or a party entitled to service of process under SCPA 1753(1)?

8. DSS demands changes to the trust document which are not required by statute or by NYS Regulations under 18 NYCRR 360-4.5. What weight, if any, does the Court give to DSS counsel in proceedings to establish an SNT?

9. Are there any additional criteria/provisions that the Court will require in a proposed SNT?

[2] 1396p(d)(4)(A); NY Social Services Law 366(2)(b)(2)(iii)

The trust is established and funded with the permission of the Court, and the trust contains the optional language in 7-1.12(e)(2)(i) which allows the trustee to make distributions from the SNT even if the distribution will impact benefits, so long as the distribution puts the beneficiary in a better position.

The SNT includes a provision requiring the Trustee to account on an annual basis. The accounting is due in January of each year, together with the annual report of the Guardian of the Property (which in this case will be a simple "zero balance" report, as all guardianship assets are now in the hands of the trustee).

The first annual accounting shows the following:

* The Trustee is paying private staff to provide additional in-home support for Michael. Michael might have staff available through the Waiver, but the family is frustrated by the high turnover, and prefer to use privately paid staff for many of these services, as they are more experienced and more reliable.

* The Trustee has been paying for cable, utilities, internet and similar expenses. The utility payments have the effect of reducing Michael's SSI by one third.

* The cable, utility and internet payments are not pro-rata. Rather, the trustee is paying the expenses in full, even though there are two people living in the apartment. Upon inquiry, the trustee tells the examiner that the other roommate has been associating with people who seem to be taking advantage of him and causing him to spend his own SSI income on their entertainment. The roommate has no guardian, no involved family, and staff from the agency that is supposed to be serving him are unhelpful, as they take the position that he can spend his money as he wishes.

10. In reviewing the annual accounting of the trustee, and what would trigger a request (by the examiner) that the matter be reviewed by the judge? In other words, what do your examiners look for when reviewing SNT accountings?

11. Assume that the Court had concerns about the administration of the trust based on the review of the examiner, and on its own initiative directed the trustee to file an interim accounting for the settlement of its accounts. In reviewing the accounting, what standard of review would be applied by the Court? Abuse of discretion? Best interest? Substituted judgment?

12. What weight would you give to Michael's opinion on the expenditures? What if he said he wanted to pay for his roommate's share, because the roommate was his best friend and he knew that he didn't have any money? Phrased differently, to what extent should courts support a trustee's decision to allow Michael to make **bad** decisions?

13. What is your reaction to a Trustee's use of trust to pay for services – such as private aides – when those same services might be funded through Medicaid? Stated more generally, how do you analyze whether a distribution qualifies as a "supplemental need", and has that analysis changed over time?

14. Trusteeship is different from guardianship, and there is a separate and well established body of law governing discretionary trusts. Once the court approves the use of a trust as the appropriate management arrangement, what is the relationship between the guardianship and the trusteeship?

Michael and his family have had enough of this freeloading roommate. His lease is up and there is enough money in the trust to purchase a modest townhouse in Michael's community. The current value of the trust is currently $450,000, and the townhome would cost $275,000 (just over 60% of the value of the trust).

15. Assume that there is no restriction on real estate purchases in the order approving the establishment of the trust or under the terms of the trust. Is this a purchase that the court would consider to be within the discretion of the trustee (meaning that the Trustee could purchase the property without prior court order)?

16. Are there any types of distributions that the court considers to be outside of the scope of the discretion of the trustee? If so, what is the legal basis for such a limitation?

The Trustee is counselled to get court approval for the real property purchase given the amount of the expense. The petition asks that title to the home be taken in the name of the guardians (and not the trustee), because Michael is well under the age where the Medicaid program would have a right of recovery against his estate, and he may one day marry and have children. Taking title outside the trust would allow the home to pass to his beneficiaries without Medicaid estate recovery if he were to die prior to reaching the age of 55 (and with a ten year retroactive limit after reaching 55).

DSS is served with process in the proceeding in light of its "remainder" interest, and files objections, arguing that title must remain in the name of the trust to protect the Department's interest.

17. Does the Trustee have an affirmative obligation to consider the Department's interest as it does an individual remainder beneficiary in other types of irrevocable trusts?

Fact Pattern: Settlement in Supreme Court

Michael's parents are appointed as Guardians under Article 17A. His grandfather is alive and well, and Michael doesn't receive a $500,000 inheritance. Instead, on his way to visit his grandfather one afternoon he gets rear ended by a Fed Ex delivery truck while at a traffic light and is severely injured. A lawsuit is filed in Supreme Court, and a significant settlement is reached.

The personal injury attorney files a proceeding under Article 12 of the CPLR seeking settlement of the lawsuit and asking the court to direct payment of the proceeds into a first party supplemental needs trust established for Michael's benefit. A bank is named as trustee. The court approves the request and the trust is established and funded. Once the settlement is paid, a stipulation of discontinuance is filed and the matter is closed.

18. What jurisdiction and/or involvement – if any – does the Surrogate's Court have over the SNT established in Supreme Court?

Would the Surrogate's Court entertain an application for relief by the trustee – e.g., a petition to pay caregiver compensation, purchase of a home, or settlement of the trustee's accounts?

19. Assume the trust is administered for a number of years, and the trustee is interested in having its accounts settled. Do the property guardians have the authority to sign an informal settlement?

If no guardian was appointed for Michael and an informal settlement agreement with releases was filed with his signature (or signed by his agent under power of attorney) pursuant to SCPA 2202, would you consider Michael bound by the agreement if he later petitions for relief against the fiduciary?

Written Materials Appended:

Landsman, Ron M., Esq., *When Worlds Collide: State Trust Law and Federal Welfare Programs*, NAELA Journal Volume 10, No. 1 (Spring 2014)

Wilcenski, Edward V., Esq. and Pleat, Tara Anne, Esq., *Administration of Special Needs Trusts: Development of an Improved Approach (Part I)* (NYS Bar Journal March 2019)

Matter of Capurso, 2019 NYLJ LEXIS 1003 (Surr. Ct. Westchester Co. 2019)

Matter of KeyBank N.A., 58 Misc. 3d 235 (Surr. Ct. Saratoga Co. 2017)

Matter of Tinsmon (Lasher), 61 Misc. 3d 218 (Surr. Ct. Albany Co. 2018)

Matter of Tinsmon (Lasher), 169 A.D.3d 1305 (Third Dept. 2019)

Matter of McMichael, 2017 NYLJ LEXIS 2245 (Surr. Ct. Queens Co. 2017)

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When Worlds Collide: State Trust Law and Federal Welfare Programs

By Ron M. Landsman, Esq., CAP

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I. Introduction

"Special needs trusts,"[1] which enable people with assets to qualify for Supplemental Security Income (SSI)[2] and Medicaid,[3] are the intersection of two different worlds: poverty programs and the tools of wealth management. Introducing trusts into the world of public benefits has resulted in deep confusion for public benefits administrators.

Trusts traditionally involve wealth and its management. SSI and Medicaid are public benefit programs for poor people. Even if adjusted for inflation, the asset limits for SSI eligibility[4] — the easiest door to Medicaid eligibility — or a year's SSI income[5] is of the same order of magnitude as just the fees for most private bank or trust firms.[6] The one valuable asset permitted — a personal residence — is eschewed as an asset in wealth management trusts.[7] SSI and Medicaid administrators and beneficiaries alike would have

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1 The term is not well defined but generally refers to trusts designed to allow their beneficiaries to enjoy their benefits while also qualifying for means-tested public benefit programs such as Supplemental Security Income (SSI) and Medicaid. *See* Stuart D. Zimring et al., Fundamentals of Special Needs Trusts § 1.02, 1-3 – 1-4 (Lexis Nexis 2013); *see also* Ron M. Landsman, Special Needs Trusts, in *A Practical Guide to Estate Planning*, ch. 14, 197–198 (Jay Soled, ed., ABA 2012). In its first published discussion implementing federal legislation approving trusts that coordinate with public benefits eligibility, the Centers for Medicare & Medicaid Services (CMS) stated that a trust under 42 U.S.C. § 1396p(d)(4)(A) (2013) was "often referred to as a special needs trust." State Medicaid Manual, "Transmittal 64," General and Categorical Eligibility Requirements, § 3259.7A, http://www.sharinglaw.net/elder/Transmittal64.htm (accessed June 6, 2013) [hereinafter Transmittal 64].

2 Created in 1972, SSI is the federal cash benefit program for low-income people who are aged (65 or older), blind, or disabled. Social Security Act, tit. XVI, § 1601, added Oct. 30, 1972, Pub. L. 92-603, tit. III, §301, 86 Stat. 1465; 42 U.S.C. §§ 1381-1383f.

3 Medicaid, created in 1965, is the joint federal-state program providing medical and remedial services to the elderly and disabled poor. It is roughly parallel to Medicare, an exclusively federal program providing medical services to the elderly and disabled who get employment-based benefits through Social Security. Social Security Act, tit. XIX, §1901, added July 30, 1965, Pub. L. 89-97, tit. I, § 121(a), 79 Stat. 343; 42 U.S.C. §§ 1396-1396w-5. Medicaid's great significance is in providing long-term remedial residential services, something not available from either Medicare or private health insurance.

4 Congress set a fixed asset limit of $1,500 for SSI eligibility in 1972 and raised it in increments of $1,000 from 1985 until it reached $2,000 in 1989. 42 U.S.C. § 1382(a)(1)(B), (3)(B). Had Congress increased that limit with the consumer price index from 1989 through April 2013, when the Consumer Price Index for All Urban Consumers (CPI-U) rose 92 percent, the SSI resource level of $2,000 would still be only $3,840. These calculations are based on data published at U.S. Dept. of Labor, Bureau of Labor Statistics, ftp://ftp.bls.gov/pub/special.requests/cpi/cpiai.txt (accessed May 28, 2013).

5 The maximum "federal benefit rate" in 2014 is $721 per month. *See Soc. Sec. Adm., SSI Federal Payment Amounts for 2014*, http://www.ssa.gov/oact/cola/SSI.html (accessed Nov. 26, 2013).

6 For example, the Bank of America trust department fee for a personal trust account, characterized on the website as competitive, has a base fee of $1,000 plus 1 percent per year on the first $1,000,000, with a minimum annual charge of $2,000. Maximum SSI income for 2014 is $8,652. *See* First Bank & Trust, *Trust & Investments*, http://www.firstbt.com/trusts-investment (accessed Nov. 29, 2013).

7 Fiduciaries generally accept these [(u)nique assets includ(ing) real estate] into trust accounts to accommodate a client's entire portfolio of assets. The most common example of this arrangement is a bank placing the family home or property into a trust. On rare occasions, a bank may *purchase* these types of assets but only if the bank has the appropriate expertise and only in accounts of significant size and sophistication. (Emphasis in original.)

Off. of the Comptroller of the Currency, *Comptroller's Handbook: Asset Management – Unique and Hard-to-Value Assets* 1 (Aug. 2012); *see also id.* at 13 (if a trust holds real property, the trustee "must

no reason to be familiar with trusts solely by involvement with SSI or Medicaid.

However, the federal agencies that administer SSI and Medicaid — the Social Security Administration (SSA) and the Centers for Medicare & Medicaid Services (CMS) — had no choice but to address how trusts would fit into SSI and Medicaid eligibility requirements given Congress's authorization of special needs trusts. The confusion arising from the merger of trust law with public benefits is sharply drawn in the agencies' attempts to define what it means for a trust to be for the sole benefit of the public benefits recipient. Public benefits administrators have focused on the distributions a trustee makes rather than the fiduciary standards that guide the trustee. The agencies have imposed detailed distribution rules that range from the picayune to the counterproductive and without regard, and sometimes contrary, to the best interests of the disabled beneficiary.[8]

This article critiques the agencies' treatment of sole benefit. It finds that the agencies, unfamiliar with trust law, overlooked state trust law as the source for understanding what it means for a trust to be for the sole benefit of a specific beneficiary. It is divided into five substantive parts:

- Part II reviews the history of Congress's treatment of trusts regarding public benefits through its decision to bring trusts inside public benefits programs;
- Part III details CMS's and SSA's interpretations of the new public benefits trusts, especially their definitions of "sole benefit" and "solely for the benefit of";
- Part IV analyzes sole benefit as a matter of state trust law, which Congress had chosen as the mechanism for implementing its policy;
- Part V reviews the reasons why CMS's and SSA's very different view of sole benefit would not be entitled to deference from the federal courts under the *Skidmore* doctrine; and
- Part VI outlines an approach CMS and SSA might take to achieve the goals they sought in monitoring the use of trusts.

II. Congress Brings Trusts Inside the Public Welfare System

Congress first legislated on trusts and Medicaid in 1986 to stop the use of trusts to avoid Medicaid's resource limits by elders needing long-term nursing home care. It then enacted the "Medicaid qualifying trust" (MQT) provision under which a trustee of a discretionary first-party trust would be deemed to exercise discretion to make any payments permitted under the terms of the trust.[9] All trust income and principal would be available

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have in-depth knowledge of prudent real property management, including market knowledge, accounting and legal expertise, diversification of holdings where possible, and careful oversight and monitoring of each asset. … If the real estate does not produce income for the trust, the bank fiduciary must determine whether retaining the property is in the best interests of the trust"). This is of course not the case for revocable *inter vivos* ("living") trusts used by the affluent but not wealthy to avoid probate, but the law of trusts has developed largely in the wealth management area.

8 For example, paying family members' travel expenses to visit the disabled beneficiary, *see infra* nn. 52–55 and accompanying text, and requiring distributions on an "actuarially sound" basis, see *infra* nn. 42- 43 and accompanying text.

9 Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9506(a), 100 Stat. 82 (1986), codified at 42 U.S.C. § 1396a(k), repealed, Omnibus Budget Reconciliation Act of 1993 (OBRA '93), Pub. L. No. 103-66, tit. XIII, § 13611(d)(1)(C), 107 Stat. 627 (1993).

if trustee discretion permitted payment for the benefit of the elder. The common view among Elder Law attorneys is that the statute was ineffective, although case law suggests otherwise.[10]

Nonetheless, after something of an onslaught of publicity about Medicaid planning,[11] Congress in 1993 enacted a new law, as part of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93), to address the use of trusts in Medicaid planning, replacing the 1986 act.[12] Under the new rules, trust assets of the Medicaid-planning settlor or his or her spouse were deemed available if there were "any circumstances" under which payment could be made to or for the benefit of the settlor.[13] This rule applied without regard to the purpose for which the trust was established or any limitations in its terms.[14] At the same time, Congress exempted three specific trusts from the new trust rules: two to protect resources (and the income they generate) and one to solve an eligibility problem related to nontrust income.[15] Congress also, for the first time, encouraged Medicaid planning by exempting from its antitransfer rules gifts to a trust for any disabled person under age 65.[16]

The decision to exempt some trusts from the Medicaid trust rules and to actively encourage donors[17] to qualify for Medicaid by funding trusts for children or grandchildren with disabilities reflected a sea change by Congress. All along, Congress's goal had been to stamp out every vestige of Medicaid planning by individuals for themselves,[18] though

10 There is only one case, out of dozens, finding nonavailability for someone seeking nursing home care. *Pollak v. Dept. of Health & Rehabilitative Servs.*, 79 So. 2d 786 (Fla. App. Dist. 4 1991); *cf. e.g. Barham by Barham v. Rubin*, 72 Haw. 308, 816 P.2d 965 (1991); *Cohen v. Commr. of Div. of Med. Assistance*, 423 Mass. 399, 668 N.E.2d 769 (1996). Others, however, allowed young adults disabled in accidents to protect personal injury recoveries. *E.g. Trust Co. of Okla. v. St. of Okla. ex rel. Dept. of Human Servs.*, 825 P.2d 1295 (Okla. 1991).

11 The extra-legislative activity that prompted enactment of the Medicaid provisions of OBRA '93 is reviewed in Mary F. Radford & Clarissa Bryan, *Irrevocability of Special Needs Trusts: The Tangled Web That is Woven When English Feudal Law is Imported into Modern Determinations of Medicaid Eligibility*, 8 NAELA J. 1, 6 (2012).

12 OBRA '93, *supra* n. 9 at § 13611; 107 Stat. at 622.

13 42 U.S.C. § 1396p(d)(3)(B)(i).

14 42 U.S.C. § 1396p(d)(2)(C)(i), (iii), (iv).

15 These are the so-called (d)(4) trusts, 42 U.S.C. § 1396p(d)(4)(A)–(C). The income trust, 42 U.S.C. § 1396p(d)(4)(B), does not raise "sole benefit" issues and therefore is not relevant here except to the extent its treatment by CMS throws light on CMS's understanding of trusts generally.

16 This is but one of the ways in which Congress provides advantageous treatment to individuals with disabilities in means-tested programs without means testing the individuals with disabilities. A person seeking Medicaid can transfer a home or other assets to a disabled child of any age without regard to the latter's wealth, 42 U.S.C. § 1396p(c)(2)(A), (B), and may make such a child the beneficiary, with priority over Medicaid, of an annuity used to "spend down" and qualify the parent for long-term care. 42 U.S.C. § 1396p(c)(1)(F)(ii).

17 The exclusion from the antitransfer rules included, *inter alia*, gifts to a trust for a donor's spouse, disabled child of any age, and any disabled person under age 65, 42 U.S.C. § 1396p(c)(2)(i)–(iv), thus allowing, for example, an elderly person to qualify for Medicaid long-term care benefits by funding a trust for a disabled child, niece or nephew, or grandchild.

18 Congress's other efforts included attempts to make transfers illegal and, when that did not work, to make giving Medicaid legal advice illegal; *see* Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 217, 110 Stat. 2008 (1996), and Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4734, 111 Stat. 522 (1997), 42 U.S.C. § 1320-7b(a)(6), known popularly as "Granny Goes to Jail"

not for others.[19] What Congress did by exempting special needs trusts from the new rules and providing an exemption from the antitransfer rules for funding trusts for others with disabilities was the opposite of its previous treatment of such trusts. Individuals with disabilities were now expressly allowed to keep assets in trust while they obtained or maintained Medicaid benefits. This was new.[20]

These new rules exempted two kinds of resource trusts for people with disabilities,[21] those with a single beneficiary and those operated by nonprofits, known as pooled trusts, with many disabled beneficiaries, each with his or her own account.[22] The most significant requirement for both types of trusts is that upon the death of the beneficiary, Medicaid programs must be reimbursed for benefits they paid for the beneficiary — before the trustee could make any distributions to heirs or legatees.[23] In both types of trusts, a parent, grandparent, legal guardian, or court may establish the trust or trust account.[24] Aside from these elements, individual and pooled trusts have some differences provided by statute. Pooled trusts, but not individual trusts, also may be established by the beneficiaries themselves.[25] There is no age limit for pooled trusts, but individual trusts must be established

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and "Granny's Lawyer Goes to Jail," respectively. The former was never enforced; enforcement of the latter was enjoined on First and Fifth Amendment grounds in *N.Y. St. Bar Ass'n v. Reno*, 999 F. Supp. 710 (N.D.N.Y. 1998).

19 Congress had long accepted that third party trusts (trusts set up and funded with other people's assets) could be established to permit beneficiaries to enjoy the benefits of both the trust and SSI or Medicaid as was done in, *e.g., First Natl. Bank of Md. v. Dept. of Health and Mental Hygiene*, 284 Md. 720, 399 A.2d 891 (1979); *Lang v. Commonwealth Dept. of Public Welfare*, 528 A.2d 1335 (Pa. 1987); and *Zeoli v. Commr. of Soc. Servs.*, 179 Conn. 83 (1979). This was a policy of necessity and prudence: To deny families the opportunity to assist a family member with a disability would drive the assistance underground, hurting the beneficiary and not likely saving much in public funds. Disinheriting the child, leaving the estate to nondisabled siblings with nonbinding instructions regarding care for the disabled child, was by the late 1980s an option of last resort given its shortcomings, to be used only in very small estates or in jurisdictions with problematic laws or administrative practices. *See e.g.* Ralph Moore, *Estate Planning for Families of Persons with Developmental Disabilities* 98 (Md. St. Plan. Council on Developmental Disabilities l989).

20 The Spousal Impoverishment provisions set forth in 42 U.S.C. § 1396r-5 and enacted five years earlier had changed the resource rules for spouses of nursing home residents seeking Medicaid, but nursing home residents themselves still, ultimately, had to meet the same strict resource limits. Those changes were preceded by judicial attempts at relief. *See In re Rose Septagenarian*, 126 Misc.2d 699 (N.Y. 1984). This is similar to the judicial relief that preceded some of what Congress did in OBRA '93 (i.e., the new income trust, 42 U.S.C. § 1396p(d)(4)(B), which was modeled on the trust approved in *Miller v. Ybarra*, 746 F. Supp. 19 (D. Colo. 1990), and the parental trusts under 42 U.S.C. § 1396(d)(4)(A), which may in part be drawn from, *e.g., Trust Co. of Okla. v. St. ex rel. Dept. of Human Servs.*, 825 P.2d 1295 (Okla.1991).

21 Congress used the Social Security definition of disability throughout. *See* 42 U.S.C. § 1396p(c)(2)(A)(ii)(II), (B)(iii), (iv), and § 1396p(d)(4)(A), (C), all referring to 42 U.S.C. § 1382c(a)(3).

22 42 U.S.C. § 1396p(d)(4)(C)(ii). A pooled trust is best likened to a 401(k) account or mutual fund; deposits are pooled for investment that everyone shares *pro rata*, but each participant maintains his or her own account for contributions and withdrawals.

23 42 U.S.C. § 1396p(d)(4)(A), (C)(iv).

24 42 U.S.C. § 1396p(d)(4)(A), (C)(iii).

25 *Compare* 42 U.S.C. § 1396p(d)(4)(A) *with* 42 U.S.C. § 1396p(d)(4)(C)(iii).

before the beneficiary turns age 65,[26] and the nonprofit may retain funds rather than reimburse Medicaid.[27] Other differences reflect the different nature of pooled trusts. These must be operated by a nonprofit entity,[28] all participants must be disabled and each must have his or her own account.[29]

Regarding transfers of assets, Congress added to the existing exemptions[30] transfers "to a trust (including a trust described in subsection (d)(4)) established solely for the benefit of" the individual's disabled child and "to a trust (including a trust described in subsection (d)(4)) established solely for the benefit of" any disabled individual under age 65.[31] "Solely for the benefit of" was used three times, once to describe exempt pooled trusts[32] and twice, in parallel provisions, to describe the trusts to which exempt transfers could be made. The term sole benefit also appears, twice, both times regarding transfers to or for "the sole benefit of the individual's spouse."[33]

Congress extended the OBRA '93 trust rules to SSI in 1999; it reintroduced an anti-transfer rule for SSI, which had been dropped in 1993.[34] The SSI provisions are similar, but not identical, to the prior Medicaid provision.[35] Whether Congress intended different

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26 42 U.S.C. § 1396p(d)(4)(A); by contrast, there is no age limit in 42 U.S.C. § 1396p(d)(4)(C).

27 42 U.S.C. § 1396p(d)(4)(C)(iv).

28 42 U.S.C. § 1396p(d)(4)(C)(i).

29 42 U.S.C. § 1396p(d)(4)(C)(iii) requires that "[a]ccounts in the trust are established solely for the benefit of individuals who are disabled … ."

30 Transfers to a spouse or disabled child were previously permitted. The change is noted in 42 U.S.C.A. § 1396p(c)(2)(B) hist. nn., 1993 amends. (West 2012).

31 42 U.S.C. § 1396p(c)(2)(B)(iii), (iv).

32 *See* 42 U.S.C. § 1396p(d)(4)(C)(iii).

33 42 U.S.C. § 1396p(c)(2)(B)(i), (ii).

34 Foster Care Independence Act of 1999 (FCIA), Pub. L. No. 106-169, tit. II, § 206(a), 113 Stat. 2833 (1999), 42 U.S.C. § 1382b(e).

35 The parallel provisions are 42 U.S.C. § 1396p(d)(1)–(5) and § 1382b(e)(1)–(5), and the subparagraph numbers correspond except that the order of (4) and (5) are switched in the SSI statute. One difference throughout is that the SSI provision does not discuss income or the effect on income. The Medicaid provisions say:

(1) These provisions apply for determinations of eligibility and amount of benefits, an income-related notion; SSI concerns only determinations of resources.

(2)(A) A trust is deemed to be established by an individual if his or her resources fund it at all and if the trust itself was established other than by will by the individual, spouse, or a court or agency acting on his behalf or at his request. SSI dispenses with the list of who may create the trust, and it changes the relevance of the will. While Medicaid reaches trusts established "other than by will," SSI reaches trusts "if any assets [of the individual or spouse] … are transferred to the trust other than by will."

(2)(B) For a trust with assets of the individual and anyone else, the Medicaid trust rules apply to the portion of the trust attributable to the individual. SSI casts the notion in terms of assets transferred to the trust.

(2)(C) Same: rules apply without regard to purpose of trust, trustee discretion, restrictions on when or whether distributions may be made or what they may be used for.

(3)(A) Same: resources of revocable trust are available. Medicaid spells out that payments to the individual are income and payments to anyone else are transfers of assets.

(3)(B) For irrevocable trusts, if payments from assets may be made under "any circumstances," then such assets are available; payments for the individual are income, and for someone else are transfers. If no payments may be made, then funding was a transfer. SSI says only that if payment may be made, the asset is available.

treatment is not clear, but that is beyond the scope of this article other than with respect to sole benefit.[36]

III. CMS and SSI Implement the Trust Provisions

A. CMS: Transmittal 64

To implement the OBRA '93 trust provisions, CMS[37] amended its *State Medicaid Manual*,[38] writing or adding Sections 3257–3259 in Transmittal 64.[39] To a large extent, CMS only restated the statutory language. It also addressed the unique situation of 42 U.S.C. § 1396p(d)(4)(B) trusts, acknowledged the state law nature of trusts, and attempted to define sole benefit and "solely for the benefit of."

In Transmittal 64 CMS said that a trust is "for the sole benefit" of a person "if the trust benefits no one but that individual, whether at the time the trust is established or at any time in the future." Conversely, a trust or transfer is not for someone's sole benefit if it "provides for funds or property to pass to a beneficiary who is not" in one of the three categories to whom exempt transfers can be made.[40] However, a trust can still make a post-mortem disposition: "[T]he trust may provide for disbursal of funds to other beneficiaries, provided the trust does not permit such disbursals until the State's [reimbursement] claim

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(4) Medicaid has the three exempt trusts. The SSI provision, 1382b(e)(5), cross-references two of them. "This subsection shall not apply to a trust described in subparagraph (A) or (C) of section 1396p(d)(4) of this title."

(5) Application to be waived where there is undue hardship under standards determined by the Secretary; the SSI provision, 1382b(e)(4), directs the SSA Commissioner to apply the undue hardship waiver.

36 The more complicated issue is whether the Medicaid programs in SSI states — which are required to provide Medicaid to all SSI beneficiaries — are allowed to deny benefits to someone on SSI because the person's (d)(4) trust does not meet state requirements. Before the SSI trust amendments, both CMS and SSA took the view that these programs were allowed to do so. The one court to look at this issue closely came to the contrary view, in part because neither agency had addressed the question anew since the enactment of the SSI trust rules. *Lewis v. Alexander*, 276 F.R.D. 421, 440 (E.D. Pa. 2011), *aff'd on other grounds*, 685 F.3d 325 (3d Cir. 2012). One court held, and others assume, that the trust exemption rules are mandatory. *Lewis v. Alexander*, 685 F.3d 325 (3d Cir. 2012), *aff'g* 276 F.R.D. 421, 438 (E.D. Pa. 2011), citing *Norwest Bank of N.D. v. Doth*, 159 F.3d 328, 330 (8th Cir. 1998); *Horowitz ex rel. Horowitz v. Apfel*, 143 F. Supp. 2d 240, 242 (E.D.N.Y. 2001), *aff'd on other grounds*, 29 Fed. Appx. 749 (2d Cir. 2002); *Sullivan v. Co. of Suffolk*, 1 F. Supp. 2d 186, 190 (E.D.N.Y. 1998), *aff'd on other grounds*, 174 F.3d 282 (2d Cir. 1999). One court is to the contrary, *Keith v. Rizzuto*, 212 F.3d 1190 (10th Cir. 2000); *see also Wong v. Doar*, 517 F.3d 247, 256–257 (2d Cir. 2009) (dicta).

37 The agency responsible for the Medicare and Medicaid programs at the time of Transmittal 64 was named the Health Care Financing Administration. Its name was changed in 2001 to the Centers for Medicare & Medicaid Services (CMS).

38 The *State Medicaid Manual* is a CMS publication that provides guidance to state Medicaid agencies. CMS, *State Medicaid Manual*, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html (accessed Jan. 14, 2014). The name is something of a misnomer; it is not a model manual. Similar to the Program Operations Manual System (POMS), it is not the product of rulemaking but appears to reflect substantial agency effort to explain and help readers understand its programs.

39 *Transmittal 64, supra* n. 1.

40 *Id*. at § 3257(B)(6), para. 3.

is satisfied."[41] CMS added that, to be "for the sole benefit of" an individual, a trust "must provide for the spending of the funds involved for the benefit of the individual on a basis that is actuarially sound based on the life expectancy of the individual involved."[42] Presumably, this provision made sure that no one else would receive any benefit from the trust. But this restriction does not apply to trusts that include a payback to the state Medicaid agency,[43] i.e., if the state Medicaid agency is entitled to payback, sole benefit does not require the funds be dispersed to or for the benefit of the beneficiary during his or her anticipated life expectancy. If a parent or grandparent funding a trust for a disabled child or grandchild wants to enjoy the exclusions under (c)(2)(B)(iii) or (iv), respectively, in which payback is not otherwise required, he or she can satisfy sole benefit by adding payback in lieu of "actuarially sound" language.

B. SSI: Program Operations Manual System (POMS)

With Congress's extension of the Medicaid trust rules to SSI,[44] the SSI unit of SSA also had to address the meaning of sole benefit. Like CMS, SSA properly acknowledged that trusts are creatures of state law.[45] Unlike CMS, SSA had no reason to defer to the states since SSI is exclusively a federal program. Also unlike CMS, SSA was not implementing its own statute; the exceptions to its antitrust rules are by statutory cross-reference to the same trusts exempted under the Medicaid statute.[46] Again unlike CMS, SSA attempted to provide directions to staff about specific state trust law issues. Unlike CMS, SSA addressed not only sole benefit, which is in the federal statute, but also a range of state trust issues.

With respect to sole benefit, SSA was loyal to the principle of congressional intent, inferring different meanings where Congress used slightly different words, and distinguishing "for the benefit of" from "for the sole benefit of." In language redolent of Transmittal 64, SSA explained that a trust is established for the benefit of an individual

> if payments … from the … trust are paid to another person … so that the individual derives *some benefit* from the payment (emphasis added).[47]

41 *Id*. at § 3257(B)(6), para. 4.

42 *Id*. at § 3257(B)(6), para. 3.

43 *Id*. at § 3257(B)(6), para. 4.

44 Congress logically enough did not extend to SSI the qualified income trust provision, 42 U.S.C. § 1396p(d)(4)(B), *see supra* n. 15 and accompanying text, which was only enacted to codify a court decision that solved a problem unique to Medicaid long-term care. Aside from that, SSI is only designed to provide a floor on income; it made no sense to allow individuals to qualify by artificially lowering their other income through a trust mechanism.

45 POMS SI 01120.199C ("Trusts are often complex legal arrangements involving State law and legal principles that require obtaining legal counsel"); *see also* POMS SI 01120.203B.1.f ("In the case of a legally competent, disabled adult, a parent … may establish a 'seed' trust using a nominal amount of his or her own money, or if State law allows, an empty or dry trust").

46 *See* 42 U.S.C. § 1382b(e)(5). But note, the SSI antitransfer provision restates the language of the Medicaid statute. *Cf*. 42 U.S.C. § 1382b(c)(1)(C)(ii)(III), (IV), with 42 U.S.C. § 1396p(c)(2)(B)(iii), (iv).

47 POMS SI 01120.201F.1.

A trust is for the sole benefit of an individual

> if the trust benefits *no one but that individual* … at any time for the remainder of the individual's life (emphasis added).[48]

After painstakingly making this distinction, SSA without explanation disregarded it and said that individual special needs trusts "for the benefit of" a disabled individual under (d)(4)(A) also must be for that person's sole benefit.[49] Sole benefit precluded a provision that would "provide benefits to other individuals or entities during the disabled individual's lifetime,"[50] but it then provided as an "[e]xception to the sole benefit rule for third party payments" any "[p]ayments to a third party that result in the receipt of goods or services by the trust beneficiary."[51]

In 2012, SSA added an example to POMS to show that reimbursing family members for travel expenses to visit the trust beneficiary was not for the sole benefit of the beneficiary.[52] SSA reconsidered in the face of vigorous protests from charities and special needs trust attorneys first by removing the example[53] but ultimately substituting rules[54] that limit payment for third party travel to two narrow exceptions.[55]

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48 POMS SI 01120.201F.2.

49 Under the special needs trust exception, the trust must be established for and used for the benefit of the disabled individual. SSA has interpreted this provision to require that the trust be for the sole benefit of the individual.
POMS SI 01120.203B.1.e.

50 *Id*.

51 POMS SI 01120.201F.2.b. Payment of administrative expenses was a further permissible exception to the sole benefit rule. POMS SI 01120.201F.2.c.

52 Example 1 — Trust provision that is not for the sole benefit of the trust beneficiary. An SSI recipient is awarded a court-ordered settlement that is placed in an irrevocable trust of which he is the beneficiary. The trust document includes a provision permitting the trustee to use trust funds to pay for the SSI recipient's family to fly from Idaho to visit him in Nebraska. The trust is not established for the sole benefit of the trust beneficiary, because it permits the trustee to use trust funds in a manner that will benefit the SSI recipient's family financially.
POMS SI 01120.201F.2, quoted in ElderLawAnswers, *POMS Changes Tighten Interpretation of 'Sole Benefit' Rule for (d)(4)(A) Trusts* (last modified Jan. 7, 2013) http://www.elderlawanswers.com/poms-changes-tighten-interpretation-of-sole-benefit-rule-for-d4a-trusts-9915 (accessed June 11, 2013).

53 ElderLawAnswers, *SSA Removes Controversial POMS Language, But Planners Remain in Limbo,* http://attorney.elderlawanswers.com/ssa-removes-controversial-poms-language-but-planners-remain-in-limbo-12067 (accessed June 11, 2013).

54 ElderLawAnswers, *SSA Revises POMS, Permits First-Party Trusts to Pay for Non-Beneficiary Travel in Some Cases,* http://attorney.elderlawanswers.com/ssa-revises-poms-permits-first-party-trusts-to-pay-for-non-beneficiary-travel-in-some-cases--12295 (accessed June 11, 2013).

55 Payment for third-party travel is permitted only if "necessary in order for the trust beneficiary to obtain medical treatment" or to "ensur[e] the safety and/or medical well-being of [an] individual" living in a nursing home, group home, or assisted living facility. POMS SI 01120.201F.2.b.

IV. The Proper Meaning of Sole Benefit Trust Comes From the State Law of Trusts

A. State Trust Law Provides a Clear, Comprehensive Meaning That Conforms to Congressional Intent

Congress chose to use trusts, creatures of state law, as the mechanism for coordinating private assets and means-tested public benefits[56] and granting special treatment for certain federal programs for beneficiaries of trusts and for the donors of such trusts. These trusts all have to be for the "sole benefit" of the trust beneficiary. There is no general federal law of trusts, nor is sole benefit a term of art in state trust law,[57] but familiar state trust law principles provide an interpretation that conforms precisely to Congress's intent in providing special treatment for beneficiaries of trusts established "solely for" their benefit, and the donors to such trusts.[58]

The notion of benefit or beneficial interest is fundamental in the law of trusts. Adding "sole" or "solely for" addresses another fundamental trustee duty, the duty to be impartial in managing the trust for the benefit of all beneficiaries. Together, these provide a definite and definitive meaning of what Congress sought to achieve in using trusts as part of the public benefits system: the needs and welfare of the person with a disability have absolute priority over those of any other beneficiary in all aspects of the trustee's management of the trust.

The beneficiary is one of the three essential elements of a trust.[59] Beneficiaries are the individuals, usually named in the trust document, to whom the trustee owes the duty

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56 *See Lewis,* 685 F.3d at 347. Congress has of course done the same in other situations in which one party manages property for the benefit of another, *e.g.* Employee Retirement Income Security Act (ERISA) Pub.L. No. 93-406, 88 Stat. 829 (1974), although some think the combination has not always been a happy one. *See* John H. Langbein, *The Supreme Court Flunks Trusts*, S. Ct. Rev. 207, 209–211, 211–212, 223–228 (1991).

57 The phrase appears but typically only as a more emphatic statement of the notion of benefit (*e.g.*, "failing to act for the sole benefit of the beneficiaries"), *Markert v. PNC Fin. Servs. Group, Inc.*, 828 F. Supp. 2d 765 (E.D. Pa. 2011); *In re Roman Catholic Archbishop of Portland in Or.*, 345 B.R. 686, 694 (Bankr. D. Or. 2006). It is different from "sole beneficiary" trusts, whose one beneficiary gets income and gets or controls principal, either during the beneficiary's lifetime or at his or her death. *See* Mark L. Ascher et al., *Scott and Ascher on Trusts* § 12.2.1 (5th ed., Aspen 2006).

58 As used by CMS and SSA, this phrase includes the trusts identified by both the resource and transfer exclusions, 42 U.S.C. §§ 1396p(d)(4)(A) and (c)(2)(B)(i)–(iv), respectively. The similar phrase in (d)(4)(C)(iii) ("Accounts … established solely for the benefit of individuals"), referring to pooled trusts, has a different purpose, to limit the use of (d)(4)(C) trusts accounts to disabled individuals, excluding the non-disabled.

59 *Restatement of the Law Third, Trusts* § 2. The others are the trustee and the property the trustee manages for the beneficiary's welfare. A trust is a fiduciary relationship involving property "subjecting the person who holds title to the property [the trustee] to duties to deal with it for the benefit of charity or for one or more persons, at least one of whom is not the sole trustee." It may appear to exist for a time without a beneficiary, because the beneficiary may not be identified with specificity at first and possibly for a long time (*viz.*, the unborn children of a class of individuals, one of whom may be the proverbial fertile octogenarian) after a trust is created. "But [i]n a more comprehensive sense, even at the outset [every] trust has existing beneficiaries by implication of law: the reversionary beneficiaries whose interests may or may not eventually materialize … ." *Id.* These are the people with beneficial interests in the property of the trust.

of loyalty. "Who the beneficiaries of a trust are depends on the manifestations of the settlor's intent."[60] It is the individual(s) selected and named — whether by name, or class, or some other characteristic[61] — by the settlor as the one(s) he or she intends to benefit and to whom the trustee owes all of his or her duties.

A beneficiary gets the benefit of the trust through the trustee's use of trust assets for his or her benefit. The trustee may give the beneficiary cash, may purchase goods or real property (e.g., an automobile, home, or computer) for his or her use, or may pay others to provide services for the beneficiary. The fact that the trustee pays someone else to do something for the beneficiary does not make the service provider a beneficiary of the trust, and that payment is not a benefit of the trust. Even naming a specific person to provide services to the trust, trustee, or beneficiary does not mean the settlor intended to give that person a beneficial interest in the trust; therefore, getting paid for providing those services is not considered getting a benefit from the trust.[62] *A fortiori*, someone not named in the trust who is paid to provide services to the beneficiary is not, by the fact of payment alone, getting a benefit under the trust.[63]

A special needs trust always has at least two beneficiaries: the current life beneficiary with a disability and whoever enjoys the benefit of the property, if any remains, after the death of the life beneficiary.[64] The trustee is not to discriminate between them unless the settlor has directed the trustee to do so.[65] Treating the beneficiaries with due regard for their respective interests[66] requires nonfavoritism in procedure[67] and results.[68] Most of the cases on the duty of impartiality involve successive beneficiaries, in which one (or more) receives income for life and the other(s) later get the principal. The trustee's duty

60 Ascher et al., *supra* n. 57, at § 12.14, 781–782; *see also Restatement of the Law Third, Trusts, supra* n. 59, at § 49.

61 A somewhat whimsical illustration might be the charitable "trust" in "The Red-Headed League," a Sherlock Holmes story by Sir Arthur Conan Doyle. *See The Adventures of Sherlock Holmes, The Red-Headed League* (http://168.144.50.205/221bcollection/canon/redh.htm) (accessed Aug. 19, 2013).

62 The question often comes up in the context of directions to employ someone in management of the trust. Even if the trust uses mandatory rather than precatory language, the person named is not necessarily a beneficiary with any rights to enforce. The person might have been named "in the belief that such employment would promote both trust administration and the interests of the beneficiaries," which leaves the employee as only that, not a beneficiary. Ascher et al., *supra* n. 57, at § 12.13, 769; *see generally id*. at 776–781.

63 *Cf. Hobbs ex rel. Hobbs v. Zenderman*, 579 F.3d 1171 (10th Cir. 2009).

64 If no one is named, property remaining would go to the probate estate of the life tenant and thus, absent a will, to his or her heirs at law.

65 Langbein, *supra* n. 56, at 987–988.

66 *See* U.T.C. §§ 803, 105(a), (b) (2010); *Restatement of the Law Second, Trusts* § 183, comment a.

67 *McNeil v. Bennett*, 792 A.2d 190 (Del. Ch. 2001), *aff'd in part and rev'd in part*, 798 A.2d 503 (Del. 2002) (communicating with the beneficiaries and letting them know of their rights and interests), discussed in Ascher et al., *supra* n. 57, at § 17.15, 1261.

68 *See e.g. In re Estate of Whitman*, 266 N.W. 28 (Iowa 1936) (where two beneficiaries are entitled to income, the trustee abuses his discretion when he permits one to live in trust property rent free); *Penny v. Wilson*, 20 Cal. Rptr. 3d 212 (Cal. App. 2004) (distributing property without taking into account appreciation and thus future tax liability); both cases are discussed in Ascher et al., *supra* n. 57, at § 17.15, 1259–1260.

is to "preserve a fair balance between them."[69] Where there are inherent differences in what each beneficiary is entitled to, as with income to one and remaining principal to the other, the trustee cannot treat them exactly the same, but the duty imposes on the trustee an obligation to consider the interest and needs of each in all of the decisions to be made.[70] To say a trust is for the sole benefit of one individual or is established "solely for [his or her] benefit" means that the duty of impartiality has been suspended and that, between the life beneficiary and any remaindermen, the trustee is to consider only the interests and needs of the sole benefit beneficiary and is to give no weight to the interests or needs of the remaindermen.

Trustees may have broad discretion in meeting the duty of impartiality, but that hardly negates there is such a duty; eliminating the duty by making a trust for the sole benefit of one beneficiary reflects a real and substantial shift in the trustee's obligations and in the resulting management and use of trust assets.[71] The trustee should not, as would otherwise be the case, consider an investment strategy designed to ensure growth of principal so that there will be something to pass on to the remainderman, nor may the trustee stint on distributions to meet needs not met by other sources or resources to ensure that there is a remainder to be distributed. The remainderman is a beneficiary,[72] one to whom the trustee may owe *some* duties. All of the beneficiaries have some interests in common — that the trustee be prudent, competent, loyal, and conscientious — and any of the beneficiaries may enforce those duties. The sole benefit requirement addresses only impartiality, not the other obligations a trustee has to all the beneficiaries.

This understanding of sole benefit squares perfectly with Congress's intent in providing for individuals with disabilities who themselves seek to enjoy the benefit of earned, inherited, or otherwise acquired assets while using SSI and Medicaid. The same is true for those who qualify for Medicaid while committing their resources to the benefit of another person with a disability, as the antitransfer exceptions permit. Congress's purpose was to make certain that the person with a disability received the beneficial enjoyment of the assets, and that is achieved by sole benefit, properly understood as a modification of the duty of impartiality.

B. Sole Benefit, Although It Derives Its Meaning from State Law, Is an Independent Federal Requirement that Preempts Contrary State Law

If state law provides a useful, functional definition of sole benefit that promotes federal policy, the next inquiry is how, if at all, that definition attaches to the federal statutory term. Federal law controls, but Congress did not oust state law entirely — rather the contrary, it adopted state law as the means for achieving its ends.

The Third Circuit in *Lewis v. Alexander* treated the interplay as a matter of preemption. The court analyzed which provisions of state law were pre-empted by the federal

69 Ascher et al., *supra* n. 57, at § 20.1, 1463.

70 *Id*. at § 20.1, 1466–1469.

71 *See e.g*. U.T.C. § 803, cmt., first unnumbered para.

72 The Uniform Trust Code has dispensed with the distinction between beneficiary and remainderman, treating them all, as they are, as beneficiaries of the trust. U.T.C. § 103 (treating as the same those with "present or future beneficial interest[s]").

statute. This is not the only, or perhaps even the best, way to analyze the conflict between state and federal law,[73] but it provides a framework for analyzing sole benefit. Here, as it has in many areas, Congress has provided a benefit within the context of state law. There is no general federal common law[74] and no general federal law of property, trusts, or estate law.[75] State law controls absent a specific federal statute, policy, or interest that requires otherwise.[76] The Supreme Court noted recently, "In most fields of activity … this Court has refused to find federal preemption of state law in the absence of either a clear statutory prescription, or a direct conflict between federal and state law."[77] Where Congress operates through state law, "the basic assumption [is] that Congress did not intend to displace state law."[78] Application of preemption resulting in a state law being unenforceable is limited to specific points of conflict.

In *Lewis v. Alexander*, this question of how much state law was abrogated was central to resolving Pennsylvania's attempt to regulate — a cynic might say strangle — pooled special needs trusts. The Third Circuit's answer can be summarized as "not very much."

> [T]here is no reason to believe [Congress] abrogated States' general laws of trusts or their inherent powers under those laws. … [W]e reject the conclusion that application of these traditional powers is contrary to the will of Congress. After all, Congress did not pass a federal body of trust law, estate law, or property law when enacting Medicaid. It relied and continues to rely on state laws governing such issues.[79]

To the extent Congress specified what was permitted as a condition to Medicaid eligibility, the state was not free to add additional requirements.[80] Reviewing the five specific provisions challenged by plaintiffs in the Third Circuit,[81] the court found that the state could not limit pooled trust retention[82] to less to 50 percent,[83] special needs trust expenditures to needs related to the individual's disability,[84] participation in pooled trusts to those who could not meet their needs without the trust,[85] or pooled trust participation to

73 The plaintiffs prevailed before the district court and argued on appeal that the question was whether the comparability requirement under 42 U.S.C. § 1396a(a)(17) precluded the more restrictive state statute, but the Third Circuit declined to take that approach. *Lewis*, 685 F.3d at 347–348, n. 21.

74 *Erie R.R. Co. v. Tompkins*, 304 U.S. 64, 58 S. Ct. 817, 82 L. Ed. 1188 (1938).

75 *Lewis*, 685 F.3d at 347.

76 *U.S. v. Little Lake Misere Land Co., Inc.*, 412 U.S. 580, 93 S. Ct. 2389 (1973).

77 *Boyle v. United Technologies Corp.*, 487 U.S. 500, 504, 108 S. Ct. 2510, 2514 (1988) (citations omitted). The exceptions are those areas involving "uniquely federal interests," such as military operations.

78 *Md. v. La.*, 451 U.S. 725, 746 (1981).

79 *Lewis,* 685 F.3rd at 347.

80 *Id.,* citing *U.S. Term Limits, Inc. v. Thornton*, 514 U.S. 779, 131 L. Ed. 2d 881 (1995).

81 Plaintiffs did not appeal the district court decision dismissing their challenge to a sixth provision of the state statute that "all distributions from the trust must be for the sole benefit of the beneficiary." *See Lewis*, 685 F.3d at 338, n. 9.

82 42 U.S.C. § 13p6p(d)(4)(C)(iv) (Medicaid payback required only "[t]o the extent that amounts remaining in the beneficiary's account upon [his or her] death … are not retained by the trust …").

83 *Lewis,* 685 F.3d at 348–350.

84 *Id.* at 350.

85 *Id.* at 350–351.

those under age 65.[86] Congress addressed each of these and made no allowance for states to limit or modify what it, Congress, would allow.

Like the four provisions struck down, the sole benefit requirement was plainly delineated by Congress and is not one that the states can modify. It is an independent element of what Congress requires for those who want to use federally funded Medicaid benefits: Preemption precludes the states from adding more to the requirement. As a practical, functional matter, it means that the remainder beneficiaries have no standing to challenge disbursements for the life beneficiary as in derogation of their rights as remaindermen, and that the life beneficiary can require the trustee to disregard the remaindermen's interests. The trustee can and should favor the beneficiary with a disability. The court in *Lewis* did not have occasion to address the meaning of sole benefit since the state had only added to its own statute a sole benefit provision similar to that in the federal statute, and the meaning of neither was at issue.[87]

The court upheld the fifth provision challenged, subjecting pooled special needs trusts to petitions for termination by the attorney general. It said that the state may subject special needs trusts, like all trusts, to court jurisdiction. The threat of termination is just one of the arsenal of general trust law provisions "for protecting the trust and the interests of its beneficiaries."[88] Congress's decision to draw on state trust law as the mechanism for implementing its Medicaid policy carries a certain tension, the court noted. If Congress has defined sole benefit trusts, the court asked, what about the other duties imposed on trustees?

> There is necessarily some tension between this conclusion [that state trust law and the states' powers under it are not abrogated] and the bar on states adding requirements. For example, even application of the trustee's traditional duty of loyalty — to administer the trust solely in the interests of the beneficiaries[89] — could be considered an extra requirement.[90]

The court later said:

> Pennsylvania's general trust law contains numerous provisions for protecting the trust and the interests of its beneficiaries. For example, Pennsylvania law imposes duties of loyalty, impartiality, prudent administration, and prudent investment.[91]

Sole benefit, understood as a modification of the duty of impartiality, would, under the Third Circuit's preemption analysis, conflict with the duty of impartiality. Because the duty of impartiality is only a default rule, however, it presents a preemption conflict only in the limited sense of precluding an option trust settlors might otherwise prefer but are denied if they want to enjoy using both resources and Medicaid or SSI.

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86 *Id*. at 351–352.
87 *Id*. at 338, n. 9.
88 *Id*. at 352–353.
89 20 Pa. Consol. Stat. Ann. § 7772(a) (West).
90 *Lewis,* 685 F.3d at 347.
91 *Id*. at 352.

The difference between the federal agencies' understanding of "for the sole benefit of" and that suggested by state law is vast. The question for a court asked to enforce the federal agencies' interpretation is whether it should defer to the agencies or, instead, review the statute, legislative history, and other authorities to come to its own independent conclusion. The following section addresses the standards for undertaking that task.

V. On the Sliding Scale of Deference to Agency Determinations, Neither CMS nor SSA has Earned the Right to Substantial Deference for Its Definition of Sole Benefit

A. Absent Careful Use of Rulemaking Authority, Deference is a Function of an Agency's Competence in the Specific Area

Judicial deference to action of an agency under a statute it administers ranges "from great respect at one end … to near indifference at the other."[92] At one end is almost total deference to agency exercise of legislative rulemaking authority given by Congress within the agency's jurisdiction.[93] It is just such authority that the Supreme Court typically has relied on in cases involving CMS and Medicaid[94] and SSA and SSI.[95] A court should defer to an agency that has engaged in legislative rulemaking under its statute if "the agency's answer is based on a permissible construction of the statute."[96] The agency's answer does not have to be compelling, or the only permissible reading, or even the one the court finds most reasonable, as long as it reflects "a reasonable accommodation of conflicting policies that were committed to the agency's care by the statute."[97] Such regulations are "given controlling weight unless they are arbitrary, capricious, or manifestly contrary to

92 *U.S. v. Mead Corp.*, 533 U.S. 218, 228, 121 S. Ct. 2164, 2172 (2001).

93 *Chevron U.S.A., Inc. v. Nat. Resources Def. Council, Inc.*, 467 U.S. 837 (1984).

94 *Wis. Dept. of Soc. Servs. v. Blumer*, 534 U.S. 473, 496, 122 S. Ct. 962, 976, 115 L. Ed. 2d 935 (2002) ("We have long noted Congress's delegation of extremely broad regulatory authority to the Secretary in the Medicaid area"); *Thomas Jefferson U. v. Shalala*, 512 U.S. 504, 512, 114 S. Ct. 2381, 2387, 129 L. Ed. 2d 405 (1994) (this broad deference is all the more warranted when, as here, the regulation concerns "a complex and highly technical regulatory program [Medicaid]," in which the identification and classification of relevant "criteria necessarily require significant expertise and entail the exercise of judgment grounded in policy concerns"); *Atkins v. Rivera*, 477 U.S. 154, 162, 106 S. Ct. 2456, 2461, 91 L. Ed. 2d 131 (1986) (where the Secretary's regulation of the Medicaid statute is supported by the plain language of the statute, it is entitled to more than mere deference or weight but is entitled to legislative effect and is controlling unless it is arbitrary, capricious, or manifestly contrary to the statute); *Schweiker v. Gray Panthers*, 453 U.S. 34, 43, 101 S. Ct. 2633, 2640, 69 L. Ed. 2d 460 (1981) ("Congress explicitly delegated to the Secretary broad authority to promulgate regulations defining eligibility requirements for Medicaid").

95 *Barnhart v. Thomas*, 540 U.S. 20, 29–30, 124 S. Ct. 376, 382 (2003); *Sullivan v. Everhart*, 494 U.S. 83, 88–89, 110 S. Ct. 960, 964 (1990); *cf. Sullivan v. Zebley*, 493 U.S. 521, 110 S. Ct. 885 (1990); *Bowen v. Yuckert*, 482 U.S. 137, 145, 107 S. Ct. 2287, 2293 (1987) ("Where, as here, the statute expressly entrusts the Secretary with the responsibility for implementing a provision by regulation, our review is limited to determining whether the regulations promulgated exceeded the Secretary's statutory authority and whether they are arbitrary and capricious") (citations omitted).

96 *Chevron*, 467 U.S. at 843.

97 *Id.* at 844–845; the quote is from *U.S. v. Shimer*, 367 U.S. 374, 382, 6 L. Ed. 2d 908 (1961).

the statute."[98] This degree of deference is warranted where the agency enjoyed, and exercised, specific rulemaking authority.[99]

Here, CMS does not enjoy and thus could not exercise the kind of specific rulemaking authority it has in determining what constitutes income or resources. The Court in *Blumer* put substantial reliance on CMS's authority under 42 U.S.C. § 1396a(a)(17), in which Congress required state plans to utilize:

> reasonable standards … which … provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient … .

The mandate for the transfer and trust rules to be in state plans, in the next subsection, provides in its entirety that state plans shall:

> comply with the provisions of section 1396p of this title with respect to liens, adjustments and recoveries of medical assistance correctly paid, transfers of assets, and treatment of certain trusts; …

42 U.S.C. § 1396p itself has nine specific grants of rulemaking authority to the secretary,[100] but none concern what constitutes a trust "for the sole benefit" of a person or established "solely for [his or her] benefit."[101] The agency can define income and resources, and as CMS has noted,[102] all of the normal rules may apply to income or assets going into or out of a trust, and as to that the agencies may well have rulemaking authority, but there is no similar clear and specific grant of such authority respecting trusts.

SSA would appear to stand on no better footing. Whatever rulemaking authority SSA has, it has no authority to make rules respecting the Medicaid program. When Congress added Medicaid-like trust rules into the SSI statute in 1999, it enacted those rules directly into Title XVI,[103] but the special needs trust exclusions were only by cross-reference to the Medicaid statute.[104] The secretary's general rulemaking authority may be relevant,[105] but it is not at all clear it extends to what the Medicaid statute means. In any

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98 *Chevron*, 467 U.S. at 844.

99 *U.S. v. Mead*, 533 U.S. at 227.

100 *Viz.*, respecting reports from issuers of long-term care insurance within the "partnership plan," 42 U.S.C. § 1396p(b)(1)(C)(iii)(VI); for waiver based on undue hardship from estate recovery, *id*. at § 1396p(b)(3)(A); for imposition of transfer penalties, *id*. at § 1396p(c)(2)(D); for paying nursing facilities to hold a bed while the individual's transfer waiver application is pending, *id*. at § 1396p(c)(2), last unnumbered para.; for applications for waivers of the trust counting rules, *id*. at § 1396p(d)(5); for what constitutes intent to obtain fair market value, return of transferred assets, or whether transfer was for another purpose, *id*. at § 1396p(c)(2)(C); for apportioning transfer penalties when both spouses require long-term care, id. at § 1396p(c)(4); for when to include annuities as trusts, *id*. at § 1396p(d)(6); and for determining what "similar financial instruments" to subject to annuity disclosure rules, *id*. at § 1396p(e)(1).

101 42 U.S.C. § 1396a(a)(18).

102 *Transmittal 64, supra* n. 1, at § 3259.7B.

103 42 U.S.C. § 1382b(e)(1)–(4). The language is not identical, but appears to reflect clarity and simplicity rather any change of policy, 42 U.S.C. § 1396p(d)(1)–(5), 1382b(e)(1)–(5).

104 *See* 42 U.S.C. § 1382b(e)(5).

105 *See City of Arlington, Tex. v. Fed. Commun. Commn.*, ___ U.S. ___, 133 S. Ct. 1863, 2013 WL 2149789 (2013) at *10, citing *Mead* as denying *Chevron* deference to an agency with rulemaking authority for

event, the secretary has not utilized it. Like CMS, SSA says the usual asset and income rules apply to what goes in or comes out of a trust, but again, that is a distinct question.[106]

Absent agency exercise of rule-making authority, judicial deference depends on the quality of the action taken by the agency, as set out in *Skidmore*:

> The fair measure of deference to an agency administering its own statute has been understood to vary with circumstances, and courts have looked to the degree of the agency's care, its consistency, formality, and relative expertness, and to the persuasiveness of the agency's position. … The weight [accorded to an administrative] judgment in a particular case will depend upon the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade, lacking power to control.[107]

This directive can be broken into perhaps five distinct areas of inquiry:

1. *Care and thoroughness*. Whether the agency action reflects consideration of all the factors that contribute to the meaning and the consequences of different choices.

2. *Consistency*. Whether the agency had come to similar decisions on similar facts, and different decisions on distinguishable facts.

3. *Formality*. Whether the agency procedure, even if short of full rulemaking, reflects a procedure that guarantees careful consideration.

4. *Relative expertness*. Whether the subject of the decision, even if within the agency's nominal jurisdiction, is one to which the agency brings greater expertise than courts or others.

5. *Validity of reasoning and persuasiveness*. The ultimate basis for deference is the power of the reasoning.

B. Application of the Skidmore *Factors Suggests Deference Is Not Appropriate*

Three of the five factors warrant extended consideration.

1. Formality

This is the first of the three areas in which a *Skidmore* factor suggests that a court should not defer to CMS or SSA. Neither agency has utilized its rulemaking authority. Transmittal 64 and POMS both reflect a lower degree of formality than notice-and-comment rulemaking. POMS has been cited by the Supreme Court to support its statutory interpretations[108] and is frequently cited by the federal appellate courts, but mostly it ap-

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action that was not rulemaking.

106 POMS cautions that payments still have to be reviewed under the regular SSI counting rules; *viz*., payments of cash and the purchase of nonexempt items or in-kind goods and services for food and shelter also would be considered income to the beneficiary. POMS SI 01120.201I.1.a, b; *see also id*. d–f.

107 *U.S. v. Mead*, 533 U.S. at 228, quoting Justice Jackson in *Skidmore v. Swift & Co*., 323 U.S. 134, 140 (1944).

108 *E.g. Wash. St. Dept. of Soc. & Health Servs. v. Guardianship Est. of Keffeler*, 537 U.S. 371, 385, 123 S. Ct. 1017, 1026 (2003) ("While these administrative interpretations are not products of formal rulemaking, they nevertheless warrant respect in closing the door on any suggestion that the usual rules of statutory construction should get short shrift for the sake of reading 'other legal process' in abstract breadth,"

pears to confirm the courts' conclusions based on other sources rather than to persuade the contrary to other authorities.[109]

2. Relative Expertise in State and Federal Law

Here, too, a *Skidmore* factor suggests, now much more strongly, that a court should not defer to either agency. Federal welfare officials have no professional expertise in state trust law. State courts have declined to defer to their state Medicaid agencies when they go outside of their specific area of competence to deal with substantive state law of property or other matters.[110] The forays of SSA, in particular, into trust law reveal such serious miscomprehension that a court should be chary of deferring to its views. In using state trust law to achieve its policy, Congress has introduced a notion foreign to state trust law, something not understood by the agencies exactly because of their lack of expertise, so that even the federal nature of the issue does not translate into agency expertise.

a. State Trust Law

SSA uses words and phrases from trust law but ascribes its own, different meaning to them. If this only concerned nomenclature, it might be a minor problem solved by keeping clear the different meanings and their uses.[111] But it goes beyond that: SSA attributes meaning to trust terms used in the federal statute that results in misconstruing Congress' intent and frustrating Congress' purpose.

i. Benefit and Beneficial Interest

SSA's most serious deviation from accepted trust law is the meaning it gives to "benefit" from a trust. SSA says that the beneficiary must derive *some* benefit under its

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citing *Skidmore,* 323 U.S. at 139–140).

109 *See e.g. Lopes v. Dept. of Soc. Servs.*, 696 F.3d 180 (2d Cir. 2012) ("The language of the relevant regulations, as clarified in the POMS and in HHS's amicus brief, convinces us that the income stream from Lopes' annuity is properly considered income, not a resource, because the annuity is non-assignable"); *Beeler v. Astrue*, 651 F.3d 954, 961–962 (8th Cir. 2011), *cert. denied*, 132 S. Ct. 2679 (2012). POMS tends to be relied on more for matters of procedure, *e.g. Gossett v. Colvin*, 527 Fed. Appx. 533 (7th Cir. 2013) (remand required where agency failed to follow procedure set out in POMS); *Sullivan v. Colvin*, 519 Fed. Appx. 985 (10th Cir. 2013) (citing POMS for proposition that a specific form is only a worksheet, not the residual functional capacity assessment *per se*), but even that is not absolute, *Carillo-Yeras v. Astrue*, 671 F.3d 731 (9th Cir. 2011) (POMS "does not impose judicially enforceable duties on either this court or the ALJ").

110 *See e.g., L.M. v. New Jersey Division of Medical Assistance,* 140 N.J. 480, 659 A.2d 450 (1995) (no deference to state Medicaid agency on meaning or operation of a qualified domestic relations order, a matter of state domestic relations law).

111 SSA defines "grantor" as the one whose assets fund a trust and who "establishes the trust with funds or property," POMS SI 01120.200B.2, and defines "grantor trust" as one in which the grantor is the "sole beneficiary," explaining that "State law on grantor trusts varies." But there is no state law of "grantor trusts," which is a term of art in federal income tax law, referring to trusts that are disregarded for income tax purposes so that all income is attributed to the person deemed the grantor. See 26 U.S.C. §§ 671–678. Where states' laws refer to grantor trusts, it means the federal tax law notion of grantor trust. E.g. Ala. Stat. Ann. § 40-18-25(j); Fla. Stat. Ann. § 201.02(b)(5). There is a notion of sole beneficiary trusts, however, and to the extent SSA limits its use of "grantor trust" to such trusts, it might introduce some confusion, but not results at odds with Congress' intent.

definition of "for the benefit of" and defines "solely for the benefit of" to mean that no one else can receive *any* benefit from the trust. It then provides an exception to this definition by allowing payments to a third party for goods or services for the benefit of the beneficiary.[112] State trust law, by contrast, defines benefit in functional terms: it is the beneficial enjoyment of trust assets or income, for which one is not required to perform a service or deliver a good. The beneficiary is the one to whom the trustee owes its duties in the use of trust assets and income.

SSA's definitions only make sense if what SSA means is that *any* payment by a trustee is a benefit of the trust to the person who receives the payment. This looks like nothing so much as SSA's old "name on the instrument" rule.[113] From that perspective, a trustee's $20 payment to a cabdriver to take the beneficiary to a doctor's office for an exam gives the cabdriver a trust benefit. Such a payment is saved from violating "sole benefit" by the POMS exception allowing payments to third parties for the purchase of goods or services for the beneficiary. A definition that accommodates the central purpose of the thing it defines only as an exception to its general rule does not have a well-grounded general rule.

Like the Ptolemaic system,[114] SSA's definitions are a jerry-built approximation of the real thing and must in time lead to inaccurate, not to say bizarre, results. This happened for example in a state Medicaid agency's attempt to deal with a trustee's payment of compensation to a mother to remain home to care for her seriously disabled son.[115] Following SSA's theory, payments to the mother were treated as giving her a benefit of the trust, in violation of the sole benefit rule, and since she was doing what mothers (or at least parents) are expected to do, it was not shoehorned into the permissible exception. A traditional analysis under state trust law of sole benefit, as a guide to trustees, might permit payments to parents, but it would do so only when to do so were in the best interests of the beneficiary.[116]

ii. Revocability

SSA has applied state trust law inconsistently and often incorrectly in determining when trusts are irrevocable. It asserts as a "general principle of trust law that if a grantor is also the sole beneficiary of a trust, the trust is revocable regardless of language in the trust to the contrary," and a trust that does not name specific individuals as beneficiaries is always revocable.[117] The modern rule, found in *Restatement of the Law (Third), Trusts,* is to the con-

112 *See* POMS SI 01120.201F.2.c, discussed above in text accompanying notes 51, 62 and 63.

113 *See* the discussion of this informal rule in *Purser v. Rahm,* 104 Wash. 2d 159, 170, 702 P.2d 1196, 1202 (1985), and the authorities cited there.

114 Ptolemy (c. A.D. 90-168) improved the accuracy of the geocentric theory's explanation of the movement of celestial bodies by positing that they moved in circles centered on other circles centered on yet other circles centered on the earth.

115 *Hobbs v. Zenderman, supra*, n. 63.

116 Application of sole benefit to payments to parents is discussed in more detail below.

117 POMS SI 01120.200D.3, first unnumbered para. The idea that a trust naming heirs, rather than specific individuals, is always revocable as a matter of law is drawn from the Doctrine of Worthier Title and the Rule in Shelley's Case, two post-feudal era rules designed to thwart attempts to avoid feudal duties. *See* Radford & Bryan, *supra* n. 11, at 14. These rules treated dispositions to the heirs of the settlor or another person as transfers to the ancestor, thus subjecting the transfer to taxes or duties that the settlor hoped to

trary: A trust is not for a sole beneficiary when the settlor "names heirs, next of kin, or similar groups to receive the remaining assets [after the beneficiary's] death"; therefore, the trust is not revocable per se. But SSA requires state-by-state analysis and finds that the rule survives absent an express judicial decision to the contrary, often overlooking statutory reversal, resulting in "unrelenting and incorrect application of the [Doctrine of Worthier Title]."[118]

This error, combined with its failure to appreciate the significance of third-party creators, can lead to anomalous results that violate long-standing state law. Parents who sought to avoid SSA's finding of revocability by having the trust name themselves as contingent beneficiaries could run afoul of the deeply established rule that no one can make a will for another person. Such a plan of distribution could easily deviate from state intestacy law depending on who survived, if anyone remarried and had later-born children, and the state's anti-lapse statute.

iii. Establishment

"Establish" is not a term of art in the law of trusts. Historically, a trust came into existence when the owner of property conveyed the beneficial interest to another. The question often requiring resolution was when, if ever, those duties arose, *viz.*, whether the conveyance itself defined the duties, whether a mere declaration by the settlor/trustee could cause enforceable duties to come into existence, or whether later acquired property could be subject to duties previously declared. A person could not establish a trust of someone else's property — that is, convey a beneficial interest to another — any more than he or she could sell it to another and convey good title. Because the trust arose from the transfer of one's own property, the person who transferred the property was the settlor who "established" the trust, and perforce that was the person who determined the terms of the trust. Similarly, because a trust involves obligations respecting property, a trust could not come into existence until a trustee was in possession of property.

In authorizing parents and grandparents to "establish" a trust, respectively, of their child's or grandchild's assets, Congress introduced a new notion into trust law – authorizing a person to establish a trust for management of *another's* property.

SSA has tried to find the meaning of "establishment" in state trust law without recognizing that Congress has created an authority that has no basis there since Congress had introduced a practice not found in state trust law. Where a person establishes a trust with his or her own assets, he or she is the grantor, as SSA says; the trust comes into existence when the trustee receives property subject to the obligations imposed by the grantor and spelled out in a trust document. SSA, focusing on what trust law accepted as a result of its premises, treats the person whose assets fund the trust as the grantor, and treats the trust as established only when assets are delivered to the trustee. And since it was the act of funding the trust that brought it into existence, the disabled beneficiary whose assets fund a special needs is the grantor, SSA reasons, so the trust does not meet all of the requirements of Section 1396p(d)(4)(A).

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avoid. Both rules have long since been repealed by statute and are largely repudiated in the United States, seen at most as rules of construction (*i.e.*, an inference unless the settlor clearly indicated a contrary intent) rather than rules of law. *See id.* at 15–16.

118 *See* Radford and Bryan, *supra* n. 11, at 29.

This misapplies state trust law. State trust law focuses on funding by the owner because that is the only person who can establish the rules of the trust governing his or her property. In the situation created by Congress, where parents are to establish a trust to hold their child's assets, the obligation that arises when the trust is funded is not determined by the funding but by the trust document executed earlier by the parents as settlors and accepted by the trustee. In most states, the terms of the document control.[119] Thus, it *is* the parents who create the trust document who are the settlors, not the child whose assets later fund the trust.

SSA gets out of this conundrum by another jerry-built solution: looking for authority in state law for the creation of a trust without property, what it calls a "dry" or "empty" trust, by which it means an unfunded *inter vivos* trust.[120] Absent express authorization of "dry" trusts, SSA treats the parent-created trust as inadequate under 42 U.S.C. § 1396p(d)(4)(A).[121] SSA has found that some states do and some states do not, citing and relying on indistinguishable state court decisions that all require a trustee have title to property.[122]

These misunderstandings of state trust law are not minor deviations from an otherwise sound approach. They concern essential features of trusts — creation, beneficial interests, and revocability. Having gotten them so wrong, SSA frankly cannot be trusted to construct a system that remains true to what Congress intended in adopting trusts to promote public benefit programs. Moreover, the fundamental incomprehension of what a trust is carries over to the problem of finding meaning in a trust for the sole benefit of a person as a matter of federal law.

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119 In determining the terms of the trust, the first resort is, of course, to the governing instrument. … [T]he terms of the governing instrument ordinarily are the terms of the trust. … [T]he governing instrument, if unambiguous, is ordinarily determinative. In such a case, extrinsic evidence is inadmissible to vary or add to the terms of the instrument … .

Ascher et al., *supra* n. 57, at § 2.2.4, 42–43.

120 See POMS SI 01120.203B.1.f. This is another misuse of existing terms from state trust law. In trust law, a dry trust is one in which the trustee has no affirmative duties, e.g. Provident Life & Accident Ins. Co. v. Little, 88 F. Supp. 2d 604, 607–608 (S.D.W. Va. 2000), and Atkins v. Marks, 288 S.W.3d 356, 367 (Tenn. Ct. App. 2008); an empty trust is one whose assets have been distributed, e.g. Giannini v. First Nat. Bank of Des Plaines, 136 Ill. App. 3d 971, 975 n. 3, 483 N.E.2d 924, 929 (Ill. App. 1st Dist. 1985).

121 See POMS PS 01825.046 (S.D.), summarizing the decision affirmed in Draper v. Colvin, ___ F. Supp. ___ (D.S.D., July 10, 2013), 2013 WL 3477272, appeal pending, No. 13-2757 (8th Cir.).

122 *Cf*. POMS PS 01825.046 (S.D.), stating that South Dakota does not authorize dry trusts, citing and relying on Higgins v. Higgins, 71 S.D. 17, 20 N.W.2d 523 (1945), for the proposition that "to be a valid trust, the provisions 'must be reasonably certain as to the property …'") with *e.g*. POMS PS 01825.042 (Pa.), which states that Maryland does authorize such trusts, citing and relying on From the Heart Church Ministries, Inc. v. African Methodist Episcopal Zion Church, 370 Md. 152, 167, 803 A.2d 528, 557–558 (2002), although the court states the opposite: "A trust [only] exists where the legal title to property is held by one or more persons …"). See also Duggan v. Keto, 554 A.2d 1126, 1133 (D.C. 1989) (a trust must have "a trustee, who holds the trust property"); Buchanan v. Brentwood Fed. Sav. & Loan Ass'n, 457 Pa. 135, 144, 320 A.2d 117 (1974) (transferee of property with duties to "deal with the property for the benefit of another person"; "one of them as trustee holds property for the benefit of the other"), also cited and relied on in POMS PS 01825.042 to find that those jurisdictions allowed so-called dry trusts.

b. Sole Benefit as a Feature of Federal Law

Even if the meaning of "sole benefit" is a question of federal law, the federal agencies can still claim no special expertise. Special needs trusts are a recent exception in the public benefits arena, and understanding sole benefit does not draw on any existing agency experience. The meaning of sole benefit does not involve a close reading of a highly complex statute with hundreds of moving parts, each of which affects dozens of others. Both agencies have the authority and the competence to address what kind of state property entities are available as resources or income and, for example, what kind of entities constitute income and what kind constitute resources, how they are counted or excluded, how they interplay with one another, and deeming from one to another; these are the kinds of statutory questions that CMS and SSA are uniquely qualified to answer. Both agencies correctly claim to continue to have primary authority to define and address the status of income and resources as they go into or come out of trusts,[123] but that is a different matter from interpreting the law of trusts or addressing how trusts should operate, which is what sole benefit properly concerns.

Nor does interpretation involve a close reading of specific legislative history and Congress-agency interchange to interpret an otherwise opaque statute.[124] CMS first addressed the issue in the wake of Congress's enactment of OBRA '93, and it has hardly visited the issue since. Special needs trusts were introduced into SSI with no history of agency action or reaction. The strongest argument in favor of the CMS/SSA definition is that Congress carried over much of the Medicaid statue to SSI after CMS had promulgated its informal State Medicaid Manual provision.

3. Validity of Reasoning and Persuasiveness

To address the validity of the agencies' reasoning requires, first, considering what question they were trying to answer. Congress's primary goal, inferred from the statutory structure, was to ensure that the person with a disability received the benefit of the resources set aside in trust. Much of what has been said above reflects the failure of CMS and SSA to understand how this operates in the context of a trust relationship. Three additional points merit discussion.

First, the definitions of sole benefit and "solely for the benefit of" add little to the statutory terms. They are the regulatory equivalent of saying the same thing, only louder.[125] Where the statute says "solely for the benefit of," both CMS and SSA say "the trust benefits no one but that individual … ."[126] It is difficult to see what the definition adds; it provides no operational direction, no indication of what the trust document should say that the statute does not already address, and no guidance to trustees on what they can or cannot do.

123 POMS SI 01120.200E; *Transmittal 64, supra* n. 1, at § 3259.7C ("funds entering and leaving [so-called Miller trusts] are not necessarily exempt from treatment under the rules of the appropriate cash assistance program"). *See supra* nn. 102 and 106.

124 *Cf. Md. Dept. of Health & Mental Hygiene v. Ctrs. for Medicare & Medicaid Servs.*, 542 F.3d 424 (4th Cir. 2008).

125 *Cf. Gonzales v. Ore.*, 546 U.S. 243, 256–257, 126 S. Ct. 904, 915 (2006) (dismissing an "interpretive" rule that "does little more than restate the terms of the statute itself").

126 POMS SI 01120.201F.2; *Transmittal 64, supra* n. 1, at § 3257.6.

Second, CMS provided the one real elaboration on the basic definition of sole benefit, its dog-in-the-manger[127] requirement for actuarially sound distributions.[128] This addition is neither well reasoned nor persuasive. In requiring minimum required distribution–type distributions, CMS is telling trustees to make distributions even when doing so is not required to pay for any goods or services the beneficiary needs or wants. This can, if it has any effect at all, only result in reducing trust resources prematurely and unnecessarily, wasting resources and potentially leaving the beneficiary with inadequate resources later in life.[129]

CMS's offer of payback as an alternative to actuarially soundness suggests that one

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127 The proverbial dog in the manger cannot use the hay that is there while keeping away the ox that could, so the hay is wasted. *Aesop's Fables* 163 (Laura Gibbs trans., Oxford World Classics 2002).

128 CMS may have meant something such as the "minimum required distribution" rules that require distributions from tax qualified retirement plans at a rate designed to exhaust the accounts during the taxpayer's actuarial lifetime. But in fact "actuarial soundness," as actuaries use the term, is a rule of caution limiting how much a plan can pay out and still be able to meet its future obligations. While it is almost always used in the context of a plan involving multiple beneficiaries, *e.g. Allied Structural Steel Co. v. Spannaus*, 438 U.S. 234 (1978), in an individual case it may mean reducing a monthly benefit to ensure that the benefit will continue during the person's entire lifetime, the opposite of what CMS likely intended.

CMS's use of the term "actuarially sound" with respect to annuities is similarly unsophisticated. It published an SSA table of life expectancies based on age and stated that "[i]f the individual is not reasonably expected to live longer than the guaranteed period of the annuity," he or she "will not receive fair market value" and the annuity is "not actuarially sound." *Transmittal 64, supra* n. 1, at § 3258.9B, para. 4.

First, this reflects a misunderstanding of the significance of an actuarial table, which shows only average life expectancy; it is not a prediction of how long any one person will live. Second, the rule does not recognize the risk element in an annuity and thus fails to treat as a transfer the purchase of a life-plus-years-certain annuity no matter what the term-certain period is.

The additional cost of the term-certain provision is the price to be paid to cover the risk that payments must be made beyond the person's actual lifetime. Thus it allows for the benefit of someone other than the annuitant. For example, if a 70-year-old man with a life expectancy (under the Medicaid table) of 12.81 years can purchase an annuity paying $3,000 per month for life for $475,000, and a life-plus-10-years-certain annuity paying that much per month costs $550,000, the cost of the term-certain benefit, which only benefits others, is $75,000 — the additional cost to purchase the right to payment (up to 10 years) beyond the annuitant's actual lifetime. That $75,000 should be treated as a transfer to the named beneficiaries, but isn't.

Congress has adopted CMS's approach in using the idea of "actuarially sound" based on SSA tables in approving the use of certain annuities in Medicaid planning, 42 U.S.C. § 1396p(c)(1)(G)(ii)(II). That may render the use of actuarial soundness immune to judicial review with respect to annuities, but the issue with respect to special needs trusts is quite different.

129 In *Lloyd v. Campbell* 120 Ohio App. 441, 196 N.E.2d 786 (Ohio App. 1964), the court rejected the beneficiary's claim that she was entitled to all current income where the trust did not specifically authorize the trustee to convert undistributed income to principal, under the trustee's duty to consider her future welfare if not in derogation of present needs.

> Most certainly, it may be logically and persuasively argued that the beneficiary's welfare and benefit is being nobly served if the trustee elects to treat excess income as principal and invests it as such, thereby increasing the fund subject to the trust and the amount that will be received by the beneficiary when she reaches age 25, and likewise increasing the amount she will receive at age 32 when the trust is terminated and final distribution of the remaining half of the principal is made to her. Of course, if the beneficiary's present benefit and welfare is neglected in order to increase the trust principal, this would be an abuse of discretion on the part of the trustee.

Id. at 449, 196 N.E.2d at 791–792.

of its reasons for requiring actuarial soundness was to protect beneficiaries from trustees who are also remainder beneficiaries. Payback would reduce if not eliminate an interested trustee's incentive to preserve funds. Perhaps unsophisticated family member trustees are swayed by payback that forecloses effective self-interest, but imposing the requirement on disinterested professional trustees suggests SSA does not fully understand or appreciate what trustees do.

Third, the agencies' definition of sole benefit fails to address trustee duties. A trust that does not relieve the trustee of his or her obligations to remainder beneficiaries under the duty of impartiality can only result in underserving the beneficiary with a disability. Without an express waiver in the trust document, a trustee must take into account both the lifetime and remainder beneficiaries' interests. The conscientious trustee might well decline to spend trust funds when it threatens the remainder beneficiaries' ultimate share. Both CMS and SSA, unsophisticated as they are in their understanding of trusts, are silent on this crucial aspect of trust administration. In their discussion of sole benefit, they have failed to understand the nub of the problem (i.e., the need to relieve a trustee of a duty of impartiality between the life and remainder beneficiaries) and instead focused their efforts on a proxy, requiring distributions for the life beneficiary.

The elements for discarding *Skidmore* deference are present. These issues are outside the normal agency purview, the agencies' analyses have pervasive errors with respect to the state trust law they attempt to analyze, and their own definitions fail to fully serve Congress's purpose and are not supported by solid reasoning.

VI. A Practical and Effective Approach to Special Needs Trust Regulation That Utilizes Trustees as Partners

The task for CMS and SSA is to use their authority to develop standards and guidelines that utilize, rather than thwart, competent, responsible, properly trained trustees as their partners in making special needs trusts an effective tool in serving the needs of people with disabilities. If this were done properly, capable trustees would be the allies of the federal and state agencies in the efficient use of limited private resources. Beneficiaries would live better, more rewarding lives to the extent that resources can make a difference, at lower cost to Medicaid, with a greater possibility of more funds recovered through payback.

As a threshold matter, the agencies would appear to have somewhat different authority but common areas of concern. Even before getting to the substance of supervision of special needs trusts and trustees, CMS and SSA should resolve between themselves whether, as the court held in *Lewis*, there is a single, nationwide rule for special needs trusts rooted in federal law except to the extent it relies on state law operation. Related, it would be a rare but impressive moment if the two sister agencies could coordinate or even combine their efforts to develop a single, uniform approach for special needs trusts.

As part of that process, the agencies ought to come to recognize the limit of their ability to manage special needs trusts. Even aside from their many errors, the agencies went fundamentally astray in focusing on benefit as a measure of each transaction rather than as a guide to trustee conduct. By focusing on who received payment, a familiar cash benefits idea, they came up with a rule that is both too narrow and too broad.

Consider whether a trustee should pay a parent to provide necessary daily care for a severely disabled child, as in *Hobbs v. Zenderman*.[130] Who benefits when a trust pays a mother a little more than minimum wage to stay home and care for her seriously disabled 7-year-old son? Under the CMS/SSA standard, as applied by a state Medicaid agency, this benefitted the mother. This was the result even though the independent corporate trustee with probate court approval concluded that paying the mother was preferable to paying substantially more while the mother worked outside the home for less.[131] The trustee was denied the opportunity to exercise its discretion and purchase the care for the child the least expensive way possible. Plainly, the definition can be too narrow when it asks, "Who gets paid for caring for a disabled 7-year-old?" and does not permit payment on facts such as these.

But by the same token, it is too broad when it asks only, "Who gets paid for caring for a disabled 7-year-old?" Who benefits when a trust pays for certified nursing aides for 24-hour care for the seriously disabled 7-year-old oldest daughter of a family of five, with a stay-at-home mother and a highly compensated father? The CMS/SSA standard would see this as the child's "sole benefit," even though the parents and the other two children plainly benefit as well. The parents are relieved of a huge burden, while the younger children might feel like they get their mother back. The trustee might well conclude that the disabled child's funds should be preserved while the family provides some of the care. A definition that always permits such payments is plainly too broad.

The proper question is not, "Who was paid to do the necessary work?" but "Is this the most cost-efficient way to take care of the child's needs, taking all of the facts and circumstances into account?" This is how state trust law typically handles these issues, under the best interests of the beneficiary standard. A trustee might answer the question differently depending on the situation of the family. Is the mother home with a housekeeper because the family does not need her income and she elected to be an at-home mother? Does the trust have sufficient assets and scheduled income from a structure to pay for full-time aides now and still have sufficient funds to meet needs potentially 80 years in the future? These are decisions best left to a trustee to make on a case-by-case basis.

SSA's recent effort to address using special needs trusts funds for travel to allow beneficiaries to visit with relatives, discussed above,[132] illustrates the limit on what an agency can do through general rules. Consider the following scenario. The Washington, D.C., parents of a severely autistic child, living in a specialized Florida facility, would like to visit him, and the facility's staff agrees that maintaining family ties is extremely beneficial for the boy. The options are to pay the cost for a round trip for one of the parents to visit the boy in Florida, perhaps including other travel costs such as car rental, hotel, and meals, or to pay the cost for two round trips for the boy and an aide to go to Washing-

130 *Hobbs*, 579 F.3d at 1171.

131 The fact that the plan was proposed by an independent corporate trustee and approved by the local probate court are among the undisputed facts that the court in *Hobbs* believed unnecessary to include in its decision justifying the result. *See In the Matter of the Steffan Hobbs Special Needs Trust*, San Juan County (N.M.), 11th Judicial Cir., Case No. CV-2003-136-6, Order Authorizing Expenditure of Funds (June 11, 2003) (http://www.naela.org/NAELADocs/PDF/NAELA%20Journal/Hobbs%206-11-2003%20order_001.pdf).

132 *See supra* nn. 52–55 and accompanying text.

ton, along with wages and other expenses for the aide.

For the trustee, the issue is the child's best interests, including both current and future needs. Assuming the cost of the parents visiting is less, the trustee can consider whether trust funds are necessary. If the family is relatively affluent and could or would go even without a trust contribution to the costs, the trustee could reasonably decline to pay the costs, based in part on the need to preserve assets for the child's long-term needs. If the family could not afford such a trip without financial support from the trust, the trustee must weigh the long-term benefits of providing family contact against the child's future needs. But the standard would not be the formalistic "Who used the service?" but the real and practical one of "What is best for the child?"

Trustees of special needs trusts are subject to state trust laws that provide numerous protections for the beneficiary and for compliance with the terms of the trust. State probate court judges and state legislatures have established well-developed protections for beneficiaries of trusts, including accountings, removal, surcharge, penalties, fines, and in some circumstances even penal sanctions. This is where the supervision of trusts should be managed, not with public benefits eligibility workers with little or no experience in how trusts are managed or with sweeping policies in federal policy manuals that cannot take into account all of the facts of individual situations.

Sole benefit refers to the standard that guides the trustee, not to specific transactions. That is the level at which CMS and SSA can and should operate. Aside from clearing up the errors arising from failing to recognize the centrality of the role of the trustee[133] and the proper use of state trust law,[134] the agencies should address trustee standards and duties, perhaps where the problems are the most complicated. Few problems are more vexing than providing a home and caregiving for a disabled child whose family is poor and cannot afford appropriate accommodations and care. These and other complicated problems would benefit from a process in which the agencies get the benefit of trustees' experience in the real world of special needs trusts.

133 For example, its analysis of (d)(4)(B) trusts, which finds that income that funds the trust is for the benefit of the beneficiary only when spent. If the trustee has an affirmative duty to use the funds for the beneficiary, under a best interests standard, funding the trust is for his or her benefit no matter when the money is spent.

134 For example, blanket imposition of the Rule in Shelley's Case and the Doctrine of Worthier Title.

Administration of Special Needs Trusts: Development of an Improved Approach (Part I)

By Edward V. Wilcenski, Esq. and Tara Anne Pleat, Esq.[1]

Introduction:

We think it fair to say that most Elder Law and Special Needs Planning attorneys have developed a level of comfort with third party special needs trust practice. Many of the rules and concepts which apply to other trusts and which are used in a traditional estate planning practice carry over quite nicely.

The same cannot be said for the practice involving first party trusts. Indeed, the very nature of first party trust practice defies efforts to create a uniform set of practice standards for drafting and administration.[2] By definition these trusts are funded with the property of individuals with disabilities (as opposed to parents or other benefactors), leading to practice variations based on:

* disability, which can be cognitive, physical, or some combination of them;
* the nature of the property interest, which can be the proceeds of a personal injury settlement, marital property, inherited or gifted assets, accumulated earnings, and federal and state benefits;
* procedural context, which can be governed by the rules of the guardianship court if the trust is being funded in connection with a guardianship proceeding, the civil practice statute if the trust is being funded as part of a court approved litigation settlement, or the rules of the family court if the trust is being incorporated into a divorce proceeding; and
* program rules for public benefits, including Supplemental Security Income, Medicaid and Section 8 among many others.

First Party Trust Administration: Uncertainty and Indecision

New York enacted a third party supplemental (special) needs trust (SNT) statute, Section 7-1.12 of New York's Estates Powers & Trusts Law ("EPTL 7-1.12") in 1993. That same year Congress carved out an exception for first party trusts in the federal Medicaid program's transfer of asset penalty provisions,[3] and in 1994 our State legislature amended EPTL 7-1.12 to be used as the drafting template for both types of special needs trusts.[4] The result is something of a hybrid: a trust borne of federal Medicaid law governing asset transfers, framed within a state trust statute which codified the holding of a watershed state court decision on third party trusts.[5]

In New York, some courts – especially in the early years after the enactment of OBRA '93 – attempted to create drafting and administration standards for first party trusts.[6]

These early decisions are inherently fact- and forum-specific. They have led to as much confusion as clarity and offer little precedential value as trial court decisions. At best, they establish little pockets of common law applicable in similar proceedings involving cases with nearly identical facts.

A survey of New York case law[7] involving first party trusts shows that:

* statutory and regulatory guidance is limited;

* In the absence of guidance, courts give excessive deference to public welfare officials and program administrators; and

* the law continues to wrestle with the concept of disability, retaining vestiges of the outdated idea that all disabilities are alike and that every individual with a disability, regardless of the nature of the disability or the existence of informal supports, requires micromanagement and rigid oversight.

This lack of clarity has had a practical impact on the availability of qualified trustees. In our experience, many capable banks and trust companies – and especially the smaller regional institutions – are second guessing their commitment to the special needs trust market.

As special needs planning attorneys we certainly feel their pain. Perhaps the most challenging aspect of first party trust practice is the lack of credible guidance in the area of administration, leaving the trustee unsure of the criteria being used to measure its conduct. Some courts are inclined to micromanage expenditures, others are not. Some rely heavily on the public benefit program representatives' opinions, others do not. Some courts have the personnel to review regular accountings of trust activity, others do not.

This uncertainty is compounded by a blurred line of demarcation between what types of activities should be considered part of the trustee's fiduciary responsibility, and which activities can and should be delegated to outside counsel, private case managers and others.

For their part, given the inconsistent decisional law in this area, court examiners and judges often substitute their judgment for that of the trustee, and default to a generalized and uncircumscribed 'best interest' standard to pick and choose which expenditures are deemed appropriate and which should be disapproved and subject to surcharge. This leaves trustees hesitant to make distributions for fear of being second guessed by someone with little or no firsthand knowledge of the beneficiary's day-to-day circumstances, and fearful of seeking professional assistance out of a concern that those expenditures will be challenged in the future.

Banks and trust companies bear some responsibility for the current state of affairs. Many entered the special needs trust market without much thought to how SNTs differ from other discretionary trusts, and they applied the same administrative and oversight practices to SNTs they used for other trusts.

As a result, in cases where beneficiaries are incapable of self-advocacy and lack any family or informal supports, SNTs often sit dormant. This was the situation in a well-publicized New York case where a professional fiduciary was chastised for failing to take affirmative steps to remain informed about the needs of its autistic beneficiary.[8] In other cases, the trustees fail to do their due diligence in investigating the availability of government benefits, instead relying exclusively on requests made by family members and guardians. This occurred in a case which received significant attention here in New York,[9] the result being a substantial surcharge against the fiduciary.

These two well-publicized decisions do not present the professional trustee in a particularly favorable light, justifiably so given the facts of the cases. But they have reinforced the perception that this area of administration is fraught with risk, and as a result many banks and trust companies are reluctant to administer SNTs.

The practical implications are significant and far reaching. The disability community needs credible, capable and competent professional trustees to administer special needs trusts, first party and third party alike. Parents and family caregivers are aging, and when they pass on, siblings and other family members may be unwilling or unable to fill their shoes. Disability service providers will continue to face cuts in Medicaid and other sources of government funding. It is a simple matter of demographics and public finance: the safety net is not what it once was, and private dollars will be needed to fill in the gaps to ensure that individuals with disabilities do not suffer as a result.

While most attorneys practicing in this area are familiar with the concept of an SNT being a discretionary trust, little has been written on how a trustee's exercise of discretion should be measured in the context of a formal accounting of trust activity. We concentrate on first party trusts in this article because of the greater risk associated with the Medicaid program's right of repayment, but the discussion of an appropriate standard of review for discretionary distributions would apply to both first party and third party trusts.

This article, the first of two, focuses on the appropriate standard of review for discretionary decisions made by trustees of SNTs. The next will provide suggestions on how a trustee might satisfy that standard by striking a balance between two credible objectives: (1) the need for court oversight of a trustee who is managing money for a beneficiary who cannot advocate for herself, and (2) deference to the trustee's right to make discretionary decisions which it reasonably believes to be consistent with its fiduciary responsibilities.

General Obligations of the Trustee of a Supplemental Needs Trust

SNTs are discretionary trusts, but they require trustees in the exercise of discretion to consider the availability of government benefits before deciding to pay privately for a good or service. In New York, our statute allows for the distribution of "net income and/or principal of [the] trust as the trustee shall deem advisable, in his or her *sole and absolute discretion*."[10]

When it was enacted in 1993, New York's statute was intended to codify the holding of Matter of Escher,[11] the first case in New York to support the right of a discretionary trustee to refuse to pay for something that might be available from a publicly funded source (or, in that case, to repay the State for benefits provided in the past). The trustee's ability to exercise discretion was central to the holding in the case, later upheld by the highest court in our State.

New York's statute goes one step further. It allows a drafting attorney to provide the trustee with discretion to make a distribution *even if the distribution causes a reduction in benefits,* so long as the beneficiary will be better off as a result.[12] In exercising this grant of discretion, a trustee must:

1. consider *current* financial eligibility rules, understanding that government benefit eligibility is not static and will continually evolve due to changes in family composition, family financial condition, and beneficiary capabilities and preferences;

2. consider services and supports that are available to the beneficiary as a result of the beneficiary's participation in one or more government funded programs; and

3. ascertain whether services and supports available at the time of a proposed distribution are sufficient to meet the beneficiary's needs and preferences, or whether additional or alternative goods and services should be purchased privately with trust assets. If the latter, the trustee must be able to document the basis for the use of private funds.

But once a trustee has done its due diligence and made the distribution, what standard does a court use to review the trustee's decision to determine whether the distribution should be upheld in a proceeding for settlement of the trustee's accounts? We think the lack of a uniformly accepted answer to this question is the source of much conflict and consternation within the fiduciary community.

Federal law does not provide a standard of review

The Statute

The federal Medicaid statute 42 USC §1396p(d)(4)(A), provides the underlying foundation for first party trusts. It has four basic requirements: the trust must be established by a parent, grandparent, guardian, a court or by the individual with a disability, the beneficiary must meet the disability criteria under the Social Security Act, the beneficiary must be under the age of sixty-five (65) years at the time the trust is funded with the beneficiary's assets, and the trust must provide that upon the beneficiary's death, State Medicaid programs be repaid for medical assistance provided during the course of the beneficiary's life.

If a first party trust complies with these four criteria, the trust will receive the associated protections under federal Medicaid and Supplemental Security Income (SSI) law: trust

assets will be disregarded in determining resource eligibility while the income counting rules of these two programs will determine how a distribution will impact benefit eligibility and amount.

With one important exception, the federal statute leaves fiduciary standards to be determined under the law of the state where the trust was established.[13] The federal transfer of asset provisions exempt transfers to first party trusts under both 42 USC §§1396 d(4)(A) and d(4)(C) which are established for the "sole benefit" of an individual with a disability. The term has been interpreted to impose a limitation on distributions, often leading to absurd results.[14] We agree with NAELA Fellow Ron M. Landsman, whose thoughtful analysis leads to the better interpretation of that term: a deviation from the traditional fiduciary obligation to treat all beneficiaries equally, both income beneficiaries and remainder beneficiaries.[15]

The Regulations

No federal regulations were ever issued in connection with the first party trust provisions of the federal statute.

The Administrative Guidelines

The Health Care Financing Administration ("HCFA", now the Centers for Medicare and Medicaid Services or "CMS") modified the State Medicaid Manual shortly after the enactment of OBRA '93 in order to provide guidance to the States in implementing the changes to federal Medicaid law.[16] As it relates to first party trusts, this federal guidance – commonly referred to as "Transmittal 64" – deals primarily with the impact of funding first party trusts on Medicaid eligibility.

The SSI program's Program Operation Manual System (POMS) contains quite a bit of guidance on how the establishment, funding and administration of trusts might impact eligibility for the SSI program. [17]

There is no discussion of a fiduciary standard of review under either set of rules.

New York courts have largely ignored the standard suggested in our statute

A reader might assume that SNT administration in New York is well settled in light of the fact that our statute says – clearly and unequivocally – that an SNT trustee has "sole and absolute discretion" to make distribution decisions. The reader would assume that trustee conduct is measured in accordance with long standing New York law governing discretionary trusts.[18] The reader would be mistaken.

New York cases involving first party trusts include personal injury settlements, guardianship proceedings and family court proceedings. Because of the inherently fact

specific nature of the cases, they do not provide a reliable and broadly applicable precedent for the drafting and administration of first party trusts.

While there are cases, including from our highest court, which explicitly acknowledge the discretionary nature of SNTs,[19] we are not aware of any decisions which considered a contested distribution from an SNT, acknowledged the trustee's discretion to make a distribution decision, and upheld the distribution notwithstanding the fact that the court might have made a different decision.[20] This level of deference to the trustee of a discretionary trust – qualified by the trustee's responsibility to ensure that its decision is both supportable on the law and facts and is duly documented – is a familiar concept to the seasoned fiduciary.[21] It underlies the professional fiduciary's willingness to accept an appointment with the understanding that every decision may at some point be called into question.

Many attorneys who represent trustees of SNTs feel as if their clients do not receive the same level of deference, leaving them like fish in a barrel to be speared by the many parties who have standing to second guess: court examiners, judges, public welfare agency attorneys, and disgruntled beneficiaries who may have behavioral and cognitive deficits that make collaborative administration difficult. The fiduciaries' concerns are legitimate.

Identifying a standard of review

Most attorneys who represent fiduciaries know that the traditional standard of review for a discretionary trust is the "abuse of discretion" standard. Yet once government benefits and disability are added to the mix, conviction wavers and the analysis becomes diluted.

There seem to be two assessment methodologies used by most practitioners, courts and commentators when analyzing distributions from SNTs. One focuses on benefit eligibility, the other uses a broad and uncircumscribed "best interest" analysis. Both assessments are relevant, but neither should be used as a substitute for the "abuse of discretion" standard when reviewing the accounts of the trustee of an SNT.

Benefit eligibility is only one factor to consider when making distributions

The language of a "typical" SNT requires consideration of the availability of publicly funded benefits before a distribution is made, with the understanding that the impact of a distribution will vary from program to program.[22] Benefit program rules are applied at the time of the distribution, and are based on the beneficiary's *current* eligibility status. So, for example, the payment of rent by a trustee will impact otherwise similarly situated beneficiaries depending on program eligibility: Medicaid, which in New York allows a trustee to make in-kind payments from an SNT, including for food and shelter, without a reduction in benefits,[23] Supplemental Security Income (SSI), the rules of which typically reduce the benefits of an SSI recipient if a trust pays for food and shelter,[24] and Supplemental Nutrition Assistance Program ("SNAP"), formerly Food Stamps, which (in

New York) may treat payments to a beneficiary's household that are permissible for Medicaid purposes as countable income for SNAP purposes, thus reducing the monthly SNAP subsidy.[25]

It is not uncommon for a distribution to have an adverse impact on one benefit and no impact or limited impact on another. If a trustee decides to pay a beneficiary's rent, there may be a limited impact on the beneficiary's SSI payment, no impact on Medicaid eligibility, but a substantial reduction in the SNAP subsidy. If the trustee's decision to pay rent is reviewed (after the fact as part of an accounting proceeding) based on its impact on government benefits, which benefit program should serve as the baseline in determining the permissibility of the distribution by the trustee?

The answer is "none of them." Program rules do not restrict or permit a distribution; rather, the rules inform the trustee and beneficiary alike whether the contemplated distribution will have an impact on benefits. The trustee must decide whether a distribution – and the resulting impact on benefits – puts the beneficiary in a better place.

The trustee's failure to consider this distinction results in over-reliance on the often *ad hoc* and arbitrary decisions of government benefit agencies, excessive deference to public welfare agency attorneys in court proceedings involving SNTs, and an obsessive focus on informal and non-binding speculation by agency staff who opine on how an issue might be addressed in a future rule or decided in a future controversy. From our perspective, the result is that the tail ends up wagging the dog.[26]

Perhaps the best example of "excessive deference" can be found in In re McMullen,[27] a trial court case involving the review of a first party trust as part of a proceeding to settle a personal injury lawsuit. Initially, the decision includes a good explanation of the court's responsibility to ensure that a proposed trust document meets the statutory criteria for first party trusts such that the beneficiary's eligibility for Medicaid would be protected.

However, in trying to reconcile a disagreement between the petitioner and the attorney for the local Medicaid agency on the terms of the proposed trust, the court announced a "prophylactic" remedy that would be applied prospectively in all proceedings brought before that Court.[28] The 'remedy' was to require a petitioner to secure written approval for the terms of a first party trust from the local Medicaid agency before the court would entertain the petition. In other words, the court would require the petitioning party to concede to the demands of the Medicaid program representative - in advance and without the right to be heard - just for the matter to be accepted for consideration.

It is unlikely that such a position would be upheld on appeal (none was taken in the case), and one can understand why a court with little statutory guidance and without competent advocacy by special needs trust counsel would try to fashion a remedy to streamline future proceedings. But the case is badly decided.

Another recent New York decision, Matter of Tinsmon[29], illustrates how public welfare agency attorneys try to use program rules to control and limit fiduciary conduct. In Tinsmon, individual co-trustees of a first party trust sought court approval to use trust funds to purchase a one-half interest in the primary residence of the beneficiary, an SSI recipient. The beneficiary already owned the other one-half interest outright. The trust did not require prior court approval, but the co-trustees were also the parents and court appointed guardians. More important, the one-half interest was owned by one of the co-trustees who had helped the beneficiary finance the purchase prior to the injury.

The co-trustees asked the court to approve the 'buy out' of the co-trustee's interest and, in effect, a distribution of the interest to the beneficiary, outright and free of trust, with the result being that the beneficiary would own the entire residence. The beneficiary was a young mother, and by leaving the home in her name her interest would pass to her children without estate recovery for expenses incurred prior to age 55.[30]

The local Medicaid agency was served with process because of the Medicaid program's right of recovery at death and – predictably - objected. The agency argued, among other things, that the transaction was prohibited under the POMS.

There is no such prohibition under the POMS. The POMS clearly contemplate that a trustee may use trust assets to purchase an item which would be exempt in determining SSI eligibility if owned by the beneficiary outright,[31] a point made clear by the Guardian *ad litem* who represented the beneficiary in the transaction. The Guardian *ad litem* recommended that the transaction proceed as proposed, and the Court ultimately approved.[32]

But what if there was an adverse impact on SSI? So long as the trustee determined that the beneficiary would be left in a better position notwithstanding, the terms of the trust and the language of New York's statute give the trustee the discretion to proceed nonetheless. Benefit eligibility is just one factor to consider in the exercise of discretion; it does not independently permit or preclude a discretionary distribution.

"Best Interest" is another factor to consider, and should not be used as a substitute for the traditional standard of review

Courts considering the disposition of litigation settlements and guardianship property will render decisions based on what they determine to be in the "best interest" of the unemancipated minor or person with a disability. Predictably, decisional law in this area tends to be very fact specific, and commonly recites the courts' responsibility to protect those who are unable to speak for themselves.[33]

A best interest assessment is properly undertaken when a trust arrangement is being recommended to a court. Whether the use of a trust (versus some other custodial arrangement) is appropriate, whether the proposed trustee is acceptable, and whether the terms of the proposed trust are consistent with the objectives and concerns of the

court should all be viewed through the "best interest" lens at the time the arrangement is being proposed.

The most frequently cited example of this practice in New York is in the Matter of Morales, where a court-appointed guardian sought to transfer litigation proceeds to a first party trust to protect benefit eligibility. Explaining that "the duties and responsibilities of the trustee to the incapacitated person are akin to those of a guardian," the court went on to require modifications to the language of the proposed document which it "deem[ed] necessary to protect the interests of the disabled person."[34] The judge then provided – right in the language of the decision - a sample trust document to be used as a "guide to the bar" for drafting first party trusts.

The "Morales Trust" document provided by the court includes provisions not required as a matter of statutory law and which many practitioners believe to be overly restrictive. The decision should be understood to provide guidance only in cases involving the establishment of SNTs in guardianship proceedings. But many New York courts continue to follow it when funding an SNT is proposed.

In the context of the *establishment and funding of an SNT*, the parties understand the rules of the game. The court must decide *whether* the SNT should be established, *who* should serve as trustee, and *how* the trust should be drafted to address the court's specific concerns in that particular case. Counsel have their opportunity to argue against modifications they believe exceed the statutory mandate or which are not necessary given the facts of that case, and ultimately the court will render its decision based on what it believes to be in the best interests of the individual before it.

But the question presented here is a different one: once an SNT has been established and funded in accordance with a court's best interest determination (or even in those cases where the SNT is established independently and without court involvement), what is the standard of review to be applied by a court when reviewing distributions made by the trustee? Little decisional law exists in New York, but one well publicized case[35] illustrates the approach taken by most courts in our experience.

In Matter of Liranzo the corporate trustee of a first party trust funded with litigation proceeds sought to settle its account and terminate the trust. The trust was initially funded with just over $420,000. Six years later, the trust had approximately $3,200 remaining. The accounting showed that most of the money was used to pay for private caregivers and taxi service for the beneficiary.

The decision begins with the judge's conclusion that the trustee breached a number of commonly understood, generalized rules of fiduciary conduct (the "duty of undivided loyalty," the obligation to administer the trust in the "sole interests of the beneficiary," and the need to "act reasonably and in good faith"). But the decision goes on to recite concepts that are less precise (criticism of distributions that "could have either been avoided or were unreasonable," the failure to "provide support for the plaintiff for as long

as possible," and "authorizing each and every discretionary disbursement requested by the infant plaintiff's mother"[36]).

In addressing the private caregiver payments, the judge criticized the trustee for accepting the mother's claim, supported by a private social worker, that the beneficiary was better off with private caregivers as opposed to Medicaid funded aides. This was not sufficient for the judge, who wrote that "the trust agreement requires that a good faith effort be made by the trustee to inquire about providers of home healthcare whose costs are covered under Medicaid."

The court also penalized the trustee for spending more than $50,000 on private taxi services based on the mother's representation that driving in a taxi was a form of therapy for the beneficiary. In the words of the judge, the trustee "should have further investigated before allowing the disbursements. This "taxi therapy" does not appear to be a responsible use of Trust fund monies consistent with prolonging the life of the Trust."[37]

A trustee might be able to work with the court's analysis of caregiver expenses, as the decision suggests that an investigation of Medicaid funded alternatives might have saved those distributions from surcharge. But testimony did show that the mother and a social worker were consulted prior to making the discretionary decision to pay privately for that care. Is that not a "good faith effort"? Was the issue the lack of independent inquiry by the trustee or a matter of inadequate documentation?

The court's analysis of the taxi expenses is more troubling. The statement that the expense "does not appear to be a responsible use of trust funds" is vague. Taxi therapy *did* appear to be responsible in the mother's eyes and in the eyes of the social worker. If the expense was hippotherapy would that have made a difference? And who better to make that assessment than the primary caregiver and a professional advocate?

Had the court articulated a clear standard of review to be applied to each trust expense, the decision would be more helpful. Instead, the judge substituted her judgment for that of the trustee as to what types of expenditures were in the best interest of the beneficiary, relying primarily on generalized statements of fiduciary responsibility to support her decision.

In the end the court refused to approve the private caregiver and taxi expenses (and a few others as well), resulting in a surcharge of over $170,000. Admittedly, when a trust with well over $400,000 is almost fully depleted in six years it does not bode well for the trustee. But egregious facts should not relieve the court of its responsibility to frame its surcharge and write its decision in a manner that leaves the parties with a clear understanding of the criteria being used to measure conduct.

What trustees need is a workable methodology for analyzing distributions – be they modest or significant, mundane or out-of-the-ordinary - once an SNT is up and running.

The first step in developing such a methodology is an agreement on the correct standard of review.

Abuse of discretion is the correct and the only workable standard of review to be applied when assessing distributions from special needs trusts.

The abuse of discretion standard is the traditional standard applied to the conduct of all discretionary trustees under New York law,[38] and is also consistent with a recent line of New York cases which take the position that SNTs should be treated no differently than other irrevocable trusts established under state law.[39]

The abuse of discretion standard is the only standard which can comfortably incorporate the legitimate objectives of the benefit eligibility assessment and the best interest assessment. Under the abuse of discretion standard, the trustee must consider the impact on eligibility and services (the benefit eligibility assessment) and the resulting benefit to the beneficiary (the best interest assessment) when making a distribution decision. Once these two factors have been reviewed, considered and documented and the distribution has been made, a reviewing court should defer to the trustee and approve the distribution unless the trustee abused its discretion by acting in bad faith or beyond the bounds of reasonable judgment.[40]

The abuse of discretion standard does not provide a 'pass' to the trustee of an SNT any more than it provides a pass to trustees of other types of discretionary trusts. All of the traditional obligations of fiduciary conduct would still apply: the need to invest prudently, the need to account in detail, the prohibition against self-dealing, etc.. But the abuse of discretion standard will protect the trustee who has complied with the traditional obligations of fiduciary conduct, and who can demonstrate that it has done its due diligence in considering a beneficiary's benefit eligibility and best interest when making a distribution decision.

Adoption of the abuse of discretion standard would help address many of the concerns of banks and other professional fiduciaries about assuming trusteeship of first party (and even third party) special needs trusts, and it would encourage more capable and credible institutions to offer their services to individuals with disabilities and their families. If clients prefer to use family members or other individuals as trustees, counsel can advise that their conduct will be measured in a fair and understandable way.

Next Issue: An Improved Approach

Once we accept the abuse of discretion standard as the correct standard of review for SNTs, the next step is to develop some practice standards and protocols to recommend to our trustee clients. In our next article we will offer some thoughts and suggestions on this topic.

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[1] The authors wish to express their thanks to NAELA Fellow Ron M. Landsman for his willingness to offer insight and comment on the ideas expressed in this article. His piece in the Spring 2014 issue of the

NAELA Journal, cited in footnote 15, remains one of the most important writings in the area of special needs planning in many years.

[2] This article is based primarily on law and practice in New York State. While we have tried to focus on general concepts which we believe to be incorporated into the law and practice of other states, we are also aware that many states have substantially modified these concepts by regulation and administrative rule. Thus we offer the standard lawyers' disclaimer: we think our positions are pretty solid here in New York, but you're on your own when you cross state lines.

[3] 42 USC §1396p(d)(4)(A), enacted as part of the Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66 (1993) ("OBRA '93").

[4] EPTL 7-1.12(a)(5(v).

[5] In re Escher, 94 Misc 2d 952 (Sur. Ct. Bronx Co. 1978), aff'd 75 AD2d 531 (1st Dept. 1980), aff'd 52 NY2d 1006 (1981).

[6] See, for example, In re Morales, N.Y.L.J., July 28, 1995, at 25 (Sup. Ct. Kings County 1995).

[7] Former New York State Bar Association Elder Law Section Chair David Goldfarb's chapter on supplemental needs trust practice in *Warren's Heaton on Surrogate's Court Practice,* 12-211.12 (Lexis 2018) includes a subchapter entitled "Court-Added Criteria for Supplemental Needs Trusts." The subchapter includes a summary of cases from a variety of New York State courts where judges required modifications to the trust document beyond what is required in our State statute, and which imposed administrative responsibilities on trustees beyond what is required in our state regulations. While the summary is interesting and informative, no credible reading of the cases would leave a practitioner with the impression that there is any uniformity of practice and procedure in in New York State.

[8] Matter of the Accounting of J.P. Morgan Chase Bank, N.A, and H.J.P. as co-Trustees of the Mark C.H. Discretionary Trust of 1995 v. Marie H., 956 N.Y.S.2d 856 (Sur. Ct. N.Y. Co. 2012).

[9] Liranzo v. LI Jewish Education/Research, 28863/1996, New York Law Journal 1202609859342 (Sup. Ct. Kings Co. 2013).

[10] EPTL 7-1.12(e)(1)(1).

[11] *Supra* n. 5.

[12] EPTL 7-1.12(e)(2)(i)(5).

[13] Lewis v. Alexander, 685 F.3d 325 (3d Cir. 2012), cert. denied 133 S. Ct. 933 (2013), involved the interplay between state trust law and federal Medicaid law. In Lewis, the State of Pennsylvania by legislation imposed limits on pooled special needs trusts not contained in the federal Medicaid statute, including a limit on the trustees' discretion to make various distributions. In striking down all of the State's restrictions other than oversight by the State Attorney General, the Court agreed that the state could supervise special needs trusts, but only in the same manner it supervises all trusts under general state trust law.

[14] In re: Estate of Skinner, N.C.App.Ct. No. COA15-284(June 21, 2016), *reversed*, 804 S.E.2d 449 (N.C. S. Ct. 2017). The Court of Appeals found that the lower court's reading of the term "sole benefit" as a rigid distribution standard would lead to the "absurd" result of a beneficiary (for whose benefit a home was purchased by the trustee) living in "bizarre isolation." The Supreme Court reversed the decision of the Court of Appeals because it used the incorrect standard of appellate review.

[15] See Landsman, Ron M., Esq., *When Worlds Collide: State Trust Law and Federal Welfare Programs*, NAELA Journal Volume 10, No. 1 (Spring 2014) for a comprehensive and persuasive piece on this topic. Interestingly, the North Carolina Court of Appeals in Skinner, *supra* n. 14., similarly interpreted the term "sole benefit" as a deviation from the traditional standard of loyalty owed to all beneficiaries.

[16] State Medicaid Manual, "Transmittal 64," General and Categorical Eligibility Requirements, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html (last visited September 12, 2018) (see, specifically, section 3259.7).

[17] *See* recent revisions to the Social Security Administration's Program Operations Manual System ("POMS") SI 01120.200 – 203, effective April 30, 2018.

[18] See Restatement [Third] of Trusts § 50(1)(b); see, also, In re: Estate of T. Harry Glick, 2005 N.Y. Misc. LEXIS 7336 (Sur. Ct. Kings Co. 2005) at page 9, citing Matter of Gilbert, 156 Misc. 2d 379 (Sur. Ct. New York Co. 1992); Trust of Frederick Brockway Gleason, Jr., 1999/4582 A, NYLJ 1202629074611, at 1 (Sur. Ct. New York Co. 2013).

[19] Matter of Abraham XX, 11 N.Y.3d 429 (2008) at 434.

[20] We are unaware of cases undertaking this analysis, with one important exception: the payment of attorney fees. These payments will always be subject to review (at least in New York), regardless of the grant of discretion and regardless of the consent of all interested parties to the amount paid. *See* Matter of Felice, 1 Misc. 3d 909(A) (Sup. Ct. Suffolk Co. 2004), which specifically addressed a trustee's argument that the supplemental needs trust document deferred to the trustee on attorney fees, and Stortecky v. Mazzone, 85 N.Y.2d 518 (1995), which confirmed the right of a probate court to review fees paid by a fiduciary even if all parties to an accounting have agreed and consented.

[21] See Restatement [Third] of Trusts § 50(1)(b); see, also, In re: Estate of T. Harry Glick, *supra* n. 18 at page 9, citing Matter of Gilbert, *supra* n. 18, and Leigh v. Estate of Leigh, 55 Misc.2d 294 (Sup. Ct. New York Co. 1967).

[22] EPTL 7-1.12(a)(5)(ii).

[23] 18 NYCRR 360-4.3(e).

[24] POMS SI 01120.200E.1.b.

[25] *Temporary Assistance (TA) and Food Stamps (FS) Policy: The Treatment of Supplemental Needs Trusts and Reverse Annuity Mortgage (RAM) Loans,* New York State Office of Temporary and Disability Assistance, 01 INF- 8 (March 8, 2001).

[26] Consider the April 2018 release of the revisions to the POMS on SNTs, *supra* n. 17. We would all agree that the changes were favorable and provided much needed clarity. But they only involve one agency's interpretation of how a distribution or investment by a trustee might impact the benefits the agency provides. They do not create distribution and administration standards that are applicable across all SNTs, and yet our impression is that many special needs planning attorneys treat them this way. The result is a misplaced and outsized emphasis on that agency's often inconsistent and arbitrary application of its own rules.

[27] Matter of McMullen, 166 Misc.2d 117 (Sup. Ct. Suffolk Co. 1995).

[28] *Id.* at 121.

[29] Matter of Tinsmon (Lasher), 79 NYS 3d 854 (Sur. Ct. Albany Co. 2018).

[30] 42 USC §1396p(b)(1)(B).

[31] POMS SI 01120.201(I)(1)(c).

[32] The Department has filed an appeal and oral argument is scheduled for January of 2019.

[33] N.Y. Surrogate's Court Procedure Act (SCPA) 1713 ("reasonable, proper and just under the circumstances"); Dinnigan v. ABC Corp., 35 Misc. 3d 1216(A) (Sup. Ct. New York Co. 2012); Matter of Teitelbaum, 11 Misc.3d 1067(A) (Sur. Ct. Rockland Co. 2006).

[34] In re Morales, 1995 N.Y. Misc. LEXIS 726, 214 N.Y.L.J. 19 (N.Y. Sup. Ct. July 28, 1995).

[35] Liranzo, *supra* n. 9.

[36] *Id*. at p. 4.

[37] *Id.* at p. 7.

[38] *Supra* n. 18. In fact, the trustee's discretion as granted under the terms of a will drafted decades ago was a critical part of the court's analysis in the seminal case on special (supplemental) needs trusts in New York, In re Escher *supra* n. 5.

[39] Matter of Kaidirmouglou, NYLJ November 5, 2004 at page 28 (Sur. Ct. Suffolk Co. 2004); Matter of KeyBank, 58 Misc.3d 235 (Sur. Ct. Saratoga Co. 2017); Matter of Feuerstein, 147 A.D.3d 688 (First Dept. 2017). New York attorneys are well advised to remember that even a wholesale adoption of the 'abuse of discretion' standard in evaluating distributions from all supplemental needs trusts will not shield attorney fees from later scrutiny. Matter of Felice, *supra* n. 20.

[40] Trust of Frederick Brockway Gleason, Jr., 1999/4582 A, NYLJ 1202629074611, at *1 (Sur. Ct. New York Co. 2013).

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Capurso

Surrogate's Court of New York, Westchester County

March 26, 2019, Decided; April 2, 2019, Published

2009-2351/A

Reporter
2019 NYLJ LEXIS 1003 *

Capurso

(In the Matter of Capurso, NYLJ, Apr. 2, 2019 at 35)

Core Terms

guardianship, best interest, decree, disability, decisions, hygiene, least restrictive, group home, decision-making, independently, individual's, terminated, guardian, appointed, restored, revoked, Rights, manage, travel, alternatives, Affirmation, petitioned, letters, courts, proxy, intellectually, psychological, psychosocial, constitutes, deprivation

Judges: [*1] Judge: Surrogate ***Brandon Sall***

Opinion

In a ***guardianship*** proceeding brought pursuant to Article 17-A of the Surrogate's Court Procedure Act, petitioner petitioned for the dissolution of his ***guardianship***. In 2010, petitioner's parents were made petitioner's 17-A guardians after it was determined that he suffered from mild intellectual and developmental disabilities. In 2017, petitioner moved to a group home and then started to work at a restaurant to which he was able to travel independently. Petitioner now argued that the ***guardianship*** should be terminated because it was no longer in his best interest. He has ample support to help him in decision-making, and it is not the least restrictive means to achieve the goal of protecting him. The court granted the petition, finding that ***guardianship*** is no longer warranted since petitioner has gained greater independence since moving to the group home, as he has been able to sustain employment, manage a bank account, maintain a social life, take care of his hygiene, and engage with a decision-making network that constitutes a less restrictive alternative to 17-A ***guardianship***.

Full Case Digest Text

The papers relied on are as follows:

1. Citation returnable on December 5, 2018;

2. Petition filed on September **[*2]** 24, 2018;

3. Affidavits of service filed on October 16, 2018 and November 21, 2018;

4. Affirmation of Michael W. Gadomski, Esq. dated September 21, 2018, with exhibits annexed; and

5. Affirmation of Lisa Herman, Esq. filed on December 18, 2018;

DECISION & ORDER

In this ***guardianship*** proceeding brought pursuant to Article 17-A of the SCPA, Stephen Capurso ("Stephen"), along with his counsel, Disability Rights New York ("Disability Rights"), petitions this court for the dissolution of his ***guardianship***, the revocation of the letters of ***guardianship*** decreed to his parents Patricia Capurso ("Patricia") and Thomas Capurso ("Thomas"), and the restoration of his full legal capacity. For the reasons set forth below, the relief requested in the petition is granted. The facts relevant to this petition are as follows:

On October 13, 2009, Patricia and Thomas filed a petition seeking a decree awarding them 17-A ***guardianship*** of the person and property of Stephen. At that time, the court had before it, in support of the application, the affidavit of Benna Dinhofer, Psy.D. and the affirmation of Claudia Sickinger, M.D., both of which basically stated, among other things, that Stephen suffered from mild intellectual and developmental **[*3]** disabilities. On May 17, 2010, Patricia and Thomas were made Stephen's 17-A guardians of the person and

property.

On April 17, 2017, Stephen, who is now 34 years old, moved to the Park Circle Individualized Alternative ("Park Circle"), a group home in White Plains, NY. At some time thereafter, Stephen trained at the Culinary Tech Center, and he started work at the Birch Collective Restaurant in White Plains, NY, travelling to work independently.

On September 24, 2018, Stephen and his counsel filed this petition, stating that the ***guardianship*** should be terminated because it was no longer in Stephen's best interest to maintain it; he has ample support from his family and community to assist him in decision-making; and it is not the least restrictive means to achieve the goal of protecting him. In support of his petition, Stephen attached his psychological assessment dated July 12, 2018, his Individualized Service Plan dated October 16, 2017 and his psychosocial evaluation dated August 1, 2018.

The psychological assessment, conducted by Benna Strober, Psy.D., one of the doctors who had submitted an affidavit in support of the initial ***guardianship***, stated that Stephen is "becoming more independent **[*4]** in all areas" including personal hygiene, cooking, shopping, maintaining employment, and going on outings with housemates without supervision. He can also make personal decisions regarding his well-being and lives in a supportive environment in a group home that has promoted his independence and increased his desire to participate in decisions that affect his life.

Dr. Strober concluded that: "Stephen's parents [should] be removed as his legal guardians and granted a healthcare proxy and a power of attorney to continue to assist Stephen with his medical and financial decisions."

The psychosocial evaluation concluded that Stephen would benefit from reversing his parents' legal ***guardianship***.

Patricia and Thomas support the relief requested in the petition.

The court appointed Mental Hygiene Legal Service ("MHLS") to represent Stephen's interest (see *SCPA 1754[1]*). The MHLS attorney investigated the circumstances surrounding the application, and she recommends that the relief sought in the petition be granted. In fact, it is the position of MHLS that Stephen has made huge improvements in his ability to function independently and that it is a positive idea to put in place less restrictive alternatives **[*5]** for Stephen than ***guardianship***.

SCPA Article 17-A ***guardianship*** is plenary, resulting in a total deprivation of an individual's liberty (see *SCPA 1750*, *1750-a*, *1750-b*; see also *Matter of Michael J.N., 2017 N.Y. Misc. LEXIS 5104 [Sur. Ct., Erie County December 27, 2017]*; *Matter of Caitlin, 2017 NYLJ LEXIS 1043 [Sur. Ct., Kings County April 24, 2017]*).[1]

The standard for whether a decree of ***guardianship*** should issue in the first instance for an intellectually and a developmentally disabled person is set forth respectively in *SCPA 1750* and *1750-a*. In accordance with the statutory provisions, a determination must be made by the court that the individual has an "impaired ability to understand and appreciate the nature and consequences of decisions which result in such person being incapable of managing himself...and/or his...affairs by reason of intellectual disability [and/or developmental disability] and that such condition is permanent in nature or likely to continue indefinitely."

SCPA 1759 states that a person for whom a 17-A ***guardianship*** has been established may petition the court to have the ***guardianship*** dissolved. To have ***guardianship*** letters revoked, a 17-A ward, such as Stephen, bears the burden of establishing that the ***guardianship*** is not in his best interest, with the determination of what is in his best interest committed to the court's discretion (see *SCPA 1751*; *SCPA 1750-a*; see also *Matter of Michael J.N., 2017 N.Y. Misc. LEXIS 5104*).

In determining whether the termination of a **[*6]** ***guardianship*** is in the best interest of the individual, courts have considered whether it is the least restrictive means to preserve and protect the rights of the person (see *Matter of Michael J.N., 2017 N.Y. Misc. LEXIS 5104*).

There are only a few reported cases in which a decree of 17-A ***guardianship*** has been revoked and an individual restored to his full rights under the law. For example, *in Matter of Dameris L. (38 Misc. 3d 570 [Sur. Ct., N.Y. County 2012])*, the husband/co-guardian of a 17-A ward petitioned the court to revoke the ***guardianship*** letters issued to him and to the ward's

[1] ***Guardianships*** decreed in accordance with SCPA 17-A are unlike those granted under Article 81 of the Mental Hygiene Law because the latter can be tailored to suit the individual needs of the person.

mother. Because the record before it reflected that Dameris L. was able to make her own decisions (albeit sometimes with the assistance of family and community support), the court terminated the ***guardianship*** and restored her legal rights.

In doing so, Surrogate Glen wrote that "New York courts have embraced the principle of least restrictive alternatives" and that the

legislature finds that it is desirable for and beneficial to persons with incapacities to make available to them the least restrictive form of intervention which assists them in meeting their needs but, at the same, time permits them to exercise the independence and self-determination of which they are capable (citations omitted).

The court also noted that the **[*7]** "legal remedy of ***guardianship*** should be the last resort for addressing an individual's needs because it deprives the person of so much power and control over his or her life" [citations omitted].

In *Matter of Michael J.N. (2017 NY Misc LEXIS 5104)*, the Surrogate's Court (Howe, S.) found that vacatur of the decree of ***guardianship*** and revocation of the letters issued to Michael's parents were in Michael's best interest. In vacating the decree, the court relied on the record before it, which demonstrated that Michael's adaptive skills, as supported by his placement in a group home, enabled him to make health care decisions and to perform his daily living tasks without a guardian. The court noted that an individual's best interest must include an assessment of his functional capacity and what he can or cannot do in managing daily affairs (see also *Matter of Gulielmo (2006 NYLJ LEXIS 5332 [Sur. Ct., Suffolk County Nov. 13, 2006]* [17-A ***guardianship*** dissolved where the record demonstrated that the individual currently was capable of conducting all activities of daily living]).

Cases where courts have refused to appoint a 17-A guardian in the first instance also are instructive on this issue. In *Matter of Caitlin (2017 NYLJ LEXIS 1043)*, the court, in denying the petition for SCPA 17-A ***guardianship***, stated that, where less restrictive alternatives were available, such **[*8]** as a durable power of attorney, a health care proxy, and community support services, it was not in Caitlin's best interest to have a guardian appointed for her and to have her "decision-making authority supplanted, regardless of good intentions and a desire by [her] family to protect [her]." In *Matter of Hytham (52 Misc. 3d 1211[A] [Sur. Ct., Kings County April 14, 2016])*, a petition for ***guardianship*** was dismissed where the individual, although intellectually in the borderline delayed range, was able to independently handle, among other things, money, purchases, grooming and cooking.

Similarly, *in Matter of Michelle M. (52 Misc3d 1211[A] [Sur. Ct., Kings County 2016])*, the court denied the relief of a decree of ***guardianship*** where the individual lived in a supported apartment, had appropriate services and had the capacity to make her own decisions. In *Matter of D.D. (50 Misc. 3d 666 [Sur. Ct., Kings County 2015])*, the court found that where less restrictive legal tools were available, appointing a 17-A guardian for a 29 year old with an intellectual disability was not in his best interests because he was high functioning, well-integrated socially, able to care for his hygiene, work and travel, and capable of making his own decisions, although sometimes done with assistance (see also *Matter of Eli T., 62 Misc. 3d 638 [Sur. Ct., Kings County 2018]* [same]; *Matter of A.E., 2015 NYLJ LEXIS 4377 [Sur. Ct., Kings County Aug. 17, 2015]* [same]; *Matter of Luis, 2014 NYLJ LEXIS 6814 [Sur. Ct., Kings County April 4, 2014]* [same]).

The record before this court demonstrates that Stephen has gained greater independence **[*9]** since moving to Park Circle, as he has been able to obtain and sustain employment, manage a bank account, maintain a social life, travel independently, take care of his hygiene, and engage with a supported decision-making network. Therefore, since Stephen has a system of supported decision making in place that constitutes a less restrictive alternative to 17-A ***guardianship***, the ***guardianship*** is no longer warranted.

Based on the above, the petition is granted, and the decree dated May 17, 2010, is vacated; the SCPA Article 17-A ***guardianship*** of Stephen is terminated; the letters of ***guardianship*** issued to Patricia and Thomas are revoked; and Stephen's full legal capacity is restored.

Patricia and Thomas now should proceed to put the health care proxy and the power of attorney in place, and they are directed to account for their proceedings as guardian of Stephens property in an expeditious manner.

THIS IS THE DECISION AND ORDER OF THE COURT

Dated: March, 2019

White Plains, NY

Matter of KeyBank N.A.

Surrogate's Court of New York, Saratoga County

September 25, 2017, Decided

2016-769

Reporter
58 Misc. 3d 235 *; 67 N.Y.S.3d 407 **; 2017 N.Y. Misc. LEXIS 3800 ***; 2017 NY Slip Op 27321 ****

[**1]** In the Matter of ***KeyBank*** National Association et al., Petitioners.

Core Terms

beneficiary, social services, eligibility, regulations, venue, surrogate's court, amend, modification, reformation, grantors, modified, social services department, trusts, disabled, law law law, drafting, requests, terms, remainder interest, parties, health department, accounting, provisions, proper venue, provides, marital deduction, cross petition, amendment amendment amendment, observations, supplemental

Headnotes/Summary

Headnotes

Trial — Place of Trial — Demand for Change of Venue — Application for Trust Modification

1. Saratoga County Surrogate's Court was the proper venue for petitioners' proceeding seeking to modify the special needs trust established for the benefit of their son, and there was no basis to transfer the proceeding to the Albany County Supreme Court. Although venue would have been appropriate in either Saratoga County or Albany County, "[w]here [proper] venue may lie in more than one county under [*SCPA 207 (1)*], the court where a proceeding is first commenced with proper venue shall retain jurisdiction" (*SCPA 207 [2]*). Surrogate's Court acknowledged jurisdiction over the matter without objection from either party. The matter represented an active and pending proceeding before the court, and was the first and only proceeding seeking to address the relief requested in the petition. There was no pending proceeding in Supreme Court, and there had never been a commensurate proceeding commenced in the Albany County Surrogate's Court. Even assuming there was an open proceeding in Supreme Court, a supreme court will defer to the surrogate's court on matters where the surrogate's court has expertise, such as the review and administration of trusts.

Trusts — Special Needs Trust — Modification

2. In a proceeding commenced pursuant to *SCPA 2101*, the special needs trust (SNT) established for the benefit of petitioners' son was modified to require the trustee, upon the death of the beneficiary, to pay certain administrative expenses prior to reimbursement to the State for all medical assistance provided to the beneficiary during his lifetime, in order to maximize his eligibility for supplemental security income. The language of the proposed SNT conformed with the applicable statutes, provided the State of New York with the remainder interest as required by Social Services Law § 366 (2) (b) (2) (iii) (A), and had no negative effect upon the beneficiary's eligibility for Medicaid. Moreover, *EPTL 7-1.9 (a)* did not apply because the SNT provided that the "[g]rantor shall have no right [to] amend, revoke, or terminate" the agreement or trust "without approval by a court of competent jurisdiction." Nothing in the authority governing an SNT increases or broadens the role of respondent Department of Social Services beyond one of assessment and determination of an applicant's initial and continuing eligibility for Medicaid into the dictation of the terms or the drafting process of an SNT. The SNT met the statutory requirements for approval, and modification was appropriate to achieve petitioners' specific intent and objective of maximizing their son's eligibility for benefits.

Counsel: *Wilcenski & Pleat PLLC*, Clifton Park (*Edward V. Wilcenski* of counsel), for petitioners.

Stephen M. Dorsey, *County Attorney*, Ballston Spa (*Hugh G. Burke* of counsel), for Saratoga County

Department of Social Services, objectant.

Judges: HON. RICHARD A. ***KUPFERMAN***, SARATOGA COUNTY SURROGATE.

Opinion by: Richard A. ***Kupferman***

Opinion

[*236] [409]** Richard A. ***Kupferman***, S.

Against the backdrop of a myriad of complex federal and state statutes and regulations governing Medicaid eligibility, this case analyzes the extent and limitations of the authority of a local department of social services in an application to modify or reform a supplemental needs trust.

Kevin J. Tyrrell (the beneficiary) was the plaintiff in a personal injury/medical malpractice action commenced on his behalf by his parents, Kenneth F. Tyrrell and Polly E. Tyrrell, in Albany County Supreme Court. By stipulation of settlement dated January 15, 2001 the underlying litigation was settled in the Albany County Supreme Court. Thereafter, by agreement dated February 15, 2001, a special needs trust (SNT) was established for the benefit of the beneficiary by his parents as lawful grantors. A review of the original SNT at the time of its creation establishes the beneficiary's parents as cotrustees along with ***KeyBank*** as the third (corporate) trustee and repository of the trust assets. Further, (1) the beneficiary of the SNT **[*237]** (Kevin J. Tyrrell) was (and remains) under 65 years of age, and (2) was (and remains) an individual with a disability thus eligible for the establishment of an SNT, and (3) the SNT was being established by the beneficiary's parents, and (4) the SNT provides the State is a Medicaid remainderman beneficiary **[**410]** upon the death of the beneficiary. Thus, there appears to be no issue that the SNT as originally written comports with and had no negative effect upon the trust beneficiary's eligibility for Medicaid and is thus a lawfully created SNT.

By order dated February 27, 2001, the Albany County Supreme Court approved the terms of the above-referenced settlement and directed that the beneficiary's share of the settlement be periodically paid into the SNT as established above. Pursuant to the terms of the order, on March 20, 2001, the parties executed a stipulation of discontinuance and filed same with the Albany County Supreme Court. Upon the filing of the stipulation of discontinuance, the matter in the Albany County Supreme Court was concluded and the parties (the beneficiary and his parents) had no further dealings in the Albany County Supreme Court and relocated soon thereafter to Saratoga County.

By verified petition dated January 5, 2017 to this court, Kenneth and Polly Tyrrell (the beneficiary's parents, grantors and trustees) as well as ***KeyBank*** National Association commenced the instant action seeking permission to amend the terms of the February 27, 2001 SNT pursuant to Surrogate's Court Procedure Act § 2101. Specifically, the SNT provides under article II that upon the death of the beneficiary, the trust will terminate and the trustee shall divide and distribute the remaining principal and accrued and undistributed income in the trust estate as follows:

> "A. In the event that the probate estate of Kevin J. Tyrrell shall contain insufficient assets to cover all funeral expenses and debts of Kevin J. Tyrrell, administration expenses of his Estate, or applicable estate taxes, the Trustee is authorized to distribute from the Trust Estate herein, to the extent of such insufficiency, such amounts as are necessary to pay said funeral expenses, debts, administration expenses and estate taxes of Kevin J. Tyrrell.
>
> "B. The Trustee shall reimburse the State of New York and/or any other state which has provided **[*238]** Medicaid assistance to Kevin J. Tyrrell during his lifetime, in an amount equal to the Medicaid assistance rendered to or paid on behalf of Kevin J. Tyrrell by such state or states. If Kevin J. Tyrrell received Medicaid assistance in more than one state, then the amount distributed to each state shall be based upon each state's proportionate share of the total amount of Medicaid assistance paid by all states on behalf of Kevin J. Tyrrell."

As written, the provision that permits the payment of funeral expenses after death of the beneficiary and prior to reimbursement to the State is now inconsistent with *42 USC § 1396p (d) (4) (A)*, which authorizes the use of an SNT by Social Security and Medicaid recipients. (*See also* Social Security Administration, Program Operations Manual System, ch SI 011, § 01120.203 [B] [3] [a].) The SNT in its current form renders the beneficiary ineligible to receive supplemental security income (SSI).

Thus, in order to render the beneficiary eligible to qualify for SSI, the petitioners have made this application seeking amendment of article II of the SNT. Specifically, the petitioners seek to amend the language of article II

to provide that upon the death of the beneficiary that the trustee may only pay those expenses enumerated in the Social Security Administration, Program Operations Manual System § 01120.203 (B) (3) (a) prior to reimbursement to the Medicaid program for all medical assistance provided to the beneficiary during his lifetime.

[411]** After receiving the instant petition, the court issued a citation returnable on January 31, 2017 to the parties and to the local social services district; e.g. the Saratoga County Department of Social Services (the Department). Upon return of the citation on January 31, 2017, counsel for the petitioners appeared as well as the Saratoga County Attorney's Office on behalf of the Department. At this appearance, the Department asked for additional time to review the instant petition and trust. The court then directed the Department to submit any objections (if so **[****2]** inclined to object) to the relief requested within 30 days and then the petitioners would have seven days within receipt upon which to respond.

Thereafter and by letter dated February 13, 2017, the Department provided its objection to the petition and its **[*239]** request to amend the terms of the SNT.[1] Specifically, the Department objected to the proposed language relative to the prepaid funeral expenses, and proceeded to make several "observations" and requests to amend the language of further sections of the trust document. In support of its position, the Department posited that the filing of the application to amend an existing SNT subjects the language of the *entire* document to modification.

In response thereto, by letter dated February 22, 2017, counsel for the petitioners submitted a reply to the specific objection of the Department, as well as replies to the Department's "observations" and requests to amend language as well as the Department's position relative to its right to have a seat at the drafting (or in the instant case, redrafting) table of the SNT. Specifically to address the Department's objection to the language of the prepaid funeral expenses, the petitioners identified that the language of the existing SNT rendered the beneficiary ineligible for SSI and the proposed amendment merely brought the language into the eligibility standards set forth in the Social Security Administration, Program Operations Manual System and under relevant federal and state guidelines for SSI eligibility. In its reply, the petitioners acknowledged that the Department does have a role in the formation and reformation of an SNT, but that role is limited to that which is specifically laid out in federal and state statutes. Specifically, to review an SNT to confirm that it meets the statutory criteria under *42 USC § 1396p (d) (4) (A)* and Social Services Law 366 (2) (b) (2) (iii) and to confirm that the SNT is being administered (and that the State's right as a remainderman under the terms of same is being upheld) consistent with statutory law and social services regulations.

The petitioners identify that nothing in the Department's objections or observations suggests that the instant SNT as written (pre- and post-amendment) fails to comply with the federal and state statutory language governing same. The petitioners likewise identify that nothing in the authority governing the drafting and approval of an SNT enlarges the role and responsibility of the Department beyond that which is expressly codified.

Thereafter, correspondence flowed between the parties, and the court encouraged counsel for both parties to work collaboratively **[*240]** at resolving the issues and disagreement between them. By letter dated April 19, 2017, counsel for the petitioners submitted a proposed decree to **[**412]** the court with a request for the court to sign same and accompanying therewith a letter which outlined that the parties had yet to reach common ground on certain issues and identified the remaining issues of disagreement. The court then scheduled a conference on the issues raised above and directed the parties to submit memoranda of law detailing their respective positions. Counsel for both sides submitted memoranda of law. The court held a telephone conference on May 11, 2017, whereupon counsel for the Department acknowledged that issues remained in disagreement, that he objected to the terms of the proposed decree and for the first time raised the issue that the entire proceeding in the Saratoga County Surrogate's Court was improperly venued.

With the issue of venue having been raised for the very first time at the May 11, 2017 **[****3]** telephone conference, the court directed counsel for the Department to file (should he so choose to do so) a motion for change of venue by May 31, 2017, and a response (by cross petition or answer) to the relief requested in the petition by May 17, 2017. Counsel for the petitioners **[***9]** was given until June 21, 2017, to respond to both the Department's motion for change of venue and answer/cross petition.

[1] While not captioned as formal objections, the court chose to accept the Department's February 13, 2017 letter as such.

Counsel for the Department filed an answer and cross petition and motion to change venue and for dismissal of the petition for failure to recite grounds for relief under CPLR 2214 (a) en toto on May 17, 2017. The court thereafter instructed counsel to segregate his papers into a motion to change venue and an answer with cross petition as had been previously directed at the May 11, 2017 telephone conference. Counsel for the Department thereafter filed a notice of motion and affirmation in support of motion to change venue on May 31, 2017, along with amendments to its original submission which the court shall consider as its answer and cross petition for affirmative relief to enable the court to implement its (the Department's) recommendations to the SNT.

In its notice of motion, the Department asserts that the petitioners' application should properly be venued in Albany County as the court of original and continuing jurisdiction from the initial 2001 drafting of the SNT. The Department moved for a transfer of proceedings pursuant to SCPA 207, 209, 501; and CPLR 503 (b) and for dismissal of the petition on **[*241]** jurisdictional **[***10]** grounds for failure to recite grounds for relief sought under CPLR 2214 (a).[2]

Further, in its answer and assuming that the court retains venue over the matter, the Department nevertheless requests that the court implement the modifications asserted in the cross petition as set forth in its correspondence of February 13, 2017. In response thereto, counsel for the petitioners filed papers in opposition to the Department's motion to transfer and dismiss, and also filed a cross motion seeking attorney's fees pursuant to 22 NYCRR 130-1.1 (c) (3). Thereafter, counsel for the Department filed a cross motion seeking sanctions against petitioners pursuant to 22 NYCRR 130-1.1 (c) (1).

Oral argument was held on July 19, 2017 before the court. After significant argument **[**413]** by counsel for both parties, the petitioners' motion for an award of attorney's fees pursuant to 22 NYCRR 130-1.1 (c) (3) and the Department's motion for sanctions were dismissed, leaving before the court the issue of venue, as well as the Department's role in the drafting and reformation of the SNT. The court shall first address the question of venue, and then consider the authority or lack thereof to modify or reform an SNT in turn herein.

In its motion for change of venue, the Department asserts that the petition is **[***11]** improperly venued in this court. At the oral argument of July 19, 2017, counsel for the Department acknowledged and stipulated that jurisdiction was not in contest, merely venue. In support of its position, the Department first identifies that the institutional trustee (***KeyBank***) is listed as having its principal place of business in Albany County and that the location of the assets of the trust are thus in Albany County as well. The Department further avers that as the original **[****4]** proceeding giving rise to the instant SNT began in Albany County Supreme Court, the proper venue is with Albany County. The petitioners object, and note that the beneficiary and the grantors/trustees (the beneficiary's parents) all reside in Saratoga County, that there is no pending matter in the Albany County Supreme Court upon which to continue **[*242]** venue and/or jurisdiction, and that venue and jurisdiction has been properly acquired by the Saratoga County Surrogate's Court upon the commencement of the instant proceeding under Sections 201, 203 and 207 of the Surrogate's Court Procedure Act.

[1] As it relates to the Saratoga County Surrogate's Court as an appropriate venue, Surrogate's Court Procedure Act § 207 (1) states that a "proper venue for [a] proceeding[ ] . . . is the county where (a) assets of the trust estate are located, or **[***12]** (b) the grantor was domiciled at the time of the commencement of a proceeding . . . , or (c) a trustee then acting resides."

There is no argument that the grantors/trustees (the beneficiary's parents) reside in Saratoga County, and did so at the *commencement* of the instant proceeding. A proceeding has been commenced concerning the trust and the grantors/trustees are domiciled in Saratoga County, thus making the Saratoga County Surrogate's Court an appropriate venue pursuant to SCPA 207 (1) (b) and (c).

Here, the court acknowledges that the institutional trustee (***KeyBank***) has its principal place of business located within Albany County, which would make Albany County an appropriate venue under SCPA 207 (1) (c) as the Department suggests. The court finds no merit in the Department's position that Albany County is an appropriate venue under SCPA 207 (1) (a) because the

[2] Upon return of the motion at oral argument on July 19, 2017, the Department conceded that the court has jurisdiction to hear and preside over the matter, thus rendering the CPLR argument to dismiss relative to jurisdiction moot. In view of the same and of the Department's acknowledgment of jurisdiction, the court will consider the issue of jurisdiction settled and will not address the Department's motion to dismiss and will consider it withdrawn.

"assets of the trust" are located at the office of the institutional trustee in Albany County. The court takes note that ***KeyBank*** is a national banking and lending institution with offices and branches throughout Saratoga County and specifically in Clifton Park, the town of residence for the grantors/trustees. The court likewise notes that the "assets **[***13]** of the trust" are funds deposited into the trust account, and given the electronic nature of modern banking readily accessible at other locales as opposed to solely from the Albany County branch.

Even if the court were to find the assets to be located in Albany County, in *Matter of Myers (45 AD3d 955, 845 NYS2d 510 [3rd Dept. 2007])*, the Appellate Division, Third Department reconciled a similar question of venue. In that case, the subject **[**414]** property of the trust was located in Steuben County and the trustee resided in Chemung County. The Appellate Division found that venue for the proceeding was properly in Chemung County as the county of residence of the trustee (as opposed to the location of the assets of the trust) under *SCPA 207 (1) (c)*. (*SCPA 207 [1]*; *see also Matter of Kelly, 17 AD3d 791, 794 NYS2d 458 [3d Dept 2005]*.)

[*243] Two of the three trustees (the beneficiary's parents) reside in Saratoga County; the third and corporate trustee (***KeyBank***) while having its principal office physically located in Albany County has joined in filing the instant application. In view of the same, Saratoga County is a proper venue under *SCPA 207 (1) (c)*.

Under the facts of the instant case, venue would appropriately be in both Saratoga County and Albany County. Accordingly, the analysis must then turn to a reading of *SCPA [****5] 207 (2)*.[3]

In the instant proceeding, there exists **[***14]** before the court a duly filed petition and commensurately proper proceeding under *SCPA 203*. As set forth above, the court acknowledges that both Albany County and Saratoga County are proper venues for the filing of this petition under *SCPA 207 (1)*. Under *SCPA 207 (2)* "[w]here [proper] venue may lie in more than one county under the provisions of subdivision one, the court where *a proceeding* is first commenced with proper venue shall retain jurisdiction" (emphasis added).

In surrogate's court, all proceedings are special proceedings commenced by the filing of a petition and pursuant to Surrogate's Court Procedure Act § 203. In addition, *SCPA 301 (a)* provides that a proceeding is commenced with the filing of a petition, provided process is issued and service on all respondents is completed within 120 days. (*See Matter of DeMaio, 13 Misc 3d 190, 819 NYS2d 648 [Sup Ct, Kings County 2006]*.)

Here, a verified petition was filed with the court on January 5, 2017, and the Department, having been duly served, appeared before the court on the return date of January 31, 2017. The court acknowledged jurisdiction over the matter without objection from either party, including the Department. In view of the same, the instant matter represents an active and pending proceeding before the Saratoga County Surrogate's Court, and is the first and only proceeding **[***15]** seeking to address the relief requested in the petition. There is no pending proceeding in the Albany County Supreme Court and there has never been a commensurate proceeding commenced in the Albany County Surrogate's Court.

Even assuming, arguendo, that there was an open proceeding or that the proceeding remained open in the Albany County **[*244]** Supreme Court, the law is well settled that a supreme court will defer to the surrogate's court on matters where the surrogate's court has expertise. (*H & G Operating Corp. v Linden, 151 AD2d 898, 542 NYS2d 868 [3d Dept 1989]*.) The review and administration of trusts is one of the experiential hallmarks of a surrogate's court. Even assuming (again, arguendo) that a subsequent proceeding were to be commenced in the Albany County Surrogate's Court, the Saratoga County Surrogate's Court would still retain possession of the matter as the "first" court upon which the proceeding was commenced. (*See SCPA 207 [2]*.)

[415]** Accordingly, the court finds that the Saratoga County Surrogate's Court is the proper venue for this matter and that there is no basis to remove this proceeding from the Saratoga County Surrogate's Court and transfer it to the Albany County Supreme Court. Therefore, the Department's motion for a change of venue is hereby denied.

[2] The court **[***16]** now directs its analysis to the true issue in contention between the petitioners and the Department, specifically what, if any, authority the local social services district has to seek modification or reformation of an existing SNT.

[3] Ignoring, parenthetically, that the Albany County trustee joined in the petitioners' request for the petition and proceeding to be held in Saratoga County.

To begin, the court notes that an SNT is a "discretionary trust established for the benefit of a person with a severe and chronic or persistent disability [*EPTL 7-1.12 (a) (5)*] that is designed to enhance the quality of the disabled individual's life by providing for special needs without duplicating services covered by Medicaid or destroying Medicaid eligibility." (*Cricchio v Pennisi, 90 NY2d 296, 303, 683 NE2d 301, 660 NYS2d 679 [1997]* [internal quotation marks omitted]; *Matter of Abraham XX., 11 NY3d 429, 900 NE2d 136, 871 NYS2d 599 [2008].)* SNT is a **[****6]** planning device authorized by federal and state law to insulate assets of a chronically ill and severely disabled individual "for the dual purpose of securing or maintaining eligibility for state-funded services, and enhancing the disabled person's quality of life with supplemental care paid by his or her trust assets." (*Abraham XX., 11 NY3d at 434*; *see also Matter of Morales, 1995 NY Misc. LEXIS 726, 214 NYLJ 19 [Sup Ct, Kings County 1995]*.)

Under the pertinent statutes, *42 USC §1396p (d) (4) (A)* and Social Services Law § 366 (2) (b) (2) (iii), neither the corpus nor the income of an SNT is considered a resource or income available to the beneficiary. (*See Abraham XX., 11 NY3d at 435*; *Cricchio, 90 NY2d at 303*; *see also 18 NYCRR 360-4.5 [b] [5] [i] [a]*.) Rather, the SNT is designed to "address[ ] the unique and **[*245]** difficult situation faced by severely disabled individuals **[***17]** with assets that are sufficient to end their Medicaid eligibility but insufficient to account for their medical costs." (*Abraham XX. at 437*.)

Such treatment is extended to an SNT as long as the trust documents setting up same conform to the language and the requirements of *EPTL 7-1.12 (a) (5)*, as well as the applicable regulations of the Department of Health (*see Cricchio, 90 NY2d at 303*; *see also* Social Services Law § 366 [2] [b] [2] [iii],[iv]). Specifically, an SNT is exempted from the general rules governing available resources and Medicaid eligibility when (1) the recipient is "disabled" as that term is defined at *42 USC § 1382c (a) (3)*, and *(2)* the SNT contains the following provision:

> "The assets of such a disabled individual which was established for the benefit of the disabled individual while such individual was under sixty-five years of age by . . .a parent, grandparent, legal guardian, or court of competent jurisdiction, if upon the death of such individual the state will receive all amounts remaining in the trust up to the total value of all medical assistance paid on behalf of such individual." (Social Services Law § 366 [2] [b] [2] [iii].)

The relationship between the SNT, its beneficiary and the State is set forth in its clearest form by the Court of Appeals decision of *Abraham XX.*, specifically that

> "[t]he SNT is available only to applicants under the age of **[***18]** 65 with severe disabilities as defined by statute. Unless the **[**416]** applicant placed excess assets in the Medicaid SNT for supplemental care, he or she would no longer be eligible for Medicaid, thus relieving the State of a substantial financial burden. In order to further Medicaid's purpose of providing medical assistance to needy persons, the State agrees to continue paying Medicaid costs—in instances where it would otherwise be relieved of this obligation—in exchange for the possibility of reimbursement upon the recipient's death. The State in a sense is like an insurer calculating risk. For every recipient who depletes the trust before death, the State can expect some trusts to have sufficient assets upon a recipient's death to offset the additional cost of continuing Medicaid payments **[*246]** for these severely disabled individuals who otherwise would be ineligible. Moreover, the State's right to reimbursement occurs only upon the death of the beneficiary—at a time when the life-enhancing purpose of the trust can no longer be effectuated. The Medicaid SNT reflects a policy decision to balance the needs of the severely disabled and the State's need for funds to sustain the system." (*Abraham XX., 11 NY3d at 436-437* [emphasis omitted].)

The State **[***19]** thus has a statutory role within the establishment and maintenance of an SNT. Specifically, the State's role is twofold: first to determine the SNT beneficiary's continued eligibility for Medicaid by ensuring that the proposed SNT comports with existing Federal and State Medicaid law, and second to protect the State's ultimate remainder interest.

Under the Federal Medicaid statute, it is the individual state departments of health that are tasked with this particular review. In New York State, it is the Department of Health that is bound by these regulations, and the responsibility for its administration falls to the local social services district of each county as the individual Medicaid provider. Specifically, the local social services district (through the Department of Social Services) is to evaluate an applicant's interest in irrevocable trusts for purposes of Medicaid eligibility.

To this end, within the framework of the SNT statutes, there are safeguards in place to protect both the beneficiary and the remainder interest. Specifically, Social Services Law §366 (2) (b) (2) (iv) clearly seeks to protect "the remainder interest" of the State by authorizing the promulgation of regulations to assure fulfillment of the **[***20]** trustee's fiduciary obligations. Further, Social Services Law § 366 (2) (b) (2) (iv) directs in relevant part that

> "[t]he department [of health] shall promulgate such regulations as may be necessary to carry out the provisions of this [section, and such] regulations shall include provisions for . . . assuring the fulfillment of fiduciary obligations of the trustee with respect to the remainder interest of the department or state; monitoring pooled trusts; applying this [section] to legal instruments and other devices **[*247]** similar to trusts, in accordance with applicable federal rules and regulations."[4]

In addition to the aforementioned, there are numerous other safeguards and oversights prescribed under the Surrogate's Court Procedure Act, the Estates, Powers and Trusts Law, the Social Services Law and Executive Law § 63.

The statutory safeguards outline the responsibilities and procedural remedies of **[**417]** the State in its review of proposed SNTs. The role of the State is clearly defined and relates specifically to the review of proposed SNTs for their comport to the relevant statutes, Medicaid eligibility and protection of the State's remainder interest. There is nothing in the Federal Medicaid statute, the New York State Social Services Law and regulations that **[***21]** expands the responsibility of the State or its local social services departments beyond its statutory role, e.g., the assessment and determination of an applicant's initial and continuing eligibility for Medicaid. The State and its local social services departments are responsible for the *review* of an SNT and have not been granted any formal authority in the *drafting* of an SNT, as such responsibility is left with the creators of the SNT.

For as the State has a statutory role in the establishment and maintenance of the SNT, so too do the trustees and fiduciaries responsible for the SNT. The responsibilities of these individuals are set forth in Article 11 of the Surrogate's Court Procedure Act and at *18 NYCRR §360-4.5(b)(5)(iii)* and require a trustee of an SNT to fulfill not only its fiduciary obligation to the SNT beneficiary but also its concomitant fiduciary obligations with respect to the State's remainder interest in the trust. Specifically, under *18 NYCRR §360-4.5(b)(iii)* the trustee must, by way of example;

> "(a) notify the appropriate social services district of the creation or funding of the trust for the benefit of an MA applicant/recipient;
>
> "(b) notify the social services district of the death of the beneficiary of the trust;
>
> "(c) notify the social services district in advance of any **[***22]** transactions tending to substantially deplete the principal of the trust, in the case of a trust **[*248]** valued at more than $100,000; for purposes of this clause, the trustee must notify the district of disbursements from the trust in excess of the following percentage of the trust principal and accumulated income: five percent for trusts over $100,000 up to $500,000; 10 percent for trusts valued over $500,000 up to $1,000,000; and 15 percent for trusts over $1,000,000;
>
> "(d) notify the social services district in advance of any transactions involving transfers from the trust principal for less than fair market value; and
>
> "(e) provide the social services district with proof of bonding if the assets of the trust at any time equal or exceed $1,000,000, unless that requirement has been waived by a court of competent jurisdiction, and provide proof of bonding if the assets of the trust are less than $1,000,000, if required by a court of competent jurisdiction."

Thus, the SNT represents a "bargain struck between the SNT beneficiary and the State" whereby the eligibility rights of the SNT beneficiary for social services are preserved, and the pecuniary remainder rights of the State are **[***23]** protected. (*See Matter of Abraham XX., 11 NY3d 429, 900 NE2d 136, 871 NYS2d 599 [2008].)*

In addition to the roles of the State and the SNT parties, the court likewise has a role in this process. The court's role is to strike a balance to protect both the beneficiary and the State's remainder interest, thereby seeking also

[4] It is important to distinguish at this point in the analysis that the New York State Department of Health is a distinct and separate entity from the Department and that the Department in and of itself has no independent authority to promulgate regulations absent the procedures found in Social Services Law § 20 (3) (a).

to protect public interest to fulfill "the ultimate goal of Medicaid—that the program 'be the payer of last resort.' " (*Matter of Costello v Geiser, 85 NY2d 103, 105, 647 NE2d 1261, 623 NYS2d 753 [1995]*; *Cricchio, 90 NY2d at 305*.)

As it relates to the court's role and responsibilities regarding an SNT, the following **[**418]** opinion most clearly defines same, specifically that

> "it is appropriate for the court to seek assurance that a proposed supplemental needs trust complies with the controlling laws and rules regarding Medicaid eligibility. This is consistent with the function of the court to assure that the best interests of the incapacitated person are promoted. It would be a clear dereliction of that duty for the court to deliberately overlook provisions of a proposed supplemental needs trust if such provisions were inconsistent with statutory guidelines and thus would bar an incapacitated person from **[*249]** receiving Medicaid benefits by its establishment. To do so would permit the diverting of assets from the ownership or title of the incapacitated person **[***24]** to another legal entity with no consequent benefit to the incapacitated person." (*Matter of McMullen, 166 Misc 2d 117, 119, 632 NYS2d 401 [Sup Ct, Suffolk County 1995]* [citations omitted].)

These provisions, however, should not be read as obviating any additional controls required by the court since the regulations promulgated by the State are for the protection of its own remainder interest whereas the court is primarily concerned with the protection of the disabled person and likewise to assure fulfillment of the establishment of an SNT; thus, "in the inherent exercise of its power, the court may fashion or condition the exercise of that privilege in such manner as it believes will sufficiently protect the interest of the disabled person." (*Matter of Goldblatt, 162 Misc 2d 888, 618 NYS2d 959 [Sur Ct, Nassau County 1994]*.)

Turning to the instant matter, the petitioners have come before this court and seek the approval of a modification with respect to the SNT for Kevin Tyrrell. The Department has reviewed the proposed modification to the SNT and has presented certain "observations" relative to same, as well as requests to modify certain language within the SNT. The Department has not raised any challenge that the SNT as written has any negative effect upon the beneficiary's **[****7]** financial eligibility for Medicaid, nor that the application and SNT should be denied.[5]

There is no dispute **[***25]** that the beneficiary (Kevin Tyrrell) is disabled and under 65 years of age. Likewise, the petitioners, as parents of the beneficiary, are lawful grantors under Social Services Law § 366 (2) (b) (2) (iii) and possess the requisite skill and competency to serve as trustees. The language of the proposed SNT is in conformance with *EPTL 7-1.12*, 7-3.1; Social Services Law § 366 (2) (b) (2) (iii) and *42 USC §§ 1396p (d) (4) (A)*; *1382b (e) (5)* and provides the State of New York (e.g., Saratoga County Department of Social Services) with the remainder interest as described in and required by Social Services Law § 366 366 (2) (b) (2) (iii) (A).

[*250] There likewise appears to be no dispute that the SNT as written comports with, and has no negative effect upon, the trust beneficiary's eligibility for Medicaid. Thus, the court finds that (1) the beneficiary of the SNT (Kevin Tyrrell) is under 65 years of age, and (2) is an individual with a disability thus eligible for the establishment of an SNT, and that (3) the SNT is being established by the beneficiary's parents and guardians, and (4) the SNT provides the State as a Medicaid remainderman beneficiary upon the death of Kevin Tyrrell.

[419]** The Department's papers and accompanying brief aver that the terms to modify the SNT must be guided by *EPTL 7-1.9 (a)*, and specifically

> "[u]pon the written consent, acknowledged or proved in **[***26]** the manner required by the laws of this state for the recording of a conveyance of real property, of all the persons beneficially interested in a trust of property, heretofore or hereafter created, the creater of such trust may revoke or amend the whole or any part thereof."

The Department believes that their consent as a beneficially interested party is necessary for the grantor to amend the trust. In support of its position, the Department relies on *EPTL 7-1.9 (a)* and cites the case of *Matter of Perosi v LiGreci (98 AD3d 230, 948 NYS2d 629 [2d Dept 2012])* in its papers. The court acknowledges that the Department is a person beneficially interested in a trust of property for purposes

[5] In court and on the record, the Department has repeatedly supported the proposed modification to the SNT (although desires that different language be used) and has stated that there would be no financial harm to the Department as a remainderman by the court's acceptance of same.

of EPTL 7-1.9 (a) and therefore their consent to amend said trust would be necessary.

However, the Department's reliance on EPTL 7-1.9 (a) is inapposite with regard to *this* specific SNT. EPTL 7-1.9 (a) does not apply in this case, because article VI of the SNT states that "this Agreement and Trust created hereby are irrevocable. The Grantor shall have no right in any respect to later, amend, revoke, or terminate this Agreement or the Trust created hereby without *approval by a court of competent jurisdiction*" (emphasis added). Likewise, the holding in Perosi can be readily distinguished. In Perosi, the approval of the local social **[***27]** services department was required to amend the terms of the trust because the subject trust was silent on the issue of amendment. Here, Article VI of the subject SNT does set forth an amendment procedure by application to a court of competent jurisdiction for approval of same.

The petitioners have exercised the specific procedure laid out in the SNT to seek an amendment by the filing of the instant **[*251]** proceeding with the court. Therefore, taking this grant of express authority to amend the SNT, the court will now set upon the analysis of judicial powers and limitations with regard to modification or reformation of an SNT. Reformation is generally available to correct mistakes in inter vivos instruments so that the written instrument accurately expresses the settlor's actual intent. As the court noted in *Matter of Dickinson* (NYLJ, Aug. 4, 1999 at 26, col 5 [Sur Ct, NY County 1999], *affd* 273 AD2d 89, 709 NYS2d 69 [2000]), reformation may not be **[****8]** used to change the terms of a trust to effectuate what the settlor would have done had the settlor foreseen a change of circumstances that has occurred.

Similar to the facts in *Dickinson*, the petitioners herein seek to correct an element of the trust so as to allow the beneficiary to maximize the availability of benefits. **[***28]** Courts have the power not only to ascertain the "validity, construction or effect" of language in a testamentary instrument (SCPA 1420), but also to reform such instrument and to add, excise, change or transpose language to effectuate a decedent's intent. (*See e.g.* Matter of Snide, 52 NY2d 193, 418 NE2d 656, 437 NYS2d 63 [1981].)

Whether construction and/or reformation is sought in the context of an estate, the paramount duty of the court is to determine the intent of the testator from a reading of the will in its entirety (Matter of Bieley, 91 NY2d 520, 695 NE2d 1119, 673 NYS2d 38 [1998]; Matter of Snide, 52 NY2d 193, 418 NE2d 656, 437 NYS2d 63 [1981]). Courts have reformed instruments so that estates could take full advantage of available tax deductions and exemptions, but only if the literal application of an instrument's provisions **[**420]** would frustrate the testator's actual intent as reflected in the court's review of the entire document. (Matter of Martin, 146 Misc 2d 144, 549 NYS2d 592 [Sur Ct, NY County 1989]; Matter of Choate, 141 Misc 2d 489, 533 NYS2d 272 [Sur Ct, NY County 1988]; Matter of Lepore, 128 Misc 2d 250, 492 NYS2d 689 [Sur Ct, Kings County 1985].)

Of specific relevance to the court's instant analysis is the holding of Matter of Lepore (128 Misc 2d 250, 492 NYS2d 689 [1985]). In Lepore, the court permitted the reformation of a will so that certain "inadvertently excluded words" could be added to the document's definition of the marital deduction (id. at 253). In Lepore, the original will defined the marital deduction under prior law, which had limited the amount of the marital deduction to the greater of $250,000 or one half the adjusted gross estate, **[***29]** instead of the unlimited marital deduction under current law. The court found that the complete reading of the will **[*252]** made it clear that the testator had intended to give his wife the largest possible bequest by use of the maximum available marital deduction, and in view thereof the court allowed reformation of the instrument to ensure that the entire residuary estate would qualify for the unlimited marital deduction.

In this case, the petitioners' intent in seeking a modification to the terms of the SNT is clearly to ensure that the beneficiary receives and is eligible for the maximum government entitlements, namely Medicaid and SSI, that are available to him. (Matter of Lepore, 128 Misc 2d 250, 492 NYS2d 689 [Sur Ct, NY County 1985]; Matter of Carcanagues, 2016 NY Misc. LEXIS 343, 2016 NY Slip Op 31765[U] [Sur Ct, NY County 2016].)

Explicitly throughout the Department's moving papers and oral argument was reliance on the concept of the "bargain" as espoused in Abraham XX. to elevate its status in the drafting and redrafting process of the SNT. It appears to the court that through its "observations" and requests to amend the language of certain provisions of the SNT, the Department seeks to expand its role beyond that of Medicaid eligibility review and into the actual drafting process of the SNT. The Department posits that as a result the "bargain" between **[***30]** the beneficiary and the State as a Medicaid eligibility remainderman that it is due a seat at the drafting table.

The Department's interpretation of the Court of Appeal's rationale of how the SNT represents a "bargain" is misguided. The bargain in an SNT represents the priority interest in the balance of the SNT upon the beneficiary's death in exchange for the beneficiary's receipt of Medicaid. This is contrary to the Department's assertion that the Court of Appeals language in *Abraham XX.* should be read to expand and somehow broaden the "bargain" and thereby authorize the Department to require additional modifications/reformations beyond the relief sought by the **[****9]** petitioners. The Department's interpretation is also contrary to the plain language of *Abraham XX.* and of the statutory authority governing SNTs.

Further, that the Department considers an SNT to be a "special" type of trust and thus seeks to broaden its authority into the dictation of the terms of an SNT or for that matter insert itself into the drafting process is likewise misplaced. This court shares the opinion of Surrogate Czygier in "that a supplemental needs trust trustee should not be treated differently than a testamentary **[***31]** or *inter vivos* trustee. There are safeguards in place to protect the lifetime beneficiary and DSS." **[*253]** (*Matter of Kaidirmaoglou, NYLJ, Nov. 5, 2004 at 16, 2004 NYLJ LEXIS 5562, *2 [Sur Ct, Suffolk [**421] County 2004]* [emphasis added].) There is nothing "special" about an SNT that would separate it from other types of trusts and thus grant an expansion of the authority of the State and its local social services department beyond that which is already provided for. To treat an SNT differently from similarly fashioned trusts without the authority to do so would set same upon the precipice of a slippery slope towards an overreach of State authority.

The court observed from its review of *Abraham XX*. that nothing within that decision suggests an intention to deviate from established state law of trusts or to expand the rights given to the state agency in court proceedings. Likewise, the court notes that there is nothing in the authority governing an SNT (the Federal Medicaid statute, the New York State Social Services Law and regulations) that increases or broadens the role of the Department beyond one of assessment and determination of an applicant's initial and continuing eligibility for Medicaid. The clearly defined role of the Department **[***32]** is to determine whether the SNT as written comports with and affects the trust beneficiary's eligibility for Medicaid.

The State and its local social services department cannot exceed that authority which has been set forth in its own regulations. The local social services department is subordinate to the State Department of Health (DOH). DOH is authorized to

"supervise [the] local social services departments and in exercising such supervision . . . *shall approve or disapprove* rules, regulations and procedures made by local social services officials within thirty days after filing of same with the commissioner; such rules, regulations and procedures shall become operative immediately upon approval or on the thirtieth day after such submission to the commissioner unless the commissioner shall specifically disapprove said rule, regulation or procedure as being inconsistent with law or regulations of the department." (*See* Social Services Law § 20 [3] [a] [emphasis added].)

The court cannot reach the Department's position that a local social services department, acting without the approval of the Department of Health, would have the unilateral authority **[*254]** to make its own rules and regulations. To do so would invite every local social services district **[***33]** across the State to implement rules that may not necessarily be cohesive or comport with existing regulations promulgated by the Department of Health.

As observed by the Court of Appeals in *Matter of Beaudoin v Toia, 45 NY2d 343, 380 NE2d 246, 408 NYS2d 417 [1978])*,

> "[i]nasmuch as the local commissioners are agents of the State department they may not substitute their interpretations of the regulations of the State department for those of the State department or the State commissioner. To recognize any such right would be to undermine the supervisory authority of the State commissioner and to invite administrative chaos." (Citations omitted; *Matter of Samuels v Berger, 55 AD2d 913, 390 NYS2d 445 [2d Dept 1977]*; *Matter of Bonfanti v Kirby, 54 AD2d 714, 387 NYS2d 461 [2d Dept 1976]*; *Matter of Barbaro v Wyman, 32 AD2d 647, 300 NYS2d 856 [2d Dept 1969]*.)

The Department misinterprets its role in this proceeding. The Department has no authority to impose demands for reformation for that which is neither mandated by statute and **[****10]** regulations nor in keeping with the grantors' intent. To echo the opinion of Surrogate Preminger in *Matter of Rubin (4 Misc 3d 634, 781 NYS2d 421 [Sur Ct, NY County 2004])*, "[t]o reform the trust[ ] in the manner requested would stretch the

doctrine of reformation beyond recognition."

[422]** Here, as the SNT meets the statutory requirements for approval as written, the court will not consider and review each and every one of the Department's "observations" and requests for modification relative to same. The court notes that none of **[***34]** the Department's proposed changes to the SNT has anything to do with the beneficiary's eligibility (or ineligibility) for Medicaid. Many of the Department's requested modifications are duplicative to the language of the SNT,[6] unnecessary as already covered under statute,[7] or in direct contravention to **[*255]** existing authority.[8] It is not necessary to mandate that which is not required by statute and regulations.[9]

It is well settled that New York courts have historically been reluctant to reform or modify the terms of a trust other than in very limited circumstances. Because a proceeding such as this seeks to modify documents which were established by a grantor based upon a set of facts and circumstances that existed at the time of creation, a court should use this form of relief sparingly. Modification, although intended to be used sparingly, is appropriate to achieve a specific objective. (*Matter of Carcanagues, 2016 NY Slip Op 31765(U) [Sur Ct, NY County 2016]*.) Here, modification of the terms of the SNT are appropriate to achieve the specific intent and objective sought by the petitioners, specifically the maximization of the beneficiary's eligibility for benefits.

In view of the same, the court will direct that article II (A) of the SNT be modified to require the **[***35]** trustee to pay those administrative expenses enumerated in the Social Security Administration, Program Operations Manual System § 01120.203 (B) (3) (a).

Further, in the court's discretionary role to "balance" the interests of the State with that of the **[****11]** beneficiary, the court directs that article VII be modified to require that the trustee shall prepare an annual accounting of the trust and file same with the local social services district, or other appropriate Medicaid entity, responsible for determining the beneficiary's Medicaid eligibility at the time of the accounting. (*See Matter of Goldblatt, 162 Misc 2d 888, 618 NYS2d 959 [Sur Ct, Nassau County 1994]*; *Matter of Morales, 214 NYLJ 19, 1995 NY Misc LEXIS 726 [Sup Ct, Kings County 1995]*.) The SNT as written directs the trustee to file its annual accounting specifically with Albany County, and the court will amend the SNT accordingly to **[*256]** permit **[**423]** the trustees to file their annual accounting with their local social services department or other appropriate Medicaid servicing entity.

It is therefore so ordered that article II, paragraph (A) of the trust agreement for the benefit of Kevin J. Tyrrell dated February 15, 2001, be modified as follows: "(A) The Trustee shall pay those administrative expenses enumerated in the Social Security **[***36]** Administration, Programs Operations Manual System SI 01120.203 (B) (3) (a)"; and it is further ordered that article VII of the trust agreement for the benefit of Kevin J. Tyrrell dated February 15, 2001, be modified as follows: "The Trustee shall prepare an annual accounting of the Trust and file same with the local social services district, or other appropriate Medicaid entity, responsible for determining Kevin J. Tyrrell's Medicaid eligibility at the time of the accounting"; and it is further ordered that all other motions not specifically addressed herein are dismissed.

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[6] The Department requests that article VIII be amended to reflect that the trustees are required to file a formal accounting for judicial approval and settlement with the court. The SNT as drafted already provides that the trustees are required to submit a final accounting for judicial settlement and the proposed amendment is duplicative.

[7] The Department requests that article V be modified to reference that the trustees are liable as per *EPTL 11-1.7* and not exonerated for failure to use reasonable care. The existence of the statute already imposes said liabilities.

[8] The Department requests that article II (b) be modified to provide notice to the local social services district within 30 days of the beneficiary's death. *18 NYCRR 360-4.5 (b) (5) (iii) (b)* directs that a trustee must notify the local social services department of the death of the trust beneficiary within a reasonable time. The Department has no authority to mandate that the SNT exceed or further define that which is already in the regulation.

[9] The Department requests that articles IX (b), (d) and XI be modified to require that all trustees (including the corporate trustee) acquire and serve with a bond. *18 NYCRR 360-4.5* directs that no bond is required from the trustees. The Department has no authority to mandate that the SNT exceed that which is already set forth under the regulation or requested by the grantors.

End of Document

Matter of Tinsmon (Lasher)

Surrogate's Court of New York, Albany County

February 22, 2018, Decided

2011-216/B

Reporter
61 Misc. 3d 218 *; 79 N.Y.S.3d 854 **; 2018 N.Y. Misc. LEXIS 3215 ***; 2018 NY Slip Op 28238 ****

[**1]** In the Matter of the Petition for Advice and Direction Pursuant to SCPA 2107 for the Guardianship Pursuant to SCPA article 17-A of Jennifer Lasher Tinsmon. Christopher J. Lasher and Helena Lasher, Petitioners.

Subsequent History: Affirmed by *Matter of Tinsmon (Lasher), 2019 N.Y. App. Div. LEXIS 1449, 2019 NY Slip Op 1471 (N.Y. App. Div. 3d Dep't, Feb. 28, 2019)*

Core Terms

eligibility, benefits, exempt, funds, guardian ad litem, titled, means-tested, ownership, guardian, mortgage, ongoing, guardianship, transferred, Traumatic, recipient, Services, provides, payback, advice, assign, reside, Brain, individually, supplemental, survivorship, outstanding, recommends, settlement, appointed, nonexempt

Counsel: **[***1]** Edward V. Wilcenski, Esq., Attorney for Petitioners, Wilcenski & Pleat, PLLC, Clifton Park, New York.

Albert Dingley, Esq., Assistant County Attorney, Albany County Department of Social Services, Albany, New York.

JulieAnn Calareso, Esq., Guardian ad Litem for Jennifer Lasher Tinsmon, The Shevy Law Firm, LLC, Albany, New York.

Judges: Hon. Stacy L. Pettit, Surrogate.

Opinion by: Stacy L. Pettit

Opinion

[*219] **[**854]** Stacy L. Pettit, S.

Before this Court is an application by petitioners Christopher J. Lasher and Helena **[**855]** Lasher for advice and direction pursuant to *SCPA 2107*. The guardian ad litem assigned for Jennifer Lasher Tinsmon has issued her report and respondent Albany County Department of Social Services has filed an answer/objections to the petition. The matter is now submitted for decision.

By way of background, Tinsmon is a 50-year-old resident of Albany County. She is unmarried and has three children ranging in age from 12 years to 19 years of age. She sustained a traumatic brain injury in February 2011 as a result of personal injury. Shortly thereafter, petitioners, her parents, were appointed as the guardians of her person and property pursuant to *SCPA article 17-A*. At that time, the mortgaged residence in which Tinsmon still resides was owned jointly **[***2]** with right of survivorship by Tinsmon and her mother, petitioner Helena Lasher (hereinafter Lasher). Tinsmon also owned bank accounts in the approximate amount of $82,000 and a vehicle. By order of this Court dated August 5, 2011, a first party supplemental needs trust was established for Tinsmon's benefit, and petitioners were appointed as trustees of the trust. The trust, which includes a pay-back provision on Tinsmon's death for outstanding Medicaid payments made on her behalf, was funded with cash assets so that she would be eligible to **[****2]** participate in government benefit programs, such as the Traumatic Brain Injury Waiver program (*see 42 USC 1396p [d] [4] [A]*; *EPTL 7-1.12*; *Social Services Law § 366 [2] [b] [2] [iii]*). Tinsmon's interest in her residence was not

transferred to the supplemental needs trust, as a residence is an exempt asset which may be retained by an individual (*see* 20 CFR 416.1212; 18 NYCRR 360-4.7). The trust has paid mortgage payments and other carrying costs for the real property since its formation. In 2017, **[*220]** the trust received $1,345,310 in settlement funds from a Supreme Court action related to Tinsmon's injury. Pursuant to the terms of that settlement, the Department received $375,000 in full satisfaction of its outstanding Medicaid lien.

Petitioners have now commenced **[***3]** a proceeding for advice and direction under SCPA 2107 with regard to Tinsmon's residence. The property was purchased in December 2010, before Tinsmon's injury, as the residence for Tinsmon and her young children, and was titled to Tinsmon and Lasher as joint tenants. Both owners were mortgagors on the original mortgage on the property in the amount of $225,028.00, and, as of August 31, 2017, the principal balance was $196,835.12. Lasher does not reside in the residence, but has personally paid one half of the mortgage payments each month from her personal checking account, while petitioners have paid the other half from the trust assets. Lasher paid a total of $14,096.44 towards the mortgage. Because Lasher is not a disinterested third party, and is a guardian and trustee for Tinsmon, petitioners seek approval from the Court to have the trust pay to purchase Lasher's interest in the property, so that Lasher's half interest in the residence may be transferred to the guardians of the property and owned solely by Tinsmon. The proposed payment to Lasher for her interest in the property is the sum of $14,096.44. Petitioners assert that ownership of the property will not affect Tinsmon's participation **[***4]** in the Traumatic Brain Injury Waiver program, or her eligibility for Supplemental Security Income, as the property is an exempt resource for eligibility purposes (*see* 20 CFR 416.1212; 18 NYCRR 360-4.7; Social Security Program Operations Manual System [POMS] SI 01130.100). Petitioners also request that the Court confirm that, as guardians, they have ongoing authority to withdraw, transfer and assign nonexempt guardianship property to the trust so as to **[**856]** maintain Tinsmon's ongoing eligibility for means-tested benefits.

The Department does not oppose the payment, or the amount of the payment, to purchase Lasher's half interest in Tinsmon's residence. The Department's opposition to the petition, instead, is to ownership of the purchased interest by Tinsmon, through her guardians. The Department believes the real property should be transferred to the trust and titled in the names of the co-trustees. In support of its argument, the Department relies upon the Program Operation Manual System (POMS) for the Social Security Administration, which provides that, if **[*221]** trust funds are used to purchase a house, "the individual (or the trust)" must be shown as the owner (*see* POMS SI 01120.201 [F] [1]). The guardian ad litem recommends **[***5]** that the Court approve the purchase, with trust assets, of Lasher's interest in the residence, and title the property to Tinsmon through her guardians, and not title the property to the trust. The guardian concludes that the proposal is in Tinsmon's best interest, as the payment sought by Lasher is not unreasonable or unfair, nor would the sale jeopardize Tinsmon's ongoing eligibility for means-tested government benefits. The guardian ad litem also recommends that the Court clarify that petitioners have the authority, as guardians, to transfer assets to the trust, but require that assets which are exempt for eligibility for means-tested government benefit programs continue to be held by the guardians, so as not to defeat any potential testamentary or intestacy distribution of such assets on Tinsmon's death.

Arguing against transfer of title of the residence to the trust, the guardian ad litem asserts **[****3]** that Tinsmon purchased the property for herself and her three young children, and would have intended to pass the home or its resulting equity to her children in the future. The guardian ad litem opines that titling the property in trust would not be in Tinsmon's best interest because **[***6]** it would thwart the potential inheritance by her children of the exempt asset, and instead, subject it to payback for any Medicaid payments accrued at the time of her death. With respect to Medicaid estate recovery, the guardian states that Medicaid does not have a right to recover for benefits paid before the Medicaid recipient reaches age 55. She notes that the trust has a payback provision for all benefits paid regardless of age; however, she states that assets owned by Tinsmon individually are not subject to estate recovery except for benefits paid after age 55 and for benefits paid within the ten-year period immediately preceding her death. According to the guardian, titling the property in the name of the trust would benefit the Department, by increasing the funds available from which it can be repaid, and would harm Tinsmon as it would divest her of her opportunity to engage in estate planning. The guardian points out that Tinsmon's present one-half ownership in the exempt residence has not caused any eligibility problems, thus, ownership of the entire interest would also not cause eligibility problems.

With respect to a trust established for the benefit of or on behalf of an **[***7]** individual, POMS provides that **[*222]** "[i]f funds from a trust that is a resource are used to purchase durable items, e.g., a car or **a house, the individual** (or the trust) must be shown as the owner of the item in the percentage that the funds represent the value of the item. When there is a deed or titling document, **the individual** (or trust) must be listed as an owner" (POMS SI 01120.201 [F] [1] [emphasis added]). While the Department argues that this section indicates that the property must be owned by and titled in the trust, the plain language of the provision provides that when trust funds are used to purchase a house, either the individual or the trust must be **[**857]** the owner, and the provision does not appear to promote one type of ownership over the other. Presumably, the trustees could expend funds to purchase a house outright for Tinsmon to be the sole owner; thus, the trustees should also be able to purchase Lasher's half-interest and name Tinsmon as the sole owner. While there may be reasons why trustees choose to hold title to real property in the trust's name, the Department has failed to establish that such a practice is required in all circumstances. Here, Tinsmon and Lasher presently **[***8]** own the home in fee simple as joint owners with survivorship rights, and have owned it in that form since before the trust's creation. Accordingly, Tinsmon already has legal title to the exempt residence. It is noted that, with respect to determining the eligibility of disabled individuals to receive supplemental security income, one's home is not included as a resource, regardless of its value (*see* *42 U.S.C. § 1382b [a] [1]*; *see also* Social Security Program Operations Manual System [POMS] SI 01130.100 [B] [1]). Nonetheless, Medicaid paid to a recipient who is age 55 or older (which Tinsmon is not) is recoverable from the estate of the recipient upon death (*see* *Social Service Law § 369*). If Tinsmon should die after age 55, the Department may still recover against Tinsmon's real property at that time should the trust funds be insufficient to repay Medicaid benefits paid on her behalf after she reaches age 55.

With respect to petitioners' request for advice and direction, the Court finds that although one of the petitioners is an interested party in the proposed transaction, the transaction appears fair and reasonable and, as it will not affect Tinsmon's eligibility for benefits, is in her best interest. Accordingly, the Court approves **[***9]** of the proposed transaction.

Petitioners also request that the Court confirm that they have ongoing authority to withdraw, transfer and assign guardianship property to the trust so as to maintain Tinsmon's **[****4]** **[*223]** ongoing eligibility for means-tested benefits. The guardian ad litem requests that the Court specify that the guardians are only permitted to transfer those assets which are not exempt from means-tested benefits, and not any assets which are exempt and could pass to Tinsmon's heirs. The Court agrees that it is unnecessary for petitioners to transfer exempt assets into the trust. Otherwise, petitioners, as guardians, have continuing authority to transfer nonexempt guardianship property to the trust in order to preserve Tinsmon's eligibility for benefits.

Finally, the guardian ad litem has submitted an affirmation of legal services along with her report. The Court finds that her requested fee of $852.50 is reasonable and orders petitioners to pay said amount. This constitutes the decision and order of the Court.

Dated: February 22, 2018

Hon. Stacy L. Pettit, Surrogate

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Matter of Tinsmon (Lasher)

Supreme Court of New York, Appellate Division, Third Department

February 28, 2019, Decided; February 28, 2019, Entered

526747

Reporter
169 A.D.3d 1305 *; 95 N.Y.S.3d 411 **; 2019 N.Y. App. Div. LEXIS 1449 ***; 2019 NY Slip Op 01471 ****; 2019 WL 960161

[**1]** Guardianship of JENNIFER LASHER ***TINSMON***. and CHRISTOPHER J. LASHER et al., Respondents; ALBANY COUNTY DEPARTMENT OF SOCIAL SERVICES, Appellant.

Prior History: *Matter of **Tinsmon** (Lasher), 61 Misc. 3d 218, 79 N.Y.S.3d 854, 2018 N.Y. Misc. LEXIS 3215 (Feb. 22, 2018)*

Core Terms

benefits, Services, trust assets, petitioners', funds, supplemental, eligibility, guidelines, mortgage, statutes, act act act, interpretations, expenditures, implementing, means-tested, state-funded, unencumbered, encumbering, first-party, restricting, contradict, acquiring, appointed, approving, deference, disabling, enhancing, expertise, impacting, obligated

Case Summary

Overview
HOLDINGS: [1]-The trial court did not err in approving petitioner parents' proposal to expend funds of a special needs trust to purchase the co-owner's interest in their mentally disabled daughter's home and pay off its mortgage, giving them title as their daughter's guardians without impacting her SSI or Medicaid benefits, as it was within their sole and absolute discretion under the trust to make expenditures for their daughter's benefit after considering any impact on her access to government benefits; [2]-There was no statutory support for respondent department of social services' contention that, in order to assure reimbursement to the entities that provided Medicaid benefits to the daughter during her life, petitioners had to either hold title to the home as trustees or provide security to the trust for its investment into the home.

Outcome
The order was affirmed.

Counsel: **[***1]** Daniel Lynch, Albany County Attorney, Albany (Albert F. Dingley of counsel), for appellant.

Wilcenski & Pleat PLLC, Clifton Park (Edward V. Wilcenski of counsel), for respondents.

Judges: Before: Egan Jr., J.P., Clark, Mulvey, Devine and Rumsey, JJ. Egan Jr., J.P., Clark, Mulvey and Rumsey, JJ., concur.

Opinion by: Devine

Opinion

[*1305] **[**412]** MEMORANDUM AND ORDER

Devine, J.

Appeal from an order of the Surrogate's Court of Albany County (Pettit, S.), entered February 22, 2018, which granted petitioners' application, in a proceeding pursuant to *SCPA 2107*, for advice and direction regarding a proposed sale of certain real property.

In 2011, Jennifer Lasher ***Tinsmon*** suffered a disabling traumatic brain injury at the age of 42. Petitioners are her parents and, following her injury, were named the guardians of her person and property. They are also the trustees of a first-party supplemental needs trust that was established in August 2011 and exists "to shelter

[***Tinsmon***'s] assets for the dual purpose of securing or maintaining eligibility for state-funded services, and enhancing [her] quality of life with supplemental care paid by [the] trust assets" (*Matter of Abraham XX., 11 NY3d 429, 434, 900 N.E.2d 136, 871 N.Y.S.2d 599 [2008]*; *see 42 USC § 1396p [d] [4]*). ***Tinsmon***'s home, which is jointly owned by herself and petitioner Helena Lasher, was not **[***2]** placed in trust inasmuch as a residence cannot be counted in determining eligibility for certain means-tested benefits (*see 42 USC § 1382b [a] [1]*; *20 CFR 416.1212 [a]*; *18 NYCRR 360-1.4 [f]*; *360-4.7 [a] [1]*). ***Tinsmon*** **[**413]** qualified for and began receiving such benefits, namely, supplemental security income (hereinafter SSI) and Medicaid benefits.

In September 2017, petitioners commenced this proceeding pursuant to *SCPA 2107* to obtain, as is relevant here, approval for their proposal to expend trust funds to purchase Lasher's interest in ***Tinsmon***'s home and pay off an encumbering mortgage on it, leaving them with title to the home as ***Tinsmon***'s guardians. Over respondent's opposition, Surrogate's Court approved the plan. Respondent now appeals.

We affirm. Petitioners proposed acquiring Lasher's interest in the home on very favorable terms and paying off the mortgage, actions that would leave ***Tinsmon***, through petitioners as her guardians, as the sole owner of an unencumbered residence without impacting her SSI or Medicaid benefits. A **[*1306]** guardian ad litem appointed for ***Tinsmon*** by Surrogate's Court supported this proposal, which appears to be well within petitioners' "sole and absolute discretion" under the trust agreement to make expenditures for ***Tinsmon***'s benefit **[***3]** after considering any impact on her access to government benefits (*see EPTL 7-1.12*). Respondent objected only to the proposed transfer of title to petitioners as ***Tinsmon***'s guardians, arguing that administrative interpretations of the applicable statutes require that petitioners either hold title to the home as trustees or provide security to the trust for its investment into the home. Respondent's interest in this regard may be explained by the fact that the trust assets remaining when ***Tinsmon*** dies, regardless of how old she is when that occurs, will be first used to reimburse the entities that provided Medicaid benefits to her during her life (*see 42 USC § 1396p [d] [4] [A]*; *Social Services Law § 366 [2] [b] [2] [iii]*; *Matter of Abraham XX., 11 NY3d at 436*; *compare Social Services Law § 369 [2]* [restricting the respondent's ability to recover against the assets of a benefits recipient who dies before reaching 55 years of age]).

Respondent does not point to, and our review does not disclose, any statutory authority that would require its desired outcome. Respondent suggests that such a requirement may be found in guidelines, used by the Social Security Administration to process SSI benefit claims, that reflect the agency's expertise in implementing the pertinent statutes and are "entitled to 'substantial deference'" (*Lopes v Department of Social Servs., 696 F3d 180, 186 [2d Cir 2012]*, quoting **[***4]** *Bubnis v Apfel, 150 F3d 177, 181 [2d Cir 1998]*; *see Matter of Jennings v Commissioner, N.Y.S. Dept. of Social Servs., 71 AD3d 98, 109, 893 N.Y.S.2d 103 [2010]*). The guidelines contradict respondent's argument, however, providing that when funds from a trust are "used to purchase durable items, e.g., a car or a house, *the individual (or the trust)* must be shown as the owner of the item in the percentage that the funds represent the [item's] value" (Program Operations Manual System [POMS] former SI 01120.201 [F] [1] [emphasis added]). Further, petitioners are not obligated to conserve trust assets for respondent's eventual benefit, which would conflict with their mandate to act for ***Tinsmon***'s benefit by using "so much (even to the extent of the whole) of the net income and/or principal of th[e] trust" (*EPTL 7-1.12 [e] [1] [1]*; *see e.g. Matter of Shah [Helen Hayes Hosp.], 95 NY2d 148, 163, 733 N.E.2d 1093, 711 N.Y.S.2d 824 [2000]*). Surrogate's Court was accordingly correct to conclude that petitioners' proposal was permissible and did not err in approving it.

To the extent that the contention is properly before us, the **[*1307]** Social Security Administration **[**414]** does not possess a "remainder interest" in the trust that would entitle it to notice of this proceeding (*Social Services Law § 366 [2] [b] [2] [v]*; *see 42 USC § 1396p [d] [4] [A]*; *SCPA 103 [39]*; *2101 [3]*). Respondent's remaining arguments have been examined and are lacking in merit.

Egan Jr., J.P., Clark, Mulvey and Rumsey, JJ., concur.

ORDERED that the order is affirmed, **[***5]** with costs.

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McMichael

Surrogate's Court of New York, Queens County

August 2, 2017, Decided; August 11, 2017, Published

2000-59/A

Reporter
2017 NYLJ LEXIS 2245 *

McMichael

(Matter of McMichael, 2000-59/A, NYLJ, Aug. 11, 2017 at 33)

Core Terms

payee, structured settlement, Originations, Funding, best interest, advice, financial consequences, fair and reasonable, independent advice, lump sum payment, self-represented, long-term, intends, monies, waived, spent

Judges: [*1] Surrogate ***Peter Kelly***

Opinion

Cite as: Matter of McMichael, 2000-59/A, NYLJ 1202795156511, at *1 (Surr., QU, Decided August 2, 2017)

Surrogate's Court, ***Queens*** County

2000-59/A

For Plaintiff: For Petitioner, J.G. Wentworth: Law Office of Michel F. Nestor, LLC. Petitioner: Nigel Criss, was self-represented

CASENAME

In the Matter of the Petition of J.G. Wentworth Originations, LLC and Nigel Criss, sole distributee of the Estate of Shanetha Dejetta McMichael, Deceased, pursuant to Article 5 Title 17 of the New York General Obligations Law.

2000-59/A

Decided: August 2, 2017

ATTORNEYS

For Petitioner, J.G. Wentworth: Law Office of Michel F. Nestor, LLC.

Petitioner: Nigel Criss, was self-represented

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In this proceeding petitioners, J.G. Wentworth Originations, LLC ("J.G. Wentworth") and Nigel Criss ("Nigel"), seek approval of the transfer of certain structured settlement payments from Nigel to J.G. Wentworth.

The structured settlement payments to which Nigel is entitled amount to $429,780.32. The discounted present value of the payments is $351,203.10. Under the proposed purchase agreement, Nigel intends to sell the payments for the net amount of $245,000.00.

As a preliminary matter, the New York Structured Settlement **[*2]** Protection Act ("SSPA") originated in response to concerns that certain structured settlement payees are vulnerable to both financial exploitation and the rapid dissipation of their awards (see *General Obligations Law §5-1701 et seq*; *In re Settlement Funding of N.Y. L.L.C.,195 Misc 2d 721, 722 [Sup Ct, Rensselaer County 2003]*). Accordingly, institutions

*2

seeking to acquire a payee's structured settlement rights are required to commence a special proceeding seeking judicial approval, irrespective of the payee's willingness to go forward with the transaction (see id; *General Obligations Law §5-1705*]).

To pass muster, the proposed transfer must be in the best interest of the payee, the transaction must be fair and reasonable, and the payee must be advised in

writing to seek independent professional advice regarding the transfer and has either received such advice or waived such advice in writing (see *Matter of J.G. Wentworth Originations, LLC v. Maurello, 2012 NY Misc LEXIS 678 [Sup Ct, Nassau County 2012]*).

Determination as to whether the transfer is in the best interests of the payee warrants a fact-sensitive and oftentimes paternalistic analysis, taking into consideration the payee's age, maturity level, income sources independent of the structured payments, whether the payee has any dependents, the stated purpose of the transfer, the extent to which the payee appears to understand the financial consequences of the transaction, and whether the payee **[*3]** has received independent advice (see *Matter of Benes v. American Gen. Annuity Serv. Corp., 2011 NY Misc LEXIS 6174 [Sup Ct, Nassau County 2011]*).

According to his affidavit, the payee, Nigel, is 18 years of age, single, with no dependents, and is currently a full time student. He seeks a lump sum payment of $245,000.00 for the purpose of purchasing a home in Allentown, Pennsylvania at a cost of $210,000.00. The remaining monies are to be used for home

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improvements, the purchase of a vehicle, and covering day-to-day expenses. According to Nigel, he plans on attending a "Barbering Program" to obtain his license. No supporting documents have been submitted by Nigel in support of the petition.

It seems that at the still-tender age of 18, Nigel intends to spend the entirety of the lump sum payment immediately, in lieu of receiving payments over time that are designed to provide for his long-term financial security. Significantly, the court observes that Nigel, upon recently reaching the age of majority, has already accessed the monies in his ***guardianship*** account which amount to approximately $186,000.00. Nigel's unfettered use of those funds is not described in the petition or his affidavit. If the funds have not been spent, they can certainly assist Nigel with the purposes set forth in his affidavit. **[*4]** If, on the other hand, they have already been spent, the court must presume that Nigel has little to show for it. Either way, both scenarios militate against granting the requested relief (see *Matter of 321 Henderson Receivables Origination LLC v. Lugo, 23 Misc 3d 1138[A] [Sup Ct, Kings County 2009]*).

In the court's view, Nigel, who has waived receiving any independent advice regarding the transaction, does not fully appreciate the long-term financial consequences of selling his payments. The court cannot sanction an impulsive transfer for which there is no real urgency, particularly when it is diametrically opposed to the very purpose of the SSPA (see e.g. *In re Settlement Funding of NY L.L.C., 195 Misc 2d 721 [Sup Ct, Rensselaer County 2003]*).

As the court has determined that the transfer is not

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in Nigel's best interests, the court need not consider whether the terms of the transaction itself are fair and reasonable. The petition is denied.

This is the decision and decree of the court.

Dated: August 2, 2017

New York Law Journal

The ABCs of the SSA

Neal A. Winston, Esq.
Winston Law Group, Boston, MA

The ABCs of the SSA – Disability Programs for Children

Prepared for the

Elder Law and Special Needs Section

New York State Bar Association

Summer Meeting, July 18-20, 2019

Boston, Massachusetts

By

Atty. Neal A. Winston[1]

Social Security programs can be difficult for parents of children with disabilities to understand. This session will describe the Supplemental Security Income (SSI) program in more detail with examples of how it might apply to your clients, as well as provide some introductory information about Social Security Disability and Disabled Adult Child Benefits.

Defining the Different SSA Programs

Beginning in 1935, "Social Security" started out as a retirement "insurance" pension program in which the worker earned "coverage" by having Social Security taxes taken out of his or her wages with equal contributions from the employer. It was quite basic: when the individual reached retirement age, then age 65, the worker could receive a "retirement benefit" pension with the monthly benefit amount based upon the amount of taxes paid over the working

[1] Member, Bar of the Commonwealth of Massachusetts, Certified Elder Law Attorney (CELA) by the National Elder Law Foundation

lifetime. Generally 10 years (40 quarters of earnings) are required to be "fully insured". In 1939, the worker's spouse and other close family members, as "dependants" or as "survivors" of the worker, were added as potential "beneficiaries" and could receive additional benefits under certain conditions. Beginning in 1956, if the worker became disabled from working prior to retirement age, then "disability" benefits could be paid. The worker's close family member dependants and survivors were eventually added as beneficiaries eligible for disability benefits of their own under certain circumstances. These programs are generally described by the SSA as Social Security Retirement Survivors Disability Insurance (RSDI) and Social Security Disability Insurance (SSDI).

Prior to 1974, most state or local government entities had their own cash benefit "welfare" programs for the aged and disabled based upon a wide range of eligibility criteria and benefit amounts. In an attempt to standardize eligibility and benefit amounts for these programs, the federal government created the Supplemental Security Income (SSI) program, which the states were required to subscribe to, effectively replacing the former federally supported state and local programs. Age, disability, and blindness were determined to be the three defined categories of need. The Social Security Administration was delegated to administer the program in all states. States were offered options that could be adopted including automatic Medicaid eligibility for all SSI recipients and supplemental amounts paid by the state to the federal SSI benefit. The SSA determined the primary SSI eligibility criteria based upon the federally uniform statute and the states could provide additional benefits with their own criteria based category and living arrangement.

Supplemental Security Income

Basic SSI Eligibility Rules:

1. The individual must be categorically eligible by being "aged" or age 65, or meet the Social Security definition of "disability" or "blindness"

2. Meet the income limit standards in which total countable monthly income is less than the SSI benefit amount for the individual's eligibility category (see 1. above) and living arrangement (see Appendix A for 2019 Federal and New York state supplement benefit levels, by category)
3. Meet the maximum countable "resource" limit amount, which is $2,000 for an individual, and $3,000 for an eligible couple, except that many resources are not countable
4. The difference between income and a resource: "Income" is anything that can be used for food or shelter and related expenses that is received in a particular month. If it is saved to the following month, it becomes a resource. A "resource" is something that the individual has ownership/control over at the beginning of any month following the month of receipt that can be used for or converted for use for food or shelter related expenses
5. Giving away resources to become eligible may create a period of ineligibility for up to 3 years
6. Meet certain citizenship or residency requirements
7. The New York State Office of Temporary and Disability Assistance (OTDA) has a detailed brochure explaining the federal SSI and state supplement (SSP) program interrelationship. See Appendix B

Detail for SSI Categorical Eligibility:

1. Proof of age 65 or greater
2. Definition of disability: Cannot do work done before, cannot adjust to other work because of medical condition(s); and disability has lasted or is expected to last for at least one year or to result in death[2]. The disability definition for a child under age 18 differs from the adult definition[3]

[2]The inability to engage in substantial gainful activity because of a medically determinable impairment or combination of impairments that can be expected to result in death or can be expected to last for a continuous period of not less than twelve months, taking into consideration age, education, and prior work experience. 20

3. Definition of blindness: Vision cannot be corrected to better than 20/200 in better eye or if visual field is 20 degrees or less, even with a corrective lens

Detail for SSI Income Eligibility

1. Countable income must not exceed the income standard for the combined federal SSI and state supplement living arrangement category levels. SSI benefits are a form of guaranteed minimum income and are reduced as countable income increases and are not payable when monthly countable income that is not disregarded reaches the maximum income level amount of the particular category, living arrangement and state supplement (see Appendix A)
2. Certain income is "disregarded" or not counted depending on source. $20 of "unearned" income and the first $65 plus ½ of the remainder of "earned" (work) income is not counted each month. For example, Social Security insurance (RSDI) benefits, monthly pensions, and bank account interest and dividends are "unearned" income. "Earned" income is received as a direct result of being paid for work performed
3. The value of free or undervalued housing or food (called "in-kind support and maintenance" or ISM) counts as income and will reduce the SSI benefit, but only up to a maximum one-third of the federal benefit rate or $257 monthly in 2019. For example, if a person receives $200. in free food in a month from a relative, it will count as unearned income and reduce benefits accordingly.

C.F.R. §§ 416.905–416.911. In determining whether an applicant has a physical or mental impairment that has lasted or can be expected to last for at least twelve continuous months or result in death, the SSA requires that the presence of the impairment must be shown by medical evidence. 20 C.F.R. §§ 416.912–416.918.

[3] The disability standard for children requires that the child (a person under the age of eighteen) have a medically determinable mental and/or physical impairment that has medical criteria or functional limitations resulting in "marked and severe functional limits" and that has lasted or is expected to last at least twelve months or result in death. 20 C.F.R. § 416.906. This means that if a child's impairments do not meet or medically equal the severity of a listed impairment, the analysis turns to whether the child's medically determinable impairments meet the functional equivalence standard. 20 C.F.R. § 416.924(b)–(f). Functional equivalence compares the child's functional capacity in six different do-mains to determine how the functions compare to similar children without disabilities. 20 C.F.R. §§ 416.926a, 416.924a. If the child has marked level functional limitations in two domains or extreme level limitations in one domain, the child will be found disability eligible for SSI. 20 C.F.R. § 416.926a(e).

Federal or state welfare benefits such HUD subsidized (section 8 and similar) housing is not counted as income

4. Income of an ineligible spouse is "deemed" as available to the eligible individual and countable to the individual as income under certain conditions. Likewise, income of the parent(s) living in the household of a child under age 18 may be "deemed" as available to the child and countable as income to the child after certain deductions

Detail for SSI Resource Eligibility

1. A resource can be "countable" or "non-countable". If countable, an individual is allowed a total of $2000 and an eligible couple is allowed $3000. Even $1 in excess countable resources available to the individual will render an individual ineligible for each month that the excess is available, including retroactive ineligibility
2. Examples of a countable resource includes cash and other liquid assets, something that can be converted to cash such as cash value of a life insurance policy or IRA, land other than where the home is located, or anything else of value that can be reasonably cashed in that is not determined to be non-countable
3. Examples of defined non-countable resources include a home, a vehicle, home furnishings, personal effects, property needed for self support, an irrevocable burial contract or burial plot, one life insurance policy of $1,500 or less, and a scholarship or fellowship
4. Resources of an ineligible spouse and parents of a child under age 18 living in the same household as the eligible individual are "deemed" as available after certain deductions

Social Security Child Disability Insurance Benefits (CDB)

The SSA describes the Child Disability Benefits (CDB) insurance program in the Social Security Handbook as follows:

Under the Social Security Disability Insurance (SSDI) program, an adult child (a person age 18 or older) may receive monthly benefits based on disability or blindness on the Social Security record of a parent as a dependent or survivor if:

- He or she has an impairment or combination of impairments that meets the definition of disability for adults. See the SSI section above for the disability and blindness definitions; and
- the disability began before age 22; and
- The adult child's parent worked long enough to be insured under Social Security and is receiving retirement or disability benefits or is deceased.

The child must not be doing any "substantial" work, and must have a medical condition that has lasted or is expected either to last for at least 12 months or to result in death.

Social Security Child Disability Benefits (CDB) is another form of Social Security dependants or survivors Childs Benefits under the insurance program in which the child of an insured worker can receive disability *insurance* benefits for life from the record of the insured parent if the child is disabled into adulthood. If the CDB benefits are less than the SSI and state supplement level, then it is possible that the individual can receive a portion of all of those benefits. Individuals generally apply for CDB benefits when they do not have enough work history or quarters of coverage on their own record to obtain SSDI benefits when they become disabled or are permanently disabled prior to adulthood. Sometimes trying to work age 22 and later, and then becoming unable to work due to a disability without having enough quarters of credits for SSDI on his or her own record may permanently disqualify an individual for CDB benefits.

If the child is receiving Child Benefits as a child, and then reaches age 18 and is disabled, then the child can transition to the adult disabled Childs Benefits program seamlessly if proper application is made. Other than the requirement that the child be disabled prior to the age of

22 continuously until such time as the parent worker that the child is dependent upon starts receiving benefits on his or her own record or dies, the eligibility criteria for CDB are similar to Childs Benefits for an individual receiving benefits as a child under age 18. If the child works (performs Substantial Gainful Activity, SGA) after age 22 and prior to the time that the worker starts receiving benefits or dies, and the child has not received DCB previously, then the child may be forever disqualified from receiving benefits

A child who has not received Childs Benefits may receive Child Disability Benefits (CDB) as long as the individual has not worked (performed SGA) after age 22 and prior to such time as the worker parent starts receiving benefits or dies and the child applies for CDB benefits

Once the child starts receiving CDB, then the benefits may be terminated if the disability ends, but reinstated under certain conditions it the disability returns. If the disability ends due to medical improvement but returns within 84 months, then the benefits will be reinstated. It will not matter that the individual has performed work during the interim

Determining What Benefits Are Being Paid

Under certain conditions, individuals can be eligible for both SSDI/CDB and SSI benefits at the same time. The SSA love of acronyms (OASDI, RSDI, SSDI, SSI, etc.) has provided perennial confusion to claimants and their attorneys over just what benefits the individual is receiving or perhaps eligible for

There are a few basic rules to determine what type of benefits an individual is receiving without contacting the SSA

- Since one reason for SSI eligibility is based on providing a minimum monthly income, having income above the SSI and state supplement limits being paid by the SSDI or CDB

insurance program each month can easily determine that the individual is only eligible for SSDI/CDB benefits and not SSI

- SSI and state supplement benefits are paid on the first of the month and CDB benefits are paid on the third day or later in the month based on the week in the month the person's birth date falls in. Since most SSI and RSDI benefits are direct deposited, looking at the individual's bank statement is a sure way of defining the benefit program and amount

- When an individual is eligible for any category of disability insurance (SSDI or CDB) benefits for 24 months or longer, then the individual will also become eligible for Medicare, which has a red, white and blue eligibility card as compared to the state issued Medicaid card, although many individuals are eligible for both medical coverage programs

Where to Obtain Benefit Eligibility Information

1. Contact the Social Security Administration by telephone either by calling the local office serving the location of the person's home or the national call in number, 800-772-1213. If requesting specific information, the individual must be on the phone and be prepared to provide Social Security number, date of birth, and mother's maiden name or some or identification generally known only to the individual

2. Visit a local office in the area where the individual or the individual's appointed representative lives. Note the hours that it is open and that offices close to the public at noon on Wednesdays. Identification will be required.

3. Go on the internet. The Social Security Administration has a very sophisticated website, providing both general information in multiple formats about everything that is SSI and Social Security, and specific information if the individual sets up a personal portal. The website is: https://www.socialsecurity.gov. Beware of any other internet website for accurate information. The Social Security Handbook gives a good simplified overview of benefits and eligibility criteria, https://www.ssa.gov/OP_Home/handbook/handbook.html. All of the program information, from federal statute to regional unique rules is located at https://www.ssa.gov/regulations/. The most detailed, and often the most helpful information is located in the Program Operations Manual System (POMS), https://secure.ssa.gov/poms.nsf/Home?readform. Go to the Table of Contents. SSI rules are found in section "SI", and CDB benefit rules are generally found in "RS", but more specifically RS 00203.080 - .090. Disability criteria for both SSI and CDB is found in section "DI"

4. There is a professional organization whose members specialize in representing individuals that are applying for SSI based on disability or SSDI. It is the National Organization of Social Security Claimants Representatives (NOSSCR). Telephone 845-682-1881 for a referral, or online, https://nosscr.org/contact-us/

5. The National Academy of Elder Law Attorneys (NAELA) has a member listserv and database that has a very large amount of SSI and Social Security information. Members advertise their interest in Social Security under listings in the member directory and are available for referrals. https://www.naela.org/

SSI and SSP Benefit Levels Chart effective January 1, 2019 (reflects the 2.8% federal COLA for January 2019)

Fed L/A Code	State Supp Code	New York State Living Arrangement	Individual			Couple		
			Federal	State	Total[1]	Federal	State	Total
A	A	**Living Alone**	$771	$87	**$858**	$1,157	$104	**$1,261**
A, C	B	**Living With Others**	$771	$23	**$794**	$1,157	$46	**$1,203**
B	F	**Living in the Household of Another** [2]	$514	$23	**$537**	$771.34	$46	**$817.34**
A	C	**Congregate Care Level 1 - *Family Care*** OCFS certified Family Type Homes for Adults; and OMH or OPWDD certified Family Care Homes						
		NYC, Nassau, Rockland, Suffolk and Westchester Counties	$771	$266.48	**$1,037.48**	$1,157	$917.96	**$2,074.96**
		Rest of State	$771	$228.48	**$999.48**	$1,157	$841.96	**$1,998.96**
A	D	**Congregate Care Level 2 - *Residential Care*** OMH or OPWDD certified Community Residences, Individualized Residential Alternatives and OASAS certified Chemical Dependence Residential Services						
		NYC, Nassau, Rockland, Suffolk and Westchester Counties	$771	$435	**$1,206**	$1,157	$1,255	**$2,412**
		Rest of State	$771	$405	**$1,176**	$1,157	$1,195	**$2,352**
A	E	**Congregate Care Level 3 – *Enhanced Residential Care*** DOH certified Adult Homes and Enriched Housing programs; and OPWDD certified Schools for the Developmentally Disabled	$771	$694	**$1,465**	$1,157	$1,773	**$2,930**
D	Z	**Title XIX (Medicaid certified) Institutions** [3]	$30	$0[4]	**$30**	N/A	N/A	N/A
A	Z	see below [5]	$771	$0	**$771**	$1,157	$0	**$1,157**

Minimum Personal Needs Allowances

Congregate Care Level 1	-	$ 148
Congregate Care Level 2	-	$ 171
Congregate Care Level 3	-	$ 204

Limits on Countable Resources

Individuals	$2,000
Couples	$3,000

Statutory References: Chapter 59 of the Laws of 2018

Revised October 23, 2018

[1] The combined federal and State SSI benefit provided to eligible individuals and eligible couples with no countable income.
[2] The *Living With Others* category includes recipients whose federal benefit has been reduced by the "value of the 1/3 reduction" (VTR) due to the federal determination that they are both: *a)* Living in someone else's household, *and b)* receiving some amount of free or subsidized food and shelter (room and board).
[3] Applies when a SSI recipient is residing in a medical facility, is not expected to return home within 90 days, and Medicaid is paying for at least 50% of the cost of care.
[4] Recipients in nursing homes licensed by DOH receive an additional monthly grant of $25 issued by OTDA called a State Supplemental Personal Needs Allowance (SSPNA). Residents of other medical facilities receive a SSPNA of $5.
[5] No State supplement is provided: a) when a SSI recipient is residing in a private medical facility and Medicaid is paying for less than 50% of the cost of care, or b) when a recipient resides in certain publicly operated residential facilities that serve more than 16 residents, or c) when a recipient resides in a public emergency shelter for 6 calendar months during a 9-month period.

Office of Temporary and Disability Assistance

Appendix B

New York State Supplement Program (SSP)

Overview

SSP provides state-funded financial assistance to aged, blind and disabled individuals and is part of the monthly benefit paid to most Supplemental Security Income (SSI) recipients.

Applying for SSP

You must submit an application for federal SSI benefits to the Social Security Administration (SSA).

SSP Eligibility

Eligibility is based on a number of factors, including age, disability, income, citizenship or qualified alien status.

SSP Benefits

Monthly benefit amounts vary depending on a variety of factors.

SSP Payment Schedule

Scheduled Availability of Benefits: April 2019 through September 2019

Reporting Changes to Your Case

You must report changes that may impact your benefits.

How to Get Proof of Your NYS SSP Benefits

If SSP recipients, their payees and authorized representatives need proof of their benefits they may request a verification letter.

Applying for SSP

You must submit an application for federal SSI benefits to the Social Security Administration (SSA). This serves as your application for SSP benefits. SSA shares this information with New York State, who will determine your eligibility for SSP benefits.

There is no online SSI Application. Please schedule an appointment with a local Social Security office to file an application.

- Social Security Office Locator; or
- Call 1-800-772-1213 (TTY 1-800-325-0778), Monday through Friday 7 am to 7 pm.

For more information on how to apply for SSI benefits, visit www.socialsecurity.gov.

SSP Eligibility

You are eligible for SSP benefits if you:

- Are an adult who is age 65 or older; or are blind or disabled; or are a child under the age of 18 who has a physical or mental impairment; and
- Reside in New York State; and
- Have limited income and resources; and
- Are a citizen or a qualified alien, or otherwise meet citizenship requirements.

SSP Benefits

Monthly benefit amounts vary depending on a variety of factors including:

- living arrangements,
- income; and
- county of residence.

View Maximum Monthly Benefit Amounts by Year:

- SSI/SSP 2019 Maximum Monthly Benefit Amounts

How You Receive Benefits

If you receive both SSI and SSP benefits, you will receive your SSP benefits the same way you chose to receive your SSI benefit.

If you receive SSP benefits but do not receive SSI benefits, you can choose how to receive your benefits. We strongly encourage you to receive benefits through direct deposit, which is safe, fast and convenient.

If you currently have a representative payee for your SSI benefits, that person will also manage your SSP benefits. If you want to change your representative payee, you must contact SSA. If you receive SSP but do not receive SSI benefits, you can assign or change a payee by calling SSP at 1-855-488-0541.

Medicaid Eligibility

If you are eligible for SSP, you will automatically be eligible for Medicaid.

Reporting Changes to Your Case

You must report changes that may impact your benefits. The following reporting requirements apply to all SSP/SSPNA recipients:

Your SSP and SSPNA eligibility as well as benefit amount is based on information received from the Social Security Administration (SSA) as well as information reported to New York State (NYS).

Your failure to report changes and/or to report any changes in a timely manner may result in a possible suspension, discontinuance, or reduction of your benefits. You may also have to repay benefits that you improperly received as a result of not reporting changes as required.

For Individuals Who Receive Both SSI and SSP Benefits:

If you receive **both** SSI and SSP benefits, you will report your changes to SSA.

Examples of changes that must be reported include, but are not limited to:

- Change of residence and/or mailing address
- Marriage, divorce or separation
- Improvement of a disability
- Income or employment changes
- Change in countable resources that exceed $2000 for an individual or $3000 for an SSI/SSP couple
- Changes in bank account information
- Changes in your payee
- Changes in who you wish to allow to receive information about your benefits

NOTE: You must report any change in your **State Living Arrangement** directly to **NYS SSP**, not to the SSA.

A change in living arrangement must be reported to NYS SSP within ten (10) days of the date of the change. **Please note that a change in who is in the household must be reported even if your address has not changed.** The death of a household member, or changes to who is living in the household are living arrangement changes that must be reported.

For Individuals Who Only Receive SSP Benefits:

If you receive **only SSP benefits**, you will report your changes directly to NYS SSP.

Examples of changes that must be reported include, but are not limited to:

- Change of residence and/or mailing address
- Marriage, divorce or separation
- Improvement of a disability
- Income or employment changes
- Change in countable resources that exceed $2000 for an individual, or $3000 for an SSI/SSP couple

- Change in living arrangement or household composition, including the death of a household member or changes to who is living in the household. **Please note that a change in who is in the household must be reported even if your address has not changed.**

The changes listed above **must be reported to NYS SSP within ten (10) calendar days** of the date of the change.

You should also tell NYS SSP about the following changes as soon as you know about them:

- Changes in bank account information
- Changes in your payee
- Changes in who you wish to allow to receive information about your benefits

The Following Information Applies To All Recipients:

All applicants and recipients must respond to requests for information and/or documentation made by SSP **within thirty (30) calendar days** from the date of the request. Failure to respond to requests for information may have a negative impact on your benefits.

Where to Report Changes or Provide Requested Information:

You may report changes to **SSA** by calling 1-800-772-1213 or by visiting your local SSA office in person.

You may report changes to SSP by calling toll free at 1-855-488-0541; OR by fax at: 518-486-3459; OR by email at: otda.sm.ssp@otda.ny.gov; OR by regular mail at:

NYS OTDA
State Supplement Program
PO Box 1740
Albany, NY 12201

NOTE: If you receive Social Security Retirement, Survivor's, or Disability payments and also receive SSP benefits, SSA does not share your federal benefit information or any changes, including address or living arrangement, with SSP and you must report changes directly to SSP.

Forms

Complete and send the following forms to tell us about changes to your:

- Living Arrangements - State Living Arrangement Form
- Bank Information - Direct Deposit Enrollment Form
  - Direct Deposit Cancellation Form
- Income - Income Verification Form
- Marital Status - Marital Status Change Form
- Designated Representative – Designated Representative Form
  - Rights and Responsibilities of Designated Representatives

Congregate Care facility representatives should report changes, including admissions, discharges, direct deposit bank account information, and income on behalf of residents using the following form:

- Congregate Care - Congregate Care Change Report Form

Where to Return Forms

Completed forms may be mailed to:

NYS OTDA State Supplement Program
PO Box 1740
Albany, NY 12201

Or may be faxed to: 518-486-3459.

Scanned forms may be emailed to: otda.sm.ssp@otda.ny.gov

How to Get Proof of Your NYS SSP Benefits

New York State Supplement Program (SSP) recipients, their payees and authorized representatives can request an SSP Benefit Verification letter in any of the following ways:

- By calling the SSP Customer Support Center toll free at 1-855-488-0541
- By emailing us at: otda.sm.ssp@otda.ny.gov
- By faxing us at 518-486-3459
- By writing us at:
  NYS OTDA
  State Supplement Program
  PO Box 1740
  Albany, New York 12201

When emailing, faxing or writing, please include the following information:

- Name
- Last four numbers of your Social Security Number
- Date of Birth
- Mailing Address

The SSP Benefit Verification letter provides information on current SSP benefits.

Benefit Verification letters are mailed directly to the recipient and/or representative's address.

Please allow at least 10 business days for the Benefit Verification letter to be received.

The Sole Benefit Trust - Whatever Happened to this Planning Tool?

Howard S. Krooks, Esq.
Elder Law Associates, PA, Boca Raton, FL

SOLE BENEFIT TRUSTS

NYSBA Elder Law Section Summer Meeting

July 19, 2019

Howard S. Krooks, Esq., CELA, CAP

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1

The Basics – Statute

The Statute - (42 USC § 1396p(c)(2)(B))

No penalty period will be imposed IF the assets -

i. were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse,

ii. were transferred from the individual's spouse to another for the sole benefit of the individual's spouse,

iii. were transferred to, or to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of, the individual's disabled child described in subparagraph (A)(ii)(II), or

iv. were transferred to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of an individual under 65 years of age who is disabled (as defined in section 1382c(a)(3) of this title).

2

The Basics - Purpose

Dual Purpose

- Avoid penalty for SSI and Medicaid
  - ✓ Not true for non SBT 3rd Party SNTs
- Assets not countable resource for grantor OR disabled beneficiary

Particularly Useful When…

- No advance planning done by parent
- Therefore, great crisis planning tool

3

The Basics – For Whom Created?

Must be for the "Sole Benefit Of" Certain Individuals

1. Spouse
   - ✓ Not a SNT
   - ✓ Known as Community Spouse Annuity Trust
2. Disabled Child or Blind Child (SNT)
   - ✓ No Age Limit – over or under 65 works
   - ✓ Must be certified blind or disabled
3. Disabled Individual (SNT)
   - ✓ Must be Under 65 and disabled

If not one of these individuals, then not SBT!

4

The Basics – Disabled Beneficiary

FOR DISABLED BENEFICIARY (NOT CS)

Usually 3rd Party SNT

- **Disabled Beneficiary (except CS)**
- **No payback provision required in statute**
  - ✓ **BUT - Some states require payback anyway**

HCFA Transmittal No. 64

- **§ 3257.6 adds to statutory provisions**

What it is Not

- **A self-settled SNT**
- **Clearly – 3rd Party Funds are used**

5

HCFA Transmittal No. 64

Clarifies Definition of "Sole Benefit Of"

Only valid if the trust benefits no one but that individual (spouse, blind or disabled child, disabled individual)

- **Whether at the time the trust is established**

OR

- **Any time in the future**

HCFA Transmittal No. 64 - § 3257.B.6.

6

HCFA Transmittal No. 64

DISTRIBUTIONS - Trust MUST provide for distributions

- **On actuarially sound basis,**
- **Using life expectancy of beneficiary**

If NOT

Then no exemption from transfer penalty rules!

7

HCFA Transmittal No. 64

DISTRIBUTIONS – You/Your Client does not wish to provide for actuarial sound distributions?

No Problem – HCFA 64 provides an alternative way to draft SBT while still meeting definition of Sole Benefit Of…

8

HCFA Transmittal No. 64

IF a SBT provides –

- **Payback Provision - Upon the death of individual any funds remaining in the trust must go to the State up to the amount of Medicaid benefits paid**

THEN -

- **Trust distributions need not be made on an actuarially sound basis**

9

HCFA Transmittal No. 64

State Interpretational Issues

Payback Trust Required - In some states, SBT MUST be a payback trust

- **Despite HCFA 64 language to the contrary – can be actuarially sound**

Naming of Other Beneficiaries - In some states, other beneficiaries can be named after full payback

- ***See Hamilton Letter dated January 19, 2001 from HHS to Raymon Harvey, Esq.***

Name Disabled Beneficiary's Estate as Remainder - In some states, you can name disabled beneficiary's estate as remainder beneficiary

10

HCFA Transmittal No. 64

Compensation of Trustee

- Is allowed by HCFA 64
- Reasonable compensation as defined by State law

Investment Costs

- Also allowed by HCFA 64
- Reasonable costs to invest or otherwise manage trust funds

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96 ADM-8

Clarifies Sole Benefit Requirements For CS

Written statement clearly limiting use and enjoyment of funds to spouse

OR

If no written statement - then the person who transferred funds may sign a statement attesting that the transfer was intended for the sole benefit of the spouse.

IN ADDITION – the social services district must conclude, based on the age of the spouse, amount of assets transferred, and the rate and amount of actual expenditures from the transferred assets for the benefit of the spouse, that the transferred assets are likely to be totally expended

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96 ADM-8

Sole Benefit Statement

I transferred the following assets to _____ on _____.

At the time of the transfer, it was my intent, and it was the agreement of myself and the transferee, that the transferred assets henceforth would be used for the sole benefit of _____.

Specifically, it was and is my intent that the assets be expended for the following purposes: _____.

I acknowledge that I have a responsibility to provide to the social services agency evidence of a continuous course of conduct by the transferee, consistent with this intent, since the time of the transfer.

I further acknowledge that, pursuant to regulations of the New York State Department of Social Services, any action by myself or the transferee which has the effect of reducing or eliminating the above-named beneficiary's use of the transferred property, or has the effect of reducing or eliminating the transferee's ownership or control of the transferred property, will be considered a transfer of assets (on the date such action is taken) which may affect my or my spouse's eligibility for Medical Assistance.

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Trusts for the Sole Benefit of the Community Spouse

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Availability of Assets in Sole Benefit Trusts – The Community Spouse

Streimer Letter - HCFA Letter Dated April 16, 1998, to Jean Galloway Ball, Esq.

1. **Compares the 'purchase of an annuity' to 'funds placed into community spouse SBT'**

2. **Considers whether actuarial soundness**

   - **Available Resource - Protects trust assets from being deemed an available resource**

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Availability of Assets in Sole Benefit Trusts – The Community Spouse

Streimer Letter Conclusion

Commercial Annuity

- **Give up control of assets in exchange for a commodity (i.e., the annuity product)**

Sole Benefit Trust

- **Actuarial soundness only applies to transfer of assets rules**
  - ✓ **But not to determine if trust assets are available**
- **Availability of Assets analyzed under § 1917(d) of the Social Security Act**

  "if there are any circumstances under which trustee can pay assets to CS…"

Implications

- **Some states will only allow creation of SBTs for CS up to the CSRA**

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Availability of Assets in Sole Benefit Trusts

Argument that Streimer Letter is Flawed

The control of assets is given up whether the funds are used to purchase an irrevocable annuity or placed into a trust for the sole benefit of the community spouse

The only condition in HCFA 64 is that the definition of "sole benefit of" must be satisfied

- **Actuarially Sound Payout**
- **CS is only beneficiary of trust assets**

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Availability of Assets in Sole Benefit Trusts

Two Cases Support Streimer Letter Interpretation

- ***McNamara v. Ohio Dep't. of Human Services, Ohio App. Ct., 2d Dist., C.A. Case No. 18234 (August 4, 2000)***
- ***Johnson v. Guhl, U.S. Dist. Ct., N.J., No. 99-CIV-5403 WGB, 2000 WL 359624 (April 7, 2000)***

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Availability of Assets in Sole Benefit Trusts

McNamara v. Ohio Dep't. of Human Services,
Ohio App. Ct., 2d Dist., C.A. Case No. 18234 (August 4, 2000)

Facts

- H created spousal annuity trust and funded with $221k
  - ✓ Entire marital estate valued at $256k
- Monthly income to H - Principal annually to H over 5 years
- W received no benefit from trust
  - ✓ So it was for sole benefit of H
- H was 76 at trust creation date, and life expectancy was 8.76 years
- H had no authority to withdraw assets from trust
- At death of H, remainder to 2 children
- Medicaid imposed 30 month penalty period

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Availability of Assets in Sole Benefit Trusts

McNamara v. Ohio Dep't. of Human Services (cont.)

Appellant's Arguments

No penalty period should be imposed on the transfer of assets into the SBT -

- Exempt spousal transfers can be made in unlimited amounts - 42 USC § 1396p(c)(2)(B)
- The CSRA does NOT operate as a restriction on the amount of exempt spousal transfers
- The trust was for the sole benefit of H notwithstanding remainder provisions to children, because only H could benefit during his lifetime

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Availability of Assets in Sole Benefit Trusts

McNamara v. Ohio Dep't. of Human Services (cont.)

Medicaid Argument

No one can benefit from the trust except CS, now or at any time in the future; therefore, naming children as residuary beneficiaries violates this rule

Holding

- Court concludes the CSRA limits amount of assets that can be transferred between spouses
- Upholds penalty for funding of SBT since the amount transferred into the trust exceeded the applicable CSRA (about $80,000 in Ohio at that time).

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Availability of Assets in Sole Benefit Trusts

McNamara v. Ohio Dep't. of Human Services (cont.)

Appellant (H) cites HCFA Transmittal No. 64 in support of his position –

"The exceptions to the transfer of assets penalties regarding interspousal transfers and transfers to a third party for the sole benefit of a spouse apply even under the spousal impoverishment provisions [contained in 1396r-5]. Thus, the institutional spouse can transfer unlimited assets to the community spouse or to a third party for the sole benefit of the community spouse."

Court dismisses this argument, stating that HCFA policy transmittals are entitled to *some* deference IF they are consistent with the plain language and purposes of the statute.

Court Reasoning - Since Congress enacted CSRA provisions, it must have intended to limit the amounts that can be transferred between spouses to this limit; otherwise, why have a CSRA?

22

Availability of Assets in Sole Benefit Trusts

McNamara v. Ohio Dep't. of Human Services (cont.)

Appellant (H) cites HCFA Transmittal No. 64 in support of his position –

WAIT - if the *McNamara* court's reasoning was adopted, there would be an impermissible transfer between spouses any time assets above the CSRA were transferred!

The court never got to the question of availability of assets issue, considering this issue to be moot in light of the improper transfer of assets between spouses.

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Availability of Assets in Sole Benefit Trusts

***Johnson v. Guhl*, 91 F.Supp.2d 754 (D.N.J. 2000)**

Facts

- **Class action seeking injunctive relief against NJ Medicaid policy of treating assets in CS Annuity Trust available resources**
- **Plaintiffs are Community Spouses and Institutionalized Spouses**
- **Some applied for Medicaid and some did not yet apply**

24

Availability of Assets in Sole Benefit Trusts

Johnson v. Guhl (cont.)

"

'There can be no doubt but that the statutes and provisions in question, involving the financing of Medicare and Medicaid, are among the most completely impenetrable texts within human experience. Indeed, one approaches them at the level of specificity herein demanded with dread, for not only are they dense reading of the most tortuous kind, but Congress also revisits the area frequently, generously cutting and pruning in the process and making any solid grasp of the matters addressed merely a passing phase.'

"

Rehabilitation Ass'n of Virginia v. Kozlowski, 42 F.3d 1444 (4th Cir. 1994)

"With this in mind, we begin."

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Availability of Assets in Sole Benefit Trusts

Johnson v. Guhl (cont.)

NJ Medicaid Policy

- Since late 1994 (when OBRA '93 compliance was implemented through HCFA 64), the use of CSATs was approved and excluded the resources contained in CSATs from countable resources of institutionalized spouse

BUT

- Streimer letter dated April 16, 1998 is cited by *Johnson* court and given deference - While not binding on the court, it is instructive…
- The corpus of the CSAT can "at some point in the future" be paid to the community spouse
- Therefore, under 1917(d) of the Social Security Act, it is an available resource to the community spouse

Same result as in *McNamara* case!

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Did Anything Positive Come from the Streimer Letter?

27

Availability of Assets in CS Sole Benefit Trusts

Streimer Letter cited in *Support of* Annuity Planning by Community Spouse

Delaware Dep't. of Health and Social Services v. Ethelda Dean, Sup. Ct., C.A. No. 00A-05-006, May 15, 2001

- **Annuity purchase by CS deemed available resource by Medicaid**
- **Medicaid denies application due to resources in excess of CSRA**
- **Lower court holds that while Transmittal 64 clearly dislikes annuities purchased to protect assets instead of retirement planning, if actuarially sound payout and fair market value received, then it is income and not a resource**
- **Pre-DRA Annuity Rules applied**
- **Streimer Letter cited in support of commercial annuity being a valid way in which to convert resources into income stream for CS**

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Availability of Assets in CS Sole Benefit Trusts

Streimer Letter cited in *Support of* Annuity Planning by CS

James v. Richman, 465 F. Supp. 2d 395, (USDC, M.D. Pennsylvania – November 21, 2006)

- **Post-DRA case citing Streimer Letter in support of community spouse annuity not being an available resource**

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Availability of Assets in CS Sole Benefit Trusts

So we find the Streimer Letter being used to *support a CS Annuity* not being a countable resource.

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Availability of Assets in CS Sole Benefit Trusts

But we still do not know if we can establish a SBT fbo CS without it being considered a countable resource!

That is, until *Hegadorn*…

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Availability of Assets in Sole Benefit Trusts

Hegadorn v. Department of Human Services Director,
Michigan Supreme Court 2019 WL 2064530 (May 19, 2019)

MAJOR BREAKTHROUGH OPINION

Facts

- **Medicaid counted assets in SBT fbo CS**
- **Any circumstances test under 1396p(d)(3)(B) applied by Michigan high court**
- **BUT – court determines that the test only applies to the Medicaid applicant, and not the CS!**
- **If an irrevocable trust can make payments only to the CS, the any circumstances test is only satisfied if there is evidence that those payments could benefit the IS**

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Availability of Assets in Sole Benefit Trusts

Hegadorn v. Department of Human Services Director,
Michigan Supreme Court 2019 WL 2064530 (May 19, 2019)

- The trusts in *Hegadorn* all provided for actuarial sound payouts and solely to or for the benefit of the CS
- Neither the CS or IS were the trustees or successor trustees
- The fact that an irrevocable trust, which includes former assets of the IS, can make payments to a CS does not automatically render the assets held by the SBT countable for purposes of the IS' Medicaid eligibility!
- The SBTs at issue all contain language stating that distributions or payments from the trust may only be made to or for the benefit of the CS

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Availability of Assets in Sole Benefit Trusts

Hegadorn v. Department of Human Services Director,
Michigan Supreme Court 2019 WL 2064530 (May 19, 2019)

- Cases were remanded for a determination as to whether payments from the trusts could be made to or for the benefit of the IS with appropriate explanations for the rationale of this decision.

BUT CONCURRING OPINION IS OMINOUS

If an IS can achieve immediate eligibility for Medicaid assistance by simply placing assets over the eligibility limit in an irrevocable trust, and also avoid the divestment penalty that accompanies that kind of divestment so as any payments from the trust are made only to the CS during his/her lifetime, then…

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Availability of Assets in Sole Benefit Trusts

Hegadorn v. Department of Human Services Director,
Michigan Supreme Court 2019 WL 2064530 (May 19, 2019)

- **The result would be a perfect loophole to Congress' carefully constructed eligibility rules.**
- **Put another way, is a transfer of assets to a third party trustee "for the sole benefit of" the CS if that transfer "benefits" the IS by allowing her to satisfy Medicaid's eligibility limits while avoiding the specific rules that apply to CS Medicaid?**
- **And, what if a SBT names as a remainder beneficiary a person or entity other than the state agency? If a third party can receive the remainder, is the transfer "for the sole benefit of" the CS?**

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Availability of Assets in Sole Benefit Trusts

Colorado FH Decision

Arapahoe County, May 14, 2008

Facts –

- **CSAT established September 2007**
  - ✓ **$223,810**
- **CS assets otherwise < CSRA**
- **Medicaid applied for – October 2007**
- **CSAT assets considered available and application denied**
- **CS sole beneficiary – check**
- **Residuary payable to CS estate**
- **CSAT actuarially sound - check**

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Availability of Assets in Sole Benefit Trusts

Colorado FH Decision

- Trust analysis under state regulations applied to determine assets available to CS (same as § 1396p(d)(3))
- "If there are any circumstances under which payments from the [irrevocable] trust could be made to or for the benefit of the individual, the following shall apply:
  - ✓ The portion of the corpus of the trust, or the income on the corpus, from which payment to the individual could be made, shall be considered as resources available to the individual."
  - ✓ § 8.110.52.B.4.a.1 Colorado Medical Assistance Manual.

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Availability of Assets in Sole Benefit Trusts

Colorado FH Decision

- Appellant argued "the individual" referred to is not the CS, but the IS
- Medicaid agency agreed "individual" refers to the grantor/IS, but argued CS was in fact a grantor in this case, even though trust established by IS, b/c CS used her power of attorney to create the trust on behalf of the IS

  HOLDING - ALJ determined that use of POA does not make the CS a grantor

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Availability of Assets in Sole Benefit Trusts

Colorado FH Decision

- Medicaid also argued that residuary payable to CS estate renders trust assets available
  - ✓ Since IS has elective share, he will have access to the assets at that time
- ALJ reasoned that these assets would then be payable from CS estate, and not the trust
- Therefore, no violation of the "any circumstances" rule

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Availability of Assets in Sole Benefit Trusts

Colorado FH Decision

- ALJ discussed *McNamara* decision re: limit on transfers to CSAT up to CSRA amount
- "Regardless of the merit of the *McNamara* opinion, the ALJ is bound to apply the State Department's regulations as written, and is not at liberty to disregard them."

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Availability of Assets in Sole Benefit Trusts

Colorado FH Decision

Holding – Further Analysis

- Trust corpus not owned by IS or CS, individually
- Trust corpus IS owned solely by the CSAT
- Although CS is a beneficiary, she is not "the individual" for purposes of applying the attribution rule under "any circumstances" test
- No Transfer Penalty - b/c trust was for sole benefit of CS, no transfer penalty applies
- Not Available Resource - b/c trust corpus was not owned by IS or CS, it is not an available resource

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Availability of Assets in Sole Benefit Trusts

BUT

- In Colorado, state can overrule ALJ decision
- That they did in this case!
- State advised they would do so in all such cases.
- Regulations were revised to remove exempt transfer provisions for sole benefit of CS
- Thus, not a viable planning tool in Colorado
- However, commercial annuities still work

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Availability of Assets in CS Sole Benefit Trusts

Conclusion Regarding CSATs/ CS SBTs

No point in going through the effort in creating a CSAT/CS SBT if the assets are going to be deemed available to the CS anyway

43

Trusts for the Sole Benefit of a Blind or Disabled Child or Disabled Individual

44

Beneficiary Receiving SSI/Medicaid or SSDI

Must Review Government Benefits Received by Disabled Individual

- **SSI and Medicaid – both means based benefits**
- **Per Streimer Letter – assets available to CS**
- **BUT - if SBT structured as SNT fbo disabled individual, then assets NOT available!**

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Beneficiary Receiving SSI/Medicaid or SSDI

Must Review Government Benefits Received by Disabled Individual

- **SSDI and Medicare – generally not means-based**
- **BUT – consider other benefits**
  - ✓ **Example – group housing**

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Comparison of SBTs to 3rd Party Irrevocable Trusts

Sole Benefit Trusts

Availability

- assets available to beneficiary, unless SNT provisions inserted into trust, AND
- Assets NOT available to grantor

Transfer of Assets Penalty

- No penalty due to statutory "sole benefit" exception

Payback

- Some states require in order to be SBT
- Some states only require actuarially sound payout

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Comparison of SBTs to 3rd Party Irrevocable Trusts

Sole Benefit Trusts

- Estate Recovery
  - ✓ No estate recovery against grantor
  - ✓ If state requires payback, then that replaces recovery
  - ✓ If no payback, then only estate recovery if state has broad definition of "estate" for recovery purposes

Third Party SNTs

- Assets NOT Available
- There IS a penalty period
- No payback
- No estate recovery

48

Who Can Fund a Third Party Sole Benefit Trust?

- **The Grantor**
- **And anyone else for that matter!**

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Massachusetts Fair Hearing

Facts –

- **Client is 79 year old woman residing in nursing home**
- **November 14, 2010**
  - ✓ **Transfer of assets to Grandson SNT**
  - ✓ **Grandson is disabled/named beneficiary of SNT**
- **December 6, 2010**
  - ✓ **Medicaid denies due to transfer of assets into SNT**
  - ✓ **Failure to establish trust as permissible under federal law**

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Massachusetts Fair Hearing

State statute similar to federal law -

- **The resources were transferred to a trust, a special needs trust, or a pooled trust created for the sole benefit of a permanently and totally disabled person who was under 65 years of age at the time the trust was created or funded. 130 CMR 520.019(D)(4).**

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Massachusetts Fair Hearing

Trust Terms

- **Distributions required on actuarial sound basis**
- **Life expectancy to be calculated in accordance with SSA tables**
- **Discretionary authority of trustee to distribute over and above mandatory distributions (per life expectancy)**
- **State to be paid back on death of disabled beneficiary**

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Massachusetts

Medicaid Arguments

The trust fails because -

- **discretionary authority of trustee is not consistent with actuarial sound requirement of HCFA 64**
- **the payback requirement applies to the person applying for Medicaid (grantor), and not the disabled beneficiary**
- **ALJ rejects both arguments and upholds trust**

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Massachusetts

Massachusetts Protocol

- **SBTs denied initially**
- **Must go to Fair Hearing to prove trust satisfies federal and MA regulations**

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I. HCFA Transmittal No. 64 Pertaining to Sole Benefit Trusts

A. Section 3257. Treatment of Assets and Treatment of Trusts

1. Section 3257.B.6. For the Sole Benefit of

A transfer is considered to be for the sole benefit of a spouse, blind or disabled child, or a disabled individual if the transfer is arranged in such a way that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future.

Similarly, a trust is considered to be established for the sole benefit of a spouse, blind or disabled child, or disabled individual if the trust benefits no one but the individual, whether at the time the trust is established or at any time in the future. However, the trust may provide for reasonable compensation, as defined by the State, for a trustee or trustees to manage the trust, as well as for reasonable costs associated with investing or otherwise managing the funds or property in the trust. In defining what is reasonable compensation, consider the amount of time and effort involved in managing a trust of the size involved, as well as the prevailing rate of compensation, if any, for managing a trust of similar size and complexity.

A transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is not the spouse, blind or disabled child, or disabled individual is not considered to be established for the sole benefit of one of these individuals. In order for a transfer or trust to be considered for the sole benefit of one of these individuals, the instrument or document must provide for the spending of the funds involved for the benefit of the individual on a basis that is actuarially sounds based upon life expectancy of the individual involved. When the instrument or document does not so provide, any potential exemption from the penalty or consideration for eligibility purposes is void.

An exception to this requirement exists for trusts discussed in §3259.7. Under these exceptions, the trust instrument must provide that any funds remaining in the trust upon the death of the individual must go to the State, up to the amount of Medicaid benefits paid on the individual's behalf. When these exceptions require that the trust be for the sole benefit of an individual, the restriction discussed in the previous paragraph does not apply when the trust instrument designates the State as the recipient of funds from the trust. Also, the trust may provide for disbursal of funds to other beneficiaries, provided the trust does not permit such disbursals until the State's claim is

satisfied. Finally, "pooled" trusts may provide that the trust can retain a certain percentage of the funds in the trust account upon the death of the beneficiary.

B. **Section 3258.10. Exceptions to Application of Asset Penalties**

Section 3258.10.B.

The assets were:

Transferred to the individual's spouse or to another for the sole benefit of the individual's spouse;

Transferred from the individual's spouse to another for the sole benefit of the individual's spouse;

Transferred to the individual's child, or to a trust (including a trust described in §3259.7) established solely for the benefit of the individual's child (The child must be blind or permanently and totally disabled, as defined by a State program established under title XVI, in States eligible to participate in such programs or blind or disabled as defined under SSI in all other States); or

Transferred to a trust (including a trust as discussed in §3259.7) established for the sole benefit of an individual under 65 years of age who is disabled as defined under SSI.

1. For the Sole Benefit of.—See §3257 for the definition of the term "for the sole benefit of."

   In determining whether an asset was transferred for the sole benefit of a spouse, child or disabled individual, ensure that the transfer was accomplished via a written instrument of transfer (e.g., a trust document) which legally binds the parties to a specified course of action and which clearly sets out the conditions under which the transfer was made, as well as who can benefit from the transfer. A transfer without such a document cannot be said to have been made for the sole benefit of the spouse, child, or disabled individual, since there is no way to establish, without a document, that only the specified individuals will benefit from the transfer.

2. Blind or Disabled as Defined Under SSI Program.—When it is alleged that an asset was transferred to or for the benefit of an individual who is blind or totally and permanently disabled, you must determine that the individual in fact meets the definitions of blindness or disability used by the SSI program (which are currently the same definitions as under the title II program) or under the State plan programs established under title XVI or under the title II program. If the individual is receiving

SSI benefits or is eligible for Medicaid as a result of blindness or disability, you can accept the determination of blindness or disability as valid evidence. However, if the individual is not receiving SSI and/or Medicaid, you must make a separate determination of blindness or disability. However, if you use more restrictive criteria under §1902(f) of the Act, you may not use a more restrictive definition of blindness or disability. Instead, you must use definitions used by the SSI program.

C. Section 3258.11. Transfers of Assets and Spousal Impoverishment Provisions. – Under §1917(c)(2)(B) of the Act, certain transfers of assets for less than fair market value are exempt from penalty. (See §3258.10 for a complete discussion of those exemptions.) Among those exemptions are transfers from an individual to a spouse, transfers from an individual to a third party for the sole benefit of a spouse, and transfers from a spouse to a third party for the sole benefit of the spouse.

Section 1924 of the Act sets forth the requirements for treatment of income and resources where there is an individual in a medical institution with a spouse still living in the community. This section of the Act provides for apportioning income and resources between the institutional spouse and the community spouse so that the community spouse does not become impoverished because the individual is in a medical institution. (See §3260 for a compete discussion of the spousal impoverishment provisions).

The exceptions to the transfer of assets penalties regarding interspousal transfers and transfers to a third party for the sole benefit of a spouse apply even under the spousal impoverishment provisions. Thus, the institutional spouse can transfer unlimited assets to the community spouse or to a third party for the sole benefit of the community spouse.

When transfers between spouses are involved, the unlimited transfer exception should have little effect on the eligibility determination, primarily because resources belonging to both spouses are combined in determining eligibility for the institutionalized spouse. Thus, resources transferred to a community spouse are still considered available to the institutionalized spouse for eligibility purposes.

The exception for transfers to a third party for the sole benefit of the spouse may have greater impact on eligibility because resources may potentially be placed beyond the reach of either spouse and thus not counted for eligibility purposes. However, for the exception to be applicable, the definition of what is for the sole benefit of the spouse (see §3257) must be fully met. This definition is fairly restrictive, in that it requires that any funds transferred be spent for the benefit of the spouse within a time-frame actuarially commensurate with the spouse's life expectancy. If this requirement is not met, the exemption is void, and a transfer to a third party may then be subject to a penalty.

II. **Federal Law Pertaining to Sole Benefit Trusts**

A. The Federal Statute – 1396p(c) Taking into account certain transfers of assets

(1) (A) – In order to meet the requirements of this subsection for purposes of section 1396(a)(18) of this title, the State plan must provide that if an institutionalized individual or the spouse of such an individual (or, at the option of the State, a non-institutionalized individual or the spouse of such an individual) disposes of assets for less than fair market value on or after the look-back date specified in subparagraph (B)(i), the individual is ineligible for medical assistance for services described in subparagraph (C)9i) (or, in the case of non-institutionalized individual, for services described in subparagraph (c)(ii) during the period beginning on the date specified in subparagraph (D) and equal to the number of months specified in subparagraph (E).

(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that –

(B) the assets –

(i) were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse,

(ii) were transferred from the individual's spouse to another for the sole benefit of the individual's spouse,

(iii) were transferred to a trust (including a trust described in subsection (d)(4) established solely for the benefit of the individual's child described in subparagraph (A)(ii)(II), or

(iv) were transferred to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of an individual under 65 years of age who is disabled (as defined in section 1382c(a)(3) of this title);

III. **New York Law Pertaining to Sole Benefit Trusts**

See 96 Adm-8 dated March 29, 1996 – Section III.A (page 5), Section IV.A.6. (pages 7- 8), and Attachment I for a discussion of New York State Department of Health policy regarding sole benefit trusts.

Florida Law Pertaining to Sole Benefit Trusts

A. **Rule 65A-1.712 SSI-Related Medicaid Resource Eligibility Criteria**

65A-1.712(3)(c) – No penalty period or period of ineligibility shall be imposed against an individual for transfers described in 42 USC § 1396p(c)(2).

1. In order for the transfer or trust to be considered to be for the sole benefit of the spouse, the individual's blind or disabled child, or a disabled individual under the age of 65, the instrument or document must provide that: (a) no individual or entity except the spouse, the individual's disabled child, or disabled individual under age 65 can benefit from the resources transferred in any way, either at the time of the transfer or at any time in the future; and (b) the individual must be able to receive fair compensation or return of the benefit of the trust or transfer during their lifetime.

2. If the instrument or document does not allow for fair compensation or return within the lifetime of the individual (using life expectancy tables noted in paragraph (b) above), it is not considered to be established for the sole benefit of the indicated individual and any potential exemption from penalty or consideration for eligibility purposes is void.

B. **ESS Manual Section 1640.0609.07 Definition of "For the Sole Benefit of" (MSSI)**

In order for the transfer to be considered to be for the sole benefit of the spouse, the individual's blind or disabled child, or a disabled individual underage 65 (and not be subject to a transfer penalty), there must be a written transfer document which legally binds the parties to a specific course of action and which clearly sets out the conditions under which the transfer was made, as well as who can benefit from the transfer.

The transfer instrument or document must provide that:

1. No individual or entity except the spouse, the individual's disabled child, or the disabled individual under age 65 can benefit from the assets or income transferred in any way either at the time of the transfer or at any time in the future; and

2. The spending of the funds involved for the benefit of the individual is actuarially sound based on the life expectancy of the individual involved; that is, the individual must be able to receive fair compensation or return of the benefit of the transferred asset during his lifetime. (Follow instructions in 1640.0609.02 and use life expectancy tables in Appendix A-14 to determine if the person will receive fair compensation in his lifetime.)
3. If the transfer instrument or document does not meet these requirements, it cannot be considered a transfer for the sole benefit of the spouse, the blind or disabled child, or disabled individual and any potential exemption from penalty or consideration for eligibility purposes is void. In this case, you need to compute the uncompensated value of the transferred funds, notify the individual and give him the opportunity to rebut the presumption that the transfer was done to become Medicaid eligible.

Note: There are two issues to consider. An individual who transfers assets to someone else for the sole benefit may not incur a transfer penalty if the transfer meets the above two criteria. For the individual who receives the transferred asset, the asset may or may not count. Assets transferred to a third party in the form of a trust for the sole benefit of the spouse must be evaluated under trust policies.

To qualify as being for the sole benefit of the spouse, the assets must be able to be paid to or for the benefit of the spouse over the spouse's lifetime. Assets transferred to a trust for the sole benefit of the spouse count as an available asset to the spouse and must be included in the couple's countable assets.

IV. Case Law/Fair Hearing Decisions and Related Material Pertaining to Sole Benefit Trusts

A. *McNamara v. Ohio Department of Human Services*, 139 Ohio App.3d 551 holding that for Medicaid eligibility purposes, the amount of resources that an institutionalized spouse could transfer to the community spouse was limited to the maximum amount that a community spouse could retain under the Community Spouse Resource Allowance, Health Care Financing Administration Transmittal No. 64 is not controlling on the issue of whether an institutionalized spouse can transfer unlimited assets to the community spouse or to a third party for the sole benefit of the community spouse, and that a spousal annuity trust would not be treated under rules governing commercially purchased annuities.

B. *James v. Richman*, 465 F.Sup.2d 395 – holding that a community spouse's annuity was not a countable resource for purposes of determining Medicaid eligibility for institutionalized spouse where at the time of the institutionalized spouse's Medicaid application, neither spouse had an ownership interest in funds used to an irrevocable actuarially sound commercial annuity as part of a retirement plan for the sole benefit of the community spouse, and the annuity was not an available resource to the extent of its market value on the basis of its alleged assignability or liquidity. Streimer Letter cited in the decision.

C. Johnson v. Guhl, 91 F.Supp.2d 754 (D.N.J. 2000) – holding that although state officials' change of policy regarding whether community spouse annuity trusts (CSATs) were countable resource in determining applicant's eligibility for New Jersey Medicaid benefits resulted in differing treatment for applicants who had used CSATs, such treatment was rationally related to legitimate end of complying with federal Medicaid Act and Congress' intent to provide medical assistance to the needy and, thus, did not violate the equal protection clause.

D. Letter dated April 16, 1998 from Robert A. Streimer, Disabled and Elderly Health Care Programs Group, Center for Medicaid and State Operations, to Jean Galloway Ball, Esq. – stating that there is a fundamental difference between the purchase of a commercial annuity, which is not considered an available resource for Medicaid purposes, and a community spouse annuity trust must be evaluated

under the trust rules set forth in section 1917(d) of the Medicaid Act, and which is considered an available resource.

E. Massachusetts Fair Hearing Memorandum of Law – addressing MassHealth's arguments against the validity of a sole benefit trust for the benefit of a community spouse, including the following: 1) that trust distributions were not mandatory (confusing discretionary authority of trustee to make distributions above and beyond actuarially sound distributions that were mandatory), and 2) the payback clause must pertain to the person who is applying for or receiving Medicaid benefits and whose eligibility is sought to be established.

F. NAELA Amicus Brief filed in *Hughes v. Colbert* (Case Pending before the 6th Circuit Court of Appeals, Case No. 12-3765)(Lower Court Decision United States District Court, Northern District of Ohio, dated May 29, 2012) – arguing that the cap on spousal transfers is limited to bringing the community spouse up to community spouse resource allowance and applies only to post-eligibility transfers of resources between spouses under 42 USC § 1396r-5(f)(1), and that 42 USC § 1396p(c)(2)(B)(i), which permits unlimited transfers between spouses without there being a resulting penalty period, is the rule that must apply to the purchase of DRA compliant annuities with IRA funds of the community spouse.

G. Colorado Fair Hearing Decision Dated May 14, 2008 – holding that the assets in a community spouse annuity trust were NOT countable resources of the community spouse.

H. Letter from Thomas E. Hamilton, Director, Disabled and Elderly Health programs Group, Health Care Financing Administration, Dated January 19, 2001 – stating that a trust providing for the sole benefit of a spouse or other individual may provide that any remaining funds in the trust would go to a designated beneficiary without violating the rule that the trust be for the sole benefit of the individual in question.

I. Delaware *Department of Health and Social Services v. Dean* (Superior Court of the State of Delaware, New Castle County, May 15, 2001) –holding that the purchase of an annuity by the community spouse was neither the transfer of an asset nor a resource for purposes of determining the Medicaid eligibility of the institutionalized spouse.

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EXHIBIT A

Hamilton Letter – Letter dated January 19, 2001, from Thomas E. Hamilton, Director, Disabled and Elderly Health Programs Group, Health Care Financing Administration

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

JAN 19 2001

Raymon B. Harvey, P.A.
One Financial Centre
650 South Shackleford Road, Suite 400
Little Rock, Arkansas 72211

Dear Mr. Harvey:

This is in response to your letter dated August 31, 2000 following up on our letter to you dated May 26, 2000 concerning Medicaid rules pertaining to treatment of trusts, transfers of assets for less than fair market value, spousal impoverishment, and time standards for determining eligibility. Your August 31 letter asked some additional questions on some of these subjects. Also, I am responding to a subsequent letter from you dated December 1, 2000 concerning the definition of "for the sole benefit of" in the context of treatment of annuities under Medicaid. I apologize for the delay in my response.

Following are responses to the questions you ask in each of the letters mentioned above. In the interest of brevity we will summarize your questions rather than repeat them in their entirety.

August 31 Letter

In our May 26 letter, we explained that if assets are transferred from one spouse to another before an eligibility determination is made under the spousal impoverishment rules, the transferred assets would still be considered available to the institutionalized spouse. Your August 31 letter asks the following questions.

- What exactly is meant by "considered available"? Does this mean that the resources continue to be counted for resource eligibility purposes no matter what happens to them?
- How would the transferred resources be considered if, prior to the institutionalized spouse's eligibility determination, the community spouse used the resources to purchase items solely for the benefit of the community spouse?

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For example, the couple's combined countable resources are $100,000. The entire amount is transferred to the community spouse, who then uses $50,000 to purchase an annuity that benefits only the community spouse, and to replace the couple's only automobile with a new one titled only in the community spouse's name. This leaves $50,000 held solely in the name of the community spouse.

Under the statute (section 1924(c)(2) of the Social Security Act) all of the couple's resources, regardless of ownership, are considered in determining eligibility for the institutionalized spouse. Resources for purposes of spousal impoverishment are counted the same way they are counted under the Supplemental Security Income (SSI) program. However, section 1924(c)(5) of the Act provides that certain specific items are excluded when counting the couple's resources, including the couple's home, a small amount set aside for burial expenses and, regardless of value, household goods, personal possessions, and one automobile. Thus, the new automobile you cite in your example would be excluded from being counted as an available resource regardless of which member of the couple owns it.

With regard to the annuity purchased by the community spouse, irrevocable annuities are not considered to be available resources under the SSI program because the individual cannot access the funds in the annuity. However, purchase of an annuity by the community spouse may constitute a transfer of assets for less than fair market value (with a potential imposition of a penalty on the institutionalized spouse) under Medicaid unless certain conditions are met.

Transfers of assets by a spouse to a third party for the sole benefit of the spouse are not subject to penalty. The purchase of an annuity would constitute a transfer to a third party (the entity selling the annuity). However, to be exempt from penalty the annuity must be both actuarially sound (as explained in State Medicaid Manual section 3258.9.B., cited in your letter) AND for the sole benefit of the community spouse (see section 3257.B.6. of the State Medicaid Manual). When applied to an annuity which benefits the community spouse, this means that the annuity must be structured so that it pays the entire value of the annuity, plus any interest earned by the annuity, as income to the community spouse during that spouse's expected life time. If the annuity is not so structured, it would be considered a transfer of assets for less than fair market value and thus subject to penalty.

To summarize, if the annuity in your example meets the requirements discussed above, it would not be counted as an available resource in determining the institutionalized spouse's eligibility, nor would it be treated as a transfer of assets for less than fair market value. Also,

the new automobile cited in your example would not be counted as a resource. That would leave the $50,000 held solely in the community spouse's name as resources that would be counted in determining the institutionalized spouse's eligibility.

December 1 Letter

This letter cites section 3257 of the State Medicaid Manual concerning the definition of the phrase "for the sole benefit of" a spouse or other designated individual. You ask whether a trust or annuity which provides that, upon the death of the beneficiary of the trust or annuity, any remaining funds would go to a designated beneficiary would violate the requirement that the trust or annuity be for the sole benefit of the individual in question.

The designation of a beneficiary to receive any funds remaining in an annuity after the death of the primary beneficiary would not, by itself, violate a requirement that the annuity be for the sole benefit of the primary beneficiary. However, as explained more fully in our above response to your August 1 letter, an annuity would violate the sole benefit requirement if it were not structured so as to pay the entire value of the annuity, plus interest, to the primary beneficiary during the beneficiary's expected lifetime.

With regard to how this would apply to a trust, again the designation of a remainder beneficiary would not, by itself, violate the sole benefit requirement. However, as explained in section 3257.B.6 of the State Medicaid Manual a trust, like an annuity, must provide for disbursal of the funds in the trust either to or for the benefit of the trust beneficiary within the beneficiary's expected lifetime. If the trust is not so structured it is not for the sole benefit of the primary beneficiary, but rather is established to at least partially benefit any designated remainder beneficiary.

Also, as explained in the manual section referenced above, a trust that is exempt from being counted under the normal Medicaid trust rules (see sections 1917(d)(4)(A), (B) and (C) of the Act) must provide that upon the death of the beneficiary the State will receive any funds remaining in the trust, up to the amount of Medicaid benefits paid for on the beneficiary's behalf. While such a trust may also designate a remainder beneficiary in addition to the State, the State must be identified as having first claim on any funds remaining in the trust upon the death of the beneficiary. Otherwise, the trust does not meet the statutory requirements for exemption from being counted under the normal Medicaid trust rules.

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I hope this information is useful to you. If you have any questions, please contact Roy Trudel of my staff at 410-786-3417.

Sincerely,

Thomas E. Hamilton

Thomas E. Hamilton
Director
Disabled and Elderly Health Programs Group

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EXHIBIT B

96 ADM-8

ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 96 ADM-8

DIVISION: Health and Long Term Care

TO: Commissioners of Social Services

DATE: March 29, 1996

SUBJECT: OBRA '93 Provisions on Transfers and Trusts

SUGGESTED DISTRIBUTION:
- Medical Assistance Staff
- Public Assistance Staff
- Legal Staff
- Fair Hearing Staff
- Staff Development Coordinators

CONTACT PERSON:
- Transfers-Robin Johnson -1-800-343-8859, ext. 67454
- Trusts-Barbara Crumb - 1-800-343-8859, ext. 32237
- NYC: Call (212) 383-2512

ATTACHMENTS:
- Attachment I Sole benefit statement (available on-line)
- Attachment II Procedures for Monitoring Exception Trusts (available on-line)
- Attachment III Explanation of the Effect of Transfer of Assets on MA Eligibility (available on-line)
- Attachment IV Life Expectancy/Actuarial Tables (available on-line)
- Attachment V Life Estate and Remainder Interest Table (available on-line)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
95 ADM-17					Section 13611 of
92 ADM-53		360-4.4(c)	SSL 366	MARG page,	OBRA'93
92 ADM-45		360-4.5	SSA 1915 (c) & (d)	356	GIS '94-MA/018
92 ADM-44					
91 ADM-37			Executive		GIS '94-MA/031
91 ADM-31			Law Sec 63		
90 ADM-29					GIS '95-MA/038
89 ADM-45					

DSS-296EL (REV. 9/89)

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I. PURPOSE

This Administrative Directive (ADM) informs social services districts of changes in the treatment of transfers and trusts in the Medical Assistance (MA) program as a result of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93).

II. BACKGROUND

Section 1917 of the Social Security Act (42 U.S.C. 1396p) requires a period of ineligibility for MA coverage of nursing facility services (penalty period) when the MA applicant/recipient (A/R) or his/her spouse transfers assets for less than fair market value within or after a specified look-back period. Prior to the enactment of OBRA '93, Section 1917(c): provided for a 30-month look-back period; provided for a maximum penalty period of 30 months; referred to transfers of "resources" rather than "assets"; and did not contain any exceptions for transfers of assets into trusts. OBRA '93 made a number of amendments to Section 1917(c).

Prior to the enactment of OBRA '93, Section 1902(k) of the Social Security Act (42 U.S.C. 1396a(k)) provided that in the case of a trust created by an A/R or his/her spouse, other than by will, the maximum amount of payments which the trustee had discretion to distribute to the A/R would be deemed available for purposes of determining MA eligibility. OBRA '93 repealed Section 1902(k) and amended Section 1917 to more fully address the availability of assets held in trust and the applicability of the transfer rule to assets transferred into trusts.

Chapter 170 of the Laws of 1994 amended Section 366 of the Social Services Law to conform to the aforementioned OBRA '93 amendments. In addition, the Department amended 18 NYCRR 360-4.4(c) and 360-4.5 to implement the provisions of Chapter 170.

III. PROGRAM IMPLICATIONS

As a result of the enactment of OBRA '93 and Chapter 170 of the Laws of 1994, a number of changes and clarifications are being made to the MA rules concerning transfers and trusts. These changes apply to MA applications and recertifications on or after September 1, 1994, and apply to transfers made and trusts created or funded on or after August 11, 1993.

A. Transfers:

- the transfer rules apply to both income and resources;
- the look-back period is increased from 30 to 60 months in the case of trust-related transfers, as described in Section IV.B of this ADM, and from 30 to 36 months for all other transfers;
- there is no 30 month cap on the length of the penalty period;

- there is no penalty for transferring assets to a trust established solely for the benefit of a person certified as disabled and under 65 years of age;
- when either spouse makes a prohibited transfer that results in a penalty period for the institutionalized spouse, the penalty period must be apportioned equally between the spouses if the community spouse subsequently becomes in need of nursing facility services;
- a penalty period is imposed for a partial month;
- clarification is provided concerning when a transfer by an individual to another is considered to be for the "sole benefit" of the individual's spouse;
- clarification is provided on the treatment of jointly held assets;
- the "Explanation of the Effect of Transfer of Assets on Medical Assistance Eligibility" has been revised to reflect the changes resulting from OBRA '93; and
- the penalty period will now begin on the first day of the month following the month of transfer.

B. Trusts:

- for a revocable trust, the total principal and income of the trust is considered available;
- for irrevocable trusts, payments actually made from the trust to or for the benefit of the A/R are available income in the month received; portions of the trust principal and income which can be paid to or for the benefit of the A/R are considered to be an available resource; and any portions of the trust principal and income which can never be paid to or for the benefit of the A/R under the terms of the trust are considered to be transferred assets for purposes of the transfer rule; and
- exceptions are made for certain trusts created for the benefit of disabled A/Rs using the A/R's assets.

IV. REQUIRED ACTION

A. Definitions

1. Assets

Assets include all income and resources of the individual and the individual's spouse. This includes income or resources which the individual or the individual's spouse is entitled to but does not receive because of any action or inaction by;

- the individual or the individual's spouse;
- a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or
- any person, including a court or administrative body, acting at the direction of or upon the request of the individual or the individual's spouse.

Examples of actions which would cause income or resources not to be received are:

- irrevocably waiving pension income;
- renouncing an inheritance or refusing to assert one's right of election against an inheritance;
- not accepting or accessing injury settlements (however, A/Rs cannot be required to initiate litigation);
- settling a tort (personal injury) action so as to have the defendant place settlement funds directly into a trust or similar device to be held for the benefit of the A/R; or
- refusing without good cause to take action to obtain a court ordered payment that is not being paid, such as an alimony award or other judgment against an individual. In the case of alimony, good cause is defined in Department Regulation 369.2(b).

NOTE: The date of transfer is the date the asset was actually available and waived. In the case of a trust, the date of the transfer is the date the trust is actually funded, regardless of the date it was created.

2. Blind or disabled:

For purposes of this directive, the terms "blind" and "disabled" mean certified blind or certified disabled, according to the requirements of the Social Security Administration.

3. Fair Market Value

Fair market value (FMV) is the estimate of the value of an asset if sold at the prevailing price at the time it was actually transferred.

Fair market value of real property or other assets may be established by means of an appraisal by a real estate broker or other qualified dealer or appraiser.

4. Individual

When the ADM refers to the creation of a trust or to a transfer of assets, the term individual or A/R includes: the individual; the individual's spouse; any person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or any person, including a court or administrative body acting at the direction of or upon the request of the individual or the individual's spouse.

5. Nursing Facility Services

Nursing facility services means:

- nursing care and health related services provided in a nursing facility (including residential health care facilities, residential treatment facilities, intermediate care facilities, and intermediate care facilities for the developmentally disabled);

- a level of care provided in a hospital which is equivalent to the level of care provided in a nursing facility; and

- care, services, or supplies furnished pursuant to a waiver under section 1915(c) or (d) of the Social Security Act, including: the Long Term Home Health Care Program, the OMRDD Home and Community-Based Services Waiver, the Traumatic Brain Injury Waiver or the Care At Home Program.

6. Sole Benefit

A transfer by an individual or the individual's spouse to another is for the sole benefit of the individual's spouse if the terms and conditions of the transfer are specified in a written instrument of transfer (such as a trust document, deed, or other signed and acknowledged statement), which is executed at or about the time of transfer, clearly limiting the use and enjoyment of the transferred property to the individual's spouse.

In the absence of a written instrument of transfer, a transfer must be considered a transfer for the sole benefit of the individual's spouse only if, at the time of application:

- the person who transferred the assets signs a statement attesting that the transfer was intended for the sole benefit of the individual's spouse; (districts may develop their own form for this purpose, or use the sample form included as Attachment I to this ADM); and

- other evidence is presented (such as evidence of a continuous course of conduct by the person to whom the assets were transferred) which establishes that the use and enjoyment of the transferred property has in the past been limited to the individual's spouse.

In addition, in order for a transfer to be considered to be for the sole benefit of the individual's spouse (regardless of whether there is a written instrument of transfer), the social services district must conclude, based on the age of the individual's spouse, the amount of assets transferred, and the rate and amount of expenditures from the transferred assets for the benefit of the individual's spouse, that the

transferred assets are likely to be totally expended within the spouse's lifetime.

The establishment of a trust for the benefit of a spouse will not be considered a transfer for the sole benefit of such spouse if: during the life of the trust, the trustee has the authority to make distributions for the benefit of anyone other than the spouse; or the trust provides that upon its termination, all or part of the remaining principal and income is to be distributed to someone other than the MA applicant/recipient, or the spouse's estate.

Note: Any subsequent action by the individual's spouse, or by the person to whom the assets were transferred for the spouse's benefit, which reduces or eliminates the spouse's beneficial use of the transferred property, or the ownership or control of the person to whom the assets were transferred, may be considered a transfer of assets by the individual's spouse on the date such action is taken. Such a transfer may affect the eligibility of either or both spouses, depending on the circumstances of the transfer.

Note: When assets are transferred by an individual or the individual's spouse to another for the sole benefit of the individual's spouse, the assets continue to be considered part of the couple's total resources for purposes of determining the amount of the community spouse resource allowance.

7. Trusts

In general, a trust is a legal instrument by which an individual gives control over his/her assets to another (the trustee) to disburse according to the instructions of the individual creating the trust. There are a number of different types of trusts, including escrow accounts and investment accounts.

a. Annuity - An annuity is an investment vehicle whereby an individual establishes a right to receive fixed periodic payments, either for life or a term of years. To the extent to which the anticipated return is commensurate with the money invested, the purchase of an annuity shall be considered a compensated transfer of assets; to the extent that the anticipated return is less than the amount invested, it shall be considered to be a trust-related transfer for less than fair market value.

b. Exception trusts - Exception trusts are trusts which are required to be disregarded as available income and resources for purposes of determining MA eligibility pursuant to the provisions of Section 366(2)(b)(2)(iii) of the Social Services Law and 18 NYCRR 360-4.5(b)(5).

Exception trusts generally will conform to the definition of supplemental needs trusts found in Section IV.A.7.e of this ADM. There are two types of exception trusts.

i. One type of exception trust is a trust created for the benefit of a disabled person under the age of 65. It must:

- be created with the individual's own assets,
- be created by the disabled person's parent or grandparent, legal guardian of the individual, or by a court of competent jurisdiction, and
- include language specifying that upon the death of the disabled person, the social services district will receive all amounts remaining in the trust, up to the amount of MA paid out on behalf of the individual.

Once established, additional funds can be added to the trust until the person reaches age 65. However, any additions to the trust made after the person reaches age 65 would be treated as a transfer of assets, and would require the imposition of a penalty period. It is the Department's position that if a district has imposed a Social Services Law Section 104-b or Section 369 lien against assets to be used to establish an exception trust, the district should attempt to have the lien satisfied (or, in the district's discretion, compromised) before the trust is established. Litigation is pending on the issue of whether enforcing such liens is allowed when the assets are to be put into an exception trust; when this litigation is concluded, the Department will notify districts promptly of the outcome and of any necessary policy changes.

ii. The other type of exception trust is a trust created for the benefit of a disabled person of any age, and is a pooled trust, as described below:

- the trust is established and managed by a non-profit association per Section 1917 (d)(4)(C)(i) of the Social Security Act;
- the assets are pooled with other assets and are managed by a non-profit organization which maintains separate accounts for each person whose assets are included in the pooled trust;
- the disabled individual's account in the trust is established by the disabled individual, by the disabled individual's parent, grandparent, or

legal guardian, or by a court of competent jurisdiction;

- the trust will be disregarded for MA purposes regardless of the age of the individual when the pooled trust account is established, or when assets are added to the pooled trust account; however, there is no exception to the transfer rules for transfers of assets to trusts created for the benefit of persons 65 years of age or older;

- upon the death of the individual, the district's right of recovery is limited to those funds not retained by the non-profit organization; and

- if the trust is subject to oversight by the Attorney General's office, no bonding (as specified in Section IV.F of this ADM) is required.

NOTE: Although exception trusts created in accordance with the criteria set forth above are exempt as resources in the eligibility determination process regardless of the disabled individual's age, for purposes of the transfer provisions, any additions to the trust after the individual becomes 65 years of age are subject to applicable transfer penalties.

It is the responsibility of the trustee of an exception trust to ensure that the funds are expended for the benefit of the chronically impaired or disabled person. In some cases, this disbursal of funds may indirectly benefit someone other than the beneficiary. Such disbursals are valid, as long as the primary benefit accrues to the chronically impaired or disabled person. For example, payment of travel expenses for a companion to a chronically impaired or disabled person going on vacation may be appropriate. Also, the abilities and capabilities of the person should be taken into account. The purchase of sophisticated computer equipment to assist a physically disabled person to communicate would be considered appropriate, while purchase of the same type of equipment for an individual who could not be trained to use it would not.

c. Irrevocable Trust - An irrevocable trust is a trust created by an individual, over which the individual may or may not be able to exercise some control, but which may not be cancelled under any circumstances.

d. Revocable Trust - A revocable trust is a trust created by an individual which the individual has the right to cancel.

e. Supplemental Needs Trust (SNT) - A supplemental needs trust, as defined in Section 7-1.12 of the Estates, Powers and Trusts Law, is a trust established for the benefit of an individual of any age with a severe and chronic or persistent impairment, designed to supplement government benefits for which the individual is otherwise eligible. Under the terms of such a trust:

i. the beneficiary does not have the power to assign, encumber, direct, distribute, or authorize distributions from the trust; and

ii. the trust document generally prohibits the trustee from expending funds in any way that would diminish the beneficiary's eligibility for or receipt of any type of government benefit.

f. Testamentary Trust - A testamentary trust is any trust established by will. Testamentary trusts are third party trusts, as defined below.

g. Third Party Trusts - A third party trust is a trust established with the funds of someone other than the A/R. A third party trust may or may not be a supplemental needs trust, as defined in Section 7-1.12 of the Estates, Powers and Trusts Law. For purposes of determining the eligibility of an A/R who is a beneficiary of a third party trust, the principal and accumulated income of the trust are not considered available to the A/R. However, any distributions of trust assets actually made to the A/R are counted as income in the month received.

Social services districts are authorized, but not required, to commence court proceedings on behalf of A/Rs who are beneficiaries of third party trusts, seeking to compel the trustee to use trust assets to pay for necessary medical care. However, if the terms of the trust specifically prohibit the trustee from using trust assets for medical care, as will be the case with trusts conforming to Section 7-1.12 of the Estates, Powers and Trusts Law, it is extremely unlikely a court will order the trustee to do so.

8. Uncompensated Value

The uncompensated value is the difference between the FMV at the time of transfer (less any outstanding loans, mortgages, or other encumbrances on the asset) and the amount received for the asset.

If the client's resources are below the appropriate MA resource level, the amount by which the MA resource level exceeds the client's resources must be deducted from the uncompensated value of the transfer. Likewise, amounts

specified in Department regulations for burial funds, but not for burial space items, also must be deducted.

Note: A transfer for "love and consideration" is not considered a compensated transfer. Also, while relatives and family members legitimately can be paid for care they provide to the individual, there is a presumption that services provided for free at the time were intended to be provided without compensation. Thus, a transfer to a relative for care provided for free in the past, normally is not a transfer of assets for FMV. However, an individual can rebut this presumption with tangible evidence. An example of acceptable evidence would be a promissory note executed at the time services were provided.

B. Look-Back Date

In the case of the transfer of assets by an individual in receipt of or applying for nursing facility services, the look-back date is 36 months prior to the first day of the month in which the individual was:

-institutionalized; and
-submitted an application for full Medical Assistance coverage, including coverage of nursing facility services.

For trust-related transfers on or after August 11, 1993, the look-back period is 60 months. Funding a new trust is a trust-related transfer. Trust-related transfers also include transfers to already existing trusts, distributions from existing trusts to someone other than the A/R, and the foreclosure of a trustee's ability to distribute trust assets to the A/R due to a "trigger provision" in the trust agreement. Thus, even though a trust is established prior to August 11, 1993, subsequent trust-related transfers which occur on or after August 11, 1993 may be subject to the new transfer provisions.

EXAMPLE: Mrs. Jones created a revocable trust in 1988. She applies for MA in December 1994. The district determines that $10,000 was removed from the trust and given to Mrs. Jones' son in October 1993. In such a situation, even though the trust was created more than 60 months ago, the social services district would consider the $10,000 to be a transfer since the activity occurred after August 10, 1993, but within the 60 months preceding the month of application. In addition, because the trust is revocable, any balance remaining in the trust is considered an available resource.

When an individual has multiple periods of institutionalization, or multiple applications (whether or not they resulted in the provision of assistance), the look-back period begins 36 months (or 60 months in the case of trust-related transfers) prior to the first day of the month in which the individual both: is in receipt of nursing facility services AND has submitted an application for full MA coverage.

NOTE: As explained in 18 NYCRR 360-4.5, certain "trigger provisions" are null and void under State law. With respect to these provisions, the triggering event has no effect on the trustee's powers and thus no transfer of assets occurs; instead, the trust assets subject to the trigger provision continue to be considered an available resource.

C. Treatment of Revocable Trusts

In the case of revocable trusts established by the A/R, the entire value of the trust is considered as an available resource.

(1) All payments made from the trust to or for the benefit of the A/R are considered available income in the month received.

(2) All payments made from the trust to a person other than the A/R are considered to be assets transferred for less than FMV for purposes of the transfer of assets rule.

D. Treatment of Irrevocable Trusts

In the case of an irrevocable trust established by the A/R, any portion of the trust principal, and income generated by the trust principal, from which no payments may be made to or for the benefit of the A/R is considered to be an asset transferred for less than FMV for purposes of the transfer of assets rule.

(1) Payments made from the trust to or for the benefit of the A/R shall be considered available income in the month received.

(2) Any portion of the principal of the trust, or the income generated from the trust, which can be paid to or for the benefit of the A/R, is considered an available resource. If the language of the trust specifies that money can be made available for a specific event, that amount shall be considered an available resource, whether or not that event has occurred.

(3) Payments which are made from trust assets considered available to the A/R, as described in paragraph (2) above, and which are not made to or for the benefit of the A/R, are considered to be assets transferred for less than FMV for purposes of the transfer of assets rule.

Note: In the case of trusts, the date on which the penalty begins is the first day of the month following the month in which the trust was funded (or a revocable trust made irrevocable), or assets were transferred for less than FMV.

E. Treatment of Exception Trusts and Third Party Trusts

In the case of exception trusts and third party trusts, the principal and accumulated income are disregarded in determining MA

eligibility. However, any trust assets actually distributed to the A/R are counted as income in the month received and as a resource if retained into subsequent months. In addition, as indicated in Section IV.A.7.g of this ADM, the social services district can go to court to compel the trustee of a third party trust to make trust assets available to a trust beneficiary, where the trustee is required or granted the discretion to make such distributions under the terms of the trust agreement.

With respect to a disabled person under age 65, a lump sum payment, such as a personal injury award or settlement, or an inheritance, will be disregarded as income or resources from the date the person has the right to take possession of the assets until the first day of the second month following that date, if the person intends to place such assets in an exception trust. In addition, assets of a disabled person under age 65 will be disregarded from the date of commencement of a court proceeding necessary to allow the assets to be placed in an exception trust until the resolution of such proceeding, assuming the disabled person or his or her representative promptly pursues the resolution of the proceeding.

In the case of a trust created from the proceeds of retroactive payments received as a result of a court settlement due the beneficiary under the SSI program, the Department shall first be entitled to reimbursement of any interim assistance paid out pending the court decision, and the representative payee shall be entitled to reimbursement of any expenses incurred in the pursuit of the settlement.

F. Oversight Responsibilities

Districts are responsible for notifying trustees of exception trusts of the information they need to maintain in order to monitor the trust activity, including but not limited to:

- providing notification to the district of the death of the beneficiary of a trust;

- providing notification to the district of any transactions made that would substantially deplete the value of the corpus (principal) of the trust;

- providing documentation to the district that there have been no transfers of assets from the trust nor any transactions from the corpus of the trust that involve transfers for less than fair market value;

- providing proof of bonding in all situations involving trusts of more than one million dollars, or when required by the court (pooled trusts subject to oversight by the Attorney General's Office do not require bonding);

- information ensuring, with respect to pooled trusts, that all trust activity is posted to the appropriate account.

Suggested procedures for meeting these responsibilities are included in Attachment II of this ADM.

In the event that a district considers any acts, omissions, or failures of the trustee to be contrary to the terms of the trust, applicable laws and regulations, or the trustee's fiduciary obligations, it can refer the matter to the Attorney General to commence a proceeding against the trustee under Section 63 of the Executive Law. It may do so by contacting:

NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL AFFAIRS
BUREAU OF HEALTH AND LONG TERM CARE LAW
40 NORTH PEARL STREET
ALBANY, NEW YORK 12243-0001
Attn: Trust Review

G. 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 a 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 look-back 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 resource 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.2. 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 look-back 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.

Example: An individual transfers $20,000 in January 1994, $20,000 in February, and $20,000 in March, all of which are uncompensated. Calculated individually, based on a regional rate for nursing facility care of $5,000 a month, the penalty period for the first transfer is from February through April (February is the first month following the month of transfer), the second transfer is from March through June, and the third is from April through July. Because these periods overlap, calculate the penalty period by adding the transfers together (a total of $60,000) and dividing by the nursing home cost ($5,000). The penalty period would run from February 1994 through January 1995.

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.

Example: An individual transfers $10,000 in January, $10,000 in May, and $10,000 in October. Assuming that the regional rate for nursing facility care is $5,000 a month, the penalty periods for transfers are, respectively, February through March, June through July, and November through December.

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, spenddown liability for the month.

4. Apportioning Penalty Periods Between Spouses

If either spouse transfers an asset (before eligibility is established) that results in a penalty for the institutionalized individual, the penalty must be apportioned equally between the spouses if the community spouse subsequently becomes in receipt of nursing facility services and applies for MA. If one spouse is no longer subject to a penalty (e.g., the spouse dies), the remaining penalty period for both spouses must be applied to the remaining spouse.

Example: Mr. Smith enters a nursing home and applies for MA, while Mrs. Smith remains in the community and is not in receipt of MA. Mrs. Smith transfers assets before Mr. Smith is determined eligible for MA and a 10-month penalty period is imposed on Mr. Smith's care. Four months into the penalty

period Mrs. Smith enters a nursing home and applies for MA. The remaining 6 months of the penalty period must be divided equally between the two spouses.

In the above example, if Mr. Smith leaves the nursing home, but his wife remains, the remaining penalty period that had been apportioned to Mr. Smith must be imposed on Mrs. Smith. If Mr. Smith returns to the nursing home, any remaining penalty is again apportioned between the two spouses.

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 not be withdrawn, and any penalty period imposed will remain in effect, even if the applicant subsequently re-applies for MA.

H. Treatment of Income as an Asset

The transfer rules apply to transfers of income. Absent some reason to believe otherwise, districts should assume that ordinary household income of an A/R and his or her spouse during the look-back period was legitimately spent on the normal costs of daily living. However, districts should determine whether the A/R or the A/R's spouse transferred a lump sum income payment or a stream of income during the look-back period.

1. Lump Sum Income Payments

If a countable lump sum income payment is transferred in the month received, a penalty period must be imposed (if no exceptions apply). To calculate the uncompensated value of the transfer, the income deductions and disregards of the Supplemental Security Income (SSI) program must be applied. If the lump sum payment is transferred in the month after receipt, it is treated as a resource and the appropriate resource disregards (not income disregards) would be allowed.

2. Stream of Income

If a stream of income (i.e., income received on a regular basis, such as a pension) or the right to a stream of income is transferred, districts must treat it as a transfer of a resource. The amount transferred is the total amount of income expected to be received during the transferor's lifetime, based on an actuarial projection of the transferor's life expectancy. Districts must reduce the uncompensated value of the transfer as necessary to take into account the appropriate MA resource level and any allowable burial funds.

I. Jointly Held Assets. The general rule is that joint property held by an A/R is considered available to the A/R to the extent of his or her interest in the property. In the absence of documentation to the contrary, it is presumed that all joint owners possess equal shares. However, there are special rules for SSI-related A/Rs concerning the availability of financial institution accounts, which are described in paragraph 1 below. In addition, with respect to an A/R who converts his or her assets into joint assets, OBRA '93 and Chapter 170 of the Laws of 1994 indicate when such a conversion constitutes a transfer of assets, as explained in paragraph 2 below.

1. Financial Institution Account Owned by an SSI-Related A/R

In accordance with SSI regulations issued on May 31, 1994, ownership of financial institution accounts (including savings, checking, and time deposits or certificates of deposit) involving an SSI-related A/R must be determined as outlined below. There is no change in MA policy to determine ownership of other types of resources.

a. SSI-Related A/R is the Sole Owner

As long as an SSI-related A/R is designated as the sole owner by the account title, and can withdraw funds and use them for his or her support and maintenance, the A/R is presumed to own all of the funds in the account, regardless of their source. This presumption cannot be rebutted.

b. SSI-Related A/R is a Joint Owner

In the absence of evidence to the contrary, if an SSI-related A/R is a joint account holder, it is presumed that all of the funds in the account belong to the A/R. If there is more than one SSI-related A/R who is a holder of the joint account, it is presumed that the funds in the account belong to the A/Rs in equal shares. To rebut this presumption, the SSI-related A/R must:

i. submit a written statement, along with corroborating written statements from the other account holders,

regarding who owns the funds, why there is a joint account, who has made deposits and withdrawals, and how withdrawals have been spent;

ii. submit account records for the months for which ownership of funds is at issue; and

iii. separate the funds owned by the SSI-related A/R from the funds of the other account holders.

2. Conversion of Individual's Assets to Jointly Held Assets

When an asset belonging to an individual is jointly held in common with another person or person in a joint tenancy, tenancy in common, or similar arrangement, the asset is considered to be transferred by the individual when any action is taken, either by the individual or any other person, that reduces or eliminates the individual's ownership or control of the asset. Merely placing another person's name on an account or asset as a joint owner does not necessarily constitute a transfer of assets. The individual may still possess ownership rights to the account or asset and have the right to withdraw all of the funds in the account at any time. However, actual withdrawal of funds from the account, or removal of the asset, by the other person would remove the funds or property from the control of the individual and so would constitute a transfer of assets. Also, if placing another person's name on the account or asset actually limits the individual's right to sell or otherwise dispose of the asset (e.g., the addition of another person's name requires that the person agree to the sale or disposal of the asset, where no such agreement was necessary before), such placement would constitute a transfer of assets.

J. Life Estates

1. Definitions

a. Life Estate

A life estate is a limited interest in real property. A life estate holder does not have full title to the property, but has the use of the property for his or her lifetime, or for a specified period. Generally, life estates are in the form of a life lease on property that the person is using, or has used, for a homestead.

b. Value of a Life Estate

Social services districts must use a reasonable method of calculating the value of a life estate, based on the current fair market value of the property and the age of the person. A life estate and remainder interest table

published by the federal Health Care Financing Administration in its State Medicaid Manual is attached for districts' information (Attachment V). This table sets forth percentages of fair market value corresponding to the values of the life estate and the remainder interest, based on the age of the person possessing the life estate. Districts may, but are not required, to use this table in calculating the value of life estates and remainder interests.

c. Value of the Remainder Interest

The value of the remainder interest is the current market value of the property less the value of the life estate.

d. Remainderperson

A remainderperson is an individual who has the right to possession or ownership of the property after the life estate holder dies or surrenders the life estate.

2. Transfers

Transferring property while retaining a life estate within the look-back period is a partially uncompensated transfer. The uncompensated value of the transfer is the value of the remainder interest at the time the life estate is created. If the remainderperson of a life estate is an individual to whom the property could be transferred without penalty, the establishment of the life estate is not a prohibited transfer.

If the holder of a life estate transfers the life estate during the look-back period, it must be determined if FMV was received for the life use. If FMV was not received, a transfer penalty must be imposed.

When an individual both transfers property (retaining a life estate) and transfers the life estate interest within the look-back period, the uncompensated value of the transfers are the value of the remainder interest at the time the life estate is created plus the value of the life estate at the time it is transferred.

Examples (using table in Attachment V)

a. Transfer of a home:

$92,000 value of the home at the time the life estate was created
x.62086 age 69
$57,119.12 value of the life estate

$92,000.00
-$57,119.12
$34,880.88 (remainder interest) uncompensated value of transfer of the home

b. Transfer of a life estate (same situation as above, but two years later):

$94,000 value of the home at the time the life estate was transferred
x.58914 age 71
$55,379.16 value of the life estate at the time the life estate was transferred

3. Availability

For the purpose of determining an A/R's net available resources, a life estate will not be considered a countable resource, and no lien may be placed on the life estate. Social services districts cannot require an A/R possessing a life estate to try to liquidate the life estate interest or to rent the life estate property.

If an A/R possessing a life estate sells the life estate interest, the proceeds of this liquidation is a countable resource for purposes of the A/R's MA eligibility. If the A/R sells the life estate interest for less than fair market value, the uncompensated value of the life estate interest is the amount transferred for purposes of the MA transfer-of-assets rule.

If an A/R possessing a life estate rents the life estate property, any net rental income received is counted in determining eligibility. If under the terms of the life estate, the life estate holder must pay taxes and maintenance, these costs can be deducted from the rental income. On the other hand, if the life estate holder does not have to pay any taxes or maintenance, a gross rental figure must be used.

The provisions of this ADM supersede any previous instructions or policies issued by this Department with respect to the MA treatment of life estates.

K. New York State Partnership for Long Term Care

Under the New York State Partnership for Long Term Care, resources are exempt. Therefore, a transfer of resources by those individuals who have purchased policies under this program (and have received three years of nursing home coverage, or six years of home care services, or a combination of nursing home care and home care services where one nursing home day equals 2 home care days) will have no effect on their eligibility for nursing facility services. Since income is not exempt, a transfer of income must be treated as specified in this directive. However, when an exempt resource that generates income is transferred, no transfer penalty is imposed.

L. Exceptions

Exceptions to the application of transfer of asset penalties are:

1. The asset transferred is the individual's home, and title to the home is transferred to;

   - the spouse of the individual;

   - a child of the individual who is under age 21;

   - a child of the individual who is certified blind or certified disabled, regardless of age;

   - the sibling of the individual who has an equity interest in the home, and who has been residing in the home and using it as their primary lawful residence for a period of at least one year immediately before the date the individual becomes institutionalized (see 89 ADM-45 page 16, for a definition of equity interest); or

   - a son or daughter of the individual (other than a child as described above) who was residing in the homestead, using it as their primary lawful residence for a period of at least two years immediately before the date the individual becomes institutionalized, and who provided care to the individual which permitted the individual to reside at home, rather than in an institution or facility.

2 An asset other than the individual's home was transferred:

   - to the individual's spouse, or to another for the sole benefit of the individual's spouse;

   - from the individual's spouse to another for the sole benefit of the individual's spouse;

   - to the individual's child who is certified blind or certified disabled; or

   - to a trust established solely for the benefit of an individual under 65 years of age who is disabled.

3. The individual or spouse intended to dispose of the assets either at FMV or for other valuable consideration.

   In determining whether an individual or the individual's spouse intended to dispose of an asset for FMV, or for other valuable consideration, the individual must establish the circumstances which caused the asset to be transferred for less than FMV. An example would be the sale of a home when the realtor appraised the property and the home was subsequently sold based on that appraisal, which was less than FMV. Generally, the individual would be required to provide written evidence of attempts to dispose of the asset for FMV, as well as evidence to support the value at which the asset was disposed.

4. The assets were transferred exclusively for a purpose other than to qualify for MA.

The individual must establish that the asset was transferred for a purpose other than to qualify for MA coverage for nursing facility services. Factual circumstances supporting a contention that assets were transferred for a purpose other than to qualify for MA include, but are not limited to: the unexpected onset of a serious medical condition subsequent to the transfer; the unexpected loss, subsequent to the transfer, of income or resources which would have been sufficient to pay for nursing facility services; or the existence of a court order specifically requiring the transfer of a certain amount of assets.

At the time of the personal interview, the A/R must be given the opportunity to establish that the transfer was made for a purpose other than to qualify for MA coverage for nursing facility services. Social services districts must not take any adverse action on an MA-only A/R who has transferred assets without first advising the client in writing of his/her right to make such a showing. Attachment III must be used to meet this requirement.

5. All or part of the assets transferred for less than FMV have been returned to the individual.

If all transferred assets are returned to the individual prior to the MA eligibility determination, no transfer penalty is imposed. If a portion of the transferred assets is returned prior to the MA eligibility determination, the uncompensated value of the transfer is reduced by the amount of assets returned.

If all transferred assets are returned after the MA eligibility determination, the existing penalty period is rescinded and the individual's eligibility for MA during such period must be redetermined as though the assets were never transferred. If a portion of the transferred assets is returned after the MA eligibility determination, the existing penalty period is recalculated, reducing the uncompensated value of the transfer(s) by the amount of assets returned; if the recalculated penalty period has already elapsed, the individual's eligibility for MA subsequent to the penalty period must be redetermined as though the returned assets were never transferred.

For purposes of these rules, transferred assets shall be considered to be returned if the person to whom they were transferred: uses them to pay for nursing facility services for the MA applicant/recipient; or provides the MA applicant/recipient with an equivalent amount of cash or

other liquid assets.

6. Imposition of a penalty would work an undue hardship.

Undue hardship exists when:

- the individual applying for nursing facility services is otherwise eligible for MA; and
- despite his/her best efforts, as determined by the social services district, the individual or the individual's spouse is unable to have the transferred asset(s) returned or to receive FMV for the asset or to void the trust; and
- the institutionalized individual is unable to obtain appropriate medical care such that the individual's health or life would be endangered without the provision of MA for nursing facility services or for home or community-based services furnished under a waiver granted under section 1915(c) or (d) of the Social Security Act.

Undue hardship cannot be claimed:

- if the client failed to fully cooperate, to the best of his/her ability, as determined by the social services district, in having all of the transferred assets returned or the trust declared void. Cooperation may include, but is not limited to, assisting in providing all legal records pertaining to the transfer or creation of the trust, assisting the district, wherever possible, in providing information regarding the transfer amount, to whom it was transferred, any documents to support the transfer or any other information related to the circumstances of the transfer; or
- if after payment of medical expenses, the individual's or couple's income and/or resources is at or above the allowable MA exemption standard for a household of the same size; or
- if the only undue hardship that would result is the individual's or the individual's spouse's inability to maintain a pre-existing life style.

M. Community Coverage

Social Services districts may elect to offer community coverage only, in cases where an individual does not anticipate the need for nursing facility services. If the district elects to provide community coverage, they must provide it as an option to the client. If the client requests full coverage, the district must complete the resource investigation. If the client requests community coverage only, the district may make their determination

based on the applicant's current resources only (see 95 ADM-17).

V. NOTICE REQUIREMENTS

Local districts must make Attachment III, "EXPLANATION OF THE EFFECT OF TRANSFER OF ASSETS ON MEDICAL ASSISTANCE ELIGIBILITY", available to all individuals who wish to establish that the transfer was made for a purpose other than to qualify for nursing facility services. In addition, this form must be given to all MA-only applicants at the time of (re)application. A copy of Attachment III must also be sent when an A/R's (re)application is denied/discontinued due to a prohibited transfer. The form must be enclosed with the appropriate mandated client notice. This notice must be reproduced by the social services district until such time as it becomes available from this Department. If a local district elects to provide community coverage, they must use the appropriate notice contained in 95 ADM-17, Community Coverage Option, along with Attachment III.

VI. SYSTEN IMPLICATIONS

Upstate: Currently, coverage code 10 (All Services Except Long-Term Care) is used in conjunction with an Anticipated Future Action (AFA) code of 505 (End of Property Transfer Prohibition) with a specific end date to indicate an individual for whom a penalty period has been established. Until a separate coverage code is established for persons electing community coverage, for all cases determined eligible for the community benefit package, enter coverage code 10, and do not make a corresponding entry into the AFA field. For those recipients who are currently in a penalty period, or receive one in the future, continue to use an AFA code 505. The presence of coverage code 10 in combination with the AFA code 505 will allow social services districts to track those recipients who are in a penalty period.

New York City: Currently, coverage code 10 (All Services Except Long-Term Care) is used to indicate an individual for whom a penalty period has been established. Until a separate coverage code is established for persons electing community coverage, for all cases determined eligible for the community coverage package, enter coverage code 10 for those persons, as well.

VII. EFFECTIVE DATE

For applications and recertifications for MA submitted on or after September 1, 1994, determine if any trust was created or a transfer occurred at any time after August 10, 1993. If so, then the provisions of this ADM must be utilized. However, the 36 month look-back period does not become fully effective until August 11, 1996 for non-trust-related transfers and August 11, 1998 for trust-related transfers, since prior to that date a full 36 month or 60 month look-back period could include a period of time prior to August 11, 1993. Any trusts created or transfers occurring prior

to August 11, 1993, are to be treated in accordance with Department Regulation 360-4.4(c). However, in the case of trusts created before August 11, 1993, districts will look at any trust activity that occurred after that date.

Richard T. Cody
Division of Health & Long Term Care

SAMPLE STATEMENT

SOLE BENEFIT

I, _____, transferred the following assets:

_____

_____

_____

_____

to _____, on _____.
(transferee) (date)

At the time of this transfer, it was my intent, and it was the agreement of myself and the transferee, that the transferred assets henceforth would be used for the sole benefit of _____.
(beneficiary)

Specifically, it was and is my intent that the assets be expended for the following purposes: _____

_____

_____

_____

I acknowledge that I have a responsibility to provide to the social services agency evidence of a continuous course of conduct by the transferee, consistent with this intent, since the time of the transfer.

I further acknowledge that, pursuant to regulations of the New York State Department of Social Services, any action by myself or the transferee which has the effect of reducing or eliminating the above-named beneficiary's beneficial use of the transferred property, or has the effect of reducing or eliminating the transferee's ownership or control of the transferred property, will be considered a transfer of assets (on the date such action is taken) which may affect my or my spouse's eligibility for Medical Assistance.

Signed: _____

Sworn to before me this

_____ day of _____, 19___

SUGGESTED PROCEDURES FOR MONITORING EXCEPTION TRUSTS

1) The district should establish a file of all exception trusts identified within the district. This file can be created and maintained manually, or within a PC based system.

2) The file should contain, at a minimum, the name of the client, CIN and case number, name of the trustee, amount of the trust, and the expected annual payments to be made according to the terms of the trust. It should also include an area to record additions to and disbursements from the fund on an annual basis.

3) At the time that the agency is made aware of the existence of an exception trust, (generally at application or recertification) they should add the trust to the file and should request the trustee to provide copies of any accountings that he is required to produce.

4) Upon receipt of this information, the district should update their file, and should evaluate the activity to ensure that no monies have been inappropriately transferred.

5) Upon notification of the death of the client, the district should forward any information on exception trusts to their recovery unit for estate recovery evaluation.

EXPLANATION OF THE EFFECT OF TRANSFER OF ASSETS ON MEDICAL ASSISTANCE ELIGIBILITY

This explains how a transfer of assets may affect your eligibility for Medical Assistance. Assets include all of your and your spouse's income and resources, including any income or resource which you or your spouse are entitled to receive but do not receive because of any action or inaction by you or your spouse. A transfer is when property or assets are given or sold from one person to another. For Medical Assistance purposes, a prohibited transfer is the voluntary giving or sale of your property or assets to another person without receiving something of equal value in return, in order to qualify for:

- nursing facility services provided in hospitals, residential health care facilities or intermediate care facilities for the developmentally disabled;

- care, services, or supplies furnished pursuant to a waiver under section 1915(c) or (d) of the Social Security Act, including: the Long Term Care Program, the OMRDD Home and Community Based Waiver, the Traumatic Brain Injury Waiver or the Care At Home Program.

The information contained in this document is applicable to all transfers made after August 10, 1993. For information on transfers made prior to that date, ask your Medical Assistance Eligibility Examiner.

The Medical Assistance Program will not pay for any of the services listed below if a prohibited transfer of countable assets (the total value of property, resources and income that are in excess of the allowable Medical Assistance resource standard) for less than fair market value is made within the 36 months before your application for Medical Assistance, or at any time after you apply for Medical Assistance to pay for the services listed in the "limited coverage" section below. In the case of trusts, we will look back for a period of 60 months. (In most cases, once you are found to be eligible for these services, a transfer by your spouse does not affect your Medical Assistance coverage.) If we decide that a prohibited transfer has been made within this time period, and you meet all other eligibility requirements, your Medical Assistance coverage will be limited for a period of time.

What does limited coverage mean?

Limited coverage means that for a period of time you will not be able to receive Medical Assistance coverage for the following types of care and services:

- nursing facility services provided in hospitals, residential health care facilities or intermediate care facilities for the developmentally disabled;

- care, services, or supplies furnished pursuant to a waiver under section 1915(c) or (d) of the Social Security Act, including: the Long Term Care Program, the OMRDD Home and Community Based Waiver, the Traumatic Brain Injury Waiver or the Care At Home Program. Examples of some of these services are:

  Congregate/home delivered meals
  Home maintenance tasks
  Housing improvement
  Social transportation
  Respite care
  Social day care
  Personal emergency response system services
  Moving assistance
  Medical social services
  Respiratory therapy
  Nutritional counseling/education services

How is the limited coverage period determined?

When you or your spouse make a transfer of assets for less than they are worth, you cannot get Medical Assistance for the services listed above for a period of time, depending upon the amount of transferred assets. We determine the number of months you are ineligible for these services by dividing the uncompensated value of the assets transferred by the average monthly rate for nursing facility services in the region where you live. The penalty period would begin the month following the month in which you made the transfer. Information on average monthly rates is available upon request from your social services district.

How do we determine the uncompensated value of the transferred assets?

We estimate the fair market value of the asset at the time it was transferred. We deduct any outstanding loans, mortgages or other encumbrances on the asset and the amount of compensation received in exchange for the asset. In addition, certain resource or income disregards may be deducted, if applicable.

What transfers do not affect your eligibility for Medical Assistance?

There are exceptions to the transfer rules. Your Medical Assistance coverage is not limited when a transfer has been made if:

1. the asset(s) was transferred to (or for the sole benefit of) your spouse, or from your spouse to you; or

2. the asset(s) was transferred from your spouse to another person for the sole benefit of your spouse; or

3. the asset(s) was transferred to your child of any age who is certified blind, or certified disabled, or to a trust established solely for the benefit of that child; or

4. the asset(s) was transferred to a trust established solely for the benefit of an individual under 65 years of age who is certified disabled.

5. the asset(s) transferred was your homestead (for example: a house or an apartment that you own), and the homestead was transferred to:

   - your spouse;

   - your minor child under age 21, or your child of any age who is certified blind or certified permanently and totally disabled;

   - your brother or sister who also has an equity interest in the home and who lived in the home for at least one year immediately before you entered a nursing facility;

   - your child (other than a child who is under 21 or who is certified blind/disabled) who was living in your home for at least two years immediately before you entered a nursing facility and who provided care which permitted you to reside at home rather than in a nursing facility.

NOTE: Although the Department does not treat a life estate possessed by you as a countable resource for purposes of determining your Medical Assistance eligibility, a life estate has value and you may be subject to a transfer penalty if you transfer your life estate interest to another person.

What other transfers do not affect your eligibility for Medical Assistance?

If you or your spouse transferred assets for less than fair market value you can still get full Medical Assistance coverage if you can prove that:

1. you or your spouse intended to sell the asset(s) at fair market value or to receive other valuable consideration in exchange for the asset(s); or

2. the asset(s) was transferred exclusively for a purpose other than to qualify for nursing care and related services as described above;or

3. all of the transferred assets have been returned.

   In the absence of the evidence described in 1. or 2. above, we will not limit your Medical Assistance coverage if we determine that despite your best efforts, as determined by the social services district, you are unable to have the transferred asset(s) returned or to receive fair market value for the asset.

We will not limit your Medical Assistance coverage if we determine that such limitation will result in undue hardship for you. We will consider undue hardship to exist if you: (a) meet all other eligibility requirements, and (b) are unable to obtain appropriate medical care without which your health or life would be in danger or if application of the transfer penalty would deprive you or your spouse of food, clothing, shelter or other necessities of life.

How can you prove the transfer was not made to qualify for these medical services?

We will presume that any prohibited transfer of assets made within 36 months (60 months for trusts), that occurred immediately before or when you became in need of nursing care and related services was made for the purpose of qualifying for Medical Assistance. If you disagree with this presumption, you should present evidence to your Medical Assistance eligibility examiner which proves that the transfer was made for some other purpose. Some factors which may establish that a transfer was made for a purpose other than to obtain Medical Assistance eligibility are:

1. sudden, unexpected onset of serious illness or disability after the transfer occurred;

2. unexpected loss of other resources or income which would have made you ineligible for Medical Assistance, after the transfer occurred;

These are examples only. All of the circumstances of the transfer will be considered as well as factors such as your age, health and financial situation at the time the transfer was made. It is important to note that you have the burden of providing this agency with complete information regarding all assets and any other relevant factors which may affect your eligibility.

What appeal rights do you have?

You will receive a written notice if we determine that your Medical Assistance coverage is to be limited based on a transfer of assets for less than fair market value. If you are in a nursing facility or require the services listed under the "limited coverage" section at the time we make our decision, the notice will tell you how long you will have limited coverage. This period will be based on the amount of assets you or your spouse has transferred for less than fair market value and the average rate for nursing facility services in the region in which you reside.

You have the right to appeal our decision to limit your coverage. Our written notice will provide you with information on how to request a conference with us to review our actions. Our notice will also provide you with information on your right to a State Fair Hearing if you believe our action is wrong.

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT YOUR
MEDICAL ASSISTANCE ELIGIBILITY EXAMINER.

LIFE EXPECTANCY TABLE
FOR FEMALES

AGE	LIFE EXPECTANCY	AGE	LIFE EXPECTANCY	AGE	LIFE EXPECTANCY
0	78.79	40	40.61	80	9.11
1	78.42	41	39.66	81	8.58
2	77.48	42	38.72	82	8.06
3	76.51	43	37.78	83	7.56
4	75.54	44	36.85	84	7.08
5	74.56	45	35.92	85	6.63
6	73.57	46	35.00	86	6.20
7	72.59	47	34.08	87	5.79
8	71.60	48	33.17	88	5.41
9	70.61	49	32.27	89	5.05
10	69.62	50	31.37	90	4.71
11	68.63	51	30.48	91	4.40
12	67.64	52	29.60	92	4.11
13	66.65	53	28.72	93	3.84
14	65.67	54	27.86	94	3.59
15	64.68	55	27.00	95	3.36
16	63.71	56	26.15	96	3.16
17	62.74	57	25.31	97	2.97
18	61.77	58	24.48	98	2.80
19	60.80	59	23.67	99	2.64
20	59.83	60	22.86	100	2.48
21	58.86	61	22.06	101	2.34
22	57.89	62	21.27	102	2.20
23	56.92	63	20.49	103	2.06
24	55.95	64	19.72	104	1.93
25	54.98	65	18.96	105	1.81
26	54.02	66	18.21	106	1.69
27	53.05	67	17.48	107	1.58
28	52.08	68	16.76	108	1.48
29	51.12	69	16.04	109	1.38
30	50.15	70	15.35	110	1.28
31	49.19	71	14.66	111	1.19
32	48.23	72	13.99	112	1.10
33	47.27	73	13.33	113	1.02
34	46.31	74	12.68	114	0.96
35	45.35	75	12.05	115	0.89
36	44.40	76	11.43	116	0.83
37	43.45	77	10.83	117	0.77
38	42.50	78	10.24	118	0.71
39	41.55	79	9.67	119	0.66

LIFE EXPECTANCY TABLE
FOR MALES

AGE	LIFE EXPECTANCY	AGE	LIFE EXPECTANCY	AGE	LIFE EXPECTANCY
0	71.80	40	35.05	80	6.98
1	71.53	41	34.15	81	6.59
2	70.58	42	33.26	82	6.21
3	69.62	43	32.37	83	5.85
4	68.65	44	31.49	84	5.51
5	67.67	45	30.61	85	5.19
6	66.69	46	29.74	86	4.89
7	65.71	47	28.88	87	4.61
8	64.73	48	28.02	88	4.34
9	63.74	49	27.17	89	4.09
10	62.75	50	26.32	90	3.86
11	61.76	51	25.48	91	3.64
12	60.78	52	24.65	92	3.43
13	59.79	53	23.82	93	3.24
14	58.82	54	23.01	94	3.06
15	57.85	55	22.21	95	2.90
16	56.91	56	21.43	96	2.74
17	55.97	57	20.66	97	2.60
18	55.05	58	19.90	98	2.47
19	54.13	59	19.15	99	2.34
20	53.21	60	18.42	100	2.22
21	52.21	61	17.70	101	2.11
22	51.38	62	16.99	102	1.99
23	50.46	63	16.30	103	1.89
24	49.55	64	15.62	104	1.78
25	48.63	65	14.96	105	1.68
26	47.72	66	14.32	106	1.59
27	46.80	67	13.70	107	1.50
28	45.88	68	13.09	108	1.41
29	44.97	69	12.50	109	1.33
30	44.06	70	11.92	110	1.25
31	43.15	71	11.35	111	1.17
32	42.24	72	10.80	112	1.10
33	41.33	73	10.27	113	1.02
34	40.23	74	9.27	114	0.96
35	39.52	75	9.24	115	0.89
36	38.62	76	8.76	116	0.83
37	37.73	77	8.29	117	0.77
38	36.83	78	7.83	118	0.71
39	35.94	79	7.40	119	0.66

LIFE ESTATE AND REMAINDER INTEREST TABLE

AGE	LIFE ESTATE	REMAINDER	AGE	LIFE ESTATE	REMAINDER
0	.97188	.02812	35	.93868	.06132
1	.98988	.01012	36	.93460	.06540
2	.99017	.00983	37	.93026	.06974
3	.99088	.00992	38	.92567	.07433
4	.98981	.01019	39	.92083	.07917
5	.98938	.01062	40	.91571	.08429
6	.98884	.01116	41	.91030	.08970
7	.98822	.01178	42	.90457	.09543
8	.98748	.01252	43	.89855	.10145
9	.98663	.01337	44	.89221	.10779
10	.98565	.01435	45	.88558	.11442
11	.98453	.01547	46	.87863	.12137
12	.98329	.01671	47	.87137	.12863
13	.98198	.01802	48	.86374	.13626
14	.98066	.01934	49	.85578	.14422
15	.97937	.02063	50	.84743	.15257
16	.97815	.02185	51	.83674	.16126
17	.97700	.02300	52	.82969	.17031
18	.97590	.02410	53	.82028	.17972
19	.97480	.02520	54	.81054	.18946
20	.97365	.02635	55	.80046	.19954
21	.97245	.02755	56	.79006	.20994
22	.97120	.02880	57	.77931	.22069
23	.96986	.03014	58	.76822	.23178
24	.96841	.03159	59	.75675	.24325
25	.96678	.03322	60	.74491	.25509
26	.96495	.03505	61	.73267	.26733
27	.96290	.03710	62	.72002	.27998
28	.96062	.03938	63	.70696	.29304
29	.95813	.04187	64	.69352	.30648
30	.95543	.04457	65	.67970	.32030
31	.95254	.04746	66	.66551	.33449
32	.94942	.05058	67	.65098	.34902
33	.94608	.05392	68	.63610	.36390
34	.94250	.05750	69	.62086	.37914

LIFE ESTATE AND REMAINDER INTEREST TABLE (cont.)

AGE	LIFE ESTATE	REMAINDER	AGE	LIFE ESTATE	REMAINDER
70	.60522	.39478	90	.28221	.71779
71	.58914	.41086	91	.26955	.73045
72	.57261	.42739	92	.25771	.74229
73	.55571	.44429	93	.24692	.75308
74	.53862	.46138	94	.23728	.76272
75	.52149	.47851	95	.22887	.77113
76	.50441	.49559	96	.22181	.77819
77	.48742	.51258	97	.21550	.78450
78	.47049	.52951	98	.21000	.79000
79	.45357	.54643	99	.20486	.79514
80	.43659	.56341	100	.19975	.80025
81	.41967	.58033	101	.19532	.80468
82	.40295	.59705	102	.19054	.80946
83	.38642	.61358	103	.18437	.81563
84	.36998	.63002	104	.17856	.82144
85	.35359	.64641	105	.16962	.83038
86	.33764	.66236	106	.15488	.84512
87	.32262	.67738	107	.13409	.86591
88	.30859	.69141	108	.10068	.89932
89	.29526	.70474	109	.04545	.95455

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EXHIBIT C

Streimer Letter - HCFA Letter Dated April 16, 1998, to Jean Galloway Ball, Esq.

HCFA LETTER CONCERNING TRUSTS FOR THE SOLE BENEFIT OF THE COMMUNITY SPOUSE

April 16, 1998

DEPARTMENT OF HEALTH & HUMAN SERVICES Health Care Financing Administration

7500 SECURITY BOULEVARD
BALTIMORE, MD 21244-1850

Jean Galloway Ball
Galloway, Ball & Cossa, P.L.C.
10300 Eaton Place
Suite 250
Fairfax, Virginia 22030-2239

Dear Ms. Ball:

I am responding to your letter to Sally Richardson concerning trusts established for the sole benefit of the community spouse under the Health Care Financing Administration's (HCFA) Transmittal No. 64. Your letter was referred to this office for reply.

At issue is a trust you prepared for a community spouse, with the community spouse as the sole beneficiary. The trust was funded using resources belonging to the community spouse and the Medicaid applicant. The son of the community spouse was named as the trustee. The trust provided for distributions on an actuarially sound basis that would result in distribution of the trust assets within the beneficiary's expected lifetime. In preparing the trust in this manner you sought to create a private annuity in the form of a trust, rather than purchase a more standard annuity from an insurance company or similar entity.

You believe, based on your reading of HCFA Transmittal No. 64 (which sets forth HCFA's interpretation of the transfer of assets and treatment of trusts provisions of the Medicaid statute), that an "annuitized" trust of the sort you prepared would protect the couple from transfer of assets penalties and protect the assets in the trust itself from being counted as an available resource in determining the Medicaid eligibility of the institutionalized spouse. The Virginia Department of Social Services agrees to the extent that establishment of the trust does not subject the institutionalized spouse to a penalty for transferring assets for less than fair market value because transfers between spouses are exempt from such penalties.

However, the Department of Social Services has held that the corpus of the trust must be counted as available to the institutionalized spouse under the provisions of section 1917(d) of the Social Security Act. The Department reasoned that under section 1917(d) a trust falls under the jurisdiction of that section if the trust was established by either member of the couple, using at least some of the Medicaid applicant's assets. Section 1917(d) applies without regard to the purpose for which the trust was established, or any restrictions on the distributions from the trust. The Department held that the trust you prepared is an irrevocable trust, the corpus of which can be paid at some point in time to the community spouse. Under

section 1917(d)(2)(B), the corpus of such a trust is considered an available resource to the beneficiary, and thus must be included as a countable resource in determining Medicaid eligibility for the institutionalized spouse under the Medicaid spousal impoverishment provisions (section 1924 of the Act).

You disagree with the Department's ruling. In an attached "Memorandum Re Community Spouse Resource Trust," you argue that the Department is creating an unreasonable distinction between private annuities of the sort your trust attempted to establish, and the more standard annuity purchased through an insurance broker. Under your interpretation, the trust you established meets the definition of an annuity because it provides for an actuarially sound schedule of payments to the trust beneficiary. You believe that "actuarial soundness" is the sole criterion under which annuities (or annuitized trusts) should be judged; thus, the funds placed in a trust such as you established should be protected from transfer of assets penalties, and from being counted as a resource in determining the institutionalized spouse's eligibility.

Although you attempt to combine the issues in question under the broad umbrella of "actuarial soundness" (citing section 3258.9.B of Transmittal No. 64), in reality the issues are separate and distinct and not subject to the connection you attempt to make. The first issue is whether the trust you prepared subjects the institutionalized spouse to a penalty under the transfer of assets provisions of section 1917(c) of the Act. It is to this issue, and only this issue, that "actuarial soundness" applies. "Actuarial soundness" is one means of determining that a transfer made to a third party was in fact made for the sole benefit of the spouse. However, it has no bearing on whether an asset is or is not a countable resource, and in fact the plain language of section 3258.9.B in no way makes such a connection. Section 3258.9.B speaks only to whether a purchase of an annuity constitutes a transfer of assets for less than fair market value.

The Department of Social Services has stipulated that no transfer penalty is applicable because transfers from one spouse to another, including transfers to a third party for the sole benefit of the spouse, are not subject to penalty. In so stipulating the Department presumably found that the trust you prepared met the requirement that the transfer be for the sole benefit of the community spouse. Thus, there is no disagreement with regard to the applicability of transfer of assets penalties in this case, and so no issue to which "actuarial soundness" is pertinent.

The only remaining issue is whether the trust you prepared protects the assets placed in the trust from being counted as resources in determining the institutionalized spouse's eligibility. As noted previously, you argue that the "annuity" aspect of the trust protects it from being counted as a resource, and the only difference between a standard annuity and your trust is the lack of involvement of an insurance broker in the establishment of your trust. While we understand the argument you make, we cannot agree with your conclusion that there is no material difference between a standard annuity and your "annuitized" trust.

A standard annuity can protect the funds used to purchase the annuity from being counted as resources in determining eligibility for Medicaid. However, there is a fundamental difference between a standard annuity and the "annuitized" trust you established. A standard annuity requires the actual purchase of a commodity; i.e., the annuity itself. A specific amount of

money is given to the entity selling the annuity, in return for which the entity contractually agrees to provide an income stream for a specified period of time. Upon completion of the transaction, the buyer no longer owns the funds used to purchase the annuity. Instead, he or she owns the annuity itself. If the annuity is irrevocable, as most annuities are, the buyer cannot reclaim ownership of the funds used to purchase the annuity. He or she is only entitled to the income stream purchased, and only for as long as the annuity stipulates. This is essentially the same as the purchase of any item or product where funds are exchanged for ownership of something else.

By contrast, the trust you prepared was not an annuity, but an irrevocable trust within the meaning of section 1917(d) of the Act, and the definition of a trust set forth in Transmittal No. 64. Section 3259.1.A.1 of that transmittal defines a trust as follows: "For purposes of this section, a trust is any arrangement in which a grantor transfers property to a trustee or trustees with the intention that it be held, managed, or administered by the trustee(s) for the benefit of the grantor or certain designated individuals (beneficiaries)." The only similarity between your trust and an annuity was the establishment of a schedule income stream under the trust, as opposed to some other means of distribution. Otherwise, establishment and funding the trust did not involve the exchange of the beneficiary's funds for a specific item or product, but merely transfer of those funds to the trustee for the benefit of the grantor, who was also the beneficiary of the trust. It is this latter arrangement that section 1917(d) and Transmittal No. 64 were specifically intended to address.

In summary, then, we must conclude with the Virginia Department of Social Service's ruling in this case. The trust you prepared was not an annuity, but rather an irrevocable trust subject to treatment under section 1917(d) of the Act, and HCFA's implementing instructions in Transmittal No. 64. While the trust you prepared met the definition of "actuarial soundness," "actuarial soundness" only pertains to whether a penalty can be imposed for transferring assets for less than fair market value when an annuity is purchased, or funds are transferred to a third party for the sole benefit of a spouse. "Actuarial soundness" does not affect the countability as resources of funds placed in a trust. The Department of Social Services correctly found that while no transfer penalty was applicable, the corpus of the trust was countable as a resource in determining the eligibility of the institutionalized spouse.

I regret that my response could not be more favorable. If you have any questions, please contact Roy Trudel of my staff at 410-786-3417.

Sincerely,

Robert A. Streimer
Disabled and Elderly Health Programs Group
Center for Medicaid and State Operations

cc: Virginia Department of Social Services, Medical Assistance Unit

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IN THE SUPREME COURT OF THE STATE OF DELAWARE

DELAWARE DEPARTMENT OF HEALTH AND SOCIAL SERVICES, DIVISION OF SOCIAL SERVICES,	§	No. 9, 2001
Defendant Below, Appellant,	§	Court Below: Superior Court of the State of Delaware in and for New Castle County
v.	§	
ETHELDA DEAN, by her attorney-in-fact, William Dean,	§	C. A. No. 00A-05-006
Plaintiff Below, Appellee.	§	

Submitted: May 15, 2001
Decided: May 15, 2001

Before **HOLLAND**, **BERGER** and **STEELE**, Justices.

ORDER

This 15th day of May, 2001, upon consideration of the briefs of the parties, it appears to the Court that the judgment of the Superior Court should be affirmed on the basis of and for the reasons set forth in its decision dated December 6, 2000.

NOW, THEREFORE, IT IS ORDERED that the judgment of the Superior Court is **AFFIRMED**.

BY THE COURT:

/s/ Myron T. Steele
Justice

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*2000 Del. Super. LEXIS 490, **

ETHELDA DEAN, by her attorney-in-fact, William Dean, Appellant, v. DELAWARE DEPARTMENT OF HEALTH AND SOCIAL SERVICES, DIVISION OF SOCIAL SERVICES, Appellee.

C.A. NO. 00A-05-006

SUPERIOR COURT OF DELAWARE, NEW CASTLE

2000 Del. Super. LEXIS 490

November 29, 2000, Submitted

December 6, 2000, Decided

SUBSEQUENT HISTORY: [*1] Released for Publication by the Court March 1, 2001.

DISPOSITION: Appeal From a Decision of the Delaware Department of Health and Social Services, Division of Social Services Decision Reversed. Motion to Supplement the Record Granted.

COUNSEL: Thomas Herlihy, III, Esquire, Herlihy, Harker & Kavanaugh, Wilmington, Delaware, for the Appellant.

Lynn D. Wilson, Esquire, Department of Justice, Wilmington, Delaware, for the Appellee.

JUDGES: Norman A. Barron, Judge.

OPINIONBY: Norman A. Barron

OPINION: MEMORANDUM OPINION

BARRON, Judge

This is the Court's decision on an appeal by William Dean, as husband and attorney-in-fact of Ethelda Dean, of a final decision of the Delaware Division of Social Services (DSS) denying Mrs. Dean's application for Medicaid benefits. Having reviewed the parties' submissions, as well as the record below, the Court concludes that the decision must be reversed.

POSTURE

Ethelda Dean, a resident of Parkview Nursing Home since January 1999, applied for Medicaid benefits to cover the costs of her long-term care. On July 15, 1999, DSS determined that Mr. and Mrs. Dean's resources exceeded the limit for Medicaid eligibility and that Mrs. Dean was therefore not eligible for [*2] Medicaid benefits at that time. On July 30, 1999, Mr. Dean reapplied for

benefits on his wife's behalf. On February 23, 2000, DSS denied her application. At Mr. Dean's request, DSS conducted a hearing on the matter on April 26, 2000. On April 28, 2000, DSS issued its final decision denying Ethelda Dean's request for a reversal of the denial of her application for benefits. Dean filed a timely appeal to this Court. Briefing is complete, and the issues are ripe for decision.

FACTS

In January 1999, Ethelda Dean was admitted to Parkview Nursing Home. Her husband, William Dean, continued to live in the marital home in Wilmington. Ethelda Dean first applied for Medicaid assistance on April 22, 1999. To help determine his wife's eligibility for Medicaid benefits, William Dean sought from DSS an assessment of the couple's assets, referred to as a "snapshot" in Medicaid parlance. The snapshot revealed that as of July 15, 1999, the couple's assets totaled $ 183,724.41, not including the Deans' home, car or other noncountable resources. n1 As the community spouse, Mr. Dean was entitled a community spouse resource allowance (CSRA) without jeopardizing his wife's eligibility for Medicaid. [*3] n2 The maximum amount of the CSRA is onehalf of the couple's combined countable resources, not to exceed an amount which Congress adjusts annually. In 1999, when Mrs. Dean applied for benefits, the cap was $ 81,960. n3 DSS determined that Dean's countable assets equaled $ 91,862.21, significantly in excess of the statutory cap. n4

- - - - - - - - - - - - - - - - - -Footnotes- - - - - - - - - - - - - - - - - -

n1 DSS Spousal Impoverishment Resource Calculation Sheet, included in Appendix to Opening Brief at A-40 through A-43. Subsequent references to this Appendix appear as "App. to Op. Br."

n2 The issues in this case pertain to Mr. Dean's resources but not to his income. In Delaware, a married applicant's eligibility for Medicaid is "determined by considering the income of the institutionalized spouse only." State of Delaware Department of Health and Social Services, Division of Social Services Medical Assistance Program (Medicaid) Manual (DSSM) $ 20990, included in Appendix to Reply Brief at C-46. Subsequent references to this Appendix appear as "App. to Rep. Br." The community spouse's income becomes an issue only when he or she does not receive sufficient income to cover the basic costs of living, in which case, he or she may seek to obtain a portion of the institutionalized spouse's income to help defray necessary costs. Mr. Dean makes no such application. [*4]

n3 Spousal Impoverishment Resource Sheet, App. to Op. Br. at A-40 through A-43.

n4 *Id.*

- - - - - - - - - - - - - - - - - -End Footnotes- - - - - - - - - - - - - - - - - -

On September 9, 1999, William Dean and his attorney met with Tamara Ince, a DSS case manager, to reapply for Medicaid on Ethelda Dean's behalf. At that time, it was determined that the Deans' countable resources had decreased to $ 135,704, apparently due in part to payment of nursing home costs. However, the total still exceeded the allowable limit by approximately $ 51,743, which DSS expected the Deans to spend on Mrs. Dean's nursing home costs. Dean indicated instead that he was purchasing a $ 53,000 annuity in order to spend down his resources to within the limit. Dean stated that he had cashed a certificate of deposit and had placed the funds in a checking account to pay for the annuity. Shortly thereafter, DSS again denied Mrs. Dean's application, and Mr. Dean requested a fair hearing.

At the hearing, Dale Krause, an attorney who specializes in "putting together

Medicaid annuities for purposes of Medicaid qualification," n5 testified at the hearing that annuity rules are established by the federal [*5] Health Care Financing Administration (HCFA), which issued a document known as HCFA Transmittal 64 (Tr. 64). According to Krause, Tr. 64 provides that a properly structured annuity can be used to spend down resources in order to ensure Medicaid eligibility. Krause further stated that he had helped Dean prepare such an annuity.

- - - - - - - - - - - - - - - - - -Footnotes- - - - - - - - - - - - - - - - - -

n5 Transcript of the Fair Hearing at 19. Subsequent references to the transcript appear as "Tr. at page no."

- - - - - - - - - - - - - - - - - -End Footnotes- - - - - - - - - - - - - - - - -

Krause testified that Mr. Dean's annuity was irrevocable, nonassignable, immediate and actuarially sound, thus rendering it a non-countable resource for purposes of Medicaid. Krause stated that Dean purchased the annuity "to guarantee Mr. Dean that he'll have X number of dollars coming over a specified period of time." n6

- - - - - - - - - - - - - - - - - -Footnotes- - - - - - - - - - - - - - - - - -

n6 Tr. at 29.

- - - - - - - - - - - - - - - - - -End Footnotes- - - - - - - - - - - - - - - - -

Tamara Ince, the DSS case manager who had met with Dean to review his [*6] application, testified at the hearing on behalf of DSS. She stated that DSS typically expects excess resources to be spent on health care costs, not resource shelters such as annuities. She stated that after the amount of the community spouse resource allowance is determined, "all other resources are to be spent on a client's care or what we consider the spending out process." n7 Ince also made it clear that DSS had concluded that Dean bought the annuity to protect his assets while simultaneously ensuring his wife's eligibility for Medicaid benefits:

> I was under the impression it was done in preparation of making him eligible for Medicaid and that was his sole purpose only. So, in that case we usually look at things of that nature. When a client spends down money or transfers money or gives money away for the sole purpose of becoming eligible for Medicaid when they actually have the resources to pay for nursing home care, we look at that as a transfer of assets. Um, again, in lieu of just being denied for being over resourced. n8

This statement clearly reflects Ince's belief that the annuity was a transfer of assets that would subject the Deans to a penalty of delaying [*7] coverage for long-term care, as opposed to being found over-resourced and therefore ineligible. The hearing officer asked if he had to concern himself with the transfer of assets rule, n9 and Dean's attorney led Ince into agreeing that there was no transfer problem because Dean did not transfer the $ 53,000 to a third party. He then led her to agree that the only issue is whether the annuity is countable or not. n10

- - - - - - - - - - - - - - - - - -Footnotes- - - - - - - - - - - - - - - - - -

n7 Tr. at 4.

n8 Tr. at 14.

n9 Tr. at 15.

n10 Tr. at 16-18.

- - - - - - - - - - - - - - - - - - -End Footnotes- - - - - - - - - - - - - - - - - -

On April 28, 2000, DSS issued its final decision upholding the denial of Ethelda Dean's application for Medicaid assistance. The hearing officer reasoned that Tr. 64 did not govern the case because Delaware does not operate a "medically needy" Medicaid program. He further found that the purchase of the annuity was an abusive shelter of assets calculated to ensure Mrs. Dean's eligibility for Medicaid. Mr. Dean filed a timely appeal to this Court.

STANDARD OF REVIEW

On appeal of a DSS decision, "the Court shall decide [*8] all relevant questions and all other matters involved, and shall sustain any factual findings of the administrative hearing decision that are supported by substantial evidence of the record as a whole." n11 Such review "necessarily aim[s] at the potential for misapplication of governing law by a State when determining the qualifications of applicants for Medicaid assistance." n12

- - - - - - - - - - - - - - - - - - -Footnotes- - - - - - - - - - - - - - - - - -

n11 Title 31 *Del. C.* § 520. *See also Dolinger v. Delaware Dep't of Health and Social Services*, Del. Super., C.A. No. 98A-06-003, Gebelein, J. (Jan. 7, 1999).

n12 *Bowden v. Delaware Dep't of Health & Social Servs, Div. of Social Servs.*, 1993 Del. Super. LEXIS 304, *5, Del. Super., C.A. No. 92A-08-001, Graves, J. (Aug. 25, 1993) (Letter Op.), *aff'd sub nom. Parsons v. Delaware Dep't of Health & Social Servs., Div. of Social Servs.*, Del. Supr., 642 A.2d 837, *cert. denied* 513 U.S. 875, 115 S. Ct. 203, 130 L. Ed. 2d 133 (1994).

- - - - - - - - - - - - - - - - - - -End Footnotes- - - - - - - - - - - - - - - - - -

ISSUES

Dean argues first that the hearing officer erred as a matter of law when he concluded [*9] that Tr. 64 does not apply to Delaware's Medicaid program. Dean also argues that the hearing officer erred as a matter of law when he ruled that William Dean's annuity was a countable resource for purposes of Ethelda Dean's Medicaid eligibility. Finally, Dean asserts that DSS violated her rights under the due process clause and the commerce clause of the federal constitution.

DSS responds that the hearing officer was correct in his rulings that Tr. 64 is inapplicable in Delaware and that Ethelda Dean was not eligible for Medicaid benefits because the Deans had excess resources. DSS also asserts that the Deans were afforded their full panoply of constitutional rights.

Because the statutory mandate requires this Court to decide "all relevant matters and all other matters involved," the Court reframes the issues in this case to ensure that all matters are addressed in a coherent manner. This Opinion addresses each of the following questions. First, does Tr. 64 apply to the case at bar? Second, if so, how does Tr. 64 affect an applicant's eligibility for Medicaid? Third, if Tr. 64 is applicable, does it require that

a penalty be imposed on the Deans for the purchase of the $ 53,000 annuity? [*10] Fourth, is the $ 53,000 countable as a resource in determining Ethelda Dean's eligibility for Medicaid?

DISCUSSION

The Medicaid program was established in 1965 n13 to provide federal funds to help pay for the medical treatment of needy persons. n14 The federal government shares the costs of Medicaid with states that elect to take part in the program; in return, participating states must comply with the requirements imposed by the Act and by the Secretary of Health and Human Services, who administers the program through the Health Care Financing Administration (HFCA). n15

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n13 Title XIX of the Social Security Act, 42 U.S.C. §§ 1396--1396r.

n14 *Martin v. Ohio Dept. of Human Serv.*, Ohio Ct. App., 130 Ohio App. 3d 512, 720 N.E.2d 576 (1998). *See also West Virginia Univ. Hosps., Inc. v. Casey*, 3d Cir., 885 F.2d 11, 15 (1989). (observing that the purpose of the Medicaid program is to provide a nationwide program of medical assistance for low income families and individuals).

n15 *See* 42 U.S.C. § 1396a (1982 ed. and Supp. II); *Schweiker v. Gray Panthers*, 453 U.S. 34, 36-37, 69 L. Ed. 2d 460, 101 S. Ct. 2633 (1981).

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[*11]

Each state Medicaid program, which must be approved by the Secretary, is basically administered by the "state within certain broad requirements and guidelines." n16 In Delaware, the Medicaid program is generally overseen by the Department of Health and Social Services, but is administered by the Division of Social Services (DSS). n17 Of the several types of programs a state may choose from, Delaware has opted for the Supplemental Security Income for the Aged, Blind and Disabled (SSI) program, with additional coverage under the optional categorically needy provision. n18 Under this program, individuals who receive (or who qualify for) SSI are automatically eligible for Medicaid, while other applicants must meet additional state and federal requirements. As long as the state criteria comport with the federal regulations governing eligibility, they will be deemed valid and enforceable. n19

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n16 *West Virginia Univ. Hosps., Inc. v. Casey*, 885 F.2d at 15.

n17 *Milne v. Dept. of Health and Social Servs.*, Del. Super., 679 A.2d 1010, 1013 (1995).

n18 *See Bowden v. Delaware Dept. of Health and Social Servs., Div. of Social Servs.*, 1993 Del. Super. LEXIS 304, Del. Super., Graves, J. (Aug. 25, 1993).
[*12]

n19 *Id.* (citing *Schweiker v. Gray Panthers*, 453 U.S. 34, 36-37, 69 L. Ed. 2d 460, 101 S. Ct. 2633 (1981)).

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Prior to 1988, a married person living in a nursing home had to "spend down" all of the couple's jointly held assets to the eligibility limit in order to

receive assistance, often reducing both husband and wife to poverty from medical expenses. n20 However, married couples often transferred their assets into the name of the spouse not seeking Medicaid benefits because only jointly held assets were considered to be available for the institutionalized spouse's medical needs. n21

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n20 *Martin v. Ohio Dep't of Human Servs.*, Ohio Ct. App., 130 Ohio App. 3d 512, 720 N.E.2d 576, 581 (1998).

n21 *Id.*

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Congress addressed both of these problems when it enacted § 1396r-5 of the Medicare Catastrophic Coverage Act of 1988 (MCCA). n22 Pursuant to § 1396r-5(c)(1)(A), a "snapshot" of the total value of the couple's resources is taken prior to [*13] filing a formal application. To avoid impoverishment of the community spouse, he or she is entitled to a community spouse resource allowance (CSRA) without affecting the applicant's eligibility for Medicaid. This allowance is not available to pay for the care of the institutionalized spouse, and it need not be spent down in order for the institutionalized spouse to qualify. The cap on the CSRA is one-half of the couple's combined resources up to a limit which Congress adjusts annually. Any resources exceeding the CSRA (and the $ 2000 allocated to the institutionalized spouse) are deemed available for the care of the institutionalized spouse. n23

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n22 42 U.S.C. § 1396r-5.

n23 The parties agree that the issues in this case pertain to resources rather than income. In Delaware, "income eligibility is determined by considering the income of the institutionalized spouse only." DSSM § 20990.

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To assist caseworkers at the state level, the HCFA has issued a document entitled the State Medicaid [*14] Manual. At issue in the case at bar is the so-called "Transmittal 64" (Tr. 64), which is an amendment to the eligibility section of the State Medicaid Manual. Tr. 64 provides instructions to Medicaid caseworkers at the state level regarding trusts as well as transfers of assets for less than fair market value. At issue in the case at bar is Tr. 64, § 3258, Transfers of Assets for Less Than Fair Market Value, which was intended to "interpret § 1917(c) of the [Social Security] Act, as amended by § 13611 of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), on the treatment of transfers of assets for less than fair market value." n24 HCFA guidelines such as Tr. 64, although not statutes or regulations, are entitled to deference by the courts as long as "they are consistent with the plain language and purposes of the statute and if they are consistent with prior administrative views." n25

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n24 Introductory language to Tr. 64, presented on the unnumbered first page, included in App. to Op. Br. at A-61.

n25 *Cleary v. Waldman*, 3d. Cir., 167 F.3d 801, 808, *cert. denied*, 528 U.S. 870,

120 S. Ct. 170, 145 L. Ed. 2d 144 (1999); *see also Elizabeth Blackwell Health Center for Women v. Knoll*, 3d Cir., 61 F.3d 170 (1995) (noting that interpretive rules promulgated by an agency with lawmaking authority will receive deference even if the agency's interpretation is not made pursuant to that lawmaking authority), *cert. denied*, 516 U.S. 1093, 133 L. Ed. 2d 760, 116 S. Ct. 816 (1996).

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[*15]

1. Tr. 64 applies to Delaware's Medicaid program. The hearing officer in the case at bar found that Tr. 64 does not apply to Delaware's Medicaid program. He reasoned that because Delaware does not operate a "medically needy" Medicaid program which requires applicants to "spend down" their excess resources on medical costs in order to apply for Medicaid, Tr. 64 has no relevance in Delaware. n26 DSS supports the hearing officer's finding, but offers no authority for it. In fact, the plain language of Tr. 64 contradicts this conclusion. The introductory section of Tr. 64 provides in part as follows:

> New Implementing Instructions--Effective Date: 12/13/94
>
> This instruction applies to all transfers made or trusts established on or after August 10, 1993.

Section § 3258.1 is even more specific, stating that "the provisions explained in these instructions apply to all States, including those using more restrictive eligibility criteria than are used by the SSI program. . . ." Thus, it is clear that Tr. 64 applies to Delaware, which is an SSI state with additional coverage for categorically eligible individuals. The Court concludes that the hearing officer erred as [*16] a matter of law when he concluded that Tr. 64 does not apply to Delaware's Medicaid program.

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n26 Final Decision of the DSS, No. 8000865183, at 4. The Court notes that Delaware does allow applicants to spend down excess resources on medical costs in order to qualify for Medicaid. Tamara Ince testified that DSS expects over-resourced applicants to pay their medical bills until their resources are within the proscribed limits.

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2. Tr. 64 provides for penalty periods but does not preclude eligibility. The introductory language to the section on transfers of assets provides that § 3258 "discusses actions which result in the denial of coverage for certain medical services to otherwise eligible institutionalized or noninstitutionalized individuals who transfer assets for less than fair market value." n27 Section 3258 further provides that, where a transfer has been made for less than fair market value, within the so-called "look back period," n28 the caseworker must impose a penalty and deny coverage of certain [*17] Medicaid services to otherwise eligible institutionalized individuals. n29 In other words, the result is a penalty, not ineligibility. This is explained in § 3258.5:

> Penalty Periods. When an individual (or spouse) makes a transfer of assets for less than fair market value, payment for certain services received by the individual is denied for a specified period of time. However, the individual remains eligible for Medicaid and can have payment made for services not subject to penalty. (See § 3258.8.) For example, an institutionalized individual who transfers assets for

> less than fair market value must be denied reimbursement for nursing facility services. However, he or she may still be eligible for reimbursement for physician's services, provided such services are not provided as part of the individual's nursing home care.

Thus, it is clear that Tr. 64 does not affect an applicant's eligibility for Medicaid, but may affect the coverage of certain services for a specified period of time.

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n27 The entire text of Tr. 64 is found in the App. to Op. Br., at A-61 through A-103. The quoted language is found at A-61. [*18]

n28 Section 3258.4. The look-back period is typically of three months duration.

n29 Section 3258.1. *See also* § 3258.8 for a detailed description of the possible penalties.

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3. No penalty accrues in the case at bar. Section 3258.9(B) addresses annuities. Dean asserts that this section is of paramount importance because 42 U.S.C. § 1396a itself includes no provisions for annuities in the Medicaid context. n30 In the section governing trusts, 42 U.S.C. § 1396p(d)(6) states that the term "trust. . . includes an annuity only to such extent and in such manner as the Secretary specifies." Tr. 64 § 3258.9(B) is the only guidance the Secretary has issued regarding annuities, and Delaware has no regulation governing annuities in the Medicaid context. The Court therefore finds that the provisions of Tr. 64 require particular deference. n31

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n30 Reply Br. at 6.

n31 *See Cleary v. Waldman*, 167 F.3d at 808; *Elizabeth Blackwell Health Center for Women v. Knoll*, 61 F.3d at 170.

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[*19]

Section 3258.9(B) makes it clear that the linchpin of the test for determining whether the purchase of an annuity is a valid purchase or is an abusive shelter of assets is whether the purchase was made for fair market value n32:

> Annuities, although usually purchased in order to provide a source of income for retirement, are occasionally used to shelter assets so that individuals purchasing them can become eligible for Medicaid. In order to avoid penalizing annuities validly purchased as part of a retirement plan but to capture those annuities which abusively shelter assets, a determination must be made with regard to the ultimate purpose of the annuity (i.e., **whether the purchase of the annuity constitutes a transfer of assets for less than fair market value**). If the expected return on the annuity is commensurate with a reasonable estimate of the life expectancy of the beneficiary, the annuity can be deemed actuarially sound. (Emphasis added).

This section clearly suggests that sheltering, that is, moving or altering, assets solely in order to qualify for Medicaid is an abuse of the Medicaid system. It does so only by implication and by contrasting a valid retirement [*20] plan with a strategy to ensure eligibility. But it stops short of prohibiting such action. Worse yet, while this section appears to denounce the purchase of an annuity for the purpose of qualifying for Medicaid, it inhibits the caseworker's ability to penalize such abuse by making the single determinative factor the question of fair market value.

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n32 "Fair market value" is defined as "an estimate of the value of an asset, if sold at the prevailing price at the time it was actually transferred." § 3258.1 (A)(1).

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In the case at bar, Dean relies on the above-cited provisions of Tr. 64 itself, while DSS relies on caselaw. Specifically, DSS argues that a recent Pennsylvania case supports its position that the purchase of an annuity to ensure Medicaid eligibility is inappropriate despite the provisions of Tr. 64. In *Dempsey v. Dep't of Public Welfare*, n33 Mr. Dempsey purchased an irrevocable annuity after his institutionalized wife's application for Medicaid had been denied because the couple was over-resourced. [*21] The *Dempsey* Court found that the Department of Public Welfare (the Pennsylvania equivalent of DSS) correctly presumed that the transfer was for less than fair market value and for the impermissible purpose of qualifying for Medicaid benefits. The first of these presumptions is key. It was based on a Pennsylvania statute which created a presumption that assets disposed of during the look-back period are transferred with the improper intent to qualify for Medicaid. n34 Delaware has no such statutory presumption, and until the General Assembly sees fit to enact one, DSS is not entitled to make this presumption, despite its obvious logic and utility. The Court notes that the statutory presumption is consistent with the spirit of Tr. 64, which clearly disapproves of transfers made solely for the purpose of qualifying for Medicaid, as discussed above. n35

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n33 Pa. Cmmw.Ct., 756 A.2d 90 (2000).

n34 *Id.* at 95.

n35 The Court further notes that § 3258.9(B) implicitly presumes that a transfer of assets for less than fair market value was for the purpose of qualifying for Medicaid. One of the possible defenses to transfer of assets penalties is that the purpose of the transfer was something other than to qualify for Medicaid. In such cases, § 3258. 10C.2, entitled Transfers Exclusively for a Purpose Other Than to Qualify for Medicaid, advises caseworkers that "verbal assurances. . . are not sufficient. Rather, convincing evidence must be presented as to the specific purpose for which the asset was transferred."

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[*22]

Without the statutory presumption that a transfer of assets during the look-back period is for less than fair market value, the Court turns to the guidance of Tr. 64 itself to determine whether Dean's annuity was purchased for less than fair market value. Pursuant to § 3258.9(B), if the annuitant's life

expectancy is less than or equal to the life of the annuity, the annuity is actuarially sound and is deemed to be purchased for fair market value. The inclusion in § 3258.9(B) of life expectancy tables to be used in making this determination underscores the significance of this factor. In response to the same issue, the court in *O.D. v. Div. of Medical Assistance & Health Services*, stated that, based on Tr. 64, "the sole test is whether the expected return on the Annuity is commensurate with a reasonable estimate of the life expectancy of the beneficiary. If so, the Annuity can be deemed to be actuarially sound, in accordance with the Federal mandate." n36

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n36 N.J. Admin., Fuley, ALJ (June 12, 1995).

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Dean [*23] asserts that he complied with the terms of § 3258 and that he purchased the annuity for fair market value. At the time of purchase, he was 79 years old and, according to the § 3258.9 life expectancy tables, he had a life expectancy of 7.4 years. The life of the annuity was five years. By this straightforward formula, his annuity was actuarially sound and therefore was not a transfer for less than fair market value.

The Court is troubled by the fact that Tr. 64 disapproves of transfers which are made for the sole purpose of qualifying for Medicaid but offers no way to identify and penalize such transfers unless they are made for less than fair market value. The *Dempsey* Court described Tr. 64 as "simply a guideline to aid caseworkers in determining whether or not an annuity appears on its face to be a legitimate instrument as opposed to an abusive shelter for assets." n37 If Tr. 64 is a valid guideline for the front line decisionmaker, that is, the caseworker, it must also be a valid guideline for the courts which review the initial decision. The standards cannot change as a case proceeds through appellate review. Furthermore, the Tr. 64 methodology is based on § 1917 of the [*24] Social Security Act, which treats transfers of assets for less than fair market value. Other courts have found that HCFA policy guidelines such as Tr. 64 are entitled to judicial deference where they are consistent with the plain language and purposes of the statute and prior administrative views. n38 DSS has not directed the Court to any specific statutory provisions which prohibit an individual from purchasing an annuity such as the one purchased by Mr. Dean. Until the HCFA amends Tr. 64, or until the Delaware General Assembly enacts a statutory presumption that transfers of assets during the look-back period are made for less than fair market value, the Court must conclude that the purchase of an annuity such as Dean's does not subject the applicant to any penalties.

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n37 *Dempsey* at 95-96 (emphasis added).

n38 *Johnson v. Guhl*, D.N.J., 91 F. Supp. 2d 754, 779 (2000), citing *Cleary v. Waldman.*, 3d Cir., 167 F.3d 801, 808 (1999).

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4. The annuity, which creates an ongoing [*25] income stream for Mr. Dean, is not a countable resource for purposes of Medicaid. The hearing officer found that the purchase of the annuity was merely a change in the form of a resource and that the annuity itself is a countable resource. The hearing officer did not address the specific characteristics of an annuity and merely assumed that an annuity is always a countable resource.

Dean argues that because the annuity is actuarially sound, it is therefore not a countable resource in determining Medicaid eligibility. n39 However, actuarial soundness is relevant only to the question of whether a transfer has been made for less than fair market value pursuant to Tr. 64. It has "no bearing on whether an asset is or is not a countable resource, and in fact the plain language of § 3258.9 in no way makes such a connection." n40 This argument has no merit.

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n39 Op. Br. at 23.

n40 HCFA letter from Robert A. Streimer, Disabled and Elderly Health Programs Group, Center for Medicaid and State Operations, at 2; included in App. to Op. Br. at A-58.

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[*26]

Dean also argues that because Delaware does not prohibit the purchase of annuities and because Tr. 64 "codifies" such purchases, "Dean's purchase of an annuity with funds previously in a CD should be handled the same as if he had used the CD funds to pay off the mortgage on his house." n41 In other words, Dean argues that the annuity is the same type of resource as the statutory noncountable resources which include the home, the car, personal effects and cemetery plot. The list of noncountable resources contained in § 1917 is an exhaustive list that does not invite additions. The Court finds no support for the argument that the annuity is a noncountable resource.

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n41 Op. Br. at 18.

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Resources other than those specifically excluded by statute are generally countable for purposes of determining Medicaid eligibility. Federal Medicaid law defines resources as follows:

> Resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert [*27] to cash to be used for his or her support and maintenance.
>
> (1) If the individual has the right, authority or power to liquidate the property or his or her share of the property, it is considered a resource. **If a property right cannot be liquidated, the property will not be considered a resource of the individual (or spouse). n42**

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n42 20 C.F.R. § 416.1201(a) (emphasis added). This regulation appears in App. to Rep. Br. at C-38.

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The DSSM definition is consistent with the federal definition. Under the Delaware definition, property is considered to be a resource if the individual has the right, authority or power to liquidate his or her share of the property. n43 Stated otherwise, the individual must have some form of ownership interest in, legal right of access to and the legal ability to use the property for his or her own support and maintenance in order for the property to be considered a resource. n44

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n43 DSSM § 410.12. [*28]

n44 DSSM § 410.12.

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With a standard, commercial irrevocable annuity, such as the one at issue in this case, the buyer purchases a commodity, that is, the annuity itself, and is entitled only to the income stream; the buyer does not own the purchasing funds and cannot reclaim them. n45 Applying the federal terminology, Dean's property right in the annuity cannot be liquidated, and therefore is not considered a resource. n46 Income, on the other hand, is defined as "the total amount of money authorized (designated by the payor) for the recipient's benefit. . . . [and] includes anything received by the individual, in cash or in kind, that can be used to meet needs for food, clothing or shelter." n47 Under these definitions, it is clear that Dean's property right in the annuity is in the form of income, not as a resource.

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n45 *Johnson v. Guhl*, 91 F. Supp. 2d at 764.

n46 See 20 C.F.R. § 416.1201(a).

n47 DSSM § 20200.1.

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[*29]

Tr. 64 also refers to the payments from a standard commercial annuity in terms of income:

> When an individual purchases an annuity, he or she generally pays to the entity issuing the annuity (e.g., a bank or insurance company) a lump sum of money, in return for which he or she is promised regular payments of income in certain amounts. These payments may continue for a fixed period of time (for example, 10 years), or for as long as the individual (or another designated beneficiary) lives. Thus creating an ongoing income stream. n48

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n48 Tr. 64, § 3258.9(B).

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Dean also urges the Court to consider a letter from Robert H. Streimer, Director of the Disabled and Elder Health Programs Group, Center for Medicaid and State Operations, HCFA. In his letter to an attorney who had created an annuitized trust for a client, Streimer distinguishes between a standard, commercial annuity (such as Dean's) and an annuitized trust:

> A standard annuity can protect the funds used to purchase the annuity from being [*30] counted as resources in determining eligibility for Medicaid. However, there is a fundamental difference between a standard annuity and the "annuitized" trust you established. A standard annuity requires the actual purchase of a commidety; i.e., the annuity itself. A specific amount of money is given to the entity selling the annuity, in return for which the entity contractually agrees to provide an income stream for a specified period of time. Upon completion of the transaction, the buyer no longer owns the funds used to purchase the annuity, instead, he or she owns the annuity itself. If the annuity is irrevocable, as most annuities are, the buyer cannot reclaim ownership of the funds used to purchase the annuity. **He or she is only entitled to the income stream purchased**, and only for as long as the annuity stipulates.

Although this letter has no procedontial value, it does reinforce the Court's conclusion that Mr. Dean's annuity constitutes income for Medicaid purposes. n49

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n49 *See Johnson v. Guhl*, 91 F. Supp. 2d at 764 (observing that the Streimer letter, while "certainly not binding on this Court, is, at the very least, instructive").

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[*31]

Based on the federal and state definition of income and resources, as well as the language of Tr. 64 and the Streimer letter, the Court concludes that Mr. Dean's property right in the annuity is in the form of income, not a resource, and that the hearing officer erred in finding otherwise.

CONSTITUTIONAL ISSUES

In light of the Court's decision regarding Ethelda Dean's eligibility for Medicaid, it is not necessary to address Dean's constitutional arguments.

MOTION TO SUPPLEMENT THE RECORD

After briefing was complete, Dean filed a motion to supplement the record by adding information regarding the purchase date of the annuity in question as well as information on another annuity. Dean submitted this information because DSS questioned whether Dean had in fact purchased the $ 53,000 annuity. The Court grants the motion to the extent that it helps document the transaction. However, because the Court finds that there was no real dispute as to whether Mr. Dean purchased the annuity, the supplemental materials and argument do not affect the outcome of the case.

Dean also submitted documentation about a $ 30,000 annuity which he had not previously disclosed. He received information [*32] from WSFS, a Wilmington

bank, about this annuity in September 2000. He apparently purchased the annuity in March 13, 2000, and acknowledges that it is a countable resource for purposes of Mrs. Dean's Medicaid eligibility determination. However, he argues that because he has paid more than $ 35,000 towards his wife's nursing home costs during the same time period, these payments more than offset the value of the annuity and therefore do not significantly affect the eligibility determination. DSS points out that Dean admits being aware of the second annuity approximately one month before the fair hearing and argues that such failure to disclose is a fraud against the State. Despite the allegations of fraud, DSS offers no remedy but merely opposes supplementing the record.

The Court notes the untimely nature of the disclosure and the failure to explain this oversight. Dean had a legal obligation to disclose this information to DSS and the hearing officer. His argument that he paid an equivalent amount in health care costs for his wife conveniently sidesteps the possible implications of his failure to disclose. As a practical matter, this Court has no authority to remand to DSS to recalculate [*33] the eligibility determination, and the Court will not undertake this calculation on its own. Finally, in light of the fact that Mr. Dean has paid an equal or greater amount towards Mrs. Dean's care, the actual difference resulting from a recalculation might not be significant. The Court grants Dean's motion to supplement the record in the interests of having a complete record.

CONCLUSION

It appears that Mr. Dean managed to convert countable resources into income, which is not countable for purposes of his wife's Medicaid eligibility. Without imputing any blame to Mr. Dean, the Court reiterates its dissatisfaction with what appears to be a loophole of potentially vast proportions in the Medicaid law. However, given the current form of both state and federal law, the Court concludes that the hearing officer's decision denying Medicaid benefits to Ethelda Dean must be, and hereby is, ***Reversed***.

It Is So ORDERED.

Norman A. Barron

Judge

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EXHIBIT D

McNamara v. Ohio Department of Human Services

tablished over the years by hard work, sacrifice and dedication." *Sethi v. WFMJ Television, Inc.* (1999), 134 Ohio App.3d 796, 812, 732 N.E.2d 451, 463. A newspaper article that fails to report a set of events with precision can easily strain that reputation. This is obviously an unpleasant occurrence. "The balance, however, is that we must have a free and unfettered public media." *Id.* I believe that in this case, that balance falls on the side of the media.

Based upon the foregoing, I would have overruled appellant's assignments of error and affirmed the grant of summary judgment.

139 Ohio App.3d 551

[551] **McNAMARA, Appellant,**

v.

OHIO DEPARTMENT OF HUMAN SERVICES, Appellee.

No. 18234.

Court of Appeals of Ohio, Second District, Montgomery County.

Decided Aug. 4, 2000.

Department of Human Services found that institutionalized spouse was ineligible to receive Medicaid nursing home vendor payments for period of thirty months upon ground that she and community spouse had improperly transferred most of their assets to "spousal annuity trust," allegedly established for sole benefit of community spouse. Institutionalized spouse appealed. The Court of Common Pleas, Montgomery County, affirmed. Institutionalized spouse again appealed. The Court of Appeals, Fain, J., held that: (1) for Medicaid eligibility purposes, amount of resources that institutionalized spouse could transfer to community spouse was limited to maximum amounts that community spouse could retain under Community Spouse Resource Allowance (CSRA) provision; (2) Health Care Financing Administration (HCFA) transmittal was not controlling; and (3) "spousal annuity trust" would not be treated under rules governing commercially purchased annuities.

Affirmed.

1. Social Security and Public Welfare ⇐241.80

Community Spouse Resource Allowance (CSRA) limits set forth in statute governing eligibility for Medicaid nursing home vendor payments supersede any inconsistent provision in statute permitting fair market value transfers from institutionalized spouse for sole benefit of community spouse; thus, for Medicaid eligibility purposes, amount of resources that institutionalized spouse may transfer to community spouse is limited to maximum amounts that community spouse may retain under CSRA provision. Social Security Act, §§ 1917 (c)(2)(B), 1924(a)(1), (f), as amended, 42 U.S.C.A. §§ 1396p(c)(2)(B), 1396r–5(a)(1), (f); Ohio Admin. Code §§ 5101:1–39–078(A)(2), 5101:1–39–36.

[552] **2. Social Security and Public Welfare ⇐241.80**

In determining whether institutionalized spouse was ineligible to receive Medicaid nursing home vendor payments for period of thirty months on ground that she and her husband had improperly transferred most of their assets to "spousal annuity trust," allegedly established for sole benefit of husband, court would not defer to Health Care Financing Administration (HCFA) transmittal stating that institutional spouse can transfer unlimited assets to community spouse or to third party for sole benefit of community spouse; such interpretation of governing statutes was inconsistent with their plain language and purposes. Social Security Act, §§ 1917 (c)(2)(B), 1924(a)(1), (f), as amended, 42 U.S.C.A. §§ 1396p(c)(2)(B), 1396r–5(a)(1), (f); Ohio Admin. Code §§ 5101:1–39–078(A)(2), 5101:1–39–36.

3. Statutes ⇐219(6.1)

Health Care Financing Administration (HCFA) transmittals concerning a Medicaid statute are entitled to some deference by reviewing courts if they are consistent with the plain language and purposes of the statute and prior administrative views.

4. Social Security and Public Welfare ⇐241.80

"Spousal annuity trust" into which institutionalized spouse and community spouse transferred most of their assets, and which was allegedly established for sole benefit of community spouse, would not be treated under rules governing commercially purchased annuities, and thus, trust assets were countable resources for purposes of determining institutionalized spouse's eligibility for Medicaid nursing home vendor payments. Social Security Act, § 1924(a)(1), (f), as amended, 42 U.S.C.A. §§ 1396r-5(a)(1), (f); Ohio Admin. Code §§ 5101:1-39-36, 5101:1-39-228.

Michael Millonig, Dayton, for appellant.

Betty D. Montgomery, Attorney General, and Patrick W. Beatty, Assistant Attorney General, Health and Human Services Section, for appellee.

FAIN, Judge.

Plaintiff-appellant Rheba McNamara appeals from a decision of the Montgomery County Court of Common Pleas affirming an administrative determination finding her ineligible to receive Medicaid nursing home vendor payments for a period of thirty months upon the ground that she and her husband had improperly transferred most of their assets to a "spousal annuity trust," allegedly established for the sole benefit of the husband. Mrs. McNamara argues that the [553] trial court erred in affirming the administrative decision because the trust instrument that she and her husband used to shelter their assets was "for the sole benefit of her spouse," and, therefore, was not a countable resource for purposes of determining her eligibility for Medicaid nursing home payments. She further argues that Section 1396p(c)(2)(B), Title 42, U.S.Code, adopted in this state as Ohio Adm.Code 5101:1-39-078(A)(2), permits an individual to make an unlimited transfer of resources to his or her spouse, notwithstanding the Community Spouse Resource Allowance limits set forth in Section 1396r-5(f), Title 42, U.S.Code, adopted in this state as Ohio Adm.Code 5101:1-39-36.

We conclude that if Section 1396p(c)(2)(B) were construed to allow an unlimited transfer of resources between spouses, the Community Spouse Resource Allowance limits established under Section 1396r-5(f) would be rendered a nullity. Therefore, we hold that pursuant to the supersession clause of Section 1396r-5(a)(1), the amount of resources that one person may transfer to his or her spouse is limited to the maximum amounts the community spouse may retain under the CSRA provision in Section 1396r-5(f). Accordingly, the judgment of the trial court is affirmed.

I

On October 5, 1997, Rheba McNamara entered the Bethany Lutheran Village nursing home. Her husband, Joseph B. McNamara, resides independently at a cottage unit at Bethany. At the time Mrs. McNamara entered the nursing home, the couple had resources valued at $256,130.87. In April 1998, Mr. McNamara, acting on the couple's behalf, created an irrevocable trust, known as the "Spousal Annuity Trust fsbo [for the sole benefit of] Joseph McNamara, dated 4/1/98." Under the terms of the trust, the monthly income from the trust corpus was to be paid to Mr. McNamara, and the principal was to be paid to Mr. McNamara in annual payments for a period of five years. Mrs. McNamara is to receive no benefit from the trust. At the time the trust was created, Mr. McNamara was seventy-six years old, and had a life expectancy of 8.76 years. He had no authority to withdraw any funds from the trust, and upon his death, any funds remaining in the trust

were to be distributed to the McNamaras' two children. Over the next several months, the McNamaras transferred over $221,000 to the trust.

In July 1998, Mrs. McNamara applied for Medicaid benefits with the Montgomery County Department of Human Services ("MCDHS"). The MCDHS determined that the McNamaras' decision to place their assets in the trust constituted an improper transfer of resources because the assets had been transferred for less than fair market value. Accordingly, the MCDHS ruled that while Mrs. McNamara was eligible for regular Medicaid, she was ineligible to receive [554] nursing home vendor payments for a period of thirty months, running from April 1, 1998 to September 30, 2000.

Mrs. McNamara appealed the denial of nursing home vendor payments to the Ohio Department of Human Services ("ODHS"). After holding a hearing on the matter, the state hearing officer affirmed MCDHS's finding that an improper transfer had occurred. Mrs. McNamara appealed the state hearing officer's decision to the ODHS. The administrative hearing examiner affirmed the state hearing officer's decision.

In June 1999, Mrs. McNamara appealed the denial of her administrative appeal to the Montgomery County Court of Common Pleas. On February 29, 2000, the trial court affirmed the order of the ODHS, declaring Mrs. McNamara ineligible to receive nursing home vendor payments for thirty months. The trial court found that the transfer of resources to the trust was an improper transfer because under the terms of the trust, any amounts remaining in the trust at the time of Mr. McNamara's death would be passed to the McNamaras' two children, and, therefore, the trust was not for the sole benefit of Mr. McNamara. The trial court further found that even if the transfer was not improper, the trust assets were still countable resources that had to be deemed available to the McNamaras to pay for the nursing home expenses because the amount of assets retained by Mr. McNamara through the use of the trust exceeded the maximum amount he was permitted to retain under the community spouse resource allowance provision.

Mrs. McNamara appeals from the trial court's decision affirming the administrative determination that she is ineligible to receive nursing home vendor payments for a period of thirty months.

II

Mrs. McNamara's first assignment of error states:

"The common pleas court ruling that there was an improper transfer and a period of ineligibility for nursing home vendor payments is an incorrect application of law."

Mrs. McNamara argues that pursuant to Section 1396p(c)(2)(B), Title 42, U.S.Code, a person may transfer an unlimited amount of funds to his or her spouse or to a third person for the sole benefit of the individual's spouse, notwithstanding the limits of the community spouse resource allowance provision contained in Section 1396r–5, Title 42, U.S.Code. Mrs. McNamara further contends that the funds she and her husband transferred into the Spousal Annuity Trust were for the sole benefit of Mr. McNamara despite the "mere" fact that the trust designates their two children as the remainder beneficiaries in the [555] event Mr. McNamara dies before the trust corpus has been distributed to him. Therefore, Mrs. McNamara contends, the transfer of a majority of their resources to the spousal annuity trust was not an improper transfer rendering her ineligible to receive Medicaid nursing home vendor payments for a period of thirty months. We disagree.

Medicaid was enacted in 1965 as Title XIX of the Social Security Act to provide federal funds to pay for the medical treatment of needy persons. *Martin v. Ohio Dept. of Human Serv.* (1998), 130 Ohio App.3d 512, 515, 720 N.E.2d 576, 578–579.

Prior to 1988, a married person in a nursing home had to "spend down" all of the couple's jointly held assets to the eligibility limit in order to receive assistance, thereby leaving the couple impoverished. *Id.* at 518, 720 N.E.2d at 580–581. However, during this same period, it was possible for a married couple to shelter significant amounts of their assets by transferring them into the name of the spouse not seeking Medicaid benefits, since only jointly held assets were considered available for the institutionalized spouse's needs. *Id.*

Congress addressed this problem by enacting the Medicare Catastrophe Coverage Act of 1988, Section 1396r–5, Title 42, U.S.Code. *Id.* While most of the provisions of the MCCA were repealed in 1989, this section has been retained. *Id.* Under the MCCA, all of a couple's resources are considered in determining Medicaid eligibility regardless of whether the assets are jointly or separately held. *Id.* Generally, the MCCA permits the spouse living outside the nursing home, "the community spouse," to retain one-half of the couple's resources without affecting the eligibility of the spouse living in the nursing home, "the institutionalized spouse," to receive Medicaid benefits. *Id.* After the couple's resources are divided in half, the community spouse's share cannot exceed a specified maximum amount, indexed to inflation, *id.*, which, at the time the McNamaras applied for nursing home payments, was approximately $80,000. See Ohio Adm.Code 5101:1–39–36(C) This adjusted amount is known as the Community Spouse Resource Allowance ("CSRA"), and any of the couple's resources exceeding the CSRA that are not otherwise excluded from consideration are deemed available to the institutionalized spouse to be used for his or her care. 130 Ohio App.3d at 518–519, 720 N.E.2d at 580–582.

The institutionalized spouse may spend down any amount in excess of the eligibility levels to receive Medicaid benefits, *id.* at 519, 720 N.E.2d at 581–582; however, an individual's ability to dispose of the excess resources is limited. For instance, if an individual transfers "his legal interest in a countable resource for less than fair market value for the purpose of qualifying for medicaid, a greater amount of medicaid, or to avoid the utilization of the resource[,]" the resource transfer is considered improper. Ohio Adm.Code 5101:1–39–07. If an individual or his or her spouse, applying for Medicaid or in receipt of Medicaid, made an |556 improper transfer of resources, that individual is subject to a period of restricted medicaid coverage for "long term care facility (LTCF) (*i.e.*, nursing home) vendor payments." Ohio Adm. Code 5101:1–39–077(B).

Mrs. McNamara acknowledges that, at first blush, application of the general transfer rule indicates that the transfer of resources that took place here was improper. However, Mrs. McNamara argues that the transfer of resources to the Spousal Annuity Trust fits within an exception to the improper transfer rule set forth in Ohio Adm.Code 5101: 1–39–078(A)(2), which essentially incorporates Section 1396 p(c)(2)(B), Title 42, U.S.Code. Ohio Adm.Code 5101: 1–39–078(A)(2) provides:

"[T]he individual may transfer resources * * * to:

"(a) The individual's spouse (or to another for the sole benefit of the spouse), or to the community spouse provided the spouse does not transfer the resources to another for less than fair market value[.]"

Ohio Adm.Code 5101: 1–39–05(A)(13) provides:

"'A transfer for the sole benefit of' means a transfer arranged in such a way that no individual or entity except the spouse * * * can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future.

"(a) A trust is considered to be established for the sole benefit of a spouse * * * if the trust benefits no one but that individual, whether at the time the trust is

established or any time in the future. * * *

"(b) A transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is not the spouse * * * is not considered to be established for the sole benefit of [the spouse]. In order for a transfer or trust to be considered to be for the sole benefit of [the spouse], the instrument or document must provide for the spending of the funds involved for the benefit of the individual on a basis that is actuarially sound based on the life expectancy of the individual involved. When the instrument or document does not so provide, any potential exemption from penalty or consideration for eligibility purposes is void."

Mrs. McNamara asserts that the issue of whether a trust has been established "for the sole benefit of a spouse" turns entirely on whether the trust instrument is "actuarially sound" and further asserts that the trust in this case is. ODHS acknowledges that the trust is actuarially sound but argues that in order for the trust to meet the "sole benefit" requirement, it must satisfy several additional criteria, including that no one except the spouse can "benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future." ODHS asserts that the McNamaras' trust violates this requirement [557] because it has remainder beneficiaries. Mrs. McNamara counters that the presence of remainder beneficiaries after Mr. McNamara's death "is a certainty under the law," whether the beneficiaries are designated in the trust, Mr. McNamara's will, or by the statute of descent and distribution contained in R.C. 2105.06. Mrs. McNamara argues that the only rational interpretation of the sole benefit requirement is that the trust must be for the sole benefit of the community spouse *during his or her lifetime,* because after the community spouse dies, he or she can no longer be a beneficiary of the trust.

Leaving aside the parties' arguments regarding whether the trust satisfied the sole benefit requirement, we conclude that there is a more fundamental flaw in the McNamaras' argument. Section 1396r–5(a)(1), Title 42, U.S.Code, states:

"In determining the eligibility for medical assistance of an institutionalized spouse * * *, the provisions of this section supersede any other provision of this subchapter (including sections 1396a(a)(17) and 1396a(f) of this title) which is inconsistent with them."

[1] The subchapter referred to is Subchapter XIX—Grants to States for Medical Assistance Programs—and, therefore, is inclusive of all of Section 1396, Title 42, U.S.Code. It follows then that the CSRA provision contained in Section 1396r–5(f) supersedes any inconsistent provision in Section 1396p(c). As ODHS points out, if Section 1396p(c)(2)(B), which has been adopted in this state as Ohio Adm.Code 5101:1–39–078(A)(2), is construed to allow an unlimited transfer of resources between spouses, then the CSRA limits established under Section 1396r–5(f), and adopted in this state as Ohio Adm.Code 5101:1–39–36, will be rendered a nullity. Accordingly, we hold that pursuant to the supersession clause of Section 1396r–5(a)(1), the amount of funds that one person may transfer to his or her spouse under Section 1396p(c)(2)(B) is limited to the maximum amounts the community spouse may retain under the CSRA provision in Section 1396r–5(f).

[2] Mrs. McNamara raises several arguments in opposition to this view. First, she cites Health Care Financing Administration ("HCFA") Transmittal 64–3258.11, which states:

[558] "The exceptions to the transfer of assets penalties regarding interspousal transfers and transfers to a third party for the sole benefit of a spouse apply even under the spousal impoverishment provisions [contained in Section 1396r–5]. Thus, the institutional spouse can transfer unlimited assets to the community spouse or to a third party for the sole benefit of the community spouse.

"* * *

"The exception for transfers to a third party for the sole benefit of the spouse may have greater impact on eligibility because resources may potentially be placed beyond the reach of either spouse and thus not be counted for eligibility purposes. However, for the exception to be applicable, the definition of what is for the sole benefit of the spouse * * * must be fully met."

Mrs. McNamara urges this court to find HCFA Transmittal 64–3258.11 to be controlling on the issue of whether an individual may make an unlimited transfer of resources to his or her spouse pursuant to Section 1396p(c)(2)(B). We decline to do so.

[3] HCFA is the federal agency responsible for promulgating Medicaid regulations. HCFA policy transmittals like Transmittal 64 are entitled to some deference by reviewing courts *if* they are consistent with the plain language and purposes of the statute and prior administrative views. *Johnson v. Guhl* (D.N.J. 2000), 91 F.Supp.2d 754, 779, citing *Cleary v. Waldman* (C.A.3, 1999), 167 F.3d 801, 808. As stated earlier, if couples like the McNamaras were permitted to make unlimited transfers of resources between them pursuant to Section 1396p(c)(2)(B), the CSRA provisions contained in Section 1396r–5(f) would be rendered a nullity. Construing Section 1396p(c)(2)(B) in the manner Mrs. McNamara requests would allow persons with unlimited resources to avail themselves of Medicaid nursing home benefits.

Mrs. McNamara acknowledges this possibility but discounts it by arguing that wealthy persons will opt for superior, private nursing home care. She further contends that Congress intentionally created this loophole in the rules governing Medicaid eligibility in order to benefit the middle class. We find both of these arguments unpersuasive. While some wealthy individuals undoubtedly will opt for private care rather than settle for nursing home services provided by Medicaid, a significant number will not, particularly those elderly citizens who place a high premium on maximizing the legacies they leave to their children. Furthermore, if Congress had intended to benefit the middle class, this could have been achieved simply by increasing the CSRA.

[4] Mrs. McNamara also argues that her trust should be treated under the rules governing annuities found in Ohio Adm. Code 5101:1–39–228. We disagree. Despite Mrs. McNamara's assertions to the contrary, Ohio Adm.Code 5101:1–39–228 relates to commercially purchased annuities and not to "annuitized" trusts like the one established by the McNamaras. See Ohio Adm.Code 5101:1–39–228(B) ("When an individual purchases an annuity, the individual generally pays to the entity issuing the annuity [e.g., a bank or insurance company] a lump sum of money, in return for which the individual is promised regular payments of income in certain amounts."). See, also, April 16, 1998 letter from HCFA's [559]Robert Streimer to private party, attached as Appendix 19 to appellant's brief ("annuitized" trust is not the same thing as a "standard" or commercially purchased annuity, since a standard annuity requires actual purchase of a commodity, *i.e.*, the annuity itself, and upon completion of the transaction, the buyer no longer owns the funds used to purchase it).

In light of the foregoing, we affirm, though on different grounds, the trial court's ruling that the McNamaras improperly transferred the majority of their resources to the Spousal Annuity Trust, and were, therefore, subject to a thirty–month period of ineligibility for receiving Medicaid nursing home vendor payments.

Accordingly, Mrs. McNamara's first assignment of error is overruled.

III

Mrs. McNamara's second assignment of error states:

"The common pleas court ruling that the assets of the Spousal Annuity Trust FSBO

Joseph McNamara, 4/1/98, are countable resources is an incorrect application of law."

Mrs. McNamara's second assignment of error has been rendered moot in light of our disposition of her first assignment of error; therefore, it is overruled as moot. See App.R. 12(A)(1)(c).

IV

Both of Mrs. McNamara's assignments of error having been overruled, the judgment of the trial court is affirmed.

Judgment affirmed.

GRADY, P.J., and FREDERICK N. YOUNG, J., concur.

139 Ohio App.3d 560

[560] **The STATE of Ohio, Appellant,**

v.

LILLY, Appellee.

No. 18099.

Court of Appeals of Ohio, Second District, Montgomery County.

Decided Aug. 4, 2000.

Defendant appealed his conviction for burglary. The Court of Appeals, Montgomery County, reversed. Discretionary appeal was allowed. The Supreme Court, Lundberg Stratton, J., reversed judgment of Court of Appeals, reinstated conviction, and remanded matter to trial court, 87 Ohio St.3d 97, 717 N.E.2d 322. On remand, the trial court granted defendant's motion to modify sentence, reducing original sentence of five years to four years. State appealed. The Court of Appeals, Fain, J., held that trial court lacked authority to modify sentence after Supreme Court reinstated conviction and remanded cause to trial court to enforce judgment of conviction.

Reversed and vacated.

1. Criminal Law ⇐1192

Trial court lacked authority on remand to modify sentence for burglary by reducing it from five to four years, following judgment of Court of Appeals that reversed conviction and subsequent judgment of Supreme Court on discretionary review that reinstated conviction and remanded cause to trial court to enforce judgment of conviction.

2. Criminal Law ⇐1192

Where an appellate court holds that a trial court has erred by failing to provide a litigant with notice and an opportunity to be heard, and remands the cause to the trial court for the purpose of holding a hearing, the mandate from the appellate court obviously encompasses reconsideration of the matters that were the subject of the hearing.

Mathias H. Heck, Jr., Montgomery County Prosecuting Attorney, and Carley J. Ingram, Assistant Prosecuting Attorney, Dayton, Appellate Division, for appellant.

Dennis J. Adkins, Dayton, for appellee.

[561] FAIN, Judge.

Plaintiff-appellant the state of Ohio appeals from an order of the trial court reducing the sentence of defendant-appellee for burglary. The state contends that the trial court was without authority to reduce the sentence.

Lilly contends that after his original conviction had been reversed by this court, and the Ohio Supreme Court subsequently reversed the judgment of this court, reinstated the conviction, and remanded the matter to the trial court, the trial court was vested with jurisdiction to modify his sentence.

We agree with the state that the trial court lacked authority, under these circumstances, to reduce Lilly's sentence. Accordingly, the order of the trial court reducing Lilly's sentence is reversed and vacated.

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1. Shepards®: McNamara v. State Dep't of Human Servs., 139 Ohio App. 3d 551, 744 N.E.2d 1216, 2000 Ohio App. LEXIS 3477(Ohio Ct. App., Montgomery County,2000)

   Client/matter: -None-

   Requested Categories: Appellate History - Requested
   Citing Decisions - None applied
   Citing Law Reviews, Treatises... - Not Requested

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Shepard's®: Report Content

Appellate History: Requested
Citing Decisions: None Applied
Citing Law Reviews, Treatises...: Not Requested

***Shepard's*®:** **McNamara v. State Dep't of Human Servs.** 139 Ohio App. 3d 551,744 N.E.2d 1216,2000 Ohio App. LEXIS 3477: (Ohio Ct. App., Montgomery County 2000)

No subsequent appellate history

Appellate History

1 - 1 of 1

	Appellate History	Court	Date
1	Citation you *Shepardized* ™ **McNamara v. State Dep't of Human Servs.** 139 Ohio App. 3d 551, 744 N.E.2d 1216, 2000 Ohio App. LEXIS 3477	Ohio Ct. App., Mont-gomery County	2000

CASEY MUNN

Shepard's®: McNamara v. State Dep't of Human Servs., 139 Ohio App. 3d 551

Citing Decisions

Narrow by:	None Applied
Analysis:	Distinguished by (2), Followed by (3), "Cited by" (2)
Court:	6th Circuit (1), Ohio (3), Florida (1), New Jersey (1)
Headnotes:	HN1 (4), HN7 (4), HN3 (2), HN2 (1), HN8 (1)

1 - 6 of 6

	Citing Decisions	Court	Date
	Ohio Court of Appeals		
1	**Distinguished by:** **Rorick v. Ohio Dep't of Job & Family Servs.** 2010 Ohio 5571, 2010 Ohio App. LEXIS 4776 *Headnotes: HN1*	Ohio Ct. App., Hamilton County	Nov. 19, 2010
2	**Distinguished by:** **Vieth v. Ohio Dep't of Job & Family Servs.** 2009 Ohio 3748, 2009 Ohio App. LEXIS 3189 *Headnotes: HN3, HN7*	Ohio Ct. App., Franklin County	July 30, 2009
3	**Cited by:** **Kopp v. Ohio Dep't of Job & Family Servs.** 2002 Ohio App. LEXIS 1628 *Headnotes: HN3* *Cited by; 2002 Ohio App. LEXIS 1628 p.15*	Ohio Ct. App., Cuyahoga County	Apr. 11, 2002
	6th Circuit - U.S. District Courts		
4	**Followed by:** **Burkholder v. Lumpkin** 2010 U.S. Dist. LEXIS 11308 *Headnotes: HN1, HN2, HN7, HN8*	N.D. Ohio	Feb. 9, 2010
	Florida District Court of Appeals		
5	**Followed by**, *and* **Cited by:** **Feldman v. Dep't of Children & Families** 919 So. 2d 512, 2005 Fla. App. LEXIS 19679, 30 Fla. L. Weekly D 2805 *Headnotes: HN1, HN7* *Followed by; 919 So. 2d 512 p.516* *Cited by; 919 So. 2d 512 p.515*	Fla. Dist. Ct. App. 1st Dist.	2005
	New Jersey Superior Court, Appellate Division		
6	**Followed by:** **Estate of F.K. v. Division of Medical Assistance and Health Services** 374 N.J. Super. 126, 863 A.2d 1065, 2005 N.J. Super. LEXIS 7 *Headnotes: HN1, HN7* *Followed by; 374 N.J. Super. 126 p.139; 863 A.2d 1065 p.1073*	App.Div.	2005

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Legend

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A	Analysis - Citing Refs. With Analysis Available	B	Blue - Neutral Level Phrase
I	Cited - Citation information available	LB	Light Blue - No Analysis Phrase
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EXHIBIT E

Johnson v. Guhl

of plaintiffs' Amended Complaint. The Court will issue an appropriate order.

Donald H. JOHNSON, et al., Plaintiffs,

v.

Michele K. GUHL, Commissioner of the New Jersey Department of Human Services, et al., Defendants.

No. 99-CIV.-5403 WGB.

United States District Court, D. New Jersey.

April 7, 2000.

Medicaid applicants residing in long-term care facilities, their non-institutionalized spouses who were beneficiaries of community spouse annuity trusts (CSATs), and prospective Medicaid applicants brought § 1983 suit against Commissioner of the New Jersey Department of Human Services and other state and county officials, challenging treatment of CSATs as countable resource in determining Medicaid eligibility. Defendants moved to dismiss and plaintiffs moved for preliminary injunction. The District Court, Bassler, J., held that: (1) court had jurisdiction over claims; (2) claims of prospective Medicaid applicants were not ripe for review; (3) plaintiffs could bring § 1983 suit to enforce provisions in Medicaid Act; (4) claims for monetary damages were barred; (5) Eleventh Amendment did not bar suit to extent that it sought injunctive and declaratory relief; (6) plaintiffs did not have property interest in benefits; (7) defendants' change in policy regarding CSATs did not violate equal protection; (8) plaintiffs were not threatened with immediate irreparable injury from state's failure to establish procedure for undue hardship hearings; and (9) plaintiffs were not likely to succeed on merits of their claim that CSATs should not be treated as countable resource for Medicaid eligibility purposes and, thus, were not entitled to preliminary injunctive relief.

Defendants' motion granted in part and denied in part, and plaintiffs' motion denied.

1. Affidavits ⇐3

District court would ignore attorney's affidavit to extent that affidavit contained legal conclusions and would consider only those matters within attorney's personal knowledge. U.S.Dist.Ct.Rules D.N.J., Local Civil Rule 7.2.

2. Federal Civil Procedure ⇐921

District court would consider plaintiffs' over length reply brief despite plaintiffs' failure to seek leave from court to file over length brief prior to filing brief; better practice would be to comply with local rule requiring party to obtain court's permission to file over length brief prior to submission of brief. U.S.Dist.Ct.Rules D.N.J., Local Civil Rule 7.2(b).

3. Federal Courts ⇐192.5

Medicaid applicants' claim that provisions and application of state Medicaid plan conflicted with federal Medicaid statutes arose under federal law and, thus, federal district court could exercise jurisdiction over claim. 28 U.S.C.A. § 1331; Social Security Act, § 1901 et seq., as amended, 42 U.S.C.A. § 1396 et seq.

4. Federal Courts ⇐12.1

All federal actions, including those for declaratory or injunctive relief, must involve case and controversy.

5. Federal Courts ⇐12.1

Ripeness is one aspect of justiciability, which determines when proper party may bring action.

6. Federal Courts ⇐34

Unless record affirmatively shows otherwise, or plaintiffs meet their burden to clearly allege facts invoking federal court's jurisdiction, presumption is that jurisdiction is lacking.

7. Federal Courts ⇐12.1

Ripeness doctrine serves to prevent federal courts from entangling themselves in abstract disagreements.

8. Federal Courts ⇐12.1

When determining whether request for declaratory judgment is ripe, court should examine: (1) fitness of issues for judicial decision, and (2) hardship to parties of withholding court consideration.

9. Declaratory Judgment ⇐204

Prospective Medicaid applicants' challenge to provisions in state Medicaid plan, seeking declaration that funds held in community spouse annuity trusts (CSATs) should not be treated as countable resource in determining Medicaid eligibility, was not ripe for review; whether applicants would be harmed by state Medicaid plan was contingent on whether they actually applied for benefits, any threat to applicants was not real and immediate, and denial of judicial review would not result in hardship to prospective applicants. Social Security Act, § 1901 et seq., as amended, 42 U.S.C.A. § 1396 et seq.

10. Civil Rights ⇐108.1

Plaintiff may sue under § 1983 unless: (1) federal statute does not create enforceable rights, privileges, or immunities within the meaning of § 1983, or (2) Congress, in the statute itself, has foreclosed enforcement of the statute under § 1983. 42 U.S.C.A. § 1983.

11. Civil Rights ⇐108.1

New Jersey Medicaid applicants who had been denied benefits could bring action under § 1983 to enforce provision in Medicaid Act requiring states to hold undue hardship hearing if applicant is denied benefits based on financial ineligibility. 42 U.S.C.A. § 1983; Social Security Act, § 1917(c)(2)(D), as amended, 42 U.S.C.A. § 1396p(c)(2)(D).

12. Civil Rights ⇐108.1

New Jersey Medicaid applicants could bring action under § 1983 to enforce provision in Medicaid Act mandating that state plan for medical assistance comply with federal Medicaid provisions with respect to transfers of assets and treatment of certain trusts, where applicants asserted that they would be eligible for benefits if state complied those provisions. 42 U.S.C.A. § 1983; Social Security Act, § 1902(a)(18), as amended, 42 U.S.C.A. § 1396a(a)(18).

13. Civil Rights ⇐207(1)

To extent that state Medicaid applicants asserted claim against state officials for monetary damages, state officials were not "persons" who could be sued under § 1983. 42 U.S.C.A. § 1983.

See publication Words and Phrases for other judicial constructions and definitions.

14. Civil Rights ⇐207(1)

To extent that state Medicaid applicants asserted claims against state officials for injunctive and declaratory relief, state officials were "persons" who could be sued under § 1983. 42 U.S.C.A. § 1983.

15. Federal Courts ⇐265, 269

Absent consent by state, suits for money damages against state or state officials in their official capacities are barred by Eleventh Amendment. U.S.C.A. Const. Amend. 11.

16. Federal Courts ⇐269, 272

Eleventh Amendment does not bar plaintiffs from suing state officials for violations of federal law when future injunctive relief is sought. U.S.C.A. Const. Amend. 11.

17. Federal Courts ⇐272

Eleventh Amendment may bar equitable relief if it in practice is money judg-

ment payable out of state treasury. U.S.C.A. Const.Amend. 11.

18. **Federal Courts** ⇐269, 272

Eleventh Amendment did not bar New Jersey Medicaid applicants' § 1983 suit against state officials challenging treatment of community spouse annuity trusts (CSATs) as countable resource in determining Medicaid eligibility, to extent that applicants sought declaratory and injunctive relief and attorney fees; although granting applicants' prospective injunctive relief would likely require state to spend more money from state treasury, such effect would be ancillary. U.S.C.A. Const. Amend. 11; 42 U.S.C.A. § 1983.

19. **Federal Courts** ⇐269

New Jersey Medicaid applicants' claims for compensatory damages against state officials in their official capacities were barred by Eleventh Amendment. U.S.C.A. Const.Amend. 11.

20. **Constitutional Law** ⇐278(1)

To establish claim for violation of constitutional procedural due process, plaintiff must show that: (1) protected property interest was taken, and (2) procedural safeguards surrounding deprivation were inadequate. U.S.C.A. Const.Amend. 14.

21. **Constitutional Law** ⇐277(1), 278.7(3)

When individual is recipient of direct Medicaid benefits, such benefits are protected property interest under due process clause and cannot be withdrawn without giving recipient notice and opportunity to be heard. U.S.C.A. Const.Amend. 14.

22. **Constitutional Law** ⇐277(1)

Applicants for New Jersey Medicaid benefits, who had never been granted benefits, did not have protected property interest in Medicaid benefits under due process clause. U.S.C.A. Const.Amend. 14.

23. **Social Security and Public Welfare** ⇐241.105

Medicaid regulation requiring applicants to be given notice of their right to fair hearing did not give applicants the right to notice of change in interpretation of Medicaid Act. Social Security Act, § 1901 et seq., as amended, 42 U.S.C.A. § 1396 et seq.; 42 C.F.R. § 431.206.

24. **Constitutional Law** ⇐278.7(3)
Social Security and Public Welfare ⇐241.105

Allegations that state officials violated state law and their own procedures in denying adequate notice and opportunity to be heard to state Medicaid applicants did not provide basis for constitutional due process claim. U.S.C.A. Const.Amend. 14.

25. **Constitutional Law** ⇐242.3(1)
Social Security and Public Welfare ⇐241.80

Although state officials' change of policy regarding whether community spouse annuity trusts (CSATs) were countable resource in determining applicant's eligibility for New Jersey Medicaid benefits resulted in differing treatment for applicants who had used CSATs, such treatment was rationally related to legitimate end of complying with federal Medicaid Act and Congress' intent to provide medical assistance to needy and, thus, did not violate equal protection clause. U.S.C.A. Const.Amend. 14; Social Security Act, § 1901 et seq., as amended, 42 U.S.C.A. § 1396 et seq.

26. **Civil Rights** ⇐209

Availability of state administrative procedures ordinarily does not foreclose resort to § 1983. 42 U.S.C.A. § 1983.

27. **Injunction** ⇐135

Issuance or denial of preliminary injunction is matter committed to sound discretion of trial court.

28. **Injunction** ⇐1

Injunction is extraordinary remedy which should be granted only in limited circumstances.

29. Injunction ⇐138.1

When ruling on motion for preliminary injunction, court must be convinced that all four of the following factors favor preliminary relief: (1) likelihood that movant will succeed on merits; (2) extent to which movant will suffer irreparable harm without injunctive relief; (3) extent to which nonmovant will suffer irreparable harm if injunction is issued; and (4) public interest.

30. Injunction ⇐138.66

New Jersey Medicaid applicants were likely to succeed on merits of their claim that state's failure to provide notice of, and establish procedures for, undue hardship hearing when applicant is denied Medicaid benefits violated federal Medicaid statute requiring such undue hardship hearings, for purposes of determining whether applicants were entitled to preliminary injunction. Social Security Act, § 1917(c)(2)(D), as amended, 42 U.S.C.A. § 1396p(c)(2)(D).

31. Injunction ⇐14

To show irreparable harm necessary for injunctive relief, plaintiff must demonstrate potential harm which cannot be redressed by legal or equitable remedy following trial; economic loss does not constitute "irreparable harm."

See publication Words and Phrases for other judicial constructions and definitions.

32. Injunction ⇐138.6

To warrant preliminary injunction, injury created by failure to issue requested injunction must be of peculiar nature, so that compensation in money cannot atone for it.

33. Injunction ⇐14

Inability to precisely measure financial harm does not make that harm irreparable or immeasurable, for purposes of granting injunctive relief.

34. Injunction ⇐138.6

To obtain preliminary injunctive relief, injury alleged must not only be irreparable, it must be imminent as well.

35. Injunction ⇐138.66

New Jersey Medicaid applicants were not threatened with immediate irreparable injury resulting from state's failure to comply with federal Medicaid statute requiring state to establish procedures for undue hardship hearings for applicants who are denied Medicaid benefits and, thus, applicants were not entitled to preliminary injunctive relief, where state officials indicated that procedures for establishing state regulations governing undue hardship hearings would soon be initiated. Social Security Act, § 1917(c)(2)(D), as amended, 42 U.S.C.A. § 1396p(c)(2)(D).

36. Injunction ⇐138.66

District court would not exercise its discretion to grant New Jersey Medicaid applicants preliminary injunction compelling state officials to comply with federal Medicaid statute by implementing regulations for undue hardship hearings, where applicants could have, but failed to, utilize New Jersey statute authorizing interested persons to petition agency to promulgate, amend or repeal any rule. Social Security Act, § 1917(c)(2)(D), as amended, 42 U.S.C.A. § 1396p(c)(2)(D); N.J.S.A. 52:14B–4(f).

37. Statutes ⇐219(6.1)

Health Care Financing Administration's (HCFA's) Guidelines and letter written by HCFA official on behalf of HCFA with respect to whether community spouse annuity trusts (CSATs) are countable resource in determining Medicaid eligibility are entitled to some deference by court interpreting Medicaid Act as long as they are consistent with plain language and purposes of statute and if they are consistent with prior administrative views, even though they are not formal regulations. Social Security Act, § 1901 et seq., as amended, 42 U.S.C.A. § 1396 et seq.

38. Injunction ⇐138.66

New Jersey Medicaid applicants who were institutionalized in long term care facilities were not likely to succeed on merits of their claim that state officials violated federal Medicaid statutes by treating community spouse annuity trusts (CSATs) as countable resource when determining Medicaid eligibility and, thus, were not entitled to preliminary injunctive relief; although Medicaid Act prohibited CSATs from triggering penalty period, Act required resources from both institutionalized spouse and community spouse to be considered for eligibility purposes. Social Security Act, §§ 1917(c)(2), 1924, as amended, 42 U.S.C.A. §§ 1396p(c)(2), 1396r–5.

Donald M. McHugh, McHugh & Macri, East Hanover, NJ, for plaintiffs.

Shirley B. Whitenack, Schenck, Price, Smith & King, LLP, Morristown, NJ, for plaintiffs.

Mary F. Rubinstein, DAG, Attorney General of New Jersey, Trenton, NJ, Meredith Van Pelt, Special Deputy Atty. Gen., Mary F. Rubinstein, for defendants Michele K. Guhl, Commissioner of the New Jersey Department of Human Services, Margaret A. Murray, Director of the New Jersey Division of Medical Assistance and Health Services.

Edwin C. Eastwood, Jr., North Bergen, NJ, for defendant Edward Testa, Director of Bergen County Board of Social Services.

Donald L. Berlin, Berlin, Kaplan, Dembling & Burke, Morristown, NJ, for defendant Elizabeth Lehmann, Director of the Morris County Board of Social Services.

OPINION

BASSLER, District Judge.

"There can be no doubt but that the statutes and provisions in question, involving the financing of Medicare and Medicaid, are among the most completely impenetrable texts within human experience. Indeed, one approaches them at the level of specificity herein demanded with dread, for not only are they dense reading of the most tortuous kind, but Congress also revisits the area frequently, generously cutting and pruning in the process and making any solid grasp of the matters addressed merely a passing phase." *Rehabilitation Ass'n of Virginia v. Kozlowski*, 42 F.3d 1444 (4th Cir.1994). With this in mind, we begin.

Plaintiffs are married couples with one spouse living in the community ("community spouse") and the other residing in a skilled nursing facility ("institutionalized spouse"). Plaintiffs challenge certain provisions of the New Jersey Medicaid plan governing Medicaid eligibility to cover the cost of the institutionalized spouse's receipt of long term care.

Defendants' motion to dismiss for failure to state a claim upon which relief may be granted is **denied** on all counts, except as to the due process and equal protection claims, and except as to all claims by those Plaintiffs who have not yet applied for Medicaid benefits. Plaintiffs' motion for preliminary injunction is **denied.**

I. *BACKGROUND*

Some of the Plaintiffs [1] are institutionalized spouses currently residing in long-term care facilities in New Jersey. (*See* First Amended Compl. ¶ 4.) [2] Of those in-

1. Juanita L. Johnson, William R. Fleming, Dorothy R. Mariani, Phyllis R. Schaible, Marie L. Hicks, Norman V. Silbernagel, Stanley Prystach, Anthony Mackron, Charles V. Banks, Richard C. Weiser, Mary Fillmore.

2. On January 19, 2000, this Court has issued a briefing schedule that required Defendants' motion to dismiss and Plaintiffs' motion for preliminary injunction to be completely briefed under Appendix N of the local rules by no later than February 22, 2000. Despite Plaintiffs' knowledge of that Defendants were in the process of briefing their motion to dismiss based on the First Amended Complaint, Plaintiffs filed a Second Amended Complaint on February 15, 2000, without seeking leave of Court because no responsive pleading had technically been filed yet. Be-

stitutionalized spouses, some have been denied Medicaid benefits and have filed fair hearing appeals,[3] and some have Medicaid applications pending.[4] (*Id.* at ¶ 5.) Some Plaintiffs are prospective Medicaid applicants.[5] (*Id.* at ¶ 6.) Plaintiffs residing in the community are the beneficiaries of Community Spouse Annuity Trusts ("CSATs").[6] (*Id.* at ¶ 7.)

In this action, Plaintiffs challenge the treatment of the CSATs as a countable resource in determining Medicaid eligibility. Because the institutionalized spouses have been denied, or will be denied benefits as a result of such treatment, Plaintiffs claim that Defendants' treatment of CSATs constitutes impermissible rulemaking in violation of their rights to due process and equal protection. Plaintiffs urge this Court to order the State to implement regulations governing undue hardship hearings.

Plaintiffs are suing Michele Guhl, Commissioner of the New Jersey Department of Human Services ("DHS"), Margaret Murray, Director of the Division of Medical Assistance and Health Services ("DMAHS"), as well as the Directors of the Board of Social Services for Bergen County and Morris County (collectively referred to as "Defendants"). The first amended complaint contains six counts: (1) 42 U.S.C. § 1983; (2) Declaratory Judgment; (3) constitutional due process; (4) improper rule making; (5)equitable estoppel and equal protection; and (6) violation of New Jersey regulations. Plaintiffs seek the following relief:

- to enjoin the fair hearings appeal of Plaintiffs' denials pending resolution of this action;
- declaratory judgment that Defendants engaged in improper rule making;
- a requirement that Defendants utilize proper standards and procedures to adopt regulations to implement undue hardship regulations;
- declaratory judgment that Defendants' denials of each of the institutionalized Plaintiffs pending Medicaid applications were illegal, null and void;
- a requirement that Defendants redetermine each Plaintiff's pending Medicaid application in accordance with current law, regulations and prior "policy" determinations;
- a declaratory judgment that prospective Medicaid applications utilizing CSATs drafted and funded prior to the adoptions of undue hardship regulations be permitted as exceptions to the transfer rules pursuant to 42 U.S.C. § 1396p(c)(2)(B)(i) and (ii);
- estoppel of Defendants from determining that Plaintiffs' contributions of available resources to CSATs constitute transfers for less than fair market value resulting in a period of ineligibility for Medicaid benefits;
- compensatory damages; and
- attorneys' fees and costs pursuant to 42 U.S.C. § 1988.

cause Plaintiffs filed their amended pleading only one week before the reply briefs were complete, the Court will not consider Plaintiffs' Second Amended Complaint despite the fact that technically, no responsive pleading had yet been filed.

3. Juanita L. Johnson, Dorothy R. Mariani, and Mary Fillmore.

4. Phyllis R. Schaible, Charles V. Banks, Marie L. Hicks, Norman V. Silbernagel, Stanley Prystasch, and Anthony Mackron (the parties later stipulated to the dismissal of Bernadine and Richard C. Weiser.)

5. William R. Fleming, Gerald Benedetto, Frances C. Denman, Harold B. Whalon, Jr., Blace LaForge.

6. Donald H. Johnson, Eugene V. Mariani, Mary Lou Fleming, William C. Schaible, Lois Benedetto, Donna R. Banks, Raymond O. Denman, Jr., Charles N. Hicks, Ann B. Silbernagel, Anna Prystasch, Mary Mackron, Janet Whalon, Bernadine Weiser, Grace LaForge, and John Fillmore.

Plaintiffs move for preliminary and permanent injunctive and declaratory relief, and Defendants move to dismiss. Oral argument was held on March 27, 2000.

To understand the issues and place them in context, a brief overview of Medicaid and its eligibility requirements for institutionalized spouses is required.

II. *MEDICAID*

A. *Overview*

The Medicaid Act[7] is a cooperative federal-state program that is jointly financed with federal and state funds. *Wilder v. Virginia Hospital Ass'n*, 496 U.S. 498, 501, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990). The purpose of the program is to "provide a nationwide program of medical assistance for low income families and individuals." *West Virginia Univ. Hosps., Inc. v. Casey*, 885 F.2d 11, 15 (3d Cir.1989).

> Although participation in the program is voluntary, participating States must comply with certain requirements imposed by the Act and regulations promulgated by the Secretary of Health and Human Services (Secretary). To qualify for federal assistance, a State must submit to the Secretary and have approved a "plan for medical assistance," § 1396a(a), that contains a comprehensive statement describing the nature and scope of the State's Medicaid program. 42 C.F.R. § 430.10 (1989).

Wilder, 496 U.S. at 501, 110 S.Ct. 2510. The Medicaid program is " 'basically administered by each state within certain broad requirements and guidelines.' " *West Virginia*, 885 F.2d at 15 (citation omitted).

On the federal level, the Secretary of the U.S. Department of Health and Human Services ("HHS") administers the program through the Health Care Financing Administration ("HCFA"). HCFA has issued guidelines, known as "Transmittal 64," or the "State Medicaid Manual," interpreting the transfer of assets and treatment of trusts provisions of the Medicaid Act [hereinafter "HCFA Guidelines" or "Transmittal 64"].[8]

The New Jersey Medical Assistance and Health Services Act, N.J.S.A. 30:4D–1, *et seq.*, authorizes New Jersey's participation in the Medicaid program. On the state level, the DMAHS, an agency contained within the DHS, is responsible for administration of the Medicaid program in New Jersey. N.J.S.A. 30:4D–4. The county welfare agencies ("CWA") assist DMAHS in administering the program by processing applications for Medicaid, including determining whether an applicant has met the income and resource eligibility standards. N.J.S.A. 30:4D–7a; N.J.A.C. 10:71–3.15. CWA staff members make their determinations based on information received from an applicant and from their own investigations to verify, supplement or clarify such information. N.J.A.C. 10:71–1.1 *et seq.*

With certain exceptions, for an individual to be eligible for Medicaid benefits, a person's income and resources must fall below a certain limit. When inventorying an applicant's income and resources to determine eligibility, Medicaid "deems" the income and resources of each spouse to be available to the other when both spouses live together in the community. When, however, one spouse enters a nursing facility ("institutionalized spouse") and is eligible for Medicaid, while the other spouse stays in the community ("community spouse"), the rules become more complex. John Bigler, Diane Archer, John Regan, *An Overview of Social Security, Medicare and Medicaid*, 65 N.Y. State Bar Journal 14 (September/October, 1993) [hereinafter "Bigler Article"]. The Medicare Catastrophic Coverage Act ("MCCA"), enacted

7. Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*, was enacted in 1965.

8. Attached to Certification of Meredith Van Pelt ("Van Pelt Certif.") and found at www.hcfa.gov/pubforms/pub45pdf/smmtoc.htm.

in 1988, and the 1993 Omnibus Budget Reconciliation Act ("OBRA") contain provisions addressing this more complex situation.

B. *Pre-MCCA and OBRA*

Prior to enactment of the MCCA, shortly after a spouse was institutionalized, each spouse was treated as a separate household. Income, such as Social Security checks, pensions, and interest or dividends from investments, were considered to belong to the spouse whose name was on the instrument conveying the funds. Consequently, when the husband, for example, entered a nursing home and the couple's pension check had the husband's name on it, all of that income was attributed to him when determining Medicaid eligibility, leaving the wife destitute. Conversely, if the wife entered the nursing home, the husband had no obligation under federal law to contribute any of that income toward the cost of the wife's care. *See* H.R.Rep. No. 100-105(II), 100th Cong., 2nd Sess., at 66 (1987), *reprinted in* 1988 U.S.C.C.A.N. 857, 889.

A similar rule was in effect for the attribution of resources. *Ibid.* Generally, in the month following institutionalization, jointly held resources to which a spouse had unrestricted access, such as a joint savings account, or resources solely held by the institutionalized spouse, were considered available to that spouse for eligibility purposes. *Ibid.* In contrast, assets solely held by the community spouse were, after the first month, considered to belong to her and she had no obligation under federal law to contribute any amount of such resources toward the costs of care of the institutionalized spouse. *Id.* at 66-67; 1988 U.S.C.C.A.N. at 889-90.

C. *Resource Rules Under MCCA and OBRA*

One of Congress' reasons for enacting the MCCA[9] was to end the "pauperization" of the community spouse "by assuring that the community spouse has a sufficient—but not excessive—amount of income and resources available ... while ... [the institutionalized] spouse is in a nursing home at Medicaid expense." *Id.* at 65, 1988 U.S.C.C.A.N. at 888. Additionally, Congress intended to close the loophole where a couple could shelter resources in the community spouse's name while the institutionalized spouse received Medicaid.

To achieve those goals, the MCCA requires that at the time of institutionalization, a "snapshot" of the total value of the couple's resources owned by either the institutionalized or community spouse is inventoried or assessed. 42 U.S.C. § 1396r-5(c)(1)(A). The spousal share is equal to half of such total value. *Id.* To avoid impoverishment of the community spouse, the community spouse is permitted to retain what is termed the "community spouse resource allowance," [10] ("CSRA"). 42 U.S.C. § 1396r-5(f)(2).

The CSRA is not considered available to pay for the care of the institutionalized spouse and need not be "spent down" in order for the applicant to be Medicaid eligible.

> If [the community spouse] actually owns less than this amount, a portion of the institutionalized spouse's resources must be transferred to [the community spouse] to raise her personal resources to the required level. Conversely, if her resources exceed this level, she is obliged to spend the excess on the costs of care of the institutionalized spouse. If she refuses, the state has the right to

9. The MCCA supersedes any inconsistent provision contained in § 1396. 42 U.S.C. § 1396r-5(a)(1).

10. The CSRA is the greatest of (1) $12,000 (adjusted annually); (2) the lesser of ½ total joint resources or $60,000 (adjusted annually); (3) an amount established pursuant to a fair hearing; or (4) an amount transferred under court order. 42 U.S.C. § 1396r-5(f)(2).

seek to enforce her obligation in the courts, but the institutionalized spouse will still qualify for Medicaid. He, too, after providing for the community spouse's MMMNA, must spend any excess for his own care. Medicaid will pay for his care only after he has spent down to the basic level of exempt resources. Bigler Article; *see* 42 U.S.C. § 1396r–5(c)(2).

To illustrate, if a couple has $100,000 in a joint savings account and jointly held stocks and mutual funds at the time the spouse is institutionalized, then $50,000 is attributable to each spouse. If the ceiling on the community spouse's share of the couple's resources was $48,000, as it was in 1992 when the MCCA was passed, then the $2,000 in excess of $48,000 would be attributed to the institutionalized spouse for the purposes of determining eligibility. Consequently, the couple would have to "spend down" $52,000 (the institutionalized spouse's $50,000 share, plus $2,000 excess resources from the community spouse's share) less the resource eligibility standard (currently $2,000) before the institutionalized spouse could qualify for Medicaid. *See* H.R.Rep. No. 100–105(II), at 77 (1987); 1988 U.S.C.C.A.N. at 900.

D. *Penalty Period for Transfer of Assets*

When an institutionalized individual who has transferred assets applies for Medicaid benefits, the application is subject to transfer and trust rules under the statutory scheme set forth in OBRA and the MCCA.

In addition to the new resource rules, discussed above, which closed the loophole where a couple could shelter resources in the community spouse's name, the Committee on Energy and Commerce, concerned about the fact that wealthy individuals could transfer resources in order to qualify for Medicaid nursing home coverage, instituted a new formula under the MCCA for calculating a penalty, (i.e. a period of ineligibility), for transferring of assets. *See* H.R.Rep. No. 100–105(II), at 73; 1988 U.S.C.C.A.N. at 896.

Under OBRA, an institutionalized spouse may be denied Medicaid eligibility if that person (or the person's spouse) has transferred any nonexempt "asset" or his or her home for less than fair market value during the 36 month period (referred to as "look-back" period) before applying for Medicaid while institutionalized. Bigler Article; 42 U.S.C. § 1396p(c)(1)(B)(i). "The term 'asset' includes all of the countable income and resources of the individual or his or her spouse, as well as those assets which these persons are entitled to but do not receive because of their own actions or the action of another person, including a court or administrative body, with legal authority to act in place of the individual or the spouse." Bigler Article; 42 U.S.C. § 1396p(e).

If an asset is transferred during the "look-back" period, then the applicant is subject to a "penalty period," which is a period of ineligibility calculated by dividing the uncompensated amount of the assets transferred by the average monthly cost of nursing home care in the particular state. Michael Feinberg, *Medicaid After OBRA '93 As It Impacts on Long–Term Care Planning*, 164 N.J. Lawyer 24 (October, 1994) [hereinafter "Feinberg article"]. For example, if an individual transfers $300,000 on January 1, 1995 to his respective family members and applies for Medicaid on December 1, 1997, his look-back period extends to December 1, 1994. Because the transfer was made before December 1, 1994, it will fall within the person's look-back period. Because the amount of the transfer was $300,000, an 88 month penalty period ($300,000 divided by $3,376 [11]) would result. Therefore, that in-

11. $3,376 was the average monthly cost of nursing home care in New Jersey in June 1994. Feinberg Article.

dividual would not be eligible for Medicaid until April 2002.

E. *Treatment of Trusts*

Next, specific rules apply for trusts created by the Medicaid applicant, the applicant's spouse, or any person, including a court or administrative body, acting "with legal authority to act in place of or on behalf of the individual or the individual's spouse" or "at the direction or upon the request of the individual or the individual's spouse." [12] The following rules apply regardless of why the trust was established; whether the trustees have or exercise any discretion under the trust; any restriction of when or whether distributions can be made from the trust; or any restrictions on the use of distributions. 42 U.S.C. § 1396p(d)(2)(C).

When a trust is revocable, under the MCCA resource rules, the corpus of the trust is considered a resource to the applicant. 42 U.S.C. § 1396p(d)(3)(A). "Because it remains available, no penalty is incurred for a transfer into a revocable trust." Peter M. Macy, *Medicaid Planning After OBRA–93: Placing the Home in a Revocable Trust*, 79 Mass.L.Rev. 2 (March 1994) [hereinafter "Macy Article"].

The treatment of an irrevocable trust in determining Medicaid eligibility depends on what type of interest the Medicaid applicant retains in the trust. If the applicant is a permitted beneficiary of an irrevocable trust, the corpus of the trust is a countable resource and any distributions to the applicant, whether made from income or principal, will be treated as income to him or her. H.R.Rep. No. 103–111(II), 103th Cong., 1st Sess., at 207–08 (1993), *reprinted in* 1993 U.S.C.C.A.N. 378, 534–35; 42 U.S.C. § 1396p(d)(3)(B)(i). "Any other payments from the trust are considered a transfer of assets by the individual." *Ibid.*

If, on the other hand, the applicant can in no way benefit from the trust, no part of the corpus will be treated as a countable resource to the institutionalized spouse. *See* HCFA Guidelines § 3259.6(C); *see also* Feinberg Article. Rather, the corpus of the trust will be considered a transfer of assets for less than fair market value and trigger a 60–month look-back period. 42 U.S.C. § 1396p(d)(3)(B)(ii); 42 U.S.C. § 1396p(c)(1)(B)(i). Certain transfers, however, such as the transfer of assets between spouses "for the sole benefit of" the other spouse, do not trigger a penalty period. 42 U.S.C. § 1396p(c)(2)(B)(i). HCFA has established that a "sole benefit" transfer is one where "no individual or entity except the spouse ... can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future." HCFA Guidelines § 3257(b)(6). A trust meets this definition if the trust provides for "spending of the funds involved for the benefit of the individual a basis that is actuarially sound based on the life expectancy of the individual involved." *Ibid.*

Exhibit A attached to the Certification of Eugene Mariani ("Mariani Cert.") is typical in form and content of the CSATs at issue here. *See* Certification of Donald McHugh, Esq. ("McHugh Cert."), ¶ 2. The CSATs are irrevocable trusts created for the "sole benefit" of the community spouse. The purpose of the trust is to qualify the institutionalized spouse for Medicaid benefits. According to the trust document, the trust is "actuarially sound" within the meaning of OBRA and the HCFA Guidelines because the entire income and corpus will be issued to the community spouse within his/her lifetime, as determined by the actuarial tables set forth in the HCFA Guidelines. Defendants do not dispute that the CSATs at issue are actuarially sound transfers "for the sole benefit of" the community spouse and are therefore not subject to a transfer penalty. As required by DMAHS, upon the death of the beneficiary (community spouse), the trust names DMAHS as the

12. 42 U.S.C. § 1396p(d)(2)(A).

first beneficiary under the CSAT. The CSAT terminates when the first of the following occurs: the corpus is exhausted; the beneficiary dies; or the actuarial life expectancy expires.

F. *Undue Hardship Provisions*

Pursuant to the Medicaid Act, the transfer rules do not render an applicant ineligible to the extent that "the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility would work an undue hardship as determined on the basis of criteria established by the Secretary." 42 U.S.C. § 1396p(c)(2)(D).

G. *New Jersey Medicaid*

Defendants do not dispute that since late 1994 (when trusts had to comply with OBRA), DMAHS had approved the use of numerous CSATs so that the community spouse trust amounts were excluded from the countable resources of the institutionalized spouse. On April 16, 1998, however, a letter was issued by Robert Streimer, on behalf of HCFA, to a private attorney in Virginia ("Streimer letter") explaining that assets in a trust established solely for the benefit of the community spouse were to be viewed in two contexts: (1) whether the transfer of assets for less than fair market value subjects the institutionalized spouse to a transfer penalty; and (2) whether the asset is a countable resource. *See* McHugh Certif., Ex. D.

While the letter is certainly not binding on this Court, it is, at the very least, instructive. In the Streimer letter, the HCFA agreed that no transfer penalty was triggered by the transferral between spouses of assets for less than fair market value. The letter provided that actuarial soundness was one means of determining that a transfer was in fact made for the sole benefit of the spouse. It disagreed, however, that actuarial soundness had any bearing on whether the trust was a countable resource. According to HCFA, the "sole benefit of" trust did not warrant the same treatment as a standard annuity because it was an irrevocable trust subject to § 1917(d) of the Social Security Act; [13] the Streimer letter explained that there is a fundamental difference between a standard annuity and the "annuitized" trust at issue.

> A standard annuity requires the actual purchase of a commodity, i.e., the annuity itself.... Upon completion of the transaction, the buyer no longer owns the funds used to purchase the annuity. Instead, he or she owns the annuity itself. If the annuity is irrevocable, as most annuities are, the buyer cannot reclaim ownership of the funds used to purchase the annuity.

Streimer Letter. By contrast, the corpus of the trust established for the sole benefit of the community spouse can, at some point in time, be paid to the community spouse. *Id.* Therefore, the author of the Streimer letter concluded that while the spouse was not subject to the transfer penalty provision, the corpus of the trust at issue was a countable resource.

After learning of HCFA's position, DMAHS, by letter dated July 6, 1999, notified the Bergen County Board of Social Services that "actuarial soundness only pertains to whether a penalty can be imposed for transferring assets to a third party for the sole benefit of a spouse" and "does not affect how resources are counted in determining eligibility." *See* McHugh Certif., Ex. A. Echoing the Streimer letter, the letter from DMAHS further explained that because CSATs can be paid at some point in time to the community spouse, the entire corpus is considered available to the community spouse. In recognition that some applications for Medicaid eligibility had been submitted in reliance on the prior approvals of CSATs and that some applications had been pending for awhile, DMAHS offered to permit the community

13. § 1917(d) of the Social Security Act is codified at 42 U.S.C. § 1396p(d).

spouse to convert the CSAT into a commercially purchased annuity, naming the state as the first remaining beneficiary. *See* Mariani Certif., Ex. C.

III. *DISCUSSION*

A. *Motion to Strike*

1. *McHugh Certification*

At oral argument, Defendants made an oral motion to strike the Certification of Donald M. McHugh, Esq., alleging that it contains legal conclusions.

Local Civil Rule 7.2 provides that "[a]ffidavits shall be restricted to statements of fact within the personal knowledge of the affiant. Argument of the facts and the law shall not be contained in the affidavits. Legal arguments and summations in affidavits will be disregarded by the Court ..."

[1] To the extent that the McHugh Certification does contain legal conclusion, those portions will be ignored. Only matters within Mr. McHugh's personal knowledge shall be considered by this Court. *See San Filippo v. Bongiovanni*, 743 F.Supp. 327, 332 n. 3 (D.N.J.1990) (striking inadmissible elements of affidavit but permitting remainder), *rev'd on other grounds*, 961 F.2d 1125 (3d Cir.), *cert. denied* 506 U.S. 908, 113 S.Ct. 305, 121 L.Ed.2d 228 (1992); *see also Lombardi v. Cosgrove*, 7 F.Supp.2d 481, 492 (D.N.J. 1997) (denying motion to strike but ignoring conclusions, beliefs, and misstatements, and using the assertions based on personal knowledge).

2. *Overlength Brief*

[2] Local Rule 7.2(b) requires that permission to file an over length brief must be obtained from the Court "prior to submission of the brief." In violation of Local Rule 7.2(b), Plaintiffs submitted a Reply Brief to Defendants' Brief in Opposition that exceeded the 15 page limit. Although Plaintiffs sought leave of Court to file an over length reply brief in the already over length brief itself, they did not seek leave *prior* to filing the over length brief as required by common sense and by the express terms of Local Rule 7.2(b). While in this instance, the Court will still consider the excess pages of Plaintiffs' reply brief, Plaintiffs are reminded that in the future, they are to abide by the court rules.

B. *Defendants' Motion to Dismiss*

1. *Standard Governing Motion to Dismiss*

Federal Rule of Civil Procedure 12(b)(6) allows a party to move for a dismissal based upon the pleader's "failure to state a claim upon which relief can be granted." Since the long-established federal policy of civil litigation is to decide cases on the proofs, district courts generally disfavor Rule 12(b)(6) motions. *Melo–Sonics Corp. v. Cropp*, 342 F.2d 856 (3d Cir.1965); *Panek v. Bogucz*, 718 F.Supp. 1228, 1229 (D.N.J.1989).

In deciding a motion to dismiss for failure to state a claim, all allegations in the pleadings must be accepted as true and the plaintiff must be given the benefit of every favorable inference that can be drawn from those allegations. *See Conley v. Gibson*, 355 U.S. 41, 48, 78 S.Ct. 99, 2 L.Ed.2d 80 (1957); *Wisniewski v. Johns–Manville Corp.*, 812 F.2d 81, 83 n. 1 (3d Cir.1987); *Markowitz*, 906 F.2d at 103. "All the rules require is a short and plain statement of the claim that gives the defendant fair notice of the plaintiff's claim and the grounds upon which it rests." *Conley*, 355 U.S. at 47, 78 S.Ct. 99.

Rule 12(b)(6) does not countenance "dismissals based on a judge's disbelief of a complaint's factual allegations." *Neitzke v. Williams*, 490 U.S. 319, 326–27, 109 S.Ct. 1827, 104 L.Ed.2d 338 (1989). "The issue is not whether a plaintiff will ultimately prevail but whether the claimant is entitled to offer evidence to support the claims." *Scheuer v. Rhodes*, 416 U.S. 232, 236, 94 S.Ct. 1683, 40 L.Ed.2d 90 (1974).

Accepting the facts in the pleadings as true and giving them all reasonable inferences, a court must dismiss under Rule 12(b)(6) "[i]f as a matter of law 'it is clear that no relief could be granted under any set of facts that could be proved consistent with the allegations.'" *Neitzke*, 490 U.S. at 326–27, 109 S.Ct. 1827.

2. *Federal Question*

[3] Plaintiffs allege that this Court's jurisdiction is based on 28 U.S.C. § 1331 [14] because their claims "arise under" federal law, namely the Medicaid provisions of the Social Security Act and the Due Process clause. Nevertheless, Defendants argue that Plaintiffs' complaint presents no federal question.

For purposes of "arising under" jurisdiction,

> [a]n action arises under the laws of the United States if and only if the complaint seeks a remedy expressly granted by a federal law or if it requires the construction of a federal statute or a distinctive policy of a federal statute requires application of federal legal principles for its disposition.

Lindy v. Lynn, 501 F.2d 1367, 1369 (3d Cir.1974). Here, to determine whether the remedies sought by Plaintiffs are warranted, the Court must apply or interpret provisions of the Medicaid Act.

Plaintiffs allege that the provisions and application of the New Jersey State Medicaid plan conflict with the Federal Medicaid plan provisions as set forth in § 1396p. For example, Plaintiffs contend that contrary to § 1396p(c)(2)(D), the State has not provided for an "undue hardship" hearing for those who have been denied Medicaid benefits. Because Plaintiffs specifically assert that state law conflicts with federal law, the case relied on by Defendants, *Concourse Rehabilitation & Nursing Center Inc. v. DeBuono*, 179 F.3d 38 (2nd Cir.1999) (holding that absent assertion of a specific conflict between the State Medicaid plan and federal law, there is no federal jurisdiction over a § 1983 claim that a State has violated provisions of its own Medicaid plan), is inapplicable. Therefore, this Court has jurisdiction over this matter pursuant to 28 U.S.C. § 1331.

3. *Standing/Ripeness*

Defendants suggest that some of the Plaintiffs, namely those that have not applied for Medicaid benefits, lack standing to bring this action. Without engaging in that determination, the Court concludes that this matter is not ripe with respect to those Plaintiffs who have not yet applied for Medicaid benefits. For ease of reference, "Plaintiffs," for this subsection only, will refer to those who have not yet applied for Medicaid benefits.

[4–7] All federal actions, including those for declaratory or injunctive relief, must involve a "case and controversy." *Philadelphia Federation of Teachers v. Ridge*, 150 F.3d 319, 322–23 (3d Cir.1998). Ripeness is one aspect of justiciability, which "'determines when a proper party may bring an action.'" *Id.* at 323 (citing *Travelers Ins. Co. v. Obusek*, 72 F.3d 1148, 1154 (3d Cir.1995)). Unless the record affirmatively shows otherwise, or plaintiffs meet their burden to clearly allege facts invoking a federal court's jurisdiction, the presumption is that jurisdiction is lacking. *Ibid.* The ripeness doctrine serves to prevent federal courts "from entangling themselves in abstract disagreements." *Ibid.* (citing *Abbott Labs. v. Gardner*, 387 U.S. 136, 148, 87 S.Ct. 1507, 18 L.Ed.2d 681 (1967), *overruled on other grounds, Califano v. Sanders*, 430 U.S. 99, 105, 97 S.Ct. 980, 51 L.Ed.2d 192 (1977)).

> Ultimately, the case must involve "'a real and substantial controversy admitting of specific relief through a decree of a conclusive character, as distinguished from an opinion advising what the law would be upon a hypothetical state of

14. 28 U.S.C. § 1331 provides: "The district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States."

facts.' " [citations omitted]. "A federal court's jurisdiction therefore can be invoked only when the plaintiff himself has suffered 'some threatened or actual injury resulting from the putatively illegal action . . .' " [citations omitted].

Presbytery of New Jersey of the Orthodox Presbyterian Church v. Florio, 40 F.3d 1454, 1463 (3d Cir.1994).

[8] When determining whether a request for declaratory judgment is ripe, a court should examine two factors: (1) " 'the fitness of the issues for judicial decision,' and (2) 'the hardship to the parties of withholding court consideration.' " *Philadelphia Federation of Teachers*, 150 F.3d at 323 (citing *Abbott Labs.*, 387 U.S. at 149, 87 S.Ct. 1507).

> Under the first criterion, various factors that enter into a court's assessment of fitness include: whether the claim involves uncertain and contingent events that may not occur as anticipated or at all; the extent to which a claim is bound up in the facts; and whether the parties to the action are sufficiently adverse. [citations omitted].

Ibid.

[9] Here, whether Plaintiffs will be irreparably harmed by Defendants' alleged wrongful conduct in determining Medicaid eligibility is contingent on numerous uncertain and contingent events including whether Plaintiffs do actually ever apply for Medicaid, whether Plaintiffs' establish a CSAT, and how many other resources Plaintiffs have. Although Plaintiffs may anticipate applying for Medicaid benefits in New Jersey, they may be unable to do so as a result of unexpected events, for example, death or moving out of New Jersey. Moreover, if and when Plaintiffs apply, there may be other unanticipated events that render this Court's decision inapplicable, such as: a change in federal or state law; a change in interpretation of federal law by the federal or state agencies administering Medicaid; or divorce, which would render the MCCA inapplicable. Finally, by the time Plaintiffs apply, Defendants may have implemented regulations governing undue hardship hearings and may, as a result, be eligible for benefits under that exception.

Additionally, there is not sufficient adversity of interests between the parties; any threat to Plaintiffs of being negatively impacted by Defendants' policies is not "real and immediate." To determine whether there is adversity of interest, which is indicative of an actual controversy, the parties must have "adverse legal interests." *Presbytery*, 40 F.3d at 1463. Although Plaintiffs need not have suffered a " 'completed harm' to establish adversity of interest," there must be a "substantial threat of real harm" and the "threat 'must remain real and immediate throughout the course of the litigation.' " *Ibid.* (citations omitted).

Plaintiffs do not identify a presently existing harm or threat, but rather, the threat of a threat. That is, Plaintiffs claim that even if they purchase commercial annuities in accordance with Defendants' current policy, they face the "real threat that DMAHS will again change its policy," which they conclude, is an "unacceptable" alternative to them. Should DMAHS again change its policy, Plaintiffs argue that they would then suffer the same irreparable harm that the other Plaintiffs face, namely eviction of the institutionalized spouse from the nursing home.

While the non-applicant Plaintiffs characterize their alternative to purchase a commercial annuity as "speculative," their allegations of injury based on an assumption or chance that Defendants will again change their policy is even more speculative. The Court will not render an opinion based on hypothetical facts. *See North Carolina v. Rice*, 404 U.S. 244, 246, 92 S.Ct. 402, 30 L.Ed.2d 413 (1971) (noting that ripeness doctrine requires "a real and substantial controversy admitting of specific relief through a decree of a conclusive character, as distinguished from an opinion

advising what the law would be upon a hypothetical state of facts.")

Therefore, whether the prospective Medicaid applicants are entitled to injunctive relief involve issues that are not fit for judicial decision under the first part of the test.

> The second factor
>
> focuses on the hardship that may be entailed in denying judicial review, and the determination whether any such hardship is cognizable turns on whether the challenged action creates a "direct and immediate" dilemma for the parties, such that the lack of pre-enforcement review will put the plaintiffs to costly choices. [citations omitted].

Ibid. Plaintiffs cannot claim that they will suffer hardship as a result of this Court's denial of judicial review of their claims. Should the Plaintiffs whose applications have been denied or are pending prevail in obtaining an injunction against Defendants, the non-applicant Plaintiffs will not be harmed. If, alternatively, the other Plaintiffs do not prevail, then the non-applicant Plaintiffs have the opportunity to do what is necessary to become eligible for Medicaid. Therefore, this action is dismissed as to those prospective Medicaid applicants.

4. *Section 1983*

[10] 42 U.S.C. § 1983 "imposes liability on anyone who, under color of state law, deprives a person 'of any rights, privileges, or immunities secured by the Constitution and laws' " of the United States. *Blessing v. Freestone*, 520 U.S. 329, 341, 117 S.Ct. 1353, 137 L.Ed.2d 569 (1997). Section 1983 provides a cause of action for violations of the Constitution as well as federal statutes. *Wilder*, 496 U.S. at 508, 110 S.Ct. 2510 (citing *Maine v. Thiboutot*, 448 U.S. 1, 4, 100 S.Ct. 2502, 65 L.Ed.2d 555 (1980)). There are, however, two exceptions. A plaintiff may sue under § 1983 unless (1) the federal statute does not create enforceable rights, privileges, or immunities within the meaning of § 1983; or (2) Congress, in the statute itself, has foreclosed enforcement of the statute under § 1983. *Ibid.*

In *Wilder*, 496 U.S. at 520–23, 110 S.Ct. 2510, the Supreme Court rejected an argument that "Congress has foreclosed enforcement of the Medicaid Act under § 1983." *See Harris v. James*, 127 F.3d 993, 997 n. 4 (11th Cir.1997).

To determine whether a federal statute creates an enforceable right under § 1983, the court must consider three factors:

> First, Congress must have intended that the provision in question benefit the plaintiff. [citation omitted]. Second, the plaintiff must demonstrate that the right assertedly protected by the statute is not so "vague and amorphous" that its enforcement would strain judicial competence. [citation omitted]. Third, the statute must unambiguously impose a binding obligation on the States. In other words, the provision giving rise to the asserted right must be couched in mandatory rather than precatory terms.

Blessing, 520 U.S. at 340–41, 117 S.Ct. 1353.

a. *Cause of Action Under § 1983*

[11] Here, Plaintiffs claim a cause of action under several provisions of the Medicaid Act. One such provision that Plaintiffs allege creates an enforceable right is 42 U.S.C. § 1396p(c)(2)(D), which provides:

> (c) **Taking into account certain transfers of assets** . . . (2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that—. . . (D) the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility would work an undue hardship as determined on the basis of criteria established by the Secretary; . . .

According to Plaintiffs, under that provision, Plaintiffs were entitled to, but were not provided with an "undue hardship"

hearing. Although Defendants claim that the State does offer every applicant an opportunity to apply for an undue hardship exception, for purposes of a motion to dismiss, Plaintiffs' allegations must be accepted as true.

A plain reading of this provision evidences that it is intended to benefit needy individuals for whom denial of Medicaid eligibility would work an undue hardship. *Compare Rodriguez v. DeBuono*, 44 F.Supp.2d 601, 611 (S.D.N.Y.), *rev'd on other grounds*, 197 F.3d 611 (2nd Cir.1999) (noting that § 1396(a)(10)(B), which provides that a "State plan ... provide ... that the medical assistance made available to any individual ... not be less in amount, duration, or scope than the medical assistance made available to any other such individual ...," is intended to benefit categorically needy persons) *with Harris*, 127 F.3d at 1010 (concluding that § 1396a(a)(19), which requires State plans provide " 'such safeguards as may be necessary to assure that ... care and services will be provided ... in a manner consistent with simplicity of administration and the best interests of the recipients,' " only imposed a generalized duty on the States without conferring any particular right upon the plaintiffs). Because Plaintiffs claim that they would have benefitted from an "undue hardship" hearing, the first element is met.

The second criterion, whether the right assertedly protected by the statute is not so "vague and amorphous" that its enforcement would strain judicial competence, is also satisfied. The Medicaid Act, 42 U.S.C. § 1396p(c)(2)(D), requires that the State's procedures to determine whether the denial of eligibility would work an undue hardship must be in accordance with standards specified by the Secretary. The Secretary administers the Medicaid program through HCFA. Section 3259.8(A) of the HCFA Guidelines provides that: "Undue hardship exists when application of the trust provisions would deprive the individual of medical care such that his/her health or his/her life would be endangered" or "when application of the trust provisions would deprive the individual of food, clothing, shelter, or other necessities of life."

According to section 3259.8(C) of the guidelines, the state has "considerable flexibility in deciding the circumstances under which [the state] will not count funds in trusts under the trust provisions because of undue hardship." Under the undue hardship provision, however, the state must, at a minimum, provide for "[n]otice to recipients that an undue hardship exception exists; [a] timely process for determining whether an undue hardship waiver will be granted; [a] process under which an adverse determination can be appealed." Section 3259.8(C).

Because the HCFA Guidelines outline how undue hardship is to be measured, enforcement of a defined standard would not "strain judicial competence." *See Wilder*, 496 U.S. at 519–20, 110 S.Ct. 2510 (rejecting argument that because Boren Amendment gives a state flexibility to adopt any rates it finds reasonable and adequate, Amendment is too "vague and amorphous" to be judicially enforceable).

Finally, the third factor is also satisfied. The use of the word "shall" in § 1396p(c)(2)(D) makes the "undue hardship" exception mandatory rather than precatory. "The language succinctly sets forth a congressional command, which is wholly uncharacteristic of a mere suggestion or 'nudge.' " *West Virginia University Hospitals, Inc. v. Casey*, 885 F.2d 11, 20 (3d Cir.1989) (citing *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 19, 101 S.Ct. 1531, 67 L.Ed.2d 694 (1981) (holding that cause of action for violation of § 1396a(a)(13)(A) of Medicaid Act arises under § 1983 in part because language of that provision is cast in the imperative)), *aff'd*, 499 U.S. 83, 111 S.Ct. 1138, 113 L.Ed.2d 68 (1991); *see also Rodriguez*, 44 F.Supp.2d at 611 (concluding that cause of action arises under § 1983 for violation of § 1396a(a)(10)(B) of Medicaid Act in part because that provision uses

mandatory, rather than precatory language); *but see Harris*, 127 F.3d at 1011 (finding that federal regulation read in conjunction with § 1396a(a)(10)(B), while it may create some federal right, does not give rise to a federal right to transportation enforceable under § 1983).

Although Plaintiffs also allege violations of subsections of § 1396a and § 1396p, they have not addressed whether those provisions give rise to enforceable rights by satisfying the three factor analysis laid out by the Supreme Court in *Blessing*.

[12] Nevertheless, just as § 1396p(c)(2)(D) provides for a cause of action under § 1983, Plaintiffs are correct that § 1396a(a)(18) also creates a federal right enforceable under § 1983. That provision mandates that "[a] State plan for medical assistance must—... comply with the provisions of section 1396p of this title with respect to ... transfers of assets, and treatment of certain trusts...." First, the specific purpose of this section is to assure state compliance with some federal standard of accounting for trusts and transfers of assets to determine eligibility. This benefits those who would be eligible for benefits under § 1396p. Because Plaintiffs contend that they would benefit from the State's compliance with § 1396p, they are part of the intended beneficiaries. Second, § 1396a(a)(18) does not strain judicial competence for a court to review whether, and in what manner, certain assets were taken into account when determining an individual's eligibility for benefits. Third, the language of this section contains mandatory rather than precatory terms.

b. *Definition of "Person" under § 1983*

Defendants argue that they cannot be sued under § 1983 because neither a state nor a state agency is a "person" under § 1983. Section 1983 states in part:

> Every *person* who, under color of any statute, ordinance, regulation, custom, or usage, of any State ... subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress....

(emphasis added).

The Supreme Court has held that "neither a State nor its officials acting in their official capacities are 'persons' under § 1983." *Will v. Michigan Dep't of State Police*, 491 U.S. 58, 71, 109 S.Ct. 2304, 105 L.Ed.2d 45 (1989); *see also Powell v. Ridge*, 189 F.3d 387, 401 (3d Cir.) (holding that when state officials are sued for damages in their official capacities, "the suit is treated as one against the state and the official is not considered to be a 'person' thereby precluding reliance on § 1983") (quoting *Will v. Michigan Dep't of State Police*, 491 U.S. 58, 71 and n. 10, 109 S.Ct. 2304, 105 L.Ed.2d 45 (1989)), *cert. denied*, — U.S. —, 120 S.Ct. 579, 145 L.Ed.2d 482 (1999). As explained in *Will*,

> Obviously, state officials literally are persons. But a suit against a state official in his or her official capacity is not a suit against the official but rather is a suit against the official's office. *Brandon v. Holt*, 469 U.S. 464, 471, 105 S.Ct. 873, 877, 83 L.Ed.2d 878 (1985). As such, it is no different from a suit against the State itself. See, e.g., *Kentucky v. Graham*, 473 U.S. 159, 165–166, 105 S.Ct. 3099, 3104–3105, 87 L.Ed.2d 114 (1985); *Monell* [*v. Dept. of Social Services of City of New York*], supra, [436 U.S. 658] at 690, n. 55, 98 S.Ct., [2018] at 2035, n. 55[56 L.Ed.2d 611 (1978)]. We see no reason to adopt a different rule in the present context, particularly when such a rule would allow petitioner to circumvent congressional intent by a mere pleading device.

Will, 491 U.S. at 71, 109 S.Ct. 2304.

In a footnote, however, the Supreme Court cautioned that:

> Of course a state official in his or her official capacity, when sued for *injunc-*

tive relief, would be a person under § 1983 because "official-capacity actions for prospective relief are not treated as actions against the State." Kentucky v. Graham, 473 U.S., at 167, n. 14, 105 S.Ct., at 3106, n. 14; *Ex parte Young,* 209 U.S. 123, 159–160, 28 S.Ct. 441, 453–454, 52 L.Ed. 714 (1908).

Id. at 71, n. 10, 109 S.Ct. 2304 (emphasis added).

[13, 14] Therefore, although Plaintiffs' claim against Defendants for monetary damages must be dismissed, to the extent that Plaintiffs seek injunctive and declaratory relief, those claims withstand Defendants' motion to dismiss. Plaintiffs may also maintain their claim for attorneys' fees. *Cf. Missouri v. Jenkins,* 491 U.S. 274, 279, 109 S.Ct. 2463, 105 L.Ed.2d 229 (1989) (noting that Eleventh Amendment does not bar an award of attorney's fees ancillary to prospective relief); *Meredith v. Federal Mine Safety and Health Review Commission,* 177 F.3d 1042, 1049 (C.A.D.C.1999) ("where attorney's fees are provided for by statute, as here, qualified immunity has no application.")

5. *Eleventh Amendment Immunity*

Defendants claim that a suit against the New Jersey Department of Human Services, Division of Medical Assistance and Health Services, Michele K. Guhl, Commissioner of the New Jersey Department of Human Services, and Margaret A. Murray, Director of DMAHS is barred by the Eleventh Amendment.[15]

[15] Defendants are correct that absent consent by a state, suits for money damages against a state or state officials in their official capacities are barred by the Eleventh Amendment. *See Kentucky v. Graham,* 473 U.S. 159, 169, 105 S.Ct. 3099, 87 L.Ed.2d 114 (1985) (concluding that Eleventh Amendment barred official capacity action for damages in § 1983 suit); *Edelman v. Jordan,* 415 U.S. 651, 94 S.Ct. 1347, 39 L.Ed.2d 662 (1974) (holding that suit against state official for retroactive monetary relief, which requires payment of funds from state treasury is barred by Eleventh Amendment).

[16, 17] The Amendment, however, does not bar Plaintiffs from suing state officials for violations of federal law where future injunctive relief is sought. *See Ex parte Young,* 209 U.S. 123, 28 S.Ct. 441, 52 L.Ed. 714 (1908) (holding that Eleventh Amendment does not prohibit suit to enjoin state Attorney General from enforcing state statute that allegedly violated Fourteenth Amendment); *see also Edelman,* 415 U.S. 651, 94 S.Ct. 1347. The theory of *Ex parte Young* is not without its limits. As explained in *Edelman,* under *Ex parte Young,* the Eleventh Amendment may bar equitable relief if it in practice is a money judgment payable out of the state treasury. *Edelman,* 415 U.S. at 666–67, 94 S.Ct. 1347. In *Edelman,* the district court had ordered the state to retroactively release and remit benefits wrongfully withheld. The Supreme Court reversed that decision concluding that such an order was "in practical effect indistinguishable in many aspects from an award of damages against the State." *Id.* at 668, 94 S.Ct. 1347. In so holding, the Court distinguished those cases in which injunctive or declaratory relief was not barred because such relief was likely to have only an "ancillary effect on the state treasury" such as in *Ex parte Young. Ibid.* In *Ex parte Young,* "the state law which the Attorney General was enjoined from enforcing provided substantial monetary penalties against railroads which did not conform to its provisions." *Id.* at 667, 94 S.Ct. 1347.

[18] Here, granting Plaintiffs prospective injunctive relief would likely require the State to spend more money from the

15. The Eleventh Amendment to the United States Constitution provides: "The Judicial Power of the United States shall not be construed to extend to any suit in law or equity commenced or prosecuted against one of the United States by Citizens of another State, or by Citizens or Subjects of a Foreign State."

state treasury than if it were left to continue its current course of conduct. Such an effect would, however, be ancillary and is therefore not barred by the Eleventh Amendment under *Ex parte Young* and *Edelman*.

[19] Therefore, Defendants' motion to dismiss is denied to the extent that Plaintiffs seek prospective injunctive relief and attorneys' fees. *See Missouri*, 491 U.S. at 279, 109 S.Ct. 2463 ("it must be accepted as settled that an award of attorney's fees ancillary to prospective relief is not subject to the strictures of the Eleventh Amendment"). Plaintiffs' claims for compensatory damages against Defendants are, however, barred by the Eleventh Amendment.

6. *Due Process Claim*

[20] To establish a claim for violation of constitutional procedural due process, a plaintiff must (1) show that a protected property interest was taken; and (2) that the procedural safeguards surrounding the deprivation were inadequate. *See Board of Regents v. Roth*, 408 U.S. 564, 568–69, 92 S.Ct. 2701, 33 L.Ed.2d 548 (1972).

Plaintiffs contend that they are entitled to proper notice regarding a change in policy that would deprive them of Medicaid benefits or "property" because they would have qualified for Medicaid absent the State's informal change of its policy regarding CSATs as a countable resource.

[21] First, it is clearly established that once an individual is a recipient of direct Medicaid benefits, such benefits are a protected property interest that cannot be withdrawn without giving the recipient notice and an opportunity to be heard. *See O'Bannon v. Town Court Nursing Center*, 447 U.S. 773, 787, 100 S.Ct. 2467, 65 L.Ed.2d 506 (1980); *see also Goldberg v. Kelly*, 397 U.S. 254, 262, 90 S.Ct. 1011, 25 L.Ed.2d 287 (1970).

[22] Although Plaintiffs have never been granted Medicaid benefits, nevertheless, without citing any supporting law, Plaintiffs contend that they have a protected property interest in Medicaid benefits. The Court disagrees. Plaintiffs are not entitled to any procedural safeguards with respect to a property interest for which they have never been deemed qualified. *See Goldberg*, 397 U.S. at 262, 90 S.Ct. 1011 (noting welfare benefits "are a matter of statutory entitlement for persons qualified to receive them"); *Board of Regents of State Colleges v. Roth*, 408 U.S. 564, 576, 92 S.Ct. 2701, 33 L.Ed.2d 548 (1972) ("The Fourteenth Amendment's procedural protection of property is a safeguard of the security of interests that a person has *already* acquired in specific benefits." (emphasis added)); *see also Oberlander v. Perales*, 740 F.2d 116, 120 (2nd Cir.1984) (recognizing that "Medicaid providers clearly have no property interest in *future* reimbursements under New York law." (emphasis added)).

[23] Even assuming Plaintiffs had a protected property interest, Plaintiffs claim that they were deprived of their right to due process in violation of the prior notice requirements set forth in 42 C.F.R. §§ 431.211,[16] 435.919,[17] and 447.205, is untenable.[18] *See* First Amended Compl.

16. 42 C.F.R. § 431.211 provides in pertinent part: "The State or local agency must mail a notice at least 10 days before the date of action, ..."

17. 42 C.F.R. § 435.919 states in relevant part: "(a) The agency must give recipients timely and adequate notice of proposed action to terminate, discontinue, or suspend their eligibility or to reduce or discontinue services they may receive under Medicaid."

18. 42 C.F.R. § 447.205 provides:

> (a) *When notice is required.* Except as specified in paragraph (b) of this section, the agency must provide public notice of any significant proposed change in its methods and standards for setting payment rates for services.
>
> (b) *When notice is not required.* Notice is not required if—
>
> (1) The change is being made to conform to Medicare methods or levels of reimbursement;
>
> (2) The change is required by court order; or

¶ 56. 42 C.F.R. § 431.211 provides that notice must be mailed at least 10 days before the date of "action." "Action" is defined in § 431.201 as "termination, suspension, or reduction of Medicaid eligibility or covered services." Because Plaintiffs have not yet been deemed Medicaid eligible, their eligibility, by definition, cannot be terminated, suspended, or reduced. Consequently, § 431.211 does not apply to Plaintiffs. Moreover, in 42 C.F.R. § 431.200, *et seq.*, which governs "Fair Hearings for Applicants and Recipients," § 431.206 [19] only gives Plaintiffs the right to notice of their right to a fair hearing; it does not give Plaintiffs the right to notice of a change in interpretation of the Medicaid Act.

Furthermore, § 435.919 requires fair hearings for Medicaid beneficiaries who have their benefits reduced, suspended, or terminated. Because Plaintiffs are merely Medicaid applicants who have been denied benefits, potential Medicaid applicants, or individuals whose applications are pending, rather than Medicaid recipients, Plaintiffs are not entitled to the rights afforded persons already receiving benefits. Moreover, 42 C.F.R. § 447.205 requires public notice when there is a proposed change in the methods and standards for setting payment rates. Therefore, that regulation does not affect applicants or potential applicants such as Plaintiffs; such notice would only affect Medicaid providers.

Additionally, Plaintiffs argue in their motion for preliminary injunction, that Defendants' "policy change" of viewing CSATs as a countable resource constitutes impermissible rule making that fails to comply with N.J.S.A. 52:14B–1, *et seq.* and that its retroactive application violates Plaintiffs' due process rights to prior notice and appeal.

[24] Allegations that Defendants violated state law and their own procedures in denying adequate notice and opportunity to be heard do not provide the basis for a constitutional due process claim. *See Concourse Rehabilitation & Nursing Center Inc. v. DeBuono*, 179 F.3d 38, 44 (2nd Cir.1999); *see also Hartwick v. Board of Trustees of Johnson County Community College*, 782 F.Supp. 1507, 1511 (D.Kan. 1992).

Therefore, Plaintiffs' due process claims are dismissed.

7. *Equal Protection*

[25] While neither party has briefed this issue, the allegation in Plaintiffs' complaint that Defendants' conduct somehow violated their constitutional rights to equal protection fails as a matter of law.

(3) The change is based on changes in wholesalers' or manufacturer' prices of drugs or materials, if the agency's reimbursement system is based on material cost plus a professional fee.
(c) *Content of notice*....
(d) *Publication of notice.* The notice must—
(1) Be published before the proposed effective date of the change; and
(2) Appear as a public announcement in one of the following publications:
(i) A State register similar to the FEDERAL REGISTER.
(ii) The newspaper of widest circulation in each city with a population of 50,000 or more.
(iii) The newspaper of widest circulation in the State, if there is no city with a population of 50,000 or more.

19. Section 431.206 provides in pertinent part:

(b) The agency must, at the time specified in paragraph (c) of this subsection, inform every applicant or recipient in writing—(1) Of his right to a hearing; (2) Of the method by which he may obtain a hearing; and (3) That he may represent himself or use legal counsel, a relative, a friend, or other spokesman.
(c) The agency must provide the information required in paragraph (b) of this section—(1) at the time that an individual applies for Medicaid; (2) At the time of any action affecting his or her claim; (3) At the time a skilled nursing facility or a nursing facility notifies a resident in accordance with § 483.12 of this chapter that he or she is to be transferred or discharged; and (4) At the time an individual receives an adverse determination by the State with regard to the preadmission screening and annual resident review requirements ...

The Equal Protection Clause commands that no State shall "deny to any person within its jurisdiction the equal protection of the laws." This provision creates no substantive rights. Instead, it embodies a general rule that States must treat like cases alike but may treat unlike cases accordingly. *Plyler v. Doe*, 457 U.S. 202, 216, 102 S.Ct. 2382, 2394, 72 L.Ed.2d 786 (1982) (" '[T]he Constitution does not require things which are different in fact or opinion to be treated in law as though they were the same' ") (quoting *Tigner v. Texas*, 310 U.S. 141, 147, 60 S.Ct. 879, 882, 84 L.Ed. 1124 (1940)). If a legislative classification or distinction "neither burdens a fundamental right nor targets a suspect class, we will uphold [it] so long as it bears a rational relation to some legitimate end." *Romer v. Evans*, 517 U.S. 620, —— [631], 116 S.Ct. 1620, 1627, 134 L.Ed.2d 855 (1996).

Vacco v. Quill, 521 U.S. 793, 799, 117 S.Ct. 2293, 138 L.Ed.2d 834 (1997) (citations omitted).

Here, Plaintiffs have not been identified as a suspect class and no fundamental rights are involved. To the extent that Defendants' conduct or "policy change" does not treat all applicants who have used CSATs alike, it can be argued that such treatment bears a rational relation to the legitimate end of complying with the federal Medicaid Act and Congress' intent to provide medical assistance to the needy. Plaintiffs' equal protection claim is therefore dismissed.

8. *Exhaustion of State Remedies*

Defendants assert that Plaintiffs' remedy for the State's denial of Medicaid eligibility is to seek redress through the State courts. If eligibility is denied, an applicant may appeal an agency's decision by obtaining a fair hearing. N.J.S.A. 30:4D–7(e); N.J.A.C. 10:49–10.3(b). If appropriate, the appeal is heard by an Administrative Law Judge ("ALJ"). The Director of DMAHS then reviews the initial decision of the ALJ and issues a final agency decision, which is appealable to the Appellate Division. *See* New Jersey Court Rules Governing Appellate Practice, R. 2:2–3(a)(2) (all final state administrative agency decisions are appealable as of right); and Administrative Procedures Act, N.J.S.A. 52:14B–12.

[26] Notwithstanding those state appeals procedures, "[t]he availability of state administrative procedures ordinarily does not foreclose resort to section 1983." *Wilder*, 496 U.S. at 524, 110 S.Ct. 2510. Additionally, as argued by Plaintiffs at the March 27, 2000 hearing, they are seeking to enforce the federal mandate that States provide applicants an opportunity to have an undue hardship hearing,[20] which is separate and distinct from a fair hearing. *See* Transcript of March 27, 2000 Hearing ("Hearing Tr."), 37:1–14.

C. *Plaintiff's Motion for Preliminary Injunction*

[27, 28] The issuance or denial of a preliminary injunction is a matter committed to the sound discretion of the trial court. *Penn Galvanizing Co. v. Lukens Steel Co.*, 468 F.2d 1021, 1023 (3d Cir. 1972). An injunction, however, is "an extraordinary remedy which should be granted only in limited circumstances." *Instant Air Freight Co. v. C.F. Air Freight, Inc.*, 882 F.2d 797, 800 (3d Cir.1989).

[29] In ruling on a motion for a preliminary injunction, the court must be convinced that all four of the following factors favor preliminary relief: (1) the likelihood that the moving party will succeed on the merits; (2) the extent to which the moving party will suffer "irreparable harm" without injunctive relief; (3) the extent to which the nonmoving party will suffer irreparable harm if the injunction is issued; and (4) the public interest. *Clean Ocean Action v. York*, 57 F.3d 328, 331 (3d Cir.

20. Defendants concede that the State does not currently have regulations implemented setting forth procedures, such as the administrative remedies, for an undue hardship hearing.

1995); *American Tel. & Tel. Co. v. Winback and Conserve Program, Inc.*, 42 F.3d 1421, 1426 (3d Cir.1994).

Plaintiffs allege that the New Jersey Medicaid plan does not comport with the federal Medicaid Act in the following respects:

(a) Failure to provide notice of and establish procedures for "undue hardship" hearing pursuant to 42 U.S.C. § 1396p(c)(2)(D) to provide a "final" level of appeal in the event of denial of Medicaid benefits based on financial eligibility for elderly institutionalized spouses;

(b) Application of financial standards for eligibility and transfer of asset rules that do not conform to 42 U.S.C. § 1396p and, in violation of N.J.S.A. 30:4D–3(i)(15)(b),[21] are more restrictive in scope, duration, or amount of services than permitted;

(c) Establishing, without basis in federal or state law, a "more restrictive" condition by requiring that New Jersey be the first named beneficiary upon the death of the community spouse to the extent of full reimbursement for Medicaid benefits paid on behalf of the institutionalized spouse; and

(d) Enunciating the "new policy" to reject CSATs in violation of N.J.S.A. 52:14B–1, *et seq.* and to apply that change retroactively in violation of 42 C.F.R. §§ 431.211, 435.919, 447.205, rights to constitutional due process and equal protection.

Each contention will be addressed in turn.

21. That provision provides in pertinent part:

> An individual who has, within 36 months, or within 60 months in the case of funds transferred into a trust, of applying to be a qualified applicant for Medicaid services in a nursing facility . . ., disposed of resources or income for less than fair market value shall be ineligible for assistance for nursing facility services . . . The period of ineligibility shall be the number of months resulting from dividing the uncompensated value of the transferred resources or income by the average monthly private payment rate for nursing facility services in the State as determined annually by the commissioner. In the case of multiple resource or income transfers, the resulting penalty periods shall be imposed sequentially. Application of this requirement shall be governed by 42 U.S.C. § 1396p(c). In accordance with federal law, this provision is effective for all transfers of resources or income made on or after August 11, 1993. Notwithstanding the provisions of this subsection to the contrary, the State eligibility requirements concerning resource or income transfers shall not be more restrictive than those enacted pursuant to 42 U.S.C. § 1396p(c).

22. *See supra* III.B.4.a., for text of 42 U.S.C. § 1396p(c)(2)(D).

1. *Undue Hardship Hearing*

a. *Likelihood of Success on the Merits*

[30] The requirement that the State Medicaid plan include a procedure to determine whether an "undue hardship" exception applies is set forth in 42 U.S.C. § 1396p(c)(2)(D).[22] It is evident from the legislative history that it is mandatory that the states provide for an undue hardship exception. Congress, specifically concerned that the states were not extending to all individuals facing hardship the protections of existing law, crafted OBRA to specifically amend existing law to require "the Secretary (1) to specify standards that State hardship determination procedures must meet, and (2) to establish criteria States must apply in determining whether a hardship exists." H.R.Rep. No. 103–111(II), 103th Cong., 1st Sess., at 207 (1993), reprinted in 1993 U.S.C.C.A.N. 378, 534.

Sections 3259.8(A) and (C) of the HCFA Guidelines provide that at a minimum, the undue hardship provision must provide for: (1) notice to a recipient that an undue hardship exists; (2) a timely process for determining whether an undue hardship waiver will be granted; and (3) a process under which an adverse determination can be appealed.

Plaintiffs contend that contrary to the mandates of 42 U.S.C. § 1396p(c)(2)(D) and the HCFA Guidelines, neither the

Medical Assistance Act in N.J.S.A. 30:4D–1 *et seq.* nor the numerous regulations implementing the State Medicaid provisions have defined or enacted hardship provisions to allow the over age 65, institutionalized Plaintiffs to appeal denial of their Medicaid applications. Moreover, they argue that under OBRA, 42 U.S.C. § 1395a(e)(3), all participating Medicaid states were to adopt all regulations enacting OBRA within one year of its effective date. According to Plaintiffs, even after six years, the State has failed to enact, as it was required to do, regulatory procedures to implement undue hardship exceptions in the State Medicaid plan pursuant to New Jersey's Administrative Procedure Act ("APA"), N.J.S.A. 52:14B–1, *et seq.*

Defendants do not contest that Plaintiffs must be permitted to apply for an undue hardship hearing and that provisions for a hearing on the hardship issue have not been codified in the New Jersey Administrative Code; rather, they assert that Plaintiffs were offered an undue hardship hearing, but have refused to pursue that option. Moreover, counsel for Defendants represented to the Court at the March 27th hearing, that the Commissioner of DMAHS will file with the New Jersey Office of Administrative Law proposed regulations establishing undue hardship hearings before the end of April, 2000. Hearing Tr. 13:17–16:17. Then the proposal would, in accordance with the procedures set forth in the state APA governing rule making, be published in the New Jersey Register for notice and comment. *Ibid.*

Nevertheless, Defendants have not, as they are required to do, instituted any regulations providing for: (1) notice to applicants that an undue hardship exception exists; (2) a timely process for determining whether an undue hardship waiver will be granted; and (3) a process under which an adverse determination can be appealed, Plaintiffs are likely to prevail on this issue.

b. *Irreparable Harm*

[31–33] In this Circuit, "to show irreparable harm a plaintiff must demonstrate potential harm which cannot be redressed by a legal or an equitable remedy following a trial. Economic loss does not constitute irreparable harm." *Acierno v. New Castle County*, 40 F.3d 645, 653 (3d Cir.1994). Thus, in order to warrant a preliminary injunction, the injury created by a failure to issue the requested injunction "must be of a peculiar nature, so that compensation in money cannot atone for it." *A.O. Smith Corp. v. F.T.C.*, 530 F.2d 515, 525 (3d Cir.1976) (citation omitted) (internal quotation marks omitted). Moreover, "[a]n inability to precisely measure financial harm does not make that harm irreparable or immeasurable." *Acierno*, 40 F.3d at 655.

[34] Additionally, the injury alleged must not only be irreparable, it must be imminent as well. *Holiday Inns of Am., Inc. v. B & B Corp.*, 409 F.2d 614, 618 (3d Cir.1969) (noting that injunctive relief "may not be used simply to eliminate a possibility of a remote future injury, or a future invasion of rights.")

[35] Defendants have represented that the procedures for establishing state regulations governing the undue hardship exception would be initiated no later than the end of April, 2000. Therefore, there is no threat of immediate irreparable injury resulting from the current absence of regulations. Furthermore, it is worth noting that even if this Court were to order Defendants to promulgate such regulations, Defendants must still follow the procedural requirements set forth in the APA to promulgate such regulations. Consequently, these regulations would not be instituted any faster than with an order from this Court.

As to these particular Plaintiffs who have not had the benefit of such regulations, Defendants have expressed a willingness to provide that hearing; moreover, despite the fact that there are not yet any state adopted standards and procedures,

section 3259.8 of the HCFA Guidelines at least provides a definition of "undue hardship" and a framework for the state standards. Therefore, Plaintiffs are, at the minimum, protected by those federal standards.

Because Plaintiffs are not subject to immediate irreparable harm, this factor weighs against granting preliminary relief.[23] Therefore, the Court need not engage in an analysis of the remaining factors to determine whether granting a preliminary injunction is appropriate.

[36] Alternatively, even if the Court were to conclude that there was the potential of immediate irreparable harm, the Court would not exercise its discretion to grant the extraordinary relief sought by Plaintiffs. Before seeking a preliminary injunction compelling Defendants to implement regulations, Plaintiffs, although not required to have done so before filing a § 1983 action, could have resorted to N.J.S.A. 52:14B–4(f), which authorizes and sets forth the procedures for an interested person to petition an agency to promulgate, amend or repeal any rule. Once such a petition is received by the agency, the agency must respond within 30 days. Plaintiffs suggest that they have not filed a petition with the DMAHS because this administrative procedure "typically results in delays of one year or more" and because DMAHS has continually been advising the Elder Law Section of the New Jersey Bar Association that proposed regulations required under OBRA, now five years overdue, will be forthcoming "shortly." If Plaintiffs truly believed that irreparable injury would result from Defendants' failure to have implemented official regulations governing undue hardship hearing, the remedy available to Plaintiffs under N.J.S.A. 52:14B–4(f) was available during the six years since the enactment of OBRA.

Therefore, Plaintiff's motion for preliminary injunctive relief on this issue will be **denied without prejudice.** In the event, however, that Defendants do not initiate the process of implementing regulations governing the undue hardship exception by the end of April 2000, or Defendants do not provide these specific Plaintiffs the opportunity to have an undue hardship in accordance with the standards set forth in the HCFA Guidelines, Plaintiffs may seek the appropriate relief from this Court.

2. *Application of Transfer Rules and Treatment of Trusts*

Here, because the CSATs are irrevocable trusts that can, in no way, benefit the applicant, Plaintiffs argue that CSATs qualify as exceptions to the transfer rules set forth in 42 U.S.C. § 1396p(c)(2)(B)(i) and (ii), and N.J.A.C. 10:71–4.7(e)(1)(i).[24] Defendants do not contest that of the Plaintiffs who have actually submitted trusts for review, all the trusts were deemed to be actuarially sound transfers for the sole benefit of the community spouse and not subject to a transfer penalty.[25] Defs.' Br. in Opp. to Mot. for Prelim-

23. Plaintiffs argue that the nursing facilities will be harmed because of the financial impact of them of not getting paid. The Court will not consider that argument because the nursing facilities are not parties to this action and Plaintiffs do not have standing to argue on behalf of those facilities.

24. N.J.A.C. 10:71–4.7(e)(1)(i) states:
If funds were transferred to another individual for the sole benefit of the community spouse prior to entry into institutional care, in order that the transfer not be considered to have been for the purposes of qualifying for Medicaid, the funds must have been transferred in the form of a legally binding trust document specifying that the trustee(s) may use the funds solely for the benefit of the community spouse. Should the transferred funds not be so designated, the transfer shall be presumed to be for the purpose of qualifying for Medicaid in accordance with the provisions of this section;

25. This renders moot Plaintiffs request that the Court estop Defendants from determining that Plaintiffs' contribution of available resources to CSATs constitute transfers for less than fair market value resulting in a period of ineligibility for Medicaid benefits.

inary, Permanent Injunction and Declarative Relief, at 23. In other words, in this circumstance, the corpus of the trust is considered a transfer of assets for less than fair market value, which would normally trigger a look-back period, but in this case, does not because the transfer was for the "sole benefit of" the community spouse. Therefore, no part of the corpus of the CSAT would be treated as a countable resource to the institutionalized spouse. *See* Feinberg article.

Although the "sole benefit of" trust does not trigger a penalty period and is not a countable resource to the grantor or institutionalized spouse, § 1396p(d)(3)(B)(ii) [26] does not expressly address whether an irrevocable trust, from which the institutionalized spouse may not benefit, and created solely for the benefit of the community spouse, is a countable resource to the community spouse in calculating the spousal share and CSRA and determining Medicaid eligibility.

Plaintiffs insist that because the CSATs are actuarially sound, as defined in HCFA Guideline § 3258.9B, and are "for the sole benefit of" the spouse, as defined in HCFA Guideline § 3257.B6, the CSATs are also not countable resources for Medicaid eligibility purposes. As argued by Defendants, however, actuarial soundness is a factor in determining whether a transfer to a third party was in fact made for the sole benefit of the spouse. *See* HCFA Guideline § 3257.B6; Streimer letter. If a transfer was made for the sole benefit of the spouse, then that determination impacts whether the transfer for less than fair market value triggers a transfer penalty and has no bearing on whether an asset is a countable resource.[27]

Next, Plaintiffs conclude that the CSAT is analogous to a commercial annuity because the CSAT annuitized payout of principal and earnings meet the HCFA Guidelines for annuities set forth in § 3258.9B.[28] HCFA Guideline 3258.9B, however, applies to annuities. Moreover, Plaintiffs' own words belie their contention: "[s]ection 3259 of HCFA 64 defines 'annuities' and specifies that Section 3258.9B controls how annuities are to be evaluated and treated. Therefore, the 'plain meaning' is that *Section 3259 trust provisions are inapplicable to annuity trusts* since Section 3258.9B controls." Pls.' Reply Br. in Support of Mot. For Preliminary Injunction, at 9 (emphasis added).

In asserting that "sole benefit of" trusts are in fact countable resources, Defendants emphasize that such trusts are not included in 42 U.S.C. § 1382b among the list of resources that are excludable. Indeed, § 3260.1 of the HCFA Guidelines defines "countable resources" are "resources [that are] not subject to exclusion."

In further support of their position, Defendants rely on the informal statement of HCFA's views set forth in the Streimer letter that "sole benefit of" trusts are countable resources. *See supra* discussion II.G. As explained in that letter, an irrevo-

26. 42 U.S.C. § 1396p(d)(3)(B)(ii) states:

> any portion of the trust from which, or any income on the corpus from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of subsection (c) of this section, and the value of the trust shall be determined for purposes of such subsection by including the amount of any payments made from such portion of the trust after such date.

27. Although Defendants as well as Plaintiffs both look to different paragraphs of § 3258.11 of the HCFA Guidelines to support their respective positions, that section is inapplicable because it merely addresses when certain transfers of assets for less than fair market value are exempt from penalty, rather than when resources are countable in determining eligibility.

28. Section 3258.9B provides in part that if an annuity is not actuarially sound, then the annuity is considered a transfer of assets for less than fair market value subjecting the individual to a penalty.

cable trust is unlike a commercial annuity because in an irrevocable trust, the corpus can be paid at some point to the community spouse, but in a standard annuity, the buyer is only entitled to the income stream purchased and cannot reclaim the funds used to purchase the annuity.

Plaintiffs respond that the Streimer letter is merely a response to a private attorney on a specific set of facts unknown to DMAHS, rather than a rule, regulation, or guideline that has ever been subjected to judicial review to determine compliance with federal law.

[37] Contrary to Plaintiffs' contentions, HCFA's Guidelines and the Streimer letter, although not formal regulations, are entitled to some deference by this Court as long as "they are consistent with the plain language and purposes of the statute and if they are consistent with prior administrative views." *Cleary v. Waldman*, 167 F.3d 801, 808 (3d Cir.) (granting deference to HCFA and HHS clearly stated views, albeit in policy letters, that states have discretion to employ either income-first or resource-first method to determine Medicaid eligibility), *cert. denied*, — U.S. —, 120 S.Ct. 170, 145 L.Ed.2d 144 (1999); *see also Skidmore v. Swift & Co.*, 323 U.S. 134, 140, 65 S.Ct. 161, 89 L.Ed. 124 (1944) (stating that where an administrative agency's interpretation is registered in informal views, as long as that agency has a delegated authority to administer the statute and the views are made "in pursuance of official duty, based upon more specialized experience and broader investigations and information than is likely to come to a judge," then those views warrant some deference); *Elizabeth Blackwell Health Center for Women v. Knoll*, 61 F.3d 170 (3d Cir.1995) (noting that interpretive rules by an agency with lawmaking authority will receive deference even if the agency's interpretation is not made pursuant to that lawmaking authority), *cert. denied*, 516 U.S. 1093, 116 S.Ct. 816, 133 L.Ed.2d 760 (1996).

[38] In examining HCFA's interpretation of the treatment of irrevocable trusts, such as the CSATs at issue here, the Court determines that the agency's view is based on a permissible construction of the statute. As stated earlier in this opinion, the MCCA, discussed *supra* n. 9, supersedes any inconsistent provisions in that subchapter; therefore, to the extent that Plaintiffs argue that 42 U.S.C. § 1396p(c)(2) is inconsistent with the MCCA, the MCCA controls. 42 U.S.C. § 1396r–5(a)(1). The MCCA provides that when computing spousal share at the time of institutionalization, a "snapshot" of all of the couple's countable resources, which includes "the total value of the resources to the extent *either* the institutionalized spouse or the community spouse has an ownership interest," is taken. 42 U.S.C. § 1396r–5(c)(1). Under the plain meaning of this section, a CSAT is a resource to the community spouse, and therefore, is part of the total value of resources in determining spousal share. As discussed earlier in this opinion, if the community spouse's share exceeds the "community spouse resource allowance," then any excess must be spent down for the care of the institutionalized spouse. *See* 42 U.S.C. § 1396r–5(c)(2)(B) ("resources shall be considered to be available to an institutionalized spouse, but only to the extent that the amount of such resources exceeds" the CSRA).

Moreover, HCFA's position does not frustrate Congress' intent in enacting the MCCA to enable the community spouse to live above the poverty level. Instead, it ensures that Medicaid, as it was intended, helps the truly needy and furthers the legislature's intent to "require couples to bear a reasonable amount of the costs of institutionalized care and thus preserve Medicaid resources." *Cleary v. Waldman*, 959 F.Supp. 222, 232 (D.N.J.1997), *aff'd* 167 F.3d 801, 807 (3d Cir.), *cert. denied*, — U.S. —, 120 S.Ct. 170, 145 L.Ed.2d 144 (1999).

It is noteworthy that ten of the Plaintiffs who have submitted trusts for review have countable resources in excess of the maximum amount that federal law permits the community spouse to retain:

Denman	$833,000
Fillmore	$492,000
Johnson	$288,000
Mariani	$272,000
Mackron	$250,000
Fleming	$236,000
Banks	$193,000
Hicks	$168,000
Schaible	$ 58,000
Silbernagle	$ 53,000
Prystasch	$ 15,000

See Certification of Elena Josephick, ¶ 7.

Finally, HCFA's Guidelines were issued after OBRA was enacted in 1993. Plaintiffs do not contend that the Guidelines are inconsistent with HCFA's prior administrative view. Additionally, the Streimer is consistent with the interpretation set forth in the Guidelines.

Therefore, because Defendants' policy of including the CSATs as a countable resource is based on HCFA's position, which is consistent with federal law, Plaintiffs are not likely to prevail on this issue. Accordingly, the Court need not determine the remaining factors to determine if injunctive relief on this issue is warranted.

3. *New Jersey as First Named Beneficiary*

a. *Likelihood of Success on the Merits*

According to Plaintiffs, prior to July 1999, the CSATs in the format utilized by Plaintiffs were routinely approved upon compliance with conditions imposed by DMAHS. Such conditions included a requirement that DMAHS be named as the first beneficiary of the CSAT upon the death of the community spouse to recover Medicaid assistance paid on behalf of the institutionalized spouse. Plaintiffs claim that this requirement was imposed notwithstanding that the estate recovery provisions mandated in 42 U.S.C. § 1396p(c) and codified in N.J.S.A. 30:4D–7.2 limit estate recovery to actions against the estate of the institutionalized spouse, not the community spouse.

42 U.S.C. § 1396p(b)(1) provides that after the death of the community spouse, states must "seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan" from the recipient's estates[29] or "upon sale of the property subject to a lien imposed on account of medical assistance paid on behalf of the individual." Similarly, N.J.S.A. 30:4D–7.2 also provides for the State's recovery from the estate of a deceased recipient for assistance correctly paid or to be paid on his behalf. As argued by Plaintiffs, the federal and state estate recovery provisions do not authorize recovery actions against the community spouse's estate.

Defendants do not address this argument and in effect, concede their error. At oral argument, defense counsel explained that DMAHS required it to be first named beneficiary because at that time, Defendants erroneously believed that the "sole benefit of" trust was an excludable resource. Hearing Tr. 74:22–75:7.

Because Plaintiffs' position is correct that this condition is "more restrictive" than permitted by federal law, Plaintiffs are likely to succeed on this issue.

b. *Irreparable Harm to Plaintiffs*

Plaintiffs, however, will not suffer any immediate irreparable harm. First, Defendants have explained that they required DMAHS to be the first named beneficiary because they had considered the "sole benefit of" trust to be an excludable resource. Because Defendants are now treating such trusts as includable, logic dictates that Defendants will no longer require DMAHS to be the first named beneficiary. Therefore, there is no potential of immediate irrepa-

29. The term "estate" includes all real and personal property included within the individual's estate under state probate law. 42 U.S.C. § 1396(b)(4).

rable harm to Plaintiffs. Plaintiffs' motion for preliminary injunction on this issue is **denied without prejudice.** In the event, however, that Defendants fail to eliminate this requirement, Plaintiffs may seek the appropriate relief.

IV. *CONCLUSION*

For the foregoing reasons, Defendants' motion to dismiss for failure to state a claim upon which relief with respect to the due process and equal protection claims, and as to all claims by Plaintiffs who are only prospective Medicaid applicants is **granted,** and Defendants' motion as to the balance is **denied.** Because Plaintiffs cannot establish immediate irreparable injury, Plaintiffs' motion for preliminary injunction is **denied.**

N.A.M.I. (NATIONAL ALLIANCE OF MENTALLY ILL OF ESSEX), et al., Plaintiffs,

v.

ESSEX COUNTY BOARD OF FREEHOLDERS, et al., Defendants.

No. CIV.99-4605.

United States District Court, D. New Jersey.

April 11, 2000.

Organization for advocacy for rights of mentally ill, taxpayer, and parent of mental health patient at long term care facility brought action challenging county's proposal to relocate facility. On defendants' motions to dismiss, the District Court, Hochberg, J., held that: (1) action was not ripe; (2) plaintiffs did not have standing to bring action; and (3) proposal did not violate Americans With Disabilities Act (ADA).

Motions granted.

1. Federal Courts ⇐12.1

In determining whether case is ripe for adjudication, court looks to (1) fitness of issues for judicial resolution and (2) hardship to parties of withholding court consideration. U.S.C.A. Const. Art. 3, § 2, cl. 1.

2. Federal Courts ⇐13.25

Action challenging county's proposal to relocate long term care facility for mental health patients was not ripe for adjudication; no plan had been adopted, former site had not been sold, proposed site had not been purchased, and features of new facility were unknown. U.S.C.A. Const. Art. 3, § 2, cl. 1.

3. Associations ⇐20(1)
Asylums ⇐8

Organization for advocacy for rights of mentally ill, taxpayer, and parent of mental health patient at long term care facility did not have standing to challenge county's proposal to relocate facility, absent evidence that members of organization or individual plaintiffs had suffered injury in fact. U.S.C.A. Const. Art. 3, § 2, cl. 1.

4. Action ⇐3

Restatement of Bill of Rights for Mental Health Patients did not create private right of action to ensure that mental health patients received required protection and services. Protection and Advocacy for Mentally Ill Individuals Act of 1986, § 201, 42 U.S.C.A. § 10841.

5. Civil Rights ⇐119.1

Proposed relocation of long term care facility for mental health patients did not violate ADA due to alleged reduction of care and services, absent evidence that patients, by reason of their disabilities, were being denied care afforded to individ-

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Document(1)

1. Shepards®: Johnson v. Guhl, 91 F. Supp. 2d 754, 2000 U.S. Dist. LEXIS 4485, 68 Soc. Sec. Rep. Service 469(D.N.J.,2000)

   Client/matter: -None-

   Requested Categories: Appellate History - Requested
   Citing Decisions - None applied
   Citing Law Reviews, Treatises... - Not Requested

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Citing Decisions: None Applied
Citing Law Reviews, Treatises...: Not Requested

***Shepard's*®:** **Johnson v. Guhl** 91 F. Supp. 2d 754,2000 U.S. Dist. LEXIS 4485,68 Soc. Sec. Rep. Service 469: (D.N.J. 2000)

No negative subsequent appellate history

Appellate History

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	Appellate History	Court	Date
1	Citation you *Shepardized* ™ **Johnson v. Guhl** 91 F. Supp. 2d 754, 2000 U.S. Dist. LEXIS 4485, 68 Soc. Sec. Rep. Service 469	D.N.J.	2000
	Subsequent		
2	B **Motion denied by**, *and* B **Injunction denied by**, *and* B **Dismissed by:** **Johnson v. Guhl** 166 F. Supp. 2d 42, 2001 U.S. Dist. LEXIS 16058, 76 Soc. Sec. Rep. Service 332	D.N.J.	2001
3	G **Affirmed by:** **Johnson v. Guhl** 357 F.3d 403, 2004 U.S. App. LEXIS 1849	3d Cir. N.J.	2004

Citing Decisions

Narrow by:	None Applied
Analysis:	Distinguished by (2), Followed by (5), "Cited by" (21)
Court:	3rd Circuit (11), 4th Circuit (2), 8th Circuit (2), 10th Circuit (1), 6th Circuit (1), 7th Circuit (1), Other Federal Decisions (1), Arizona (1), Delaware (1), Illinois (1), Indiana (1), Massachusetts (1), Ohio (1), Rhode Island (1), Wisconsin (1)
Headnotes:	HN70 (7), HN62 (6), HN64 (6), HN21 (4), HN68 (4), HN17 (3), HN20 (3), HN24 (3), HN28 (3), HN19 (2), HN22 (2), HN23 (2), HN25 (2), HN27 (2), HN34 (2), HN35 (2), HN5 (2), HN65 (2), HN66 (2), HN71 (2), HN1 (1), HN15 (1), HN16 (1), HN18 (1), HN26 (1), HN39 (1), HN43 (1), HN48 (1), HN55 (1), HN58 (1), HN60 (1), HN63 (1), HN69 (1), HN8 (1)

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	Citing Decisions	Court	Date
	3rd Circuit - U.S. District Courts		
1	**Cited by:** **Dultz v. Velez** 726 F. Supp. 2d 480, 2010 U.S. Dist. LEXIS 86596 *Headnotes: HN19, HN71* *Cited by; 726 F. Supp. 2d 480 p.483*	D.N.J.	2010
2	**Followed by:** **Tristani v. Richman** 609 F. Supp. 2d 423, 2009 U.S. Dist. LEXIS 24493, 77 Fed. R. Serv. 3d (Callaghan) 69 *Headnotes: HN71* *Followed by; 609 F. Supp. 2d 423 p.457*	W.D. Pa.	2009
3	**Distinguished by**, *and* **Followed by:** **Lewis v. Rendell** 501 F. Supp. 2d 671, 2007 U.S. Dist. LEXIS 57009 *Headnotes: HN17, HN18, HN19, HN20, HN23, HN27, HN28, HN39, HN62, HN63, HN69* *Distinguished by; 501 F. Supp. 2d 671 p.692* *Followed by; 501 F. Supp. 2d 671 p.687*	E.D. Pa.	2007
4	**Cited by:** **James v. Richman** 465 F. Supp. 2d 395, 2006 U.S. Dist. LEXIS 84846 *Headnotes: HN8, HN34, HN62, HN64, HN66, HN70* *Cited by; 465 F. Supp. 2d 395 p.401*	M.D. Pa.	2006
5	**Cited by:** **Estate of Witty v. Primus Telcoms. Group, Inc.** 2006 U.S. Dist. LEXIS 47898	D.N.J.	July 13, 2006

Shepard's®: Johnson v. Guhl, 91 F. Supp. 2d 754

	Citing Decisions	Court	Date
6	**Cited by:** **Kwasnik v. Leblon** 2005 U.S. Dist. LEXIS 25823 *Headnotes: HN5*	D.N.J.	Aug. 8, 2005
7	**Distinguished by:** **Mersmann v. Cont'l Airlines** 335 F. Supp. 2d 544, 2004 U.S. Dist. LEXIS 19064, 150 Lab. Cas. (CCH) P59932 *Headnotes: HN5* *Distinguished by; 335 F. Supp. 2d 544 p.555*	D.N.J.	2004
8	**Cited by:** **Johnson v. Guhl** 166 F. Supp. 2d 42, 2001 U.S. Dist. LEXIS 16058, 76 Soc. Sec. Rep. Service 332 *Headnotes: HN1, HN16, HN20, HN21, HN22, HN23, HN24, HN34, HN43, HN48, HN58, HN60, HN62, HN64, HN68, HN70*	D.N.J.	2001
9	**Cited by:** **Mertz v. Houstoun** 155 F. Supp. 2d 415, 2001 U.S. Dist. LEXIS 10918 *Headnotes: HN20, HN22, HN62, HN64, HN70* *Cited by; 155 F. Supp. 2d 415 p.421*	E.D. Pa.	2001
10	**Cited by:** **S. Camden Citizens in Action v. N.J. Dep't of Envtl. Prot.** 145 F. Supp. 2d 505, 2001 U.S. Dist. LEXIS 5988, 52 Env't Rep. Cas. (BNA) 1571, 31 Envtl. L. Rep. 20675 *Headnotes: HN15, HN28* *Cited by; 145 F. Supp. 2d 505 p.537*	D.N.J.	2001
11	**Cited by:** **Novartis Consumer Health, Inc. v. Johnson & Johnson-Merck Consumer Pharms. Co.** 129 F. Supp. 2d 351, 2000 U.S. Dist. LEXIS 20269, 2001-1 Trade Cas. (CCH) P73200, 57 U.S.P.Q.2d (BNA) 1522 *Headnotes: HN55* *Cited by; 129 F. Supp. 2d 351 p.362*	D.N.J.	2000
4th Circuit - U.S. District Courts			
12	**Cited by:** **A.W. Irrevocable Special Needs Trust v. Cansler** 2011 U.S. Dist. LEXIS 95628 *Headnotes: HN17*	M.D.N.C.	July 19, 2011

	Citing Decisions	Court	Date
13	LEB **Cited by:** **Maryland Community Health Sys. v. Glendening** 115 F. Supp. 2d 599, 2000 U.S. Dist. LEXIS 15873, 71 Soc. Sec. Rep. Service 558 *Headnotes: HN35* *Cited by; 115 F. Supp. 2d 599 p.604*	D. Md.	2000
	6th Circuit - U.S. District Courts		
14	LEB **Cited by:** **Burkholder v. Lumpkin** 2010 U.S. Dist. LEXIS 11308 *Headnotes: HN68, HN70*	N.D. Ohio	Feb. 9, 2010
	7th Circuit - U.S. District Courts		
15	G **Followed by:** **American Soc'y of Consultant Pharmacists v. Patla** 138 F. Supp. 2d 1062, 2001 U.S. Dist. LEXIS 2061 *Headnotes: HN35* *Followed by; 138 F. Supp. 2d 1062 p.1069*	N.D. Ill.	2001
	8th Circuit - U.S. District Courts		
16	LEB **Cited by:** **Geston v. Olson** 2012 U.S. Dist. LEXIS 67926 *Headnotes: HN70*	D.N.D.	Apr. 24, 2012
17	G **Followed by:** **Ctr. for Special Needs Trust Admin., Inc. v. Olson** 2011 U.S. Dist. LEXIS 44437 *Headnotes: HN17, HN24, HN25*	D.N.D.	Apr. 25, 2011
	10th Circuit - Court of Appeals		
18	LEB **Cited by:** **Morris v. Okla. Dep't of Human Servs.** 685 F.3d 925, 2012 U.S. App. LEXIS 13971 *Headnotes: HN62, HN70*	10th Cir. Okla.	2012
	Other Federal Decisions		
19	LEB **Cited by:** **Novartis Consumer Health Inc. v. Johnson & Johnson-Merck Consumer Pharms. Co.** 57 U.S.P.Q.2d (BNA) 1522 *Cited by; 57 U.S.P.Q.2d (BNA) 1522 p.1530*	D.	Dec. 22, 2000
	Arizona Court of Appeals		
20	LEB **Cited by:** **Barral v. Ariz. Health Care Cost Containment Sys. Admin.** 2012 Ariz. App. Unpub. LEXIS 329 *Headnotes: HN64*	Ariz. Ct. App.	2012

Citing Decisions	Court	Date
Other Delaware Decisions		
21 LEB **Cited by:** **Dean v. Delaware Dep't of Health & Social Servs.** 2000 Del. Super. LEXIS 490 *Headnotes: HN21, HN65, HN66, HN68*	Del. Super. Ct.	Dec. 6, 2000
Illinois Supreme Court		
22 LEB **Cited by:** **Poindexter v. State** 229 Ill. 2d 194, 890 N.E.2d 410, 2008 Ill. LEXIS 307, 321 Ill. Dec. 688 *Headnotes: HN21, HN62, HN70* *Cited by; 229 Ill. 2d 194 p.196; 890 N.E.2d 410 p.413; 321 Ill. Dec. 688 p.691*	Ill.	2008
Indiana Court of Appeals		
23 LEB **Cited by:** **State v. Hammans** 870 N.E.2d 1071, 2007 Ind. App. LEXIS 1730 *Headnotes: HN24, HN25, HN26, HN27, HN28* *Cited by; 870 N.E.2d 1071 p.1075*	Ind. Ct. App.	2007
Massachusetts Appeals Court		
24 LEB **Cited by:** **Normand v. Dir. of the Office of Medicaid** 77 Mass. App. Ct. 634, 933 N.E.2d 658, 2010 Mass. App. LEXIS 1204 *Headnotes: HN64* *Cited by; 77 Mass. App. Ct. 634 p.637; 933 N.E.2d 658 p.661*	Mass. App. Ct.	2010
Ohio Court of Appeals		
25 LEB **Cited by:** **McNamara v. State Dep't of Human Servs.** 139 Ohio App. 3d 551, 744 N.E.2d 1216, 2000 Ohio App. LEXIS 3477 *Headnotes: HN68* *Cited by; 139 Ohio App. 3d 551 p.558; 744 N.E.2d 1216 p.1221*	Ohio Ct. App., Montgomery County	2000
Other Rhode Island Decisions		
26 LEB **Cited by:** **Jordan v. R.I. Dep't of Human Servs.** 2007 R.I. Super. LEXIS 94 *Headnotes: HN64*	R.I. Super. Ct.	2007
Wisconsin Court of Appeals		

Shepard's®: Johnson v. Guhl, 91 F. Supp. 2d 754

	Citing Decisions	Court	Date
27	G **Followed by:** **Estate of Gonwa v. Wis. Dep't of Health & Family Servs.** 2003 WI App 152, 265 Wis. 2d 913, 668 N.W.2d 122, 2003 Wisc. App. LEXIS 563 *Headnotes: HN21, HN65* *Followed by; 265 Wis. 2d 913 p.926; 668 N.W.2d 122 p.129*	Wis. Ct. App.	2003

Legend

●	Warning - Negative Treatment is Indicated	R	Red - Warning Level Phrase
Q	Questioned - Validity questioned by citing references	O	Orange - Questioned Level Phrase
▲	Caution - Possible negative treatment	Y	Yellow - Caution Level Phrase
◆	Positive - Positive treatment is indicated	G	Green - Positive Level Phrase
A	Analysis - Citing Refs. With Analysis Available	B	Blue - Neutral Level Phrase
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!	Warning - Negative case treatment is indicated for statute		

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EXHIBIT F

James v. Richman

465 F.Supp.2d 395
United States District Court,
M.D. Pennsylvania.

Robert A. JAMES by his next friend and attorney in fact, Josephine A. JAMES, Plaintiff,
v.
Estelle B. RICHMAN, in her official capacity as Secretary of the Commonwealth of Pennsylvania, Department of Public Welfare, Defendant.

Civil Action No. 3:05–CV–2647. | Nov. 21, 2006.

Synopsis

Background: Institutionalized **spouse** brought action against the Secretary of the Commonwealth of Pennsylvania, Department of Public Welfare, alleging that Secretary's decision to deny him **Medicaid** benefits, on ground that **annuity** purchased by **community spouse** was an **available** resource to be counted in determining institutionalized **spouse's Medicaid** eligibility, violated the **Medicaid** Act, federal regulations governing **annuities** established by the United States Department of **Health** and Human Services, and the Supremacy Clause of the United States Constitution. Parties cross-moved for summary judgment.

Holdings: The District Court, Caputo, J., held that:
[1] it had federal question jurisdiction over the action;
[2] institutionalized **spouse** showed actual success on merits of his claim, supporting his motion to permanently enjoin the denial of **Medicaid** benefits;
[3] institutionalized **spouse** showed that he would suffer irreparable injury if his request for a permanent injunction were not granted, supporting his motion to permanently enjoin the denial of **Medicaid** benefits;
[4] institutionalized **spouse** showed that granting of permanent injunction would not inflict more harm upon the Secretary than the refusal to grant it would harm him;
[5] institutionalized **spouse** showed that it was in the public interest to permanently enjoin the denial of **Medicaid** benefits; and
[6] judgment declaring Pennsylvania statute which governs **Medicaid** eligibility and **annuities** invalid as preempted by federal law was not warranted.

Plaintiff's motion granted in part and denied in part, and defendant's motion denied.

West Headnotes (10)

[1] **Federal Courts**
⇐ Social security, welfare, and public housing laws, generally

District Court had federal question jurisdiction over institutionalized **spouse's** action against the Secretary of the Commonwealth of Pennsylvania, Department of Public Welfare, alleging that Secretary's decision to deny him **Medicaid** benefits, on ground that **annuity** purchased by **community spouse** was an **available** resource to be counted in determining institutionalized **spouse's Medicaid** eligibility, violated the **Medicaid** Act, federal regulations governing **annuities**, and the Supremacy Clause of the United States Constitution, where the case required the Court to apply or interpret provisions of the **Medicaid** Act in order to determine whether remedies institutionalized **spouse** sought were warranted. U.S.C.A. Const. Art. 6, cl. 2; 28 U.S.C.A. § 1331; **Medicaid** Act, § 1901 et seq., 42 U.S.C.A. § 1396 et seq.

6 Cases that cite this headnote

[2] **Injunction**
⇐ Grounds in general; multiple factors

In deciding whether to grant a permanent injunction, the court must consider whether: (1) the moving party has shown actual success on the merits; (2) the moving party will be irreparably injured by the denial of injunctive relief; (3) the granting of the permanent injunction will result in even greater harm to the defendant; and (4) the injunction would be in the public interest.

1 Cases that cite this headnote

[3] **Injunction**
⇐ **Health** care; Medicare and **Medicaid**

Community spouse's annuity was not a countable resource for purposes of determining **Medicaid** eligibility for institutionalized **spouse**, and, thus, institutionalized **spouse** showed actual success on merits of his claim that Pennsylvania Department of Public Welfare's (DPW) denial of his application for **Medicaid** benefits on ground that **annuity** was an **available** resource was in violation of Social Security Act, supporting his motion to permanently enjoin the denial of **Medicaid** benefits, where, at time of institutionalized **spouse's Medicaid** application, neither **spouse** had an ownership interest in funds used to purchase irrevocable actuarially sound commercial **annuity** as part of retirement plan for sole benefit of **community spouse**; **annuity** was not an **available** resource to extent of its market value on basis of its alleged assignability or liquidity. Medicare Catastrophic Coverage Act of 1988, § 303(a)(1)(B), 42 U.S.C.A. § 1396r–5(b)(1); 20 C.F.R. § 416.1201(a)(1).

5 Cases that cite this headnote

[4] **Health**

Marital **assets** in general

Health

Trusts

So long as the principal or corpus of an irrevocable **annuity** or **trust** cannot be reached by the **Medicaid** applicant or his or her **spouse**, the income derived from such an **asset** cannot be counted as a resource for **Medicaid** purposes, notwithstanding that income stream's market value in the eyes of a third party. Medicare Catastrophic Coverage Act of 1988, § 303(a)(1)(B), 42 U.S.C.A. § 1396r–5(b)(1).

3 Cases that cite this headnote

[5] **Injunction**

Health care; Medicare and **Medicaid**

Institutionalized **spouse** showed that he would suffer irreparable injury if his request for a permanent injunction against the Secretary of the Commonwealth of Pennsylvania, Department of Public Welfare were not granted, supporting his motion to permanently enjoin the denial of **Medicaid** benefits on ground that **annuity** purchased by **community spouse** was allegedly an **available** resource to be counted in determining institutionalized **spouse's Medicaid** eligibility, where institutionalized **spouse** would be required to privately pay for his nursing facility care at a private pay rate of $5,000 per month or else risk being forced to leave the nursing facility, and he could not be compensated by monetary relief, since the Eleventh Amendment precluded an award of retroactive payment by a federal court. U.S.C.A. Const.Amend. 11; Medicare Catastrophic Coverage Act of 1988, § 303(a)(1)(B), 42 U.S.C.A. § 1396r–5(b)(1).

[6] **Injunction**

Health care; Medicare and **Medicaid**

Institutionalized **spouse** showed that granting of an injunction to permanently enjoin the denial of **Medicaid** benefits on ground that **annuity** purchased by **community spouse** was allegedly an **available** resource to be counted in determining institutionalized **spouse's Medicaid** eligibility would not inflict more harm upon the Secretary of the Commonwealth of Pennsylvania, Department of Public Welfare than the refusal to grant it would harm institutionalized **spouse**, where the harm institutionalized **spouse** would suffer, if forced to privately pay $5,000 per month in nursing facility care or else be required to vacate the nursing facility, was substantial. Medicare Catastrophic Coverage Act of 1988, § 303(a)(1)(B), 42 U.S.C.A. § 1396r–5(b)(1).

[7] **Injunction**

Health care; Medicare and **Medicaid**

Institutionalized **spouse** showed that it was in the public interest to permanently enjoin the denial of **Medicaid** benefits by the Secretary of the Commonwealth of Pennsylvania, Department of Public Welfare, where the Secretary denied **Medicaid** assistance to him in violation of

federal law, i.e., on erroneous ground that annuity purchased by community spouse was an available resource to be counted in determining institutionalized spouse's Medicaid eligibility. Medicare Catastrophic Coverage Act of 1988, § 303(a)(1)(B), 42 U.S.C.A. § 1396r–5(b)(1).

[8] **Declaratory Judgment**
Discretion of Court

Federal district courts wield broad and selective discretion in determining whether to entertain a declaratory judgment action.

2 Cases that cite this headnote

[9] **Declaratory Judgment**
Necessity, utility and propriety

Declaratory Judgment
Termination or settlement of controversy

A federal court has discretion to entertain a declaratory judgment action when it finds that the declaratory relief sought: (1) will serve a useful purpose in clarifying and settling the legal relations in issue, and (2) will terminate and afford relief from the uncertainty, insecurity, and controversy giving rise to the proceeding.

2 Cases that cite this headnote

[10] **Declaratory Judgment**
Statutes Relating to Particular Subjects

Judgment declaring Pennsylvania statute which governs Medicaid eligibility and annuities invalid as preempted by federal law was not warranted, where such declaratory relief was neither useful nor necessary to clarifying the legal relations in issue or affording relief to institutionalized spouse in action against the Secretary of the Commonwealth of Pennsylvania, Department of Public Welfare, alleging that Secretary's decision to deny him Medicaid benefits, on ground that annuity purchased by community spouse was an available resource to be counted in determining institutionalized spouse's Medicaid eligibility, violated the Medicaid Act, federal regulations governing annuities, and the Supremacy Clause. U.S.C.A. Const. Art. 6, cl. 2; Medicaid Act, § 1901 et seq., 42 U.S.C.A. § 1396 et seq.; 62 P.S. § 441.6.

2 Cases that cite this headnote

West Codenotes

Validity Called into Doubt
62 P.S. § 441.6.

Attorneys and Law Firms

*398 Kevin R. Grebas, Marshall & Associates, Wilkes–Barre, PA, Matthew J. Parker, Marshall & Associates, Jersey Shore, PA, for Plaintiff.

Michael L. Harvey, Office of Attorney General, Harrisburg, PA, for Defendant.

Opinion

MEMORANDUM

CAPUTO, District Judge.

Presently before the Court are cross motions for summary judgment filed by Plaintiff Robert A. James and Defendant Estelle B. Richman, Secretary of the Commonwealth of Pennsylvania, Department of Public Welfare. (Docs. 30 and 32.) For the reasons stated below, Plaintiff's motion for summary judgment, as to his request for a permanent injunction, will be granted. Plaintiff's request for a declaratory judgment will be denied. Defendant's motion for summary judgment will be denied. The Court has jurisdiction over this matter pursuant to 28 U.S.C. § 1331.

STATUTORY BACKGROUND

Pennsylvania participates in the Federal Medicaid Program established by Title XIX of the Social Security Act, also known as the Medicaid Act, 42 U.S.C. § 1396 *et seq.* Under the Act, the states are granted federal funding to establish plans to dispense assistance to qualified needy individuals.

On November 22, 2005, the Luzerne County Assistance Office determined that Plaintiff was not eligible for **Medicaid** assistance because he did not receive fair consideration for resources used to purchase the **annuity**. (Ex. D.)

On December 12, 2005, the Department of Public Welfare issued a new PA 162 Notice to Plaintiff, advising him that the notice he had previously received, on November 22, 2005, was rescinded, and that he was "ineligible for nursing home payment at this time. Excess resources exist due to the **availability** of the $250,000 **annuity**. You may reapply when resources are within eligibility limits." (Doc. 28 ¶ 12.) The reason for the rejection for **Medicaid** assistance is that, in the view of Defendant, the **annuity** has a value of $185,000.00 and therefore represents **assets** that are beyond the CSRA, and are therefore **available** for payment for nursing care. Defendant offers the declaration of Michael Goodman, Chief Executive Officer of J.G. Wentworth, a finance company specializing in the purchase of **annuities**, as ***400** evidence of the value and marketability of the **annuity**, despite the non-assignment language placed in the endorsement. (Doc. 17–2.)

Plaintiff timely appealed the Department's decision to the Office of Hearings and Appeals. (Doc. 28 ¶ 14.) Plaintiff's appeal is still pending. *Id.* If denied **Medicaid** benefits, Plaintiff will have to privately pay for his nursing facility care at a private rate of over $5,000 per month. (Doc. 28 ¶ 13.)

On December 21, 2005, Plaintiff filed a Complaint in this Court. (Doc. 1–1.) Plaintiff alleged that Defendant's decision to deny him **Medicaid** benefits, on the ground that the **annuity** purchased by Plaintiff's **spouse** is an **available** resource to be counted in determining **Medicaid** eligibility, violates the **Medicaid** Act, 42 U.S.C. § 1396 *et seq.*, the federal regulations governing **annuities** established by the United States Department of **Health** and Human Services under 42 U.S.C. § 1396p(d)(6), as well as the Supremacy Clause of the United States Constitution, U.S. CONST. art. VI, cl. 2. (Doc. 1–1 ¶ 1.) Plaintiff sought to enjoin Defendant from denying him **Medicaid** benefits and to have the recently enacted Commonwealth of Pennsylvania statute, known as Act 42, 62 PA. STAT. ANN.. § 441.6,[1] which governs **Medicaid** eligibility and **annuities**, declared preempted under the Supremacy Clause. (Doc. 1–1 ¶ 1.)

On March 6, 2006, Plaintiff filed a Request for Temporary Restraining Order and Motion for Preliminary Injunction. (Doc. 10–1.) On March 20, 2006, this Court granted Plaintiff's request and motion, enjoining Defendant from denying Plaintiff **Medicaid** until a final decision on the merits of this action. (Doc. 19.)

On May 17, 2006, a Case Management Conference was conducted, wherein the parties agreed to file cross-motions for summary judgment for the Court's consideration. (Docs. 26–27.) The parties filed joint stipulations of facts and exhibits. (Docs. 28–29.) On July 31, 2006, Plaintiff filed his motion for summary judgment on his request to permanently enjoin Defendant from denying him **Medicaid** assistance and to obtain a declaratory judgment holding that Act 42, 62 PA. STAT. ANN.. § 441.6, is preempted under the Supremacy Clause. (Doc. 30.) Defendant filed her cross-motion for summary judgment on August 2, 2006. (Doc. 32.) Both parties filed briefs in support of their motions, as well as briefs in opposition to their adversary's motion. (Docs. 31, 33, 37, 39.) Consequently, this matter is fully briefed and ripe for disposition.

JURISDICTION

While the **Medicaid** Act does not guarantee rights to individuals, it compels **states** to draft a plan that is in conformity with federal law. *See* ***401** *Sabree v. Richman*, 367 F.3d 180, 182 (3d Cir.2004). When a **state** drafts a plan that is not in conformity with federal law, and the plan leads to the denial of **Medicaid** benefits, an adversely affected **Medicaid** applicant has grounds to raise a federal question pursuant to 28 U.S.C. § 1331.

Here, Plaintiff claims that the Commonwealth has enacted legislation—Act 42, 62 PA. STAT. ANN.. § 441.6—that is inconsistent with federal law and one or more parts of that legislation has been relied upon in denying **Medicaid** assistance to Plaintiff.

However, Defendant has expressly disavowed any reliance upon Act 42, 62 PA. STAT. ANN.. § 441.6, in denying Plaintiff **Medicaid** benefits. (Def. Br. In Opp. 3; Doc. 37.) Rather, Defendant has relied throughout this case solely upon her construction of the federal **Medicaid** Act and its regulations to support her denial of **Medicaid** benefits to Plaintiff. Indeed, Act 42, 62 PA. STAT. ANN.. § 441.6, is not mentioned in any of Defendant's briefs submitted to this Court, nor in Defendant's PA 162 notice sent to Plaintiff,

The federal funding is conditioned upon the state's adoption of a plan which complies with the requirements imposed by the Act and by the Secretary of the United States Department of Health and Human Services, who administers the Medicaid program through the Health Care Financing Administration ("HCFA"). The Department of Public Welfare is the regulatory body charged with administering Medicaid assistance throughout the Commonwealth of Pennsylvania. *See* 62 PA. STAT. ANN.. § 403. The Medicare Catastrophic Coverage Act of 1988 ("MCCA"), 42 U.S.C. § 1396r–5, amended the Medicaid Act, adding spousal impoverishment provisions which "permit a spouse living at home (called the 'community spouse') to reserve certain income and assets to meet the minimum monthly maintenance needs he or she will have when the other spouse (the 'institutionalized spouse') is institutionalized, usually in a nursing home, and becomes eligible for Medicaid." *Wis. Dep't of Health & Family Servs. v. Blumer,* 534 U.S. 473, 478, 122 S.Ct. 962, 151 L.Ed.2d 935 (2002). In adopting the MCCA, Congress sought to protect community spouses from becoming impoverished, yet, at the same time, preclude financially secure couples from receiving Medicaid assistance. *Id.* at 480, 122 S.Ct. 962.

The MCCA provides that "no income of the community spouse shall be deemed available to the institutionalized spouse." 42 U.S.C. § 1396r–5(b)(1). "The community spouse's income is thus preserved for that spouse and does not affect the determination whether the institutionalized spouse qualifies for Medicaid." *Blumer,* 534 U.S. at 480–81, 122 S.Ct. 962.

The MCCA, however, treats assets differently. The MCCA shelters a standard amount of assets called the "community spouse resource allowance" or "CSRA." *Id.* at 477, 122 S.Ct. 962. To determine the CSRA, the total of all the couple's resources, whether owned jointly or severally, is calculated as of the time one spouse is institutionalized; half of that total is then allocated to each spouse. 42 U.S.C. § 1396r–5(c)(1)(A). That amount is the CSRA and is subject to a ceiling. 42 U.S.C. § 1396r–5(c)(2)(B), (f)(2)(A), (g). In determining eligibility, the CSRA is not considered available to the institutionalized *399 spouse, but all resources above the CSRA must be spent in order for the institutionalized spouse to be eligible for Medicaid. *Blumer,* 534 U.S. at 482–83, 122 S.Ct. 962.

FACTUAL BACKGROUND

The undisputed material facts, as stipulated to by the parties, are as follows. Plaintiff Robert A. James is a seventy-eight (78) year old resident of Summit Health Care nursing facility in Wilkes–Barre, Pennsylvania. (Doc. 28 ¶ 1.) Plaintiff has at all relevant times been married to Josephine A. James, who is seventy-six (76) years of age. (Doc. 28 ¶ 5.)

On August 10, 2005, Plaintiff, then seventy-seven (77) years of age, was admitted into Summit Health Care nursing facility, where he has since resided. (Doc. 28 ¶¶ 3–4.) On September 20, 2005, Plaintiff filed a Resource Assessment with the Department of Public Welfare at the Luzerne County Assistance Office. (Doc. 28 ¶ 6.) Therein, Plaintiff stated that he and his wife's available resources, as of the date of Plaintiff's admission to Summit Health Care nursing facility, totaled $381,443.00. *Id.* After allowing for the CSRA, and the institutionalized spouse's allowance, Plaintiff and his wife had available resources totaling $278,343.00. (Doc. 28 ¶ 7.)

In order to reduce their assets to the required level of spousal impoverishment, on September 12, 2005, Mrs. James purchased a single premium immediate irrevocable annuity from General Electric Assurance Company, a commercial insurance company licensed to sell in the Commonwealth of Pennsylvania, for $250,000.00. (Doc. 28 ¶ 8.) This annuity was payable to Mrs. James in monthly amounts of $2,937.71, beginning October 1, 2005 and ending on September 1, 2013, an eight (8) year period. *Id.* The terms of the endorsement to the annuity provide "[t]his Contract may not be surrendered, transferred, collaterally assigned, or returned for a return of the premium paid. This Contract is irrevocable and has no cash surrender value. An Owner may not amend this Contract or change any designation under this Contract." (Doc. 28 ¶ 9.) The parties agree that this annuity is actuarially sound.

On September 15, 2005, Plaintiff purchased a new vehicle for $28,550.00. (Doc. 28 ¶ 10.) At this point, all resources beyond those permitted by the CSRA and the institutionalized spouse's allowance had been spent or converted to the annuity. *Id.*

Thereafter, on September 20, 2005, Plaintiff filed an application for Medicaid coverage to assist with the payment of Plaintiff's nursing facility bill, seeking eligibility for September 15, 2005. (Doc. 28 ¶ 11.)

which instead cites 55 PA.CODE §§ 178.4 and 178.121. Moreover, Plaintiff even acknowledges that Defendant is not enforcing Section 441.6(d) against him. (Pl.'s Br. 14.) Consequently, notwithstanding Plaintiff's contentions, this case does not present the issue of whether Act 42, 62 PA. STAT. ANN.. § 441.6, conflicts or frustrates the purpose of the federal Medicaid Act, and thereby would be preempted.

[1] Instead, this action is based upon Defendant's alleged misinterpretation of the pertinent federal law regarding irrevocable actuarially sound commercial annuities. As such, this case requires the Court to apply or interpret provisions of the federal Medicaid Act in order to determine whether the remedies sought by Plaintiff are warranted. *See Johnson v. Guhl,* 91 F.Supp.2d 754, 766 (D.N.J.2000). Therefore, this case presents a federal question, vesting this Court with jurisdiction under 28 U.S.C. § 1331. *See Mass. Ass'n of Older Americans v. Sharp,* 700 F.2d 749, 752–53 (1st Cir.1983) (vacating district court order denying preliminary injunctive relief in case involving a termination of Medicaid benefits based on a misinterpretation by the state of pertinent federal law and regulations regarding redeterminations of Medicaid eligibility); *see also Mont v. Heintz,* 849 F.2d 704, 709–10 (2d Cir.1988) (failure of state to employ standard of need set in compliance with federal law in calculating periods of ineligibility for AFDC recipients in manner contemplated by federal law constitutes "practice" violative of federal law); *cf. Mertz v. Houstoun,* 155 F.Supp.2d 415, 424 (E.D.Pa.2001) (holding that "there is federal jurisdiction to adjudicate a claim that despite adoption of a conforming Medicaid plan, a state routinely assesses eligibility in a manner which conflicts with federal law such that it has effectively supplanted its written plan with a contrary practice"). *See generally Lindy v. Lynn,* 501 F.2d 1367, 1369 (3d Cir.1974) (federal question jurisdiction exists if plaintiff's claim requires the construction of a federal statute).[2]

*402 LEGAL STANDARD

Summary judgment is appropriate if "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." FED. R. CIV. P. 56(c). A fact is material if proof of its existence or nonexistence might affect the outcome of the suit under the applicable substantive law. *See Anderson v. Liberty Lobby, Inc.,* 477 U.S. 242, 248, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986).

Where there is no material fact in dispute, the moving party need only establish that it is entitled to judgment as a matter of law. Where, however, there is a disputed issue of material fact, summary judgment is appropriate only if the factual dispute is not a genuine one. *See id.* at 248, 106 S.Ct. 2505. An issue of material fact is genuine if "a reasonable jury could return a verdict for the nonmoving party." *Id.*

Where there is a material fact in dispute, the moving party has the initial burden of proving that: (1) there is no genuine issue of material fact; and (2) the moving party is entitled to judgment as a matter of law. *See* 10A CHARLES ALAN WRIGHT, ARTHUR R. MILLER & MARY KAY KANE, FEDERAL PRACTICE AND PROCEDURE: CIVIL 2D § 2727 (2d ed.1983). The moving party may present its own evidence or, where the nonmoving party has the burden of proof, simply point out to the Court that "the nonmoving party has failed to make a sufficient showing of an essential element of her case." *Celotex Corp. v. Catrett,* 477 U.S. 317, 323, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986).

All doubts as to the existence of a genuine issue of material fact must be resolved against the moving party, and the entire record must be examined in the light most favorable to the nonmoving party. *See White v. Westinghouse Elec. Co.,* 862 F.2d 56, 59 (3d Cir.1988). Once the moving party has satisfied its initial burden, the burden shifts to the nonmoving party to either present affirmative evidence supporting its version of the material facts or to refute the moving party's contention that the facts entitle it to judgment as a matter of law. *See Anderson,* 477 U.S. at 256–257, 106 S.Ct. 2505.

The Court need not accept mere conclusory allegations, whether they are made in the complaint or a sworn statement. *Lujan v. Nat'l Wildlife Fed'n,* 497 U.S. 871, 888, 110 S.Ct. 3177, 111 L.Ed.2d 695 (1990). In deciding a motion for summary judgment, "the judge's function is not himself to weigh the evidence and determine the truth of the matter but to determine whether there is a genuine issue for trial." *Anderson,* 477 U.S. at 249, 106 S.Ct. 2505.

DISCUSSION

A. Permanent Injunction

[2] In deciding whether to grant a permanent injunction, the Court must consider whether: "(1) the moving party has shown actual success on the merits; (2) the moving party will be irreparably injured by the denial of injunctive relief; (3) the granting of the permanent injunction will result in even greater harm to the defendant; and (4) the injunction would be in the public interest." *Shields v. Zuccarini,* 254 F.3d 476, 482 (3d Cir.2001).

1. Actual Success on the Merits

a.

In granting Plaintiff's request for a temporary restraining order and motion for preliminary injunction, this Court found that Plaintiff was likely to succeed on the merits of his claims that he was being denied Medicaid assistance by Defendant ***403** in violation of federal law and regulations, and that Act 42, 62 PA. STAT. ANN.. § 441.6, is preempted by the Supremacy Clause of the United States Constitution. (Doc. 19.) Given a second look at Plaintiff's claims, the Court is of the opinion that Plaintiff is being denied Medicaid assistance in violation of federal law. However, as Defendant has disavowed any reliance upon Act 42, 62 PA. STAT. ANN.. § 441.6, in denying Plaintiff Medicaid benefits, the Court will decline to issue a declaratory judgment that Act 42, 62 PA. STAT. ANN.. § 441.6, is preempted by the Supremacy Clause.

b.

[3] Federal law provides that an applicant can transfer assets to his or her spouse so long as they are for the spouse's benefit. 42 U.S.C. § 1396p(c)(2)(B)(i); Transmittal 64, §§ 3257.B.6 and 3258.11. Section 1396p(d)(2)(a)(ii) provides, in pertinent part, that "an individual shall be considered to have established a trust if the assets of the individual were used to form all or part of the corpus of the trust and if the individual or the individual's spouse established the trust." Section 1396p(3)(B)(i) provides that, in the case of an irrevocable trust, if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made, shall be considered resources available to the individual.

"A trust includes an annuity only to the extent and in such manner as the secretary specifies." 42 U.S.C. § 1396p(d)(6). Transmittal 64 to the State Medicaid Manual contains provisions dealing with the issue of when an annuity is to be considered an irrevocable trust rather than a transfer of assets. *See* Transmittal 64, § 3258.9B. It also describes how annuities are treated under the trust provision, stating:

> "Annuities, although usually purchased in order to provide a source of income for retirement, are occasionally used to shelter assets so that individuals purchasing them can become eligible for Medicaid. In order to avoid penalizing annuities validly purchased as part of a retirement plan but to capture those annuities which abusively shelter assets, a determination must be made with regard to the ultimate purpose of the annuity (i.e., whether the purchase of the annuity constitutes a transfer of assets for less than fair market value). If the expected return on the annuity is commensurate with a reasonable estimate of life expectancy of the beneficiary, the annuity can be deemed actuarially sound."

Id.

In *Mertz v. Houstoun,* 155 F.Supp.2d 415, 426–27 (E.D.Pa.2001), the United States District Court for the Eastern District of Pennsylvania held that available assets may become unavailable assets and not countable in determining Medicaid eligibility for the institutionalized spouse when an irrevocable actuarially sound commercial annuity is purchased for the sole benefit of the community spouse. The *Mertz* court reasoned that, "[b]ecause at the time of [the Medicaid] application[,] neither spouse has an ownership interest in the funds used to purchase such an annuity, the funds are not a countable resource in calculating the CSRA." *Id.* at 426. In purchasing the annuity to provide an income stream to the community spouse, a transfer is made to a third party for the sole benefit of the community spouse that cannot be penalized consistent with federal law. *Id.* This income stream, the court noted, is not a countable resource in calculating the CSRA, as federal law provides that no income of the community spouse ***404** may be deemed available to the institutionalized spouse. *Id.* at 427;

see also 42 U.S.C. § 1396r–5(b)(1). The court concluded that these provisions effectively allow a couple to "convert countable resources into income of the **community spouse** which is not countable in determining **Medicaid** eligibility for the institutionalized **spouse** by purchasing an irrevocable actuarially sound commercial **annuity** for the sole benefit of the **community spouse**." *Mertz*, 155 F.Supp.2d at 427. The court voiced its displeasure with this loophole in federal law, which essentially enables couples to achieve eligibility outcomes inconsistent with the "purpose of the MCCA and indeed the whole thrust of the **Medicaid program** which is to provide assistance to those truly in need." *Id.* This Court relied on the *Mertz* case in granting Plaintiff's requests for preliminary relief, concluding that Mrs. James' irrevocable actuarially sound commercial **annuity** was likely not a countable resource for purposes of determining Plaintiff's **Medicaid** eligibility.

c.

Defendant offers two alternative arguments in support of her decision to deny Plaintiff **Medicaid** benefits. Defendant asserts, first, that, notwithstanding the non-assignment provision in the **annuity** endorsement, Mrs. James' **annuity** has a market value, and, therefore, is liquid and must be considered a countable resource above the CSRA, thus precluding Plaintiff's eligibility for **Medicaid**. Alternatively, Defendant contends that, if the **annuity** is not marketable and liquid, Mrs. James' contractual right to receive payments—i.e., the stream of income derived from the **annuity** contract and not the **annuity** itself—is marketable and has a monetary value above the CSRA which **makes** Plaintiff ineligible for **Medicaid** benefits. These arguments will be taken up in turn.

i. The Annuity

Defendant contends that, while the endorsement on the **annuity** forbids assignments, it does not invalidate them. Therefore, this provision only eliminates Mrs. James' *right* to assign the **annuity**—it does not limit her *power* to assign the **annuity**.[3] To this end, Defendant offers the unsworn declaration of Michael Goodman, Chief Executive Officer of J.G. Wentworth, as evidence that Mrs. James' **annuity** is readily marketable and has a monetary value of $185,000, which J.G. Wentworth would be willing to pay to purchase the **annuity**, notwithstanding its non-assignment provision. Defendant has also offered a **letter** from Meredith G. Van Pelt, Esq., Department of **Health** and Human Services, **Centers** for Medicare and **Medicaid** Services, in which Ms. Van Pelt states that under federal **Medicaid** rules concerning treatment of resources, "any **annuity** that can be sold is countable as a resource in determining eligibility." (CMS **letter** from ***405** Meredith G. Van Pelt, Esq., Office of Legal and Regulatory Affairs, **Center** for **Medicaid** and **State Operations**, at 1; Doc. 21–2 p. 1.) As such, Defendant contends that the $185,000 fair market value of the **annuity** must be counted as an **available** resource above the CSRA, thus precluding Plaintiff from qualifying for **Medicaid** benefits. *See* 20 C.F.R. § 416.1201(a)(1) ("If the individual has the right, authority or *power* to liquidate the property or his or her share of the property, it is considered a resource") (emphasis added).[4]

Defendant's argument, while attractive on the surface, would contravene the edicts of Transmittal 64, § 3258.9B, which clearly **states** that **annuities** purchased as part of a valid retirement plan—regardless of their putative marketability in the view of a third party and the generally prevailing rules of contract law—are not to be penalized. As such, if such an irrevocable actuarially sound commercial **annuity** were purchased as part of a retirement plan for the sole benefit of the **community spouse**, there can be no penalty imposed upon the **Medicaid** applicant.

Defendant, however, argues that "actuarial soundness is relevant only to the question of whether a transfer has been **made** for less than fair market value pursuant to [Transmittal 64]. It has no bearing on whether an asset is or is not a countable resource, and in fact the plain language of [section] 3258.9 in no way **makes** such a connection." *Dean v. Dep't of Health & Soc. Servs.*, No. Civ. A00A–05–006, 2000 WL 33201237, *7 (Del.Super.Ct. Dec.6, 2000) (citing **HCFA letter** from Robert A. [redacted], **Disabled** and **Elderly Health Programs Group, Center** for **Medicaid** and **State Operations**). As such, Defendant asserts, an **annuity**, notwithstanding its actuarial soundness, may be a countable resource for purposes of determining **Medicaid** eligibility.

The Court disagrees, giving precedence to Transmittal 64, §§ 3258.9B and 3258.11 B, both of which clearly indicate that there can be no penalty on an **annuity** that is irrevocable and actuarially sound and is purchased for the sole benefit of the **community spouse**. *See Mertz*, 155 F.Supp.2d at 426 (resources may be placed beyond the reach of either

spouse, and thus not counted for eligibility purposes, with the purchase of an actuarially sound irrevocable commercial annuity for the sole benefit of the community spouse). Consequently, Defendant's argument is rejected.

ii. The Income Stream

Alternatively, Defendant argues that, even if the annuity is not assignable, the income stream derived from the annuity is liquid and has market value, thereby making the value of the income stream a resource to be counted towards the CSRA.

Indeed, Defendant has cited precedent making this same distinction between the annuity itself and the income stream derived *406 from the annuity. In *Estate of Gross v. North Dakota Department of Human Services*, the Supreme Court of North Dakota held that, where there was evidence of a secondary market and monetary value for the income stream derived from a non-assignable annuity, the income stream is a countable asset for purposes of determining Medicaid eligibility. 687 N.W.2d 460, 466 (N.D.2004) ("Here, there is evidence from which a reasoning mind could have reasonably concluded there was a market for the monthly payments or income stream from the annuity.... We therefore conclude ... [that] the annuity was a countable asset for purposes of [determining] Medicaid eligibility").[5]

Defendant also points to the definition of "resources" contained in 20 C.F.R. § 416.1201(a), which provides that "resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance." "If the individual has the right, authority or power to liquidate the property or his or her share of the property, it is considered a resource. [Conversely, if] a property right cannot be liquidated, the property will not be considered a resource of the individual (or spouse)." 20 C.F.R. § 416.1201(a)(1). Defendant thus argues that, even if Mrs. James does not have the right or power to assign her annuity, she does have the right and power to liquidate her contractual right to receive annuity payments, thus making the fair market value of this contractual right—$185,000 based on the evidence presented by Defendant—a countable resource under 20 C.F.R. § 416.1201(a)(1). Accordingly, Defendant contends that Plaintiff has resources in excess of the CSRA and is ineligible for Medicaid benefits.

The Court disagrees. Defendant essentially argues that, even if the income stream itself cannot be considered for purposes of determining Medicaid eligibility, the market value of that income stream should be a countable resource to preclude eligibility. Such a rule would completely undermine federal law, which excludes income of the community spouse from factoring into the institutionalized spouse's Medicaid eligibility. Indeed, a holding that the market value of an income stream derived from an irrevocable actuarially sound annuity is a countable resource would effectively contravene the MCCA, which provides that "no income of the community spouse shall be deemed available to the institutionalized spouse." 42 U.S.C. § 1396r–5(b)(1). To be sure, Defendant's argument blurs the distinction drawn by the MCCA between assets and income.

[4] Rather, so long as the principal or corpus of an irrevocable annuity or trust cannot be reached by the applicant or spouse, the income derived from such an asset cannot be counted as a resource for Medicaid purposes, notwithstanding that income stream's market value in the eyes of a third party. *Mertz*, 155 F.Supp.2d at 426 ("[b]ecause at the time of [the Medicaid] application[,] neither spouse has an ownership interest in the funds used to purchase such an annuity, the funds are not a countable resource in calculating the CSRA"); *see also Dean*, 2000 WL 33201237, at 7 ("the buyer [of an irrevocable *407 commercial annuity] ... is entitled only to the income stream; the buyer does not own the purchasing funds and cannot reclaim them") (citing *Johnson v. Guhl (Johnson I)*, 91 F.Supp.2d 754, 764 (D.N.J.2000)).

As such, the Court rejects Defendant's argument, and concludes that the income stream derived by Mrs. James from the irrevocable actuarially sound commercial annuity is not a countable resource, notwithstanding the evidence presented by Defendant as to its marketability and resale value. Consequently, the Court holds that Plaintiff has established actual success on the merits of his claim that he is being denied Medicaid assistance in violation of federal law.

2. Irreparable Injury

[5] The Plaintiff has shown that he will suffer irreparable injury if his request for a permanent injunction were not granted. It is undisputed that Plaintiff would be required to privately pay for his nursing facility care at a private pay rate of $5,000 per month or else risk being forced to leave

the nursing facility. (Doc. 28 ¶ 13; Doc. 19 p. 7.) Plaintiff cannot be compensated by monetary relief as the Eleventh Amendment, U.S. CONST. amend XI, precludes an award of retroactive payment by a federal court. *See Edelman v. Jordan,* 415 U.S. 651, 678, 94 S.Ct. 1347, 39 L.Ed.2d 662 (1974). As such, there is not an adequate remedy at law to redress the denial of **Medicaid** benefits. A permanent injunction is therefore appropriate.

3. Harm to Defendant and Public Interest

[6] The Court's granting of a permanent injunction will not inflict more harm upon Defendant than the Court's refusal to grant it would harm Plaintiff, as the harm Plaintiff would suffer, if forced to privately pay $5,000 per month in nursing facility care or else be required to vacate the nursing facility, is substantial.

[7] Also, the Court finds that it is in the public interest to grant Plaintiff's request for a permanent injunction, as Defendant has denied **Medicaid** assistance to Plaintiff in violation of federal law, notwithstanding the fact that Plaintiff has effectively achieved a **Medicaid** eligibility outcome inconsistent with the "purpose of the MCCA and indeed the whole thrust of the **Medicaid program** which is to provide assistance to those truly in need." *Mertz,* 155 F.Supp.2d at 427. However, it is for Congress to close this loophole in federal law. Accordingly, the Court will grant Plaintiff's request to permanently enjoin Defendant from denying him **Medicaid** benefits based upon the $250,000 **annuity** purchased by Mrs. James in September of 2005.

B. Declaratory Judgment

1. Legal Standard

[8] Under the Declaratory Judgment Act, 28 U.S.C. § 2201–2202, "[i]n a case of actual controversy within its jurisdiction ... any court of the United States, upon the filing of an appropriate pleading, may declare the rights and other legal relations of any interested party seeking such declaration, whether or not further relief is or could be sought." 28 U.S.C. § 2201(a). The Supreme Court has explained that the Declaratory Judgment Act is "an enabling Act, which confers discretion on the courts rather than an absolute right upon the litigant." *Wilton v. Seven Falls Co.,* 515 U.S. 277, 287, 115 S.Ct. 2137, 132 L.Ed.2d 214 (1995) (internal quotations and citations omitted). Thus, federal district courts " 'wield broad and selective discretion' in determining whether to entertain a declaratory judgment action." ***408** *Canal Ins. Co. v. Paul Cox Trucking,* Civ. A. No. 1:05–CV–2194, 2006 WL 2828755, at *2 (M.D.Pa. Oct.2, 2006) (quoting *State Farm Mut. Auto Ins. Co. v. Lavanture,* Civ. A. No. 1:05–CV2523, 2006 WL 1344051, at *2 (M.D.Pa. May 16, 2006)).

[9] A federal court has discretion to entertain a declaratory judgment action when it finds that the declaratory relief sought "(i) will serve a useful purpose in clarifying and settling the legal relations in issue; and (ii) will terminate and afford relief from the uncertainty, insecurity, and controversy giving rise to the proceeding." *CGU Life Ins. Co. of Am. v. Metro. Mortgage & Secs. Co.,* 131 F.Supp.2d 670, 674 (E.D.Pa.2001).

Here, Plaintiff requests that this Court declare Act 42, 62 PA. STAT. ANN.. § 441.6, invalid as preempted by the federal **Medicaid** Act and the Supremacy Clause.

2. Analysis

[10] The Court will deny Plaintiff's request for a declaratory judgment that Act 42, 62 PA. STAT. ANN.. § 441.6, is invalid as preempted by federal law. As previously mentioned, Defendant has expressly disavowed any reliance upon Act 42 or section 441.6 in denying Plaintiff **Medicaid** benefits. (Def. Br. In Opp. 3; Doc. 37.) Rather, Defendant relies solely upon her construction of the federal **Medicaid** Act and its regulations to support her denial of **Medicaid** benefits to Plaintiff. Act 42, 62 PA. STAT. ANN.. § 441.6, is not mentioned in any of Defendant's briefs submitted to this Court, nor in Defendant's PA 162 notice sent to Plaintiff, which cites 55 PA.CODE §§ 178.4 and 178.121. Moreover, Plaintiff even acknowledges that Defendant is not enforcing Section 441.6(d) against Plaintiff. (Pl.'s Br. 14.) Consequently, notwithstanding Plaintiff's contentions, this case does not present the issue of whether Act 42, 62 PA. STAT. ANN.. § 441.6, conflicts or frustrates the purpose of the federal **Medicaid** Act, and thereby would be preempted. As such, declaratory relief is neither useful nor necessary to clarifying the legal relations in issue or affording relief to Plaintiff. Accordingly, the Court will deny Plaintiff's request for a declaratory judgment.

CONCLUSION

For the above-stated reasons, the Court will grant Plaintiff's motion for summary judgment as to his request for a permanent injunction. Plaintiff's request for a declaratory judgment will be denied. Defendant's motion for summary judgment will be denied.

An appropriate Order will follow.

ORDER

NOW, this *21st* day of November, 2006, **IT IS HEREBY ORDERED** that:

(1) Plaintiff **Robert** A. James' Motion for Summary Judgment (Doc. 30) is:

(A) **GRANTED** as to his request for a permanent injunction;

(B) **DENIED** as to his request for a declaratory judgment;

(2) Defendant is **PERMANENTLY ENJOINED** from denying Plaintiff **Robert** A. James **Medicaid** benefits based on the $250,000 **annuity** purchased on September 12, 2005 by Plaintiff's wife, Josephine A. James.

(3) Defendant's Motion for Summary Judgment (Doc. 32) is **DENIED.**

Footnotes

1 In July of 2005, the Commonwealth passed Act 42, 62 PA. STAT. ANN. . § 441.6, which added restrictions on **annuities** not contained in the federal **Medicaid** Act, including:

> (b) Any provisions in an **annuity** owned by an applicant or **spouse** of an applicant that has the effect of limiting the right of such owner to sell, transfer or assign the right to receive payments thereunder, or restricts the right to change the designated beneficiary thereunder, is void.
>
> (c) In determining eligibility for Medical Assistance, there shall be a rebuttable presumption that any **annuity** or contract to receive money is marketable without undue hardship.
>
> (d) An **annuity** will not be considered an **available** resource if the **annuity** names the Department as the residual beneficiary of any funds remaining due under the **annuity** at the time of death of the **annuitant**, not to exceed the amount of Medical Assistance expended on the individual during his or her lifetime.

2 While this case does not fall within the class of **Medicaid** cases involving a **state** plan that allegedly conflicts with the federal **Medicaid** Act, which would certainly present a federal question, *see, e.g., Johnson,* 91 F.Supp.2d at 766, neither does it fall in the class of cases in which it is only alleged that a **state** has violated its own **Medicaid** plan, which do not present a federal question, *see, e.g., Concourse Rehab. & Nursing Ctr., Inc. v. DeBuono,* 179 F.3d 38, 44 (2d Cir.1999). The Court believes this case to be closer to the former type of case, as federal law must be interpreted in order to determine whether Defendant has misinterpreted it. As such, federal question jurisdiction exists.

3 Under the generally prevailing rules of contract law, a contractual right can be assigned unless "the substitution of a right of the assignee for the right of the assignor would materially change the duty of the obligor, or materially increase the burden or risk imposed on him by his contract, or materially impair his chance of obtaining return performance, or materially reduce its value to him, or ... [the] assignment is validly precluded by contract." RESTATEMENT (SECOND) OF CONTRACTS § 317(2)(a)-(c) (1981). "A contract term limiting assignments gives the obligor a right to damages for breach of the terms forbidding assignment, but does not render the assignment ineffective." *Id.* § 322(2)(b); *Int'l Telecomms. Exch. Corp. v. MCI Telecomms. Corp.*, 892 F.Supp. 1520 (N.D.Ga.1995) (a nonassignability clause in a contract is treated as a personal covenant that does not invalidate an otherwise proper transfer, unless the clause expressly states that any assignment is "void").

4 Indeed, without so finding, the Court observes that the substitution of an assignee (possibly J.G. Wentworth) would not materially change the duty of the obligor (General Electric Assurance Company), as the only duty placed upon the obligor is to send the beneficiary of the **annuity** a check once a month. Assignment of the **annuity** would also not increase the risk imposed upon the obligor, as Mrs. James has already purchased the **annuity**, having remitted the full purchase price of $250,000 to General Electric Assurance Company in September of 2005. Consequently, assignment of the **annuity** would not materially change its terms, nor would it impose an additional burden or risk upon General Electric Assurance Company. Moreover, the non-assignment provision, as pointed out by Defendant, merely forbids assignments—it does not render an assignment void or invalid. As such, assignment of the **annuity** is not precluded under contract law because all that is limited is Mrs. James' *right* to assign the **annuity**, not her *power* to do so.

5 *See also Estate of Pladson v. Traill County Soc. Servs.*, 707 N.W.2d 473, 480–81 (N.D.2005) (suggesting that if there were evidence of an **available** market and resale value for the purchased **annuity**, the contractual right to the **annuity** payments or income stream would be considered an **available** resource for purposes of determining **Medicaid** eligibility); *A.B. v. Div. of Med. Assistance & Health Servs.*, 374 N.J.Super. 460, 865 A.2d 701, 706 (2005) (same); *Estate of F.K. v. Div. of Med. Assistance & Health Servs.*, 374 N.J.Super. 126, 863 A.2d 1065, 1077 (2005) (same).

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EXHIBIT G

Hegadorn v. Department of Human Services Director, Michigan Supreme Court 2019 WL 2064530 (May 19, 2019)

Syllabus

This syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader.

HEGADORN v DEPARTMENT OF HUMAN SERVICES DIRECTOR
TRIM v DEPARTMENT OF HUMAN SERVICES DIRECTOR
TINDLE v DEPARTMENT OF HEALTH AND HUMAN SERVICES

Docket Nos. 156132, 156133, and 156134. Argued October 9, 2018 (Calendar No. 3). Decided May 9, 2019.

Plaintiffs Mary A. Hegadorn (Docket No. 156132), Dorothy Lollar (Docket No. 156133), and Roselyn Ford (Docket No. 156134) were elderly women receiving long-term care in nursing homes. In each case, the plaintiff, an "institutionalized spouse," began receiving long-term care at a nursing home at her own expense. After their institutionalization, each plaintiff's husband, a "community spouse," created an irrevocable trust that was solely for his own benefit (an SBO trust). The couples then transferred a majority of their individual and marital property to each SBO trust or its trustee, giving up any claim of title to that property. A short time after each SBO trust was formed, each institutionalized spouse applied for Medicaid benefits. The Department of Health and Human Services and its director (collectively, the department) determined that the entire value of the principal of each SBO trust was a countable asset for the purpose of determining each institutionalized spouse's eligibility for Medicaid benefits and denied their applications because the value of the trust assets put their countable resources above the $2,000 threshold. Plaintiffs contested the department's determinations regarding their respective applications, and in each case, an administrative law judge (ALJ) affirmed the department's determination. Hegadorn and Lollar separately appealed the ALJ decisions in the Livingston Circuit Court, and Ford appealed in the Washtenaw Circuit Court. With respect to Hegadorn and Lollar, the court, Michael P. Hatty, J., reversed the ALJ's decisions, as did the court, Timothy P. Connors, J., with respect to Ford. Plaintiffs all died during the appeals process, and their personal representatives—Ralph D. Hegadorn, Deborah D. Trim, and Denise Tindle—have been substituted as parties for Hegadorn, Lollar, and Ford, respectively. The Court of Appeals granted the department's applications for leave to appeal in each case, and the Court ordered the cases consolidated. In a published per curiam opinion, the Court of Appeals, M. J. KELLY, P.J., and STEPHENS and O'BRIEN, JJ., reversed, holding that assets placed by an institutionalized individual's spouse into an SBO trust are countable assets for determining whether an individual is eligible for Medicaid benefits. 320 Mich App 549 (2017). The Supreme Court granted plaintiffs' application for leave to appeal. 501 Mich 984 (2018).

In a unanimous opinion by Justice BERNSTEIN, the Supreme Court *held*:

Marital assets placed in an irrevocable trust for the sole benefit of a community spouse are not automatically considered countable assets for the purpose of an institutionalized spouse's initial eligibility determination for Medicaid long-term-care benefits. Rather, such assets become countable only if circumstances exist under which the trust could make a payment to or for the benefit of the institutionalized spouse. Accordingly, the Court of Appeals judgment and the ALJ's final hearing decisions in each case were vacated.

1. The department administers Michigan's Medicaid program in accordance with policies contained in several publications, including the *Bridges Eligibility Manual*, the Social Security Administration's *Program Operations Manual System*, and the *State Medicaid Manual*. A person who falls in the optional medically needy category, like each plaintiff here, cannot qualify for Medicaid benefits if his or her countable assets and income exceed $2,000 during the period in which he or she applies for benefits. The extent to which the principal of a trust is a countable asset depends on the terms of the trust and whether any of the principal consists of countable assets or countable income. With respect to irrevocable trusts, the department must count as the person's countable asset the value of the countable assets in the trust principal if there is any condition under which the principal could be paid to or on behalf of the person from an irrevocable trust. Additional rules applicable only to institutionalized spouses are described in the Medicare Catastrophic Coverage Act (MCCA), codified at 42 USC 1396r-5.

2. When determining an institutionalized spouse's eligibility for Medicaid benefits, a computation of the couple's total joint resources is taken as of the beginning of the first continuous period of institutionalization in order to determine the amount of the "spousal share" allocated to the community spouse. The couple's resources are divided into those that are countable and those that are exempt. One-half of the total value of their countable resources "to the extent either the institutionalized spouse or the community spouse has an ownership interest" is considered a spousal share. The spousal share allocated to the community spouse qualifies as the community spouse resource allowance (CSRA), which is the monetary value of assets that may be retained by or transferred to the community spouse without those resources being counted against the institutionalized spouse for his or her initial eligibility determination. Once the amount of the CSRA is determined, a second calculation is required to determine the resources available to the institutionalized spouse for the purpose of determining the institutionalized spouse's initial Medicaid eligibility. This calculation is based on the resources available to the institutionalized spouse on the day that the institutionalized spouse submits his or her application for Medicaid benefits. In determining the resources of an institutionalized spouse at the time of application for benefits, 42 USC 1396r-5(c) provides that all the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse to the extent that they exceed the CSRA. After the month in which an institutionalized spouse is determined to be eligible for benefits, no resources of the community spouse shall be deemed available to the institutionalized spouse. While the MCCA contains provisions governing the treatment of income paid from a trust, its general resource allocation provisions are silent with regard to the treatment of assets or resources held by a trust. The MCCA also does not provide a definition for the term "resources," but the term does not include those things excluded by 42 USC 1382b(a) or (d). Assuming without deciding that the principal of an irrevocable trust constitutes a resource as that term is used in 42 USC 1396r-5, such a resource is not "held by" the institutionalized or community spouse. The property that makes up the principal of a trust is not

owned by or otherwise directly available to the beneficiary. Instead, the trustee holds title to the property that constitutes the principal of a trust and holds it in trust for the beneficiary. The trust beneficiary, on the other hand, holds a right to enforce the performance of the trust in equity. Unless the beneficiary is also a trustee, the beneficiary does not own the property forming the principal of the irrevocable trust.

3. The first two paragraphs of the Medicaid trust rules contained in 42 USC 1396p(d) describe to whom the rules apply and how to determine whether that person created a trust. Under 42 USC 1396p(d)(1), for purposes of determining an individual's eligibility for, or amount of, benefits under a state plan, subject to 42 USC 1396p(d)(4), the rules specified in 42 USC 1396p(d)(3) apply to a trust established by such individual. Because Medicaid benefits are granted only to those who apply for them and who also meet the eligibility requirements, if an eligibility determination is being made, then the "individual" referred to in 42 USC 1396p(d)(1) must be a person applying for Medicaid benefits or a person who has been approved for a yet-to-be-determined amount of benefits. Applied to the context of this appeal, the individual referred to is the institutionalized spouse, who is the Medicaid applicant. The plain language of 42 USC 1396p(d)(1) thus provides that, to determine an institutionalized spouse's eligibility for Medicaid benefits, the rules outlined in 42 USC 1396p(d)(3) govern trusts established by the institutionalized spouse. Under 42 USC 1396p(d)(2), an individual has established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will: the individual, the individual's spouse, a person with legal authority to act in place of or on behalf of the individual or the individual's spouse, or a person acting at the direction or upon the request of the individual or the individual's spouse. Therefore, when a community spouse creates a trust, other than by will, using assets of his or her institutionalized spouse, that action is legally attributed to the institutionalized spouse for the purposes of the institutionalized spouse's Medicaid eligibility determination.

4. To determine whether assets held by an irrevocable trust are available to the applicant and thus countable for his or her initial eligibility determination, the "any-circumstances rule" set forth in 42 USC 1396p(d)(3)(B) applies. This rule states in part that if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual. Correctly applying the any-circumstances rule requires understanding to whom "the individual" refers. The use of the definite article "the" preceding "individual" suggests that the term refers to a single person, as opposed to an open class of all people. Additionally, 42 USC 1396p(d)(1) uses "an individual" to refer to a person applying for Medicaid benefits or a person who qualifies for an amount of benefits that is yet to be determined. This provision then states that 42 USC 1396p(d)(3) applies to a trust established by that applicant or recipient. Thus, while "an individual" in 42 USC 1396p(d)(1) can be read as referring to a potential class of persons, when "such individual" establishes a trust, that class is reduced to a single person for the purposes of 42 USC 1396p(d)(3). 42 USC 1396p(d)(2) also refers to "an individual," and it contrasts that term with "the individual's spouse." Reading these provisions together, it follows that when Paragraph (3) refers to "the individual," it is referring to the same individual whose eligibility for, or amount of, benefits is being determined and who has established a trust under Paragraph (2): the applicant for or recipient of Medicaid benefits. When considering the eligibility of an institutionalized spouse for Medicaid

benefits, "the individual" must be read as referring to the institutionalized spouse to the exclusion of the community spouse, who, by definition, is not applying for or receiving Medicaid benefits. Because the *Bridges Eligibility Manual* incorporates the any-circumstances rule into Michigan's Medicaid policies, this same restriction applies, despite the manual's use of the term "person" in place of "individual." The any-circumstances rule, therefore, makes assets held by an irrevocable trust available to an institutionalized spouse if there are any circumstances, whether likely or hypothetical, under which the trust could make a payment to or for the benefit of the institutionalized spouse. If an irrevocable trust can make payments only to the community spouse, then those payments will satisfy the any-circumstances rule only if there is evidence that the payments could be for the benefit of the institutionalized spouse. If application of 42 USC 1396p(d)(3)(B) makes assets held by an irrevocable trust available to an institutionalized spouse, then the value of such assets is countable for the purposes of 42 USC 1396r-5(c).

5. The language of the trust documents themselves determines whether the SBO trusts at issue allow for a payment to be made "to or for the benefit of" the institutionalized spouses. The SBO trusts at issue are irrevocable trusts, meaning the principal of each trust is not automatically rendered available to the institutionalized spouse under 42 USC 1396p(d)(3)(A) and (B). Furthermore, the property and income that make up the principal of the SBO trusts at issue are not held by the institutionalized spouses or the community spouses. Rather, title to the property that is now the principal of each trust was transferred to the trust or trustee, and the money that forms part of the principal was moved into bank accounts controlled by the trustee. There was no suggestion that the community spouses retained possession of the tangible property that forms the principals of the trusts. Therefore, the principals of the SBO trusts are not automatically considered resources available to any of the spouses under 42 USC 1396r-5(c). Accordingly, the principal of each SBO trust can be considered a resource available to the institutionalized spouse, and thus a countable asset, only if made so by operation of the any-circumstances rule in 42 USC 1396p(d)(3)(B). Each of the SBO trusts at issue instructs the trustee to deplete the entirety of the principal during the community spouse's lifetime. Because the community spouses are not themselves applying for or receiving Medicaid benefits, they are not "the individual" referred to in 42 USC 1396p(d)(3)(B). Thus, the Court of Appeals erred by holding that the possibility of a distribution from each SBO trust to each community spouse automatically made the assets held by each SBO trust countable assets for the purposes of the respective institutionalized spouses' initial eligibility determination. Accordingly, the Court of Appeals judgment was reversed, the final administrative hearing decision in each case was vacated, and each case was remanded to the appropriate administrative tribunal for the proper application of the any-circumstances test. If the ALJs determine that circumstances exist under which payments from the trusts could be made to or for the benefit of the institutionalized spouse, then the ALJs should explain this rationale and affirm the department's decision. However, if no such circumstances exist, the ALJs should reverse the department's decisions and order that the Medicaid applications be approved.

Court of Appeals judgment reversed; tribunal decisions vacated; cases remanded to the appropriate tribunals for further proceedings.

Chief Justice MCCORMACK, concurring, agreed that property held in these SBO trusts was not countable toward Medicaid's resource limit because "the individual" in 42 USC 1396p(d)(3)(B) refers to the Medicaid applicant. She wrote separately to explain that, although

the issue was not presented in these cases, she believed the plaintiffs' transfer of assets into the trusts triggered Medicaid's divestment rules, thus undermining plaintiffs' overall planning strategy by disqualifying them from receiving benefits despite having satisfied Medicaid's threshold resource test. She stated that the majority opinion should not be interpreted as permitting a married Medicaid applicant to shelter and preserve any amount of wealth without restriction and then immediately receive financial assistance as if the applicant did not have that amount.

Justice CAVANAGH did not participate in the disposition of this case because the Court considered it before she assumed office.

Michigan Supreme Court
Lansing, Michigan

OPINION

FILED May 9, 2019

STATE OF MICHIGAN

SUPREME COURT

RALPH D. HEGADORN, Personal Representative of the Estate of MARY HEGADORN,

Plaintiff-Appellant,

v No. 156132

DEPARTMENT OF HUMAN SERVICES DIRECTOR,

Defendant-Appellee.

DEBORAH D. TRIM, Personal Representative of the Estate of DOROTHY LOLLAR,

Plaintiff-Appellant,

v No. 156133

DEPARTMENT OF HUMAN SERVICES DIRECTOR,

Defendant-Appellee.

DENISE TINDLE, Personal Representative
of the ESTATE OF ROSELYN FORD,
Plaintiff-Appellant,

v No. 156134

DEPARTMENT OF HEALTH AND
HUMAN SERVICES,
Defendant-Appellee.

BEFORE THE ENTIRE BENCH (except CAVANAGH, J.)

BERNSTEIN, J.

In these consolidated cases, the individual plaintiffs[1] were elderly women receiving long-term care in nursing homes. In each case, the plaintiff, an "institutionalized spouse,"[2] began receiving long-term care at a nursing home at her own expense. One to two months later, each plaintiff's husband, a "community spouse,"[3] created an irrevocable trust that was solely for his own benefit. Such a trust is commonly called a "solely for the benefit of," or "SBO," trust.[4] The couples then transferred a majority of their individual and

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[1] The original plaintiffs, Mary Hegadorn, Dorothy Lollar, and Roselyn Ford, are now deceased, and the personal representatives of their respective estates have continued this action on their behalf. For ease of reference, this opinion will use "plaintiffs" to refer collectively to the original plaintiffs who initiated these proceedings.

[2] An "institutionalized spouse" is a person who is in a "medical institution or nursing facility" or who is described in 42 USC 1396a(a)(10)(A)(ii)(VI), is likely to meet these requirements "for at least 30 consecutive days," and is married to a person who is not in such a facility. 42 USC 1396r-5(h)(1)(A) and (B).

[3] A "community spouse" is "the spouse of an institutionalized spouse." 42 USC 1396r-5(h)(2).

[4] The parties and the Court of Appeals often refer to the SBO trusts at issue as "Medicaid trusts." This is an accurate label under state regulations, although the label is not used in the federal Medicaid statutes. A Medicaid trust is any trust or trust-like instrument that

marital property to each SBO trust or its trustee, giving up any claim of title to that property. Distributions or payments from each SBO trust were to be made on an actuarially sound basis and solely to or for the benefit of the community spouse. The actuarially sound distribution schedule required that each trustee distribute the income and resources held by the trust to each community spouse at a rate that would deplete the trust within the community spouse's expected lifetime. A short time after each SBO trust was formed, each institutionalized spouse applied for Medicaid benefits. The Department of Health and Human Services[5] and its director (collectively, the Department) determined that the entire value of the principal of each SBO trust was a countable asset for the purpose of determining each institutionalized spouse's eligibility for Medicaid benefits. Thus, the Department concluded that each institutionalized spouse did not show the requisite financial need because the value of the trust assets put their countable resources above the monetary threshold, and it denied each application.

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meets the following five criteria: (1) "[T]he person whose resources were transferred to the trust is someone whose assets or income must be counted to determine [Medicaid] eligibility"; (2) the trust was established by the person, the person's spouse, or someone else acting in place of or at the direction of the person or the person's spouse; (3) "[t]he trust was established on or after August 11, 1993"; (4) the trust was not established by will; and (5) the trust is not a "special needs trust" or "pooled trust" as defined by state regulations. See Michigan Department of Human Services, *Bridges Eligibility Manual (BEM) 401*, BPB 2014-015 (July 1, 2014), pp 5-7. It is undisputed that the trusts at issue meet these criteria.

[5] The Department of Community Health was merged with the Department of Human Services in 2015 after the plaintiffs in Docket Nos. 156132 and 156133 filed their complaints. The combined agency is now the Department of Health and Human Services. Executive Order No. 2015-4. See *In re Rasmer Estate*, 501 Mich 18, 26 n 3; 903 NW2d 800 (2017).

In each case, the plaintiff unsuccessfully contested the Department's decision in an administrative appeal, but each decision was then reversed on appeal in the circuit court. On appeal in the Court of Appeals, all three cases were consolidated, and the Department's denial decisions were reinstated in a published opinion.

With the cases having been appealed in this Court, we conclude that the Court of Appeals erred in its interpretation of the controlling federal statutes, which caused the Court of Appeals to improperly reinstate the Department's denial decisions. As explained in this opinion, the fact that an irrevocable trust, which includes former assets of an institutionalized spouse, can make payments to a community spouse does not automatically render the assets held by the trust countable for the purpose of an institutionalized spouse's initial eligibility determination. See 42 USC 1396p(d)(3)(B); 42 USC 1396r-5(c)(2). Accordingly, we reverse the judgment of the Court of Appeals. Because the administrative hearing decision in each case suffered from the same faulty reasoning used by the Court of Appeals, this legal error may have caused the administrative law judges (ALJs) to forgo a more thorough review of the Medicaid applications at issue or to disregard other avenues of legal analysis. Therefore, rather than order that the Medicaid applications be approved at this time, we vacate the hearing decision of the ALJ in each case and remand these cases to the appropriate administrative tribunal for any additional proceedings necessary to determine the validity of the Department's decision to deny plaintiffs' Medicaid applications.[6]

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[6] The Court of Appeals also held that it was permissible for the Department to apply changes in its application of *BEM 401* and in its reading of the federal Medicaid statutes to

I. FACTS AND PROCEDURAL HISTORY

This appeal involves three cases that have been consolidated for the purpose of appellate review. In Docket No. 156132, Mary Ann Hegadorn (Mrs. Hegadorn) began receiving long-term care at the MediLodge Nursing Home in Howell, Michigan, on December 20, 2013. Approximately one month later, her husband, Ralph D. Hegadorn (Mr. Hegadorn), established the "Ralph D. Hegadorn Irrevocable Trust No. 1 (Sole Benefit Trust)." (Hegadorn Trust). Mr. Hegadorn is the beneficiary of the Hegadorn Trust, and neither he nor his wife is the trustee or successor trustee. Section 2.2 of the Hegadorn Trust states that the "Trustee shall distribute the Resources of the Trust at a rate that is calculated to use up all of the Resources during" Mr. Hegadorn's expected lifetime, and it includes a suggested distribution schedule that is based on the Department's policies. The Hegadorn Trust also lists another trust as a possible residual beneficiary, stating:

> At my death, if my Spouse is surviving, Trustee shall distribute the remaining trust property to the trustee of the Special Supplemental Care Trust for Mary Ann Hegadorn, created by my Will dated the same day as this Agreement, as my Will may be amended from time to time. [Hegadorn Trust, § 3.3 (formatting altered).]

On April 24, 2014, Mrs. Hegadorn applied for Medicaid benefits. The Department subsequently denied Mrs. Hegadorn's application, determining that her countable assets, including the assets that were placed in the Hegadorn Trust, exceeded the applicable financial eligibility limit.

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applications filed before such changes occurred. We need not reach this issue, because we have determined that the Court of Appeals erred in its interpretation of the controlling Medicaid statutes.

In Docket No. 156133, Dorothy Lollar (Mrs. Lollar) began receiving long-term care at the MediLodge Nursing Home in Howell, Michigan, on May 1, 2014. Approximately a month and a half later, Mrs. Lollar's husband, Dallas H. Lollar (Mr. Lollar), established the "Dallas H. Lollar Irrevocable Trust" (Lollar Trust), which provided that it was intended to "be a 'Solely for the Benefit of' trust." Mr. Lollar is the beneficiary of the Lollar Trust, and neither he nor his wife is the trustee or successor trustee. Section 2.2 of the Lollar Trust states that the Trustee "shall . . . pay or distribute" to Mr. Lollar, "or for [his] sole benefit, during [his] lifetime such part or all of the net income and principal" of the Trust "as Trustee determines is necessary to distribute the resources in [sic] an actuarially sound basis . . . ." The Lollar Trust also lists another trust as a possible residual beneficiary, stating that in the event of Mr. Lollar's death, he "give[s] all the rest, residue and remainder of this Sole Benefit Trust to the Dallas H. Lollar Revocable Trust Agreement U/A/D June 19, 2014, and administered according to the terms of that Agreement." Lollar Trust, § 3.2b (formatting altered). On July 21, 2014, Mrs. Lollar applied for Medicaid benefits. The Department subsequently denied Mrs. Lollar's application, determining that her countable assets, including the assets that were placed in the Lollar Trust, exceeded the applicable financial eligibility limit.

In Docket No. 156134, Roselyn Ford (Mrs. Ford) began receiving long-term care at the Saline Evangelical Nursing Home in Saline, Michigan, on December 5, 2013. About a month later, Mrs. Ford's husband, Herbert W. Ford (Mr. Ford), established the "Herbert Ford Irrevocable Trust" (Ford Trust), which provided that it was intended to be "a 'solely for the benefit of' trust." Mr. Ford is the beneficiary of the Ford Trust, and neither he nor his wife is the trustee or successor trustee. The Ford Trust also provides that the "Trustee

shall . . . pay or distribute to [Mr. Ford], or for [his] sole benefit, during his lifetime whatever part of the net income and principal (the Resources) of the Trust that Trustee determines is necessary to distribute the resources on an actuarially sound basis." Section 3.2 of the Ford Trust lists as possible residual beneficiaries separate trusts to be established by Mr. Ford's will for the benefit of his living children and the descendants of his deceased children. On January 30, 2014, Mrs. Ford applied for Medicaid benefits. The Department subsequently denied Mrs. Ford's application, determining that her countable assets, including the assets that were placed in the Ford Trust, exceeded the applicable financial eligibility limit.[7]

Each plaintiff timely requested an administrative hearing to contest the Department's decision. With respect to Mrs. Hegadorn's and Mrs. Lollar's cases, a consolidated hearing was held before ALJ Landis Y. Lain, who affirmed the Department's decision. With respect to Mrs. Ford's case, a hearing was held before ALJ Alice C. Elkin, who similarly affirmed the Department's decision. Each ALJ agreed with the Department that *Bridges Eligibility Manual (BEM) 401* required the Department to count the assets held by each trust because the trust could make payments to the community spouse. The ALJs further concluded that this was consistent with the controlling federal statutes. The ALJs made no factual findings and rendered no conclusions of law regarding possible payments to the trusts that are listed as residual beneficiaries in the SBO trusts.

[7] We note that the Ford Trust and Lollar Trust also reserve to the community spouses a special testamentary power of appointment, which allows them to appoint, by will, items or funds held by the trust directly to their children or their children's descendants. This power does not allow for appointments to any other individuals or entities.

The plaintiff in each case appealed in the appropriate circuit court and, in each case, the circuit court reversed the ALJ's decision. The Department appealed each circuit court decision in the Court of Appeals, which consolidated the cases. In a published opinion, the panel reversed the circuit courts and reinstated the ALJs' decisions to deny benefits. Plaintiffs timely sought leave to appeal in this Court. We granted plaintiffs' application in an order entered March 7, 2018, stating:

> The parties shall include among the issues to be briefed whether: (1) the Court of Appeals clearly erred in holding that the trust assets of the plaintiffs' spouses and decedent Lollar's spouse are "countable assets" for purposes of Medicaid eligibility; and (2) the Department of Health and Human Services could base its decision on the retroactive application of a department policy adopted more than 45 days after the plaintiffs' applications were filed. [*Hegadorn v Dep't of Human Servs Dir*, 501 Mich 984 (2018).]

II. STANDARD OF REVIEW

Resolution of this appeal turns on whether the federal Medicaid statutes, which govern certain aspects of the Department's Medicaid policies, allow the Department to count the assets held in a community spouse's SBO trust in determining an institutionalized spouse's eligibility for Medicaid. Final agency decisions are subject to judicial review pursuant to the Michigan Constitution, see Const 1963, art 6, § 28, and the Administrative Procedures Act (APA), MCL 24.201 *et seq*. The Michigan Constitution provides:

> All final decisions . . . of any administrative officer or agency . . . which are judicial or quasi-judicial and affect private rights or licenses, shall be subject to direct review by the courts as provided by law. This review shall include, as a minimum, the determination whether such final decisions . . . are authorized by law . . . . [Const 1963, art 6, § 28.]

The APA provides that, unless a different scope of review is established by law,

> the court shall hold unlawful and set aside a decision or order of an agency if substantial rights of the petitioner have been prejudiced because the decision or order is any of the following:
>
> (a) In violation of the constitution or a statute.
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> * * *
>
> (f) Affected by other substantial and material error of law. [MCL 24.306(1).]

The APA further instructs that "[t]he court, as appropriate, may affirm, reverse or modify the decision or order or remand the case for further proceedings." MCL 24.306(2).

An administrative agency's interpretation of a statute that it is obligated to execute is entitled to "respectful consideration," but it "cannot conflict with the plain meaning of the statute." *In re Rovas Complaint Against SBC Mich*, 482 Mich 90, 108; 754 NW2d 259 (2008). We review issues of statutory interpretation de novo. *Walters v Nadell*, 481 Mich 377, 381; 751 NW2d 431 (2008). "The principal goal of statutory interpretation is to give effect to the Legislature's intent, and the most reliable evidence of that intent is the plain language of the statute." *South Dearborn Environmental Improvement Ass'n, Inc v Dep't of Environmental Quality*, 502 Mich 349, 360-361; 917 NW2d 603 (2018). When interpreting federal statutes, we strive to "give effect to the will of Congress[.]" *Walters*, 481 Mich at 381 (quotation marks and citations omitted.)

This case also requires us to construe language in trust documents. The proper construction of a trust, like the construction of a will, is a question of law subject to de novo review. See *In re Raymond Estate*, 483 Mich 48, 53; 764 NW2d 1 (2009). Our goal in interpreting trust language is to determine and give effect to the trustor's intent. *Id.* at 52. We begin by examining the language of the trust itself, and, if there is no ambiguity,

we interpret it according to its plain and ordinary meaning. *Id.*; *In re Maloney Trust*, 423 Mich 632, 639; 377 NW2d 791 (1985).

III. ANALYSIS

A. OVERVIEW OF MEDICAID

The Medicaid program is governed by a complex web of interlocking statutes, as well as regulations and interpretive documents published by state and federal agencies. The program was created by Title XIX of the Social Security Act of 1965, PL 89-97; 79 Stat 343, codified at 42 USC 1396 *et seq*. Medicaid is generally a need-based assistance program for medical care that is funded and administered jointly by the federal government and individual states. *Ketchum Estate v Dep't of Health & Human Servs*, 314 Mich App 485, 488; 887 NW2d 226 (2016). At the federal level, the program is administered by the Secretary of Health and Human Services through the Centers for Medicare & Medicaid Services (CMS). The *State Medicaid Manual* is published by CMS to help guide states in their administration of the program, including how to determine an applicant's eligibility for benefits. See *Ark Dep't of Health & Human Servs v Ahlborn*, 547 US 268, 275; 126 S Ct 1752; 164 L Ed 2d 459 (2006). " 'Each participating State develops a plan containing reasonable standards . . . for determining eligibility for and the extent of medical assistance' within boundaries set by the Medicaid statute and Secretary of Health and Human Services." *Wis Dep't of Health & Family Servs v Blumer*, 534 US 473, 479; 122 S Ct 962; 151 L Ed 2d 935 (2002), quoting *Schweiker v Gray Panthers*, 453 US 34, 36-37; 101 S Ct 2633; 69 L Ed 2d 460 (1981). "In formulating those standards, States must 'provide for taking into account only such income and resources as are, as determined in

accordance with standards prescribed by the Secretary, *available* to the applicant.' " *Blumer*, 534 US at 479, quoting 42 USC 1396a(a)(17)(B).

Medicaid benefits are provided automatically for the "categorically needy," meaning persons who receive welfare payments through Aid to Families with Dependent Children (AFDC), 42 USC 601 *et seq.*, or Supplemental Security Income (SSI), 42 USC 1382 *et seq.*[8] See 42 USC 1396a(a)(10)(A); Social Security Administration, *Program Operations Manual System* (SSA *POMS*), SI 01715.020 (August 2, 2016), available at <https://secure.ssa.gov/apps10/poms.nsf/lnx/0501715020> (accessed May 2, 2019) [https://perma.cc/E6Q9-WSMB]. Congress has also enacted an optional program, in which states may elect to participate, for those who are deemed "medically needy." *Ark Dep't of Human Servs v Schroder*, 353 Ark 885, 890; 122 SW3d 10 (2003); 42 USC 1396a(a)(10)(A)(ii). Although medically needy individuals meet the nonfinancial requirements under either the AFDC or the SSI programs, they become eligible for Medicaid benefits only when their incomes and assets are reduced below certain established levels. See 42 USC 1396a(a)(10)(C); 42 CFR 435.301(b)(2) and (3) (2018);

[8] By completing a "1634 agreement," a state may request that the Social Security Administration (SSA) make certain Medicaid eligibility determinations when making SSI eligibility determinations and agree to provide Medicaid benefits to those individuals whom the SSA deems eligible. Social Security Administration, *Program Operations Manual System* (SSA *POMS*), SI 01730.010 (February 6, 2013), available at <https://secure.ssa.gov/apps10/poms.nsf/lnx/0501730010> (accessed May 2, 2019) [https://perma.cc/23YU-EYDR]. In states that execute a 1634 agreement, like Michigan, an application for SSI benefits is also an application for Medicaid benefits. SSA *POMS*, SI 01730.005 (February 6, 2013), available at <https://secure.ssa.gov/apps10/poms.nsf/lnx/0501730005> (accessed May 2, 2019) [https://perma.cc/2L5F-6NWX].

42 CFR 435.320 (2018). Michigan has elected to include this optional coverage for the medically needy in its state Medicaid plan. Therefore, Michigan must comply with the requirements imposed by the federal Medicaid statutes. See *In re Rasmer Estate*, 501 Mich 18, 25; 903 NW2d 800 (2017); 42 USC 1396a. Plaintiffs here fall within the medically needy category for those over the age of 65. Therefore, to be eligible for Medicaid benefits, they were required to reduce their countable incomes and assets to or below $2,000. See *Mackey v Dep't of Human Servs*, 289 Mich App 688, 698; 808 NW2d 484 (2010); *BEM 400* (July 1, 2014), p 7; *BEM 402* (April 1, 2014), p 4.

As the United States Supreme Court has noted, "[b]ecause spouses typically possess assets and income jointly and bear financial responsibility for each other, Medicaid eligibility determinations for married applicants have resisted simple solutions." *Blumer*, 534 US at 479. Prior to 1988, to become eligible for Medicaid benefits, a married individual who was admitted to a nursing home was required to "spend down" all the assets jointly held with his or her spouse who remained in the marital home. See HR Rep No 100-105(II), at 59, 65-67 (2d Sess 1988), as reprinted in 1988 USCCAN 857, 881, 888-890. That changed with the enactment of the Medicare Catastrophic Coverage Act of 1988 (MCCA), codified at 42 USC 1396r-5.[9] As the Supreme Court has recently explained, the MCCA was enacted "to protect community spouses from 'pauperization' while preventing financially secure couples from obtaining Medicaid assistance," which is why "Congress

[9] Congress later repealed most of the MCCA through the Medicare Catastrophic Coverage Repeal Act of 1989, PL 101-234; 103 Stat 1979, but the spousal-impoverishment-prevention provisions contained in 42 USC 1396r-5 were retained.

installed a set of intricate and interlocking requirements with which States must comply in allocating a couple's income and resources." *Blumer*, 534 US at 480.

Since the enactment of the MCCA, Congress has made numerous additional amendments of the Medicaid statutes to adapt the program to changing economic realities while striving to prevent abuse of the program. Many of these adjustments concern the use and evaluation of estate planning tools like trusts and annuities. The Consolidated Omnibus Budget Reconciliation Act of 1985, PL 99-272; 100 Stat 82, formerly codified at 42 USC 1396a(k), instructed states to treat as countable assets the maximum amount of a trust's principal a trustee could pay to a Medicaid applicant if the trustee were to exercise his or her discretionary authority, whether or not that discretion was actually exercised. See 1 Kove & Kosakow, Irrevocable Trusts (4th ed, October 2018 update), § 27:9. The Omnibus Budget Reconciliation Act of 1993 (OBRA 93), PL 103-66; 107 Stat 312, repealed 42 USC 1396a(k) and replaced it with the current Medicaid trust rules. See 42 USC 1396p(d); 1 Irrevocable Trusts, § 27:9.[10] States that choose to participate in the Medicaid program are required to "comply with the provisions of section 1396p of [Title XIX] with respect to liens, adjustments and recoveries of medical assistance correctly paid, transfers of assets,, [sic] *and treatment of certain trusts*[.]" 42 USC 1396a(18) (emphasis added). As our review of these Medicaid statutes demonstrates, Congress has been

[10] There are also provisions, which are not at issue here, that subject an applicant to penalties for nonexempt transfers of resources during the five-year look-back period. See 42 USC 1396p(c)(1) through (5). Additional rules governing the evaluation of annuities were added by the Deficit Reduction Act of 2005, PL 109-171; 120 Stat 4, and codified at 42 USC 1396p(c)(1)(F) and (G), but they also are not at issue here, and their enactment did not modify the Medicaid trust rules codified at 42 USC 1396p(d).

particularly active in its efforts to prevent spousal pauperization while at the same time limiting the ability of wealthier individuals to shelter income and assets using estate planning tools.

B. TREATMENT OF TRUST RESOURCES FOR AN INSTITUTIONALIZED SPOUSE'S INITIAL ELIGIBILITY DETERMINATION

The main issue in this appeal is whether assets making up the principal of an irrevocable SBO trust are countable assets for the purpose of determining an institutionalized spouse's initial eligibility for Medicaid. In Michigan, the Department administers the state Medicaid program. The Department's policies are contained in several publications, including the *BEM*, the SSA *POMS*, and the *State Medicaid Manual*.[11] A person who falls in the optional medically needy category, like each plaintiff here, cannot qualify for Medicaid benefits if his or her *countable assets* and income exceed $2,000 during the period in which he or she applies for benefits. See *Mackey*, 289 Mich App at 698; *BEM 400* at 7; *BEM 402* at 4. According to *BEM 401*, "[h]ow much of the principal of a trust is a countable asset depends on" "[t]he terms of the trust" and "[w]hether any of the principal consists of countable assets or countable income." *BEM 401* (July 1, 2014), p 10. With respect to irrevocable trusts, such as those at issue here, *BEM 401* instructs the Department to "[c]ount as the person's countable asset the value of the countable assets in

[11] The *State Medicaid Manual* is published by the CMS to help guide states in administering the Medicaid program. The manual is not a product of formal rulemaking and does not have the force of law. *Hobbs ex rel Hobbs v Zenderman*, 579 F3d 1171, 1186 n 10 (CA 10, 2009). However, federal courts generally consider the manual to be strong persuasive authority to the extent that it is consistent with the purpose and text of federal statutes. *Id.*; *Hughes v McCarthy*, 734 F3d 473, 478 (CA 6, 2013).

the trust principal if there is any condition under which the principal could be paid to or on behalf of the person from an irrevocable trust." *Id.* at 11. The legal authority for *BEM 401* derives from two parts of the federal Medicaid statutes: 42 USC 1396a and 42 USC 1396p. See *BEM 401* at 17-18. However, additional rules applicable only to institutionalized spouses are described in 42 USC 1396r-5. These additional rules serve as a starting point for evaluating an institutionalized spouse's eligibility for Medicaid benefits.

1. 42 USC 1396r-5

When determining an institutionalized spouse's eligibility for Medicaid benefits, a computation of the couple's total joint resources is taken "as of the beginning of the first continuous period of institutionalization," which may or may not be the same month in which one applies for benefits. 42 USC 1396r-5(c)(1)(A). The stated purpose of this first computation is to determine the amount of the "spousal share" allocated to the community spouse. 42 USC 1396r-5(c)(1)(A)(ii). The couple's resources are divided into those that are countable and those that are exempt.[12] One-half of the total value of their countable resources "to the extent either the institutionalized spouse or the community spouse has an ownership interest" is considered a spousal share. *Id.*

"The spousal share allocated to the community spouse qualifies as the [community spouse resource allowance or] CSRA, subject to a ceiling . . . indexed for inflation" by

[12] While 42 USC 1396r-5 does not use the terms "countable" and "exempt," it provides that the term "resources" does not include those things excluded by 42 USC 1382b(a) or (d). See 42 USC 1396r-5(c)(5). Items excluded under those sections include the couple's home, 42 USC 1382b(a)(1); household goods and personal effects, 42 USC 1382b(a)(2)(A); and funds set aside for burial expenses, 42 USC 1382b(d).

Congress. *Blumer*, 534 US at 482. The CSRA is the monetary value of assets that may be retained by or transferred to the community spouse without those resources being counted against the institutionalized spouse for his or her initial eligibility determination. See 42 USC 1396r-5(c)(2)(B) and (f); *Blumer*, 534 US at 482-483. Available resources in excess of the CSRA will generally disqualify an institutionalized spouse from receiving Medicaid benefits unless they are spent down prior to filing an application. 42 USC 1396r-5(c)(2); *Blumer*, 534 US at 482-483.

Once the amount of the CSRA is determined, a second calculation is required to determine the resources available to the institutionalized spouse for the purpose of determining the institutionalized spouse's initial Medicaid eligibility. 42 USC 1396r-5(c)(2). This calculation is based on the resources available to the institutionalized spouse on the day that the institutionalized spouse submits his or her application for Medicaid benefits. "In determining the resources of an institutionalized spouse at the time of application for benefits . . . , *all the resources held by* either the institutionalized spouse, community spouse, or both, shall be considered to be *available to* the institutionalized spouse" to the extent that they exceed the CSRA. 42 USC 1396r-5(c)(2)(A) and (B) (emphasis added). "[A]fter the month in which an institutionalized spouse is determined to be eligible for benefits . . . , no resources of the community spouse shall be deemed available to the institutionalized spouse." 42 USC 1396r-5(c)(4). While the MCCA contains provisions governing the treatment of income paid from a trust, see 42 USC 1396r-5(b)(2)(B),[13] its general resource allocation provisions are silent with regard to the

[13] Any income payable solely to a community spouse from a trust is considered to be

treatment of assets or resources held by a trust. The MCCA also does not provide a definition for the term "resources," but the term does not include those things excluded by 42 USC 1382b(a) or (d). See 42 USC 1396r-5(c)(5).

We are asked to consider whether the principal of an irrevocable trust, created using assets of both spouses but which may distribute payments only to or for the benefit of the community spouse, is a countable asset for the purpose of the institutionalized spouse's initial eligibility determination. Stated differently, is the principal of the irrevocable trust a "resource[] held by either the institutionalized spouse, community spouse, or both," such that it is considered "available to the institutionalized spouse"? 42 USC 1396r-5(c)(2)(A).

Assuming without deciding that the principal of an irrevocable trust constitutes a resource as that term is used in 42 USC 1396r-5, such a resource is not "held by" the institutionalized or community spouse.[14] The property that makes up the principal of a trust is not owned by or otherwise directly available to the beneficiary. Instead, the *trustee* holds title to the property that constitutes the principal of a trust and holds it in trust for the beneficiary. See MCL 700.7401; *Equitable Trust Co v Milton Realty Co*, 261 Mich 571,

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income available only to that community spouse. 42 USC 1396r-5(b)(2)(B)(ii) (stating that if income is paid solely to the institutionalized spouse or the community spouse, "the income shall be considered available only to that respective spouse[.]"). Generally, the MCCA preserves a community spouse's income for that spouse so as to avoid affecting the institutionalized spouse's eligibility for Medicaid. See *Blumer*, 534 US at 480-481.

[14] While "held" is undefined in the statute, *Merriam-Webster's Collegiate Dictionary* (11th ed) relevantly defines "hold" as "to have possession or ownership of or have at one's disposal[.]" "When a word or phrase is not defined by the statute in question, it is appropriate to consult dictionary definitions to determine [its] plain and ordinary meaning . . . ." *People v Rea*, 500 Mich 422, 428; 902 NW2d 362 (2017).

577; 246 NW 500 (1933) (holding that "[t]o create a trust, there must be an assignment of designated property to a trustee with the intention of passing title thereto, to hold for the benefit of others").[15] The trust beneficiary, on the other hand, holds a right to "enforce the performance of the trust in equity." MCL 555.16. See also *Union Guardian Trust Co v Nichols*, 311 Mich 107; 18 NW2d 383 (1945). Unless the beneficiary is also a trustee, the beneficiary does not own the property forming the principal of the irrevocable trust. If either spouse retained possession and use of trust property, then the question might be closer, but that question is not raised here. In summary, the principal of an irrevocable trust generally will not be a resource available to either spouse according to 42 USC 1396r-5(c), because such property is not held by either spouse. The principal of an irrevocable trust may, however, be made legally available to an institutionalized spouse by way of the Medicaid trust rules contained in 42 USC 1396p(d).

2. 42 USC 1396p(d): THE MEDICAID TRUST RULES

The first two paragraphs of the Medicaid trust rules describe to whom the rules apply and how to determine whether that person created a trust. Paragraph (1) of the Medicaid trust rules begins by stating, "For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, subject to paragraph (4), the rules specified in paragraph (3) shall apply to a trust established by such

[15] *Black's Law Dictionary* similarly defines a "trustee" as "[s]omeone who stands in a fiduciary or confidential relation to another; esp., one who, having legal title to property, holds it in trust for the benefit of another and owes a fiduciary duty to that beneficiary." *Black's Law Dictionary* (10th ed).

individual."[16] 42 USC 1396p(d)(1). While, generally speaking, an "individual" is "a particular being or thing," i.e., "a single human being," *Merriam-Webster's Collegiate Dictionary* (11th ed), the context of a term's usage in a statute affects its meaning, see *South Dearborn*, 502 Mich at 361. Here, the context in which "an individual" is used limits the scope of possible human beings to which 42 USC 1396p(d)(1) refers.

Paragraph (1) provides that Subsection (d) applies to determining "an individual's eligibility for, or amount of, benefits . . . ." 42 USC 1396p(d)(1). Medicaid benefits are granted only to those who apply for them and who also meet the eligibility requirements. Thus, if an eligibility determination is being made, then the "individual" referred to in Paragraph (1) must be an applicant for Medicaid; similarly, language directing the reader's attention to the amount of benefits provided indicates that the "individual" is either an applicant for or a current recipient of Medicaid benefits. It follows that "an individual" in 42 USC 1396p(d)(1) is a person applying for Medicaid benefits or a person who has been approved for a yet-to-be-determined amount of benefits. Applied to the context of this appeal, the individual referred to here is the institutionalized spouse, who is the Medicaid applicant. The plain language of 42 USC 1396p(d)(1) thus provides that, to determine an institutionalized spouse's eligibility for Medicaid benefits, the rules outlined in 42 USC 1396p(d)(3) govern trusts established by the institutionalized spouse.

[16] Paragraph (4) provides special rules for the treatment of three types of trusts that are not at issue in this appeal. See 42 USC 1396p(d)(4).

Paragraph (2) of the same subsection provides the criteria for determining whether "an individual" has established a trust. 42 USC 1396p(d)(2). For the purposes of Subsection (d), "an individual" has

> established a trust if assets[17] of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will:

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[17] 42 USC 1396p(h) provides the following definition of "assets":

> (1) The term "assets", with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action—
>
> (A) by the individual or such individual's spouse,
>
> (B) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse, or
>
> (C) by any person, including any court or administrative body, acting at the direction or upon the request of the individual or such individual's spouse.

The Court of Appeals cited this definition for the proposition that "Congress has clearly indicated that an institutionalized individual's assets include not only those that he or she has, but *also* those that his or her spouse has, 42 USC 1396p(h)(1), and that remains true even when those assets are placed into a trust by the spouse, 42 USC 1396d(d)(2)(A)(i) and (ii)." *Hegadorn v Dep't of Human Servs Dir*, 320 Mich App 549, 569; 904 NW2d 904 (2017). This statement is partially correct.

Generally speaking, marital assets are considered jointly and, before the trusts were formed, income and resources belonging to the community spouse would be considered assets of the institutionalized spouse. However, once resources are moved into an irrevocable trust, they cease being assets owned or held by either spouse and become assets owned and held by the trust or trustee. Moreover, transferring one's income and property to one's spouse or directly into a trust is not an "action . . . by the individual or such individual's spouse" that deprives either spouse of "resources which the individual or such

(i) The individual.

(ii) The individual's spouse.

(iii) A person, including any court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.

(iv) A person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse. [42 USC 1396p(d)(2)(A).]

Therefore, when a community spouse creates a trust, other than by will, using assets of his or her institutionalized spouse, that action is legally attributed to the institutionalized spouse for the purposes of the institutionalized spouse's Medicaid eligibility determination.

Deciding that an institutionalized spouse is an individual who has established a trust does not, however, end the inquiry. Paragraph (2) only describes the conditions for when a Medicaid applicant is deemed to have established a trust. The rules described in Paragraph (3) govern whether the assets held by such a trust are available to the Medicaid applicant and thus countable for his or her initial eligibility determination.

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individual's spouse is entitled to . . . ." 42 USC 1396p(h)(1). Resources that one presently has both title to and possession of are not resources that one is entitled to in the future, and transferring away such resources does not trigger 42 USC 1396p(h)(1). This is consistent with CMS's interpretation of the definition of "asset," see CMS, *State Medicaid Manual*, § 3257(B)(3) (rev 64), which lists among the examples of actions that trigger the asset rule: (a) waiving the right to payment of pension income, (b) waiving a right to receive an inheritance, (c) rejecting or refusing to accept injury settlements, and (d) diverting tort settlements. Each example presents a situation in which someone has a legal right to receive income or property in the future, but that right is never realized because of some affirmative action. Such conditions do not exist here.

3. 42 USC 1396p(d)(3)(B): THE ANY-CIRCUMSTANCES RULE

Once it is determined that a Medicaid applicant has established a trust, the question becomes whether assets held by the trust are available to the applicant. The trust rules in 42 USC 1396p(d)(3) treat revocable trusts and irrevocable trusts differently. Generally, the principal of a revocable trust is always considered an asset available to the Medicaid applicant who formed the trust. See 42 USC 1396p(d)(3). This is unsurprising, as a trustor can typically dissolve a revocable trust and reclaim title and possession of those things held by the trust.

The rules for irrevocable trusts are more intricate. Notably, the rules do not assume that assets placed in an irrevocable trust are available to the Medicaid applicant. Instead, when assessing an irrevocable trust, the "any-circumstances rule" applies:

> (i) if there are *any circumstances* under which *payment from the trust could be made to or for the benefit of the individual*, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made *shall be considered resources available to the individual*, and payments from that portion of the corpus or income—
>
> (I) to or for the benefit of the individual, shall be considered income of the individual, and
>
> (II) for any other purpose, shall be considered a transfer of assets by the individual subject to subsection (c); and
>
> (ii) any portion of the trust from which, or any income on the corpus from which, no payment could under any circumstances be made to the individual *shall be considered*, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) *to be assets disposed by the individual for purposes of subsection (c)*, and the value of the trust shall be determined for purposes of such subsection by including the amount of any payments made from such portion of the trust after such date. [42 USC 1396p(d)(3)(B) (emphasis added).]

Focusing on the statutory language, "any" is undefined within the statute itself, but is commonly defined as "one or some indiscriminately of whatever kind" or "one, some, or all indiscriminately of whatever quantity." *Merriam-Webster's Collegiate Dictionary* (11th ed). Thus, the use of the term "any circumstances" demonstrates that we are to consider not only obvious circumstances, but also those that are hypothetical or even unlikely. However, the rule also includes key limitations. The rule instructs us to consider only possible "payments from the trust," indicating that there must be a nexus between the trust and the recipient or beneficiary of the payment. We are next told that only those payments that could be made "to or for the benefit of the individual" fall within the rule. If there are circumstances under which payments from the trust can be made to or for the benefit of the individual, then the portion of the principal of the trust from which such payments would come is deemed available to the individual, and thus countable for determining the individual's eligibility for Medicaid benefits. If no such circumstances exist, then the portion of the principal derived from the applicant's assets is not a countable asset for the applicant's eligibility determination. See 42 USC 1396p(c).[18]

Correctly applying the any-circumstances rule requires understanding to whom "the individual" refers in 42 USC 1396p(d)(3)(B). The Department urges us to read "the individual" as referring to anyone whose resources must be evaluated in assessing a Medicaid application, without regard to whether that person is the Medicaid applicant or

[18] If assets held by a trust are not assets available to the Medicaid applicant, then those trust assets are treated as assets transferred by the applicant, which may subject the applicant to divestment penalties. See 42 USC 1396p(c). As the Department has stated, divestment penalties are not at issue in this appeal. See Appellee's Brief, p 14.

the applicant's spouse. Applied here, the Department reads "the individual" as referring to the person applying for Medicaid benefits (the institutionalized spouse), the community spouse, or both. This was also the meaning adopted by the Court of Appeals. However, we conclude that this interpretation suffers from several critical flaws.

As already discussed, the context in which a statutory term is used affects its meaning. See *South Dearborn*, 502 Mich at 361. As with Paragraphs (1) and (2) of 42 USC 1396p(d), the context in which "the individual" is used limits the scope of possible human beings to which 42 USC 1396p(d)(3)(B) refers. The first limitation is the use of the definite article "the" preceding "individual." This suggests that "the individual" referred to in 42 USC 1396p(d)(3)(B)(i) is a single person, as opposed to an open class of all people. See *Massey v Mandell*, 462 Mich 375, 382 n 5, 614 NW2d 70 (2000) (" 'The' and 'a' have different meanings. 'The' is defined as 'definite article. 1. (used, [especially] before a noun, with a specifying or particularizing effect, as opposed to the indefinite or generalizing force of the indefinite article a or an) . . . .' *Random House Webster's College Dictionary*, p 1382.").

Additionally, Paragraph (1) of Subsection (d) begins by stating, "[f]or purposes of determining *an individual's* eligibility for, or amount of," Medicaid benefits, "the rules specified in paragraph (3) shall apply to a trust established by *such individual*." 42 USC 1396p(d)(1) (emphasis added). As discussed in Part III(B)(2) of this opinion, Paragraph (1) uses "an individual" to refer to a person applying for Medicaid benefits or a person who qualifies for benefits, but the amount of those benefits must be determined.[19] Paragraph

[19] The *State Medicaid Manual* generally uses the term "individual" in the same manner:

(1) then states that Paragraph (3) applies to a trust established by that applicant or recipient. Thus, while "an individual" in Paragraph (1) can be read as referring to a potential class of persons, when "such individual" establishes a trust, that class is reduced to a single person for the purposes of Paragraph (3). Paragraph (2) of Subsection (d) also refers to "an individual" when describing whether such individual established a trust, and it contrasts that term with "the individual's spouse." 42 USC 1396p(d)(2)(A)(i) and (ii).

Reading these provisions together, it follows that when Paragraph (3) refers to "the individual," it is referring to the same individual whose eligibility for, or amount of, benefits is being determined and who has established a trust under Paragraph (2): the applicant for or recipient of Medicaid benefits. When considering the eligibility of an institutionalized spouse for Medicaid benefits, "the individual" must be read as referring to the institutionalized spouse to the exclusion of the community spouse, who, by definition, is not applying for or receiving Medicaid benefits.[20]

We find further support for this reading by reference to markedly different language in the rules governing trusts under the SSI program. See 42 USC 1382b(e)(2) and (3). The SSI program contains a nearly identical any-circumstances rule with one key difference: it

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"Individuals to Whom Trust Provisions Apply.--This section applies to any individual who establishes a trust and who is an applicant for or recipient of Medicaid." CMS, *State Medicaid Manual*, § 3259.3 (rev 64), p 3-3-109.26.

[20] According to CMS, there may be an exception to this rule when the community spouse is acting on the applicant's behalf. See CMS, *State Medicaid Manual*, § 3259.6(D), p 3-3-109.29 ("Payments are considered to be made to the individual when any amount from the trust . . . is paid directly to the individual *or to someone acting on his/her behalf*, e.g., *a guardian or legal representative*.") (emphasis added). However, we need not reach this issue today.

explicitly differentiates between the individual and the individual's spouse. See 42 USC 1382b(e)(3)(B) ("[I]f there are any circumstances under which payment from the trust could be made to or for the benefit of *the individual* (*or of the individual's spouse*) . . . .") (emphasis added). "Where Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion." *Russello v United States*, 464 US 16, 23; 104 S Ct 296; 78 L Ed 2d 17 (1983) (quotation marks and citation omitted). See also *Farrington v Total Petroleum, Inc*, 442 Mich 201, 210; 501 NW2d 76 (1993) ("Courts cannot assume that the Legislature inadvertently omitted from one statute the language that it placed in another statute, and then, on the basis of that assumption, apply what is not there."). When Congress intended a provision of the Medicaid or SSI statutes to apply to both the applicant and the applicant's spouse, it has stated so expressly. Moreover, the Medicaid trust rules in 42 USC 1396p(d) were added by OBRA 93, six years before Congress added the SSI trust rules in 42 USC 1382b(e) with the Foster Care Independence Act of 1999, PL 106-169; 113 Stat 1822. Had Congress intended the two rules to operate identically, as the Department suggests, then Congress likely would have used identical language in both 42 USC 1396p(d)(3)(B) and 42 USC 1382b(e)(3)(B).[21]

[21] The Department further argues that *BEM 401* requires evaluating a Medicaid applicant's resources under both the Medicaid and the SSI any-circumstances rules. We find no legal support for this proposition. First, as already discussed, *BEM 401* cites 42 USC 1396a and 42 USC 1396p as the legal basis for the rule, not 42 USC 1382b(e). Second, Michigan's state Medicaid plan states that the Department "complies with the provisions of section 1917d of the [Social Security] Act, as amended by OBRA 93, with regard to trusts."

Reading "the individual" in this manner and in the context of this appeal, 42 USC 1396p(d)(3)(B) refers only to an institutionalized spouse and not a community spouse. As *BEM 401* is based primarily on 42 USC 1396p(d)(3)(B) and incorporates the any-circumstances rule into Michigan's Medicaid policies, this same restriction applies to *BEM 401*, despite the use of the term "person" in place of "individual." The any-circumstances rule, therefore, makes assets held by an irrevocable trust available to an institutionalized spouse if there are any circumstances, whether likely or hypothetical, under which the trust could make a payment to or for the benefit of the institutionalized spouse. If an irrevocable trust can make payments only to the community spouse, then those payments will satisfy the any-circumstances rule only if there is evidence that the payments could be for the benefit of the institutionalized spouse.[22] If application of 42 USC 1396p(d)(3)(B) makes

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Michigan Department of Health and Human Services, *State Plan Under Title XIX of the Social Security Act Medical Assistance Program*, Attachment 2.6A, p 26 (effective July 1, 1996). Section 1917d is codified at 42 USC 1396p(d), not 42 USC 1382b(e). Third, the Department's argument is foreclosed by 42 USC 1396a(a)(10)(G), which instructs a state to "disregard the provisions of subsections (c) and (e) of section [42 USC] 1382b" when it applies the "eligibility criteria of the [SSI] program under subchapter XVI for purposes of determining eligibility for medical assistance under the State plan of an individual who is not receiving [SSI] . . . ." Congress added 42 USC 1396a(a)(10)(G) and the SSI trust rules with the enactment of the Foster Care Independence Act. Plaintiffs here are medically needy applicants who are not receiving SSI; therefore, 42 USC 1382b(c) and (e) do not apply to evaluating their eligibility for Medicaid benefits.

[22] The Supreme Judicial Court of Massachusetts interprets the any-circumstances rule, 42 USC 1396p(d)(3)(B)(i), in the same manner. See *Daley v Secretary of Executive Office of Health & Human Servs*, 477 Mass 188, 193; 74 NE3d 1269 (2017) ("The effect of the [any-circumstances] test is that if the trustee is afforded even a 'peppercorn of discretion' to make payment of principal to the applicant, or if the trust allows such payment based on certain conditions, then the entire amount that the applicant could receive under 'any state of affairs' is the amount counted for Medicaid eligibility.").

assets held by an irrevocable trust available to an institutionalized spouse, then the value of such assets is countable for the purposes of 42 USC 1396r-5(c).

There is no inconsistency created by our reading of 42 USC 1396r-5 and 42 USC 1396p(d), and therefore the preemptive provision of 42 USC 1396r-5(a)(1) does not apply.[23] As discussed before, the general resource-allocation rules of 42 USC 1396r-5(c), on their own, do not treat assets held by a trust as a resource available to either spouse. If a resource is not available to either spouse, then it is not a countable asset for the purpose of an institutionalized spouse's initial eligibility determination. See 42 USC 1396r-5(c)(2). The specific provisions governing the treatment of trusts in 42 USC 1396p(d) make the vast majority of assets held by a trust created by an institutionalized spouse available to that spouse by operation of law, while leaving open the possibility that some such assets will remain legally unavailable. The general provisions of 42 USC 1396r-5 can therefore be read in harmony with the specific provisions of 42 USC 1396p(d), and no inconsistency exists. See *People v Calloway*, 500 Mich 180, 185-186; 895 NW2d 165 (2017) ("[W]hen a statute contains a general provision and a specific provision, the specific provision controls."); *People v Mazur*, 497 Mich 302, 313; 872 NW2d 201 (2015) ("Under the [*in pari materia*] doctrine, statutes that relate to the same subject or that share a common purpose should, if possible, be read together to create a harmonious body of law.").

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[23] 42 USC 1396r-5(a)(1) states:

> In determining the eligibility for medical assistance of an institutionalized spouse (as defined in subsection (h)(1)), the provisions of this section supersede any other provision of this subchapter (including sections 1396a(a)(17) and 1396a(f) of this title) which is inconsistent with them.

In summary, the principal of an irrevocable trust formed solely for the benefit of a community spouse is not per se a "resource available" to an institutionalized spouse under 42 USC 1396r-5(c)(2) for the purpose of determining an institutionalized spouse's eligibility for Medicaid benefits. Assets making up the principal of such a trust are not automatically considered countable assets for Medicaid eligibility determinations. However, the principal of an irrevocable trust *may* become a resource available to an institutionalized spouse, and thus a countable asset, if the following conditions are met: (1) assets of the institutionalized spouse are used to form the principal of the trust, 42 USC 1396p(d)(2)(A); (2) the institutionalized spouse, his or her spouse, or one of the other entities listed under 42 USC 1396p(d)(2)(A)(i) through (iv) established the trust using a means other than a will; and (3) there are "any circumstances under which payment from the trust could be made to or for the benefit of" the institutionalized spouse, 42 USC 1396p(d)(3)(B)(i).

IV. APPLICATION

To determine whether the SBO trusts at issue allow for a payment to be made "to or for the benefit of" the institutionalized spouses, we must look to the language of the trust documents themselves. 42 USC 1396p(d)(3)(B); *BEM 401* at 10. If the principal of each SBO trust at issue is rightly considered to be a countable asset, the Department properly denied plaintiffs' applications. However, if the Department has deemed, as countable assets, property that the federal statutes do not consider available to plaintiffs, then the Department's decisions are contrary to law.

It is undisputed that each plaintiff is an individual whose eligibility for Medicaid benefits is being determined under 42 USC 1396p(d)(1). It is also undisputed that, in each case, assets of the institutionalized spouse were used to establish the SBO trusts. Accordingly, the institutionalized spouses in these cases are individuals who have established a trust pursuant to 42 USC 1396p(d)(2). The SBO trusts at issue are irrevocable trusts, meaning the principal of each trust is not automatically rendered available to the institutionalized spouse. 42 USC 1396p(d)(3)(A) and (B). Furthermore, the property and income that make up the principal of the SBO trusts at issue are not held by the institutionalized spouses or the community spouses. Rather, title to the property that is now the principal of each trust was transferred to the trust or trustee, and the money that forms part of the principal was moved into bank accounts controlled by the trustee. There also has been no suggestion that the community spouses retain possession of the tangible property that forms the principals of the trusts. Therefore, the principals of the SBO trusts are not automatically considered resources available to any of the spouses under 42 USC 1396r-5(c). Accordingly, the principal of each SBO trust can be considered a resource available to the institutionalized spouse, and thus a countable asset, only if made so by operation of the any-circumstances rule in 42 USC 1396p(d)(3)(B).

As the Court of Appeals correctly noted, each of the SBO trusts at issue instructs the trustee to "use up" or deplete the entirety of the principal during the community spouse's lifetime. All three SBO trusts also include language instructing the trustees to distribute the assets "on a[n] actuarially sound basis," which means that the "spending must be at a rate that will use up all the resources during the person's lifetime." *BEM 405* (July 1, 2014), p 12. However, the Court of Appeals erroneously concluded that, because the

community spouses could be paid by the trusts, this automatically created a " 'condition under which the principal could be paid to or on behalf of the person from an irrevocable trust,' " meaning that "the assets in each trust were properly determined to be countable assets by the Department. *BEM 401* at 12." *Hegadorn v Dep't of Human Servs Dir*, 320 Mich App 549, 563-564; 904 NW2d 904 (2017). The Court of Appeals read the word "person" in *BEM 401* as referring to both the applicants and their spouses in all circumstances. As already discussed, the rule in *BEM 401* is derived from 42 USC 1396a and the any-circumstances rule in 42 USC 1396p(d)(3)(B). The any-circumstances rule makes assets in an irrevocable trust available to a Medicaid applicant only if there are circumstances under which "a payment from the trust" could be made "to or for the benefit of" the applicant. 42 USC 1396p(d)(3)(B). The Department's contrary interpretation and application of *BEM 401*, which incorporates the federal any-circumstances rule into Michigan's Medicaid policies, is not entitled to respectful consideration because it is foreclosed by the text of 42 USC 1396p(d)(3)(B). See *Rovas*, 482 Mich at 108.

In determining whether payments can be made from a trust to an individual or for the individual's benefit, CMS instructs the Department to "take into account any restrictions on payments, such as use restrictions, exculpatory clauses, or limits on trustee discretion that may be included in the trust." CMS, *State Medicaid Manual*, § 3259.6(E) (rev 64), p 3-3-109.30. The SBO trusts at issue all contain language stating that distributions or payments from the trust may only be made to or for the *benefit* of the *respective community spouse* and that the trust resources may be used only for the

community spouse's benefit.[24] The ALJs and the Court of Appeals recognized this but erred by concluding that payments to or for the benefit of the community spouses were available to the institutionalized spouses. Because the community spouses are not themselves applying for or receiving Medicaid benefits, they are not "the individual" referred to in 42 USC 1396p(d)(3)(B).[25] Thus, the Court of Appeals erred by holding that the possibility of a distribution from each SBO trust to each community spouse automatically made the assets held by each SBO trust countable assets for the purposes of

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[24] See Lollar Trust, § 2.2 ("Trustee shall from time to time during the fiscal year pay or distribute to me, or for my sole benefit, during my lifetime . . . part or all of the net income and principal . . . . During my lifetime, no Resources of the Trust can be used for anyone other than me, except for Trustee fees."); Hegadorn Trust, § 2.2 ("Trustee shall from time to time during the fiscal year pay or distribute to me, or for my sole benefit, during my lifetime . . . part or all of the net income and principal . . . . During my lifetime, no Resources of the Trust can be used for anyone other than me."); Ford Trust, § 2.2 ("Trustee shall from time to time during the fiscal year pay or distribute to me, or for my sole benefit, during my lifetime . . . part of the net income and principal . . . . During my lifetime, no Resources of the Trust may be used for anyone other than me, except for Trustee Fees.").

[25] We note that CMS has advised that "the individual" might sometimes include an applicant's spouse when that spouse is acting on behalf of the applicant. See CMS, *State Medicaid Manual*, § 3257(B)(1), p 3-3-109 ("As used in this instruction, the term 'individual' includes the individual himself or herself, as well as . . . [t]he individual's spouse, *where the spouse is acting in the place of or on behalf of the individual*[.]") (emphasis added); § 3259.6(D), p 3-3-109.29 ("Payments are considered to be made to the individual when any amount from the trust . . . is paid directly to the individual *or to someone acting on his/her behalf*, e.g., *a guardian or legal representative*.") (emphasis added). There are documents in the administrative record indicating that Mr. Hegadorn was made the legal guardian of his wife prior to creating the Hegadorn Trust and that Mrs. Lollar granted to her husband a durable power of attorney prior to the creation of the Lollar Trust. ALJ Lain made no findings of fact or conclusions of law with regard to these legal instruments, and the Department has not argued that these documents should affect our analysis. Accordingly, we decline to address whether these legal instruments affect plaintiffs' eligibility for benefits at this time.

the respective institutionalized spouses' initial eligibility determination.[26] Accordingly, we reverse the Court of Appeals judgment because it was premised on an incorrect reading of the controlling statutes and thus was contrary to law. It follows that the ALJs' decisions are also contrary to law and cannot stand, given that they all suffer from the same faulty reasoning employed by the Court of Appeals. See MCL 24.306(1)(a) and (f).

The question now becomes what relief should be granted. The APA gives this Court some discretion in crafting relief that is appropriate to each case arising from an administrative appeal. See MCL 24.306(2) ("The court, as appropriate, may affirm, reverse or modify the decision or order or remand the case for further proceedings."). The sheer complexity of the Medicaid program and the Department's legitimate concerns about potential abuse are paramount considerations in determining what relief is warranted. We further note that, given the reasoning employed in resolving the administrative appeals, the ALJs may have forgone consideration of alternative avenues of legal analysis. In light of these concerns, we decline to order that the Department approve plaintiffs' Medicaid applications at this time. Instead, we vacate the final administrative hearing decision in

[26] We acknowledge that our decision on this issue is at odds with the opinion of the United States Court of Appeals for the Third Circuit in *Johnson v Guhl*, 357 F3d 403, 408-409 (CA 3, 2004) (holding that 42 USC 1396p(d)(3)(B)(i) is satisfied if "[o]nce the community spouse receives these payments, there is nothing preventing her or him from sharing them with the institutionalized spouse as well."). While the Third Circuit appears to agree that "the individual" refers to an applicant for or recipient of Medicaid benefits, its conclusory analysis disregards the statutory language requiring that the payment be a "payment *from the trust*" that "could be made *to or for the benefit of* the individual." 42 USC 1396p(d)(3)(B)(i) (emphasis added). The Third Circuit's broad language also effectively reads away any difference in the language used in the § 1396p(d)(3) any-circumstances rule and the § 1382b(e) any-circumstances rule.

each case and remand each case to the appropriate administrative tribunal for the proper application of the any-circumstances test. If the ALJs determine that circumstances exist under which payments from the trusts could be made to or for the benefit of the institutionalized spouse, then the ALJs should explain this rationale and affirm the Department's decision. However, if no such circumstances exist, the ALJs should reverse the Department's decisions and order that the Medicaid applications be approved.

V. CONCLUSION

Neither 42 USC 1396r-5 nor 42 USC 1396p(d) automatically makes marital assets placed in an irrevocable trust for the sole benefit of a community spouse countable assets for the purpose of an institutionalized spouse's initial eligibility determination. Rather, such assets become countable only if circumstances exist under which the trust could make a payment to or for the benefit of the institutionalized spouse. Accordingly, we reverse the judgment of the Court of Appeals.

Because the ALJs' decisions were largely grounded in the same flawed legal reasoning that was employed by the Court of Appeals, we vacate the final hearing decision of the ALJ in each case. We remand all three cases for any additional administrative proceedings necessary to evaluate the legal validity of the Department's decision to deny each plaintiff's Medicaid application. See MCL 24.306(2). We do not retain jurisdiction.

Richard H. Bernstein
Bridget M. McCormack
Stephen J. Markman
Brian K. Zahra
David F. Viviano
Elizabeth T. Clement

STATE OF MICHIGAN

SUPREME COURT

RALPH D. HEGADORN, Personal Representative of the Estate of MARY HEGADORN,

Plaintiff-Appellant,

v No. 156132

DEPARTMENT OF HUMAN SERVICES DIRECTOR,

Defendant-Appellee.

DEBORAH D. TRIM, Personal Representative of the Estate of DOROTHY LOLLAR,

Plaintiff-Appellant,

v No. 156133

DEPARTMENT OF HUMAN SERVICES DIRECTOR,

Defendant-Appellee.

DENISE TINDLE, Personal Representative of the ESTATE OF ROSELYN FORD,

Plaintiff-Appellant,

v No. 156134

DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Defendant-Appellee.

MCCORMACK, C.J. (*concurring*).

The plaintiffs[1] applied for Medicaid to help defray the costs of nursing-home services. That's what Medicaid is for, but eligibility for its financial assistance is means-tested. To satisfy Medicaid's income and resource limits while preserving their assets, the plaintiffs each formed and funded an irrevocable "solely for the benefit of" (SBO) trust. The critical feature of these SBO trusts is that during each plaintiff's *spouse's* lifetime, distributions from the trusts could be made only to that spouse. I agree with the majority that property held in these SBO trusts is not countable toward Medicaid's resource limit because "the individual" in 42 USC 1396p(d)(3)(B) refers to the Medicaid applicant.

But I also believe that the plaintiffs' transfer of assets into the trusts triggers Medicaid's divestment rules. This issue has not been presented here, for understandable procedural reasons. I believe such a discussion is necessary, however, as a caution. If I am correct, then the plaintiffs' overall planning strategy would be undermined: although they would be able to satisfy Medicaid's threshold resource test, the plaintiffs would be disqualified from receiving Medicaid benefits for a time period calculated by reference to the value of the transferred assets. And because their strategy involves irrevocable trusts, there is no way to unwind the transfer. In short, the majority opinion should not be interpreted as permitting a married Medicaid applicant to shelter and preserve any amount of wealth without restriction, and then immediately receive financial assistance as if she did not have it.

[1] "The plaintiffs" refers to the original plaintiffs who began these proceedings.

I. MEDICAID BACKGROUND

The federal Medicaid Assistance Program (Medicaid), enacted as Title XIX of the Social Security Act, 42 USC 1396 *et seq.* (the Medicaid Act or the Act), is a program through which the federal government shares, along with participating states, the cost of providing financial assistance for medical services to "families with dependent children and [to] aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services . . . ." 42 USC 1396-1. State participation in the program is optional. States that do participate, however, must comply with federal law, including those provisions set forth in 42 USC 1396p regarding "liens, adjustments and recoveries of medical assistance correctly paid[,] transfers of assets, and treatment of certain trusts[.]" 42 USC 1396a(a)(18). In Michigan, the program is administered by the Department of Health and Human Services (the Department), of which defendant is the director. MCL 400.105; see note 5 of the majority opinion.

To be eligible for Medicaid financial assistance for nursing-home services, each plaintiff's countable assets[2] could not exceed $2,000. See Part III(B)(1) of the majority opinion. The plaintiffs established these SBO trusts to reduce their countable assets to satisfy this limit.

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[2] The term "assets" encompasses both "resources" and "income." 42 USC 1396p(h)(1). While the parties use the term "countable assets" to refer to Medicaid's nonincome eligibility criteria, it should be understood that, for purposes of determining financial eligibility, "resources" and "income" are evaluated differently. See 42 USC 1396r-5(b) and (c) and Part I(A) of this opinion.

A. ELIGIBILITY FOR NURSING-HOME SERVICES

For married applicants such as the plaintiffs, the eligibility rules for nursing-home services begin with the "spousal impoverishment" provisions of the Medicaid Act. See 42 USC 1396r-5. Enacted by Congress in 1988, these provisions "permit a spouse living at home (called the 'community spouse') to reserve certain income and assets to meet the minimum monthly maintenance needs he or she will have when the other spouse (the 'institutionalized spouse'[3]) is institutionalized, usually in a nursing home, and becomes eligible for Medicaid." *Wis Dep't of Health & Family Servs v Blumer*, 534 US 473, 478; 122 S Ct 962; 151 L Ed 2d 935 (2002).

Congress achieved this in two ways. First is the treatment of income. For any month in which the institutionalized spouse receives nursing-home services, the Medicaid Act provides that "no income of the community spouse shall be deemed available to the institutionalized spouse." 42 USC 1396r-5(b)(1). "The community spouse's income is thus preserved for that spouse and does not affect the determination whether the institutionalized spouse qualifies for Medicaid. In general, such income is also disregarded in calculating the amount Medicaid will pay for the institutionalized spouse's care after

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[3] The term "institutionalized spouse" refers to "an individual who . . . is in a medical institution or nursing facility . . . and . . . is married to a spouse who is not in a medical institution or nursing facility[.]" 42 USC 1396r-5(h)(1). The "community spouse" is "the spouse of an institutionalized spouse." 42 USC 1396r-5(h)(2). Elsewhere, Congress has used the term "institutionalized individual" to refer to "an individual who is an inpatient in a nursing facility . . . ." 42 USC 1396p(h)(3). Congress, however, has not provided a specific definition for the spouse of an "institutionalized individual," presumably because 42 USC 1396p (unlike the spousal-impoverishment provisions) applies to Medicaid applicants regardless of their marital status. More confusing yet, Congress in 42 USC 1396p uses undefined terms such as "an individual," "the individual," and "the individual's spouse."

eligibility is established." *Blumer*, 534 US at 480-481; see 42 USC 1396r-5(b)(2). The spousal-impoverishment provisions also establish a "minimum monthly maintenance needs allowance." 42 USC 1396r-5(d)(3). Under 42 USC 1396r-5(d), if the community spouse's income is ever less than the allowance, the Act permits the institutionalized spouse to reallocate her income (up to the amount of the shortfall) to the community spouse, thereby resulting in Medicaid's paying a greater portion of the institutionalized spouse's nursing-home expenses. *Blumer*, 534 US at 481-482.

The second way in which Congress protects a community spouse is through the Act's treatment of marital resources and the "community spouse resources allowance" (CSRA). As the Court explained in *Blumer*:

> For purposes of establishing the institutionalized spouse's Medicaid eligibility, a portion of the couple's assets is reserved for the benefit of the community spouse. [42 USC 1396r-5(c)(2)]. To determine that reserved amount (the CSRA), the total of all of the couple's resources (whether owned jointly or separately) is calculated as of the time the institutionalized spouse's institutionalization commenced; half of that total is then allocated to each spouse (the "spousal share"). [42 USC 1396r-5(c)(1)(A)]. The spousal share allocated to the community spouse qualifies as the CSRA, subject to [a statutory maximum and minimum]. The CSRA is considered unavailable to the institutionalized spouse in the eligibility determination, but all resources above the CSRA (excluding a small sum set aside as a personal allowance for the institutionalized spouse, currently $2,000 . . .) must be spent before eligibility can be achieved. [42 USC 1396r-5(c)(2)]. [*Blumer*, 534 US at 482-483.]

Together, these rules "assur[e] that the community spouse has a sufficient—but not excessive—amount of income and resources available." *Id.* at 480 (citation and quotation marks omitted).

B. THE MEDICAID TRANSFER RULES

To prevent an institutionalized individual from simply giving away her assets to satisfy the Medicaid Act's eligibility criteria, Congress implemented a divestment penalty. This penalty is based on a look-back date—a set time before the individual's application for Medicaid benefits. 42 USC 1396p(c)(1)(B).[4] If an institutionalized individual or her spouse "disposes of assets for less than fair market value" at any point after the look-back date, 42 USC 1396p(c)(1)(A), she is disqualified from receiving financial assistance for nursing-home services for a length of time set by statutory formula, see 42 USC 1396p(c)(1)(D) and (E). That disqualification applies regardless of whether the individual is otherwise eligible for or even receiving Medicaid financial assistance. See *id.* The period of disqualification is determined by dividing the total uncompensated value of the transferred assets by the average monthly cost of nursing-home services. 42 USC 1396p(c)(1)(E)(i).

In plainer terms, if either spouse disposes of assets for less than fair market value after the look-back date, the institutionalized spouse is disqualified from receiving financial assistance for a period that approximates the uncompensated value of the transferred assets.

But as with most rules, there are exceptions. There are certain "permissive" asset transfers, set forth in 42 USC 1396p(c)(2), that will not trigger a penalty:

> (c) Taking into account certain transfers of assets
>
> * * *
>
> (2) An individual shall not be ineligible for medical assistance by reason of [42 USC 1396p(c)(1)] to the extent that—

[4] Here, 60 months before plaintiffs' dates of application.

* * *

(B) the assets—

(i) were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse,

(ii) were transferred from the individual's spouse to another for the sole benefit of the individual's spouse,

(iii) were transferred to, or to a trust (including a trust described in [42 USC 1396p(d)(4)]) established solely for the benefit of, the individual's child described in [42 USC 1396p(c)(2)(A)(ii)(II)[5]], or

(iv) were transferred to a trust (including a trust described in [42 USC 1396p(d)(4)]) established solely for the benefit of an individual under 65 years of age who is disabled[.][6]

The permissive transfers set forth at 42 USC 1396p(c)(2)(B)(i) and (ii) are important here. They allow unlimited transfers between an institutionalized individual and her spouse (that is, between the institutionalized spouse and the community spouse). This is sensible: as discussed, the Medicaid Act's resource rules require the Department to begin its initial resource evaluation by computing "the total value of the resources to the extent either the institutionalized spouse or the community spouse has an ownership interest . . . ." 42 USC 1396r-5(c)(1)(A)(i); see *Blumer*, 534 US at 482-483.

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[5] That is, a child who is under 21, blind, or disabled.

[6] Additionally, the Medicaid Act permits an individual to transfer his or her home without incurring a penalty, so long as the transferee is the individual's spouse or, under specific conditions, close relatives. 42 USC 1396p(c)(2)(A). While the value of an individual's home is generally not included in the initial resource evaluation, a home is considered an "asset" for purposes of the transfer rules. See 42 USC 1396p(c)(5); 42 USC 1382b(a)(1). Thus, a transfer of the home after the look-back date will incur a divestment penalty, unless the transfer is specifically permitted under 42 USC 1396p(c)(2)(A).

Again, in plainer terms: there is no reason to penalize an interspousal transfer of assets because resources belonging to both spouses are combined in determining an applicant's *eligibility*. Because spousal resources are accounted for in the Medicaid eligibility process no matter which spouse holds them, there is no need to penalize a transfer from one spouse to the other.

In addition to interspousal transfers, the Medicaid Act does not penalize a transfer from either spouse to a third party if the transfer is "for the sole benefit of" the Medicaid applicant's spouse (the community spouse). 42 USC 1396p(c)(2)(B)(i) and (ii). Unlike interspousal transfers, however, this exception can have a much greater impact on eligibility, because resources that are "held" by a third party might not be considered countable assets for purposes of Medicaid's financial eligibility determination. See 42 USC 1396r-5(c)(2)(A) ("In determining the resources of an institutionalized individual . . . [,] except as provided in subparagraph (B) [concerning the CSRA], all the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse . . . ."). This exemption is pivotal to the plaintiffs' Medicaid planning strategy; if the transfers of assets into the SBO trusts are not "for the sole benefit of" the community spouse, then the transfers should incur a divestment penalty.

Congress also provided specific transfer rules for two categories of assets: the purchase of an annuity and the purchase of a promissory note, loan, or mortgage. For annuities, 42 USC 1396p(c)(1)(F) provides that "the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value"—that is, a penalized transfer—"unless . . . (i) the State is named as the remainder beneficiary in the first position for at

least the total amount of medical assistance paid on behalf of the institutionalized individual under this subchapter; or (ii) the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value." This provision ensures that if a community-spouse annuitant does not survive the annuity's term, the state agency, rather than a third-party beneficiary or heir (other than a minor or disabled child), will be paid the remaining annuity payments up to the total amount of Medicaid assistance paid on behalf of the institutionalized spouse.[7] See *Hutcherson v Arizona Health Care Cost Containment Sys Admin*, 667 F3d 1066, 1070 (CA 9, 2012) ("We will give the plain meaning to the unambiguous language in § 1396p(c)(1)(F)(i), which allows states to reach a deceased community spouse's annuity for costs incurred on behalf of an institutionalized spouse.").

Additionally, 42 USC 1396p(c)(1)(G) provides that an annuity "purchased by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services" will be treated as an "asset" unless the annuity is purchased with proceeds from certain retirement accounts or the annuity contract is irrevocable and nonassignable,

[7] Likewise, Congress has required a state payback provision to be included in any trust that is exempt from the general trust rules. See 42 USC 1396p(d)(4). Thus, while certain transfers of assets into exempt trusts are permitted penalty-free, see 42 USC 1396p(c)(2)(B)(iii) and (iv), those assets are still subject to a Medicaid payback. The only nonpenalized transfer of assets not subject to Medicaid payback, other than transfers "for the sole benefit of" the community spouse, are transfers directly to a blind or disabled child and the transfer of a home under specific conditions. See 42 USC 1396p(c)(2)(B)(iii) (incorporating the description of a blind or disabled child in 42 USC 1396p(c)(2)(A)(ii)(II)); 42 USC 1396p(c)(2)(A).

the contract is actuarially sound, and the payments are equal during the term of the annuity. The Department has interpreted these latter requirements (irrevocable and nonassignable, actuarially sound, and providing for equal monthly payments) as applying to all annuities purchased with countable resources; otherwise, the transfer is subject to penalty. See Michigan Department of Health and Human Services, *Bridges Eligibility Manual 401* (July 2014), p 5.[8] The purchase of a community-spouse annuity that satisfies the requirements of 42 USC 1396p(c)(1)(F) and (G)—a "qualified" community-spouse annuity—will not trigger a divestment penalty, because the transfer is for "the sole benefit of" the community spouse. 42 USC 1396p(c)(2)(B)(i) and (ii).

For the purchase of a debt obligation, 42 USC 1396p(c)(1)(I) provides, for purposes of the transfer rules, that "the term 'assets' includes funds used to purchase a promissory note, loan, or mortgage," unless the debt instrument: (i) has an actuarially sound repayment term, (ii) is payable in equal installments, and (iii) does not allow for cancellation of the balance upon the death of the lender. 42 USC 1396p(c)(1)(I)(i) through (iii). In plainer terms, if the debt instrument does not satisfy these requirements, the transferred assets (the assets used to purchase the note, loan, or mortgage) will be subject to a divestment penalty.

While there is considerably less caselaw addressing 42 USC 1396p(c)(1)(I) than that addressing annuities, when such transfers are challenged, courts have considered whether the transaction is bona fide or an attempt to circumvent the Medicaid eligibility and transfer rules. See *Landy v Velez*, 958 F Supp 2d 545, 554 (D NJ, 2013) ("To be bona fide, an

[8] The Medicaid Act also requires an applicant to disclose in her application any interest she or her spouse has in an annuity, regardless of whether the annuity is countable as a resource. See 42 USC 1396p(e).

informal cash loan must (1) be enforceable under state law, (2) be in effect at the time of the transaction, (3) contain an acknowledgement of an obligation to repay and (4) have a plan for repayment (5) which is feasible in light of 'the amount of the loan, the [borrower]'s resources and income, and the [borrower]'s living expenses.' "), quoting Social Security Administration, *Program Operations Manual System*, SI 01120.220(D)(1) through (5).

These annuity and debt obligation rules were added by the Deficit Reduction Act of 2005, PL 109-171; 120 Stat 4 (the DRA). In enacting the DRA, Congress "sought to further close loopholes in the Medicaid Act." *Hutcherson*, 667 F3d at 1069. The DRA achieved this by "restrict[ing] the use of annuities by Medicaid applicants in order to prevent applicants from sheltering their assets in anticipation of Medicaid eligibility." *Carlini v Velez*, 947 F Supp 2d 482, 486 (D NJ, 2013); see also *Morris v Oklahoma Dep't of Human Servs*, 685 F3d 925, 935-938 (CA 10, 2012) (explaining how the conversion of spousal resources into a stream of future payments for the community spouse exploits the Act's separate treatment of income postinstitutionalization). Such restrictions further Congress's interest in "preventing financially secure couples from obtaining Medicaid assistance." *Blumer*, 534 US at 480.

All these restrictions make little sense, however, if 42 USC 1396p(c) and (d) allow married couples to immediately transfer unlimited assets to a community spouse, without incurring any divestment penalty, simply by placing assets into an SBO trust.

C. MEDICAID'S TRUST RULES

Section 1396p(d) provides a "comprehensive system of asset-counting rules for determining who qualifies for Medicaid." *Lewis v Alexander*, 685 F3d 325, 332 (CA 3,

2012). Enacted by the Omnibus Budget Reconciliation Act (OBRA) of 1993, PL 103-66; 107 Stat 312, see Part III(A) of the majority opinion, the current trust rules responded to "Medicaid's original asset-counting rules, [under which] individuals could put large sums of money in trust, thereby vesting legal title to those assets in the trust and reducing (on paper) the amount of assets owned by the individual." *Lewis*, 658 F3d at 332. "In the 1993 OBRA amendments, Congress established a general rule that trusts would be counted as assets for the purpose of determining Medicaid eligibility." *Id.* at 333.

The majority has explained well the general rules for revocable and irrevocable trusts. But one feature bears emphasis: Congress has specifically exempted three types of trusts from those general trust rules. See 42 USC 1396p(d)(4)(A) through (C).[9] Two of these "(d)(4) trusts"—special-needs trusts and pooled trusts (42 USC 1396p(d)(4)(A) and (C))—allow a *disabled* beneficiary to receive assets without disqualifying the beneficiary for Medicaid assistance. The third, a qualified-income trust (42 USC 1396p(d)(4)(B)), allows individuals in certain states to control the amount of income used to determine Medicaid eligibility. All of these trusts serve very different purposes than SBO trusts. But just as with the rules for annuities, the rules for these exempted (d)(4) trusts require that, upon the death of the trust beneficiary (or beneficiaries), any remaining trust assets must be used to pay back the state agency up to the amount of Medicaid financial assistance expended on behalf of the trust beneficiary or beneficiaries. See 42 USC 1396p(d)(4)(A), (B)(ii), and (C)(iv).

[9] And certain transfers into these (d)(4) trusts are exempt from the divestment penalty. See 42 USC 1396p(c)(2)(B)(iii) and (iv).

The plaintiffs' Medicaid planning strategy—SBO trusts—implicates the general rules for irrevocable trusts at 42 USC 1396p(d)(3)(B). As the majority explains, any property held in an SBO trust is not an available "resource" of the married couple for purposes of Medicaid's financial eligibility determination, because the trust is irrevocable and legal title is held by the third-party trustee; the trust property is therefore not countable, because it "is not held by either spouse." And because the terms of these SBO trusts require that any distribution be made to the plaintiffs' spouses (the community spouses) for the spouses' lifetimes, there can never be "any circumstances under which payment from the [SBO] trust could be made to or for the benefit of" these plaintiffs. 42 USC 1396p(d)(3)(B)(i).

Normally, such a transfer would trigger the divestment penalty, as the property held in trust is "assets disposed by the [institutionalized] individual for purposes of" the transfer rules. 42 USC 1396p(d)(3)(B)(ii). But according to the plaintiffs, the transfer of marital assets into these SBO trusts are exempt from the divestment penalty, because they are transfers to a third party (the trusts) "for the sole benefit of" the community spouse. See 42 USC 1396p(c)(2)(B)(i) and (ii). In short, the plaintiffs' theory is that an institutionalized individual can achieve immediate (penalty-free) eligibility for Medicaid financial assistance by simply placing any assets over the eligibility limit in an irrevocable trust, and also avoid the divestment penalty that accompanies that kind of divestment, so long as any payments from the trust are made only to the community spouse during his lifetime.

The result: a perfect loophole to Congress's carefully constructed eligibility and transfer rules.

D. THE STATUTORY TEXT: "FOR THE SOLE BENEFIT OF"

I agree with the majority that "the individual" in 42 USC 1396p(d)(3)(B) refers to the Medicaid applicant.[10] But I doubt the plaintiffs' interpretive victory will ultimately prove to be an effective Medicaid planning strategy. The strategy only works if the plaintiffs can avoid a divestment penalty. The plaintiffs believe they can do so because their transfers of assets into the SBO trusts were "for the sole benefit of" the community spouses. 42 USC 1396p(c)(2)(B). The lower courts were never presented with this question because the Department had no reason to impose a penalty, given its conclusion that these plaintiffs did not satisfy the Act's eligibility criteria. The majority opinion sensibly declines to address the penalty issue. Because I see a significant hurdle for plaintiffs whenever this question is addressed, I write separately to explain.

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[10] The plaintiffs emphasize that Congress did include "the individual's spouse" within what the majority describes as the "any-circumstances rule" of 42 USC 1396p(d)(3)(B), as Congress did with the comparable Supplemental Security Income (SSI) provision. While my analysis differs from that of the Court of Appeals, I agree with the panel that Congress intended for spousal resources to be evaluated jointly and that the interpretation urged by the plaintiffs runs counter to that intent, especially given the spousal-impoverishment provisions. The majority concludes that this was not a mere oversight because of Congress's inclusion of "the individual's spouse" in the rules governing the SSI program. Maybe. But I'm not as convinced as the majority that the omission was intentional. As the majority observes, "the Medicaid trust rules in 42 USC 1396p(d) were added by OBRA 93, six years before Congress added the SSI trust rules in 42 USC 1382b(e) . . . ." In other words, when Congress enacted 42 USC 1396p(d)(3)(B), it was writing on a clean slate—there was no comparable SSI statute. And Congress has not amended 42 USC 1396p(d)(3)(B) at any time since. But even if Congress intended for the SSI rules to operate differently, or if instead Congress was putting a finer point on what it thought to be the existing Medicaid rule (and should have also amended that rule), I nevertheless agree with the majority that the Act's reference to "the individual" in 42 USC 1396p(d)(3)(B) unambiguously refers to the Medicaid applicant.

Congress has not defined "for the benefit of [the institutionalized spouse]" in the trust rules. 42 USC 1396p(d)(3). Likewise, Congress has not defined "for the sole benefit of [the community spouse]" in the transfer rules. 42 USC 1396p(c)(2)(B). If words are not defined by statute, we give them their ordinary meaning. The definitions of "sole" and "benefit" are uncontroversial. For example, *Merriam-Webster's Collegiate Dictionary* (11th ed) defines the term "benefit" as "something that promotes well-being" and "useful aid." "Sole" is defined as "having no sharer" and "being the only one." *Id.* Other dictionaries agree. And the statutory text gives us another clue: a payment "for the benefit of" an individual must mean something different than a payment "to" an individual, given Congress's use of both connected by "or" in 42 USC 1396p(d)(3)(B) ("to *or* for the benefit of the [institutionalized] individual") and 42 USC 1396p(c)(2)(B)(i) ("to the individual's spouse *or* to another for the sole benefit of the individual's spouse") (emphasis added).

So is a transfer of assets to a third-party trustee "for the sole benefit of" the community spouse if that transfer "benefits" the institutionalized spouse by allowing her to satisfy Medicaid's eligibility limits while avoiding the specific rules that apply to community-spouse annuities? And if the community spouse receives a payment from an SBO trust and then shares that payment with the institutionalized spouse, is that a circumstance in which "payment from the trust" is "made . . . for the benefit of" the institutionalized spouse?[11]

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[11] So thought the United States Court of Appeals for the Third Circuit in *Johnson v Guhl*, 357 F3d 403, 408-409 (CA 3, 2004). *Johnson* concerned the use of so-called "community spouse annuity trusts" (CSATs) in the state of New Jersey. CSATs, like these SBO trusts, were irrevocable and "designed to provide a stream of annuity payments to the community spouse for the duration of his or her life." *Guhl*, 357 F3d at 406. If the trust named the

Even harder: what if an SBO trust names as a remainder beneficiary a person or entity other than the state agency? That is, if a third party can receive the remainder, is the transfer "for the sole benefit of" the community spouse?

The simplest answer might be "yes"—there *are circumstances* under which a distribution from an SBO trust to a community spouse is "for the benefit of" the institutionalized spouse, and there *are persons* other than the community spouse who might "benefit" from a transfer of assets into an irrevocable SBO trust, if that transfer and trust make the institutionalized spouse eligible for benefits. If that's right, then there are

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state agency as the first remainder beneficiary, New Jersey would not consider the trust property as a countable asset. *Id.* The state changed its policy after the federal Department of Health and Human Services advised that such trusts should, in fact, be considered countable assets. *Id.* The plaintiffs challenged this interpretation. The Third Circuit agreed with the state:

> As this is a question of statutory interpretation, we begin (and end) our inquiry with the relevant statute, 42 U.S.C. § 1396p(d)(3)(B). That provision provides, in subsection (i), that "[i]n the case of an irrevocable trust—if there are any circumstances under which payment from the trust could be made to or for the benefit of [the institutionalized spouse whose assets are used to establish the trust], the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual. . . ." Both parties agree that CSATs are irrevocable trusts. They are generally funded with marital assets (assets that belong to both spouses). Moreover, CSATs are designed so that the corpus and the income on the corpus will provide the community spouse a stream of payments. Once the community spouse receives these payments, there is nothing preventing her or him from sharing them with the institutionalized spouse as well. Section 1396p(d)(3)(B)(i) thus squarely covers CSATs—as "circumstances [exist] under which payment from the trust could be made to or for the benefit of" the institutionalized spouse—and deems them countable resources. Accordingly, we affirm the District Court ruling that plaintiffs' CSAT assets are countable resources. [*Guhl*, 357 F3d at 408-409 (alterations in original).]

circumstances under which a distribution from an SBO trust to a community spouse is "for the benefit of" the institutionalized spouse and the assets held in trust should be considered available resources or income for purposes of determining each plaintiffs' eligibility for Medicaid. And if there are persons other than the community spouse who might "benefit" from a transfer of assets into an irrevocable SBO trust, then the plaintiffs should be subject to a divestment penalty.

But that expansive interpretation—one that defines becoming eligible for Medicaid as a benefit—might prove too much. That understanding would prohibit Medicaid planning strategies that Congress has endorsed. After all, the purchase of a qualified community-spouse annuity "benefits" the institutionalized spouse if the conversion of resources to income allows the institutionalized spouse to satisfy Medicaid's financial eligibility limits without incurring a divestment penalty. See *Morris*, 685 F3d at 935-938. And, of course, the transfer rules themselves permit certain transfers to (d)(4) trusts, which might also benefit the institutionalized spouse in the eligibility determination. See 42 USC 1396p(c)(2)(B)(iii) and (iv).[12]

But the statutory requirement that the transfer be "for the *sole* benefit of" the community spouse is still a hurdle that the plaintiffs must overcome if they are to receive immediate financial assistance. On this point, the statute's plain language, and federal guidance, are instructive.

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[12] But here too, the transferred assets may be subject to a payback mechanism, because that is a condition of all the (d)(4) trust exceptions. See Part I(B) of this opinion.

There are no federal regulations interpreting 42 USC 1396p. The Centers for Medicare & Medicaid Services (CMS),[13] however, has provided guidance on the meaning of "for the sole benefit of" in the State Medicaid Manual, which includes an explanation of the transfer rules:

> For the Sole Benefit of.--A transfer is considered to be for the sole benefit of a spouse, blind or disabled child, or a disabled individual if the transfer is arranged in such a way *that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future.*
>
> Similarly, a trust is considered to be established for the sole benefit of a spouse, blind or disabled child, or disabled individual *if the trust benefits no one but that individual, whether at the time the trust is established or any time in the future.* However, the trust may provide for reasonable compensation, as defined by the State, for a trustee or trustees to manage the trust, as well as for reasonable costs associated with investing or otherwise managing the funds or property in the trust. In defining what is reasonable compensation, consider the amount of time and effort involved in managing a trust of the size involved, as well as the prevailing rate of compensation, if any, for managing a trust of similar size and complexity.
>
> *A transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is not the spouse, blind or disabled child, or disabled individual is not considered to be established for the sole benefit of one of these individuals.* In order for a transfer or trust to be considered to be for the sole benefit of one of these individuals, the instrument or document must provide for the spending of the funds involved for the benefit of the individual on a basis that is actuarially sound based on the life expectancy of the individual involved. When the instrument or document does not so provide, any potential exemption from penalty or consideration for eligibility purposes is void.
>
> An exception to this requirement exists for trusts discussed in § 3259.7 [concerning the trust exemption found at 42 USC 1396p(d)(4) for

[13] At the federal level, the Medicaid program is administered by the Secretary of Health and Human Services, who in turn exercises his authority through CMS.

> supplemental needs trusts and special-needs trusts]. *Under these exceptions, the trust instrument must provide that any funds remaining in the trust upon the death of the individual must go to the State, up to the amount of Medicaid benefits paid on the individual's behalf.* When these exceptions require that the trust be for the sole benefit of an individual, the restriction discussed in the previous paragraph does not apply when the trust instrument designates the State as the recipient of funds from the trust. Also, the trust may provide for disbursal of funds to other beneficiaries, provided the trust does not permit such disbursals until the State's claim is satisfied. Finally, "pooled" trusts may provide that the trust can retain a certain percentage of the funds in the trust account upon the death of the beneficiary. [CMS, *State Medicaid Manual*, § 3257(B)(6) (rev 64), p 3-3-109.2 (emphasis added).]

The manual provides the following guidance on the use of irrevocable trusts and the meaning of "to or for the benefit of":

> C. Irrevocable Trust - Payments From All or Portion of Trust Cannot, Under Any Circumstances, Be Made to or for the Benefit of the Individual.--When all or a portion of the corpus or income on the corpus of a trust cannot be paid to the individual, treat all or any such portion or income as a transfer of assets for less than fair market value . . . .
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> * * *
>
> D. Payments Made From Revocable Or Irrevocable Trusts to or on Behalf of Individual.--Payments are considered to be made to the individual when any amount from the trust, including an amount from the corpus or income produced by the corpus, is paid directly to the individual or to someone acting on his/her behalf, e.g., a guardian or legal representative.
>
> *Payments made for the benefit of the individual are payments of any sort, including an amount from the corpus or income produced by the corpus, paid to another person or entity such that the individual derives some benefit from the payment.* For example, such payments could include purchase of clothing or other items, such as a radio or television, for the individual. Also, such payments could include payment for services the individual may require, or care, whether medical or personal, that the individual may need. Payments to maintain a home are also payments for the benefit of the individual.
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> * * *

> G. Use of Trust vs. Transfer Rules for Assets Placed in Trust.--When a nonexcluded asset is placed in a trust, *a transfer of assets for less than fair market value generally takes place.* An individual placing an asset in a trust generally gives up ownership of the asset to the trust. If the individual does not receive fair compensation in return, you can impose a penalty under the transfer of assets provisions. [CMS, *State Medicaid Manual*, § 3259.6 (rev 64), pp 3-3-109.28 through 3-3-109.30 (emphasis added).]

The manual does not address the specific interpretation of 42 USC 1396p(d)(3)(B) that the plaintiffs advance,[14] but it offers insight. First, when evaluating whether there is "any circumstance under which payment from the trust could be made to or for the benefit of" the institutionalized spouse, the question is whether the payment is "paid to another person or entity such that the [institutionalized] individual derives some benefit from the payment." CMS, *State Medicaid Manual*, § 3259.6(D), p 3-3-109.29.

The manual is entitled to respectful consideration because this interpretation is entirely consistent with the statutory text and the ordinary meaning of "sole" and "benefit." See *Skidmore v Swift & Co*, 323 US 134, 139-140; 65 S Ct 161; 89 L Ed 124 (1944) (explaining when an administrative policy is entitled to deference). The question, then, is not whether the community spouse is free to share the payment with the institutionalized spouse, but whether the payment itself results in a direct benefit to the institutionalized spouse, such as a purchase of goods or services for the institutionalized spouse. Cf. *Johnson*, 357 F3d at 408-409.

But there's more to do. As the manual explains, "[w]hen a nonexcluded asset is placed in a trust, a transfer of assets for less than fair market value generally takes place." CMS, *State Medicaid Manual*, § 3259.6(G), p 3-3-109.30. That is, the transfer is subject

[14] See generally CMS, *State Medicaid Manual*, § 3259, pp 3-3-109.24 through 3-3-109.38.

to a divestment penalty. This is because 42 USC 1396p(d)(3)(B)(ii) directs that for "any portion of the trust from which . . . no payment could under any circumstances be made to the [institutionalized] individual," that portion "shall be considered . . . to be assets disposed by the individual for purposes of" the transfer rules.

This point is critical. The plaintiffs believe that the transfer of assets into these SBO trusts is exempt from the divestment penalty because it was a transfer of assets "for the sole benefit of" the plaintiffs' spouses. I am not convinced.

As the manual explains, "[a] transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is not the spouse . . . is not considered to be established for the sole benefit of [the spouse]." CMS, *State Medicaid Manual*, § 3257(B)(6), p 3-3-109.2. And the relevant period for determining whether the "funds or property . . . pass to a beneficiary who is not the spouse" extends to "any time in the future." *Id.* If there is any person (other than the community spouse) who might stand to benefit from the transfer of assets into an SBO trust, the transfer results in a penalty. This fits with the dictionary definitions, too—if there is another person who might benefit from the transfer, the transfer is not for the "sole" benefit of the community spouse.

In these cases, the plaintiffs' SBO trusts generally reserved in the community spouse a testamentary power of appointment.[15] That is, if any plaintiff's spouse died before all

[15] The Lollar Trust, for example, provided the community spouse with a special testamentary power of appointment for any balance held in trust. See Lollar Trust, Section 3.2. The Hegadorn Trust directed that, if the community spouse predeceased plaintiff Hegadorn, the "Trustee shall distribute the remaining trust property to the trustee of the *SPECIAL SUPPLEMENTAL CARE TRUST FOR MARY ANN HEGADORN*"; otherwise, any balance would be administered under the terms in the community spouse's will. Hegadorn Trust, Sections 3.2-3.4. The Ford Trust provided the community spouse with a

property held in trust could be distributed to him, the remainder would be distributed according to the spouse's will. Thus, when the plaintiffs transferred their assets into these SBO trusts, there was the potential that, at some point in the future, a person other than the community spouses (the yet-to-be-determined remainder beneficiaries) might benefit from the transfer. Therefore, despite their name, these "solely for the benefit of" trusts were not for the sole benefit of the community spouse.[16]

What's more, the plaintiffs' interpretation of the Act makes little sense given the annuity rules and the (d)(4) trusts. Like these SBO trusts, an annuity presents the potential of a remainder beneficiary if the community spouse dies before the annuity's term. But Congress has written specific affirmative rules permitting the use of community-spouse annuities as a valid Medicaid planning strategy—so long as the annuity is actuarially sound

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special testamentary power of appointment limited to his heirs; if that power was not fully exercised, the trustee was directed to "divide the remaining Trust property . . . into separate trusts, equal in value, one for each living Child and one for then living Descendants, collectively, of each deceased Child." Ford Trust, Section 3.2.

The payment terms of the trusts are less clear; while all the trusts require the trustee to make distributions on an "actuarially sound" basis, the trustee is not prohibited from distributing all of the trust property nearly immediately, in a lump-sum payment, contrary to the requirements placed on annuities. See Lollar Trust, Section 2.2; Hegadorn Trust, Section 2.2; Ford Trust, Section 2.2.

[16] The possibility of a remainder beneficiary is always present in a trust, either as provided for in the trust instrument or by operation of law. If the plaintiffs' SBO trusts did not include a residuary clause, any property held in an SBO trust would revert to the settlor (or the settlor's heirs) upon the death of the community spouse. MCL 555.18. Perhaps, then, the transfer of assets into an SBO trust should *always* result in the imposition of a divestment penalty.

and the state agency is named as a remainder beneficiary.[17] And the remainder-beneficiary rule for annuities shows that Congress did not intend to create an easy alternative with all the advantages and none of the disadvantages. See, e.g., *Breighner v Mich High Sch Athletic Ass'n, Inc*, 471 Mich 217, 232; 683 NW2d 639 (2004) ("[A] statutory term cannot be viewed in isolation, but must be construed in accordance with the surrounding text and the statutory scheme."). Likewise, where Congress has permitted transfers to certain (d)(4) trusts free from penalty, see 42 USC 1396p(c)(2)(B)(iii) and (iv), Congress has explicitly required a payback mechanism in the recipient trust. See note 7 of this opinion.

E. THE MEDICAID ACT AS A WHOLE

As the Supreme Court explained in *Blumer*, "[e]ach participating State develops a plan containing reasonable standards for determining eligibility for and the extent of medical assistance within boundaries set by the Medicaid statute and the Secretary of Health and Human Services." *Blumer*, 534 US at 479 (cleaned up). And those standards must "comply with the provisions of [42 USC 1396p] . . . ." 42 USC 1396a(a)(18). If the plaintiffs' interpretation of the Act is correct, SBO trusts would be available as a Medicaid planning strategy in every state that has elected to cover the medically needy. Yet no other jurisdiction has endorsed the legality of this type of Medicaid planning. Rather, the only

[17] The only circumstance in which a third party might stand to "benefit" from a qualified community-spouse annuity is if that party is named as a second (or later) remainder beneficiary and the state agency is fully paid back for all financial assistance provided to the institutionalized spouse. But the annuity must also be irrevocable, actuarially sound, and paid out in substantially equal monthly payments; otherwise, the transfer will be penalized. See Part I(B) of this opinion. A community-spouse annuity is thus an unreliable strategy for passing wealth to others, to say the least, as it requires the premature death of the community spouse.

appellate court to have even considered such a theory rejected it, albeit on other grounds. *Johnson*, 357 F3d at 408-409.

If the plaintiffs were successful in avoiding the divestment penalty, their planning strategy would make meaningless the complex set of rules governing Medicaid eligibility. Consider, for example, an irrevocable trust that is funded with marital assets after the look-back date. The hypothetical trust provides that the third-party trustee must not make any distribution to the community spouse until after the Department has made a determination on the institutionalized spouse's eligibility (which must be made within 45 days from the date of application, see 42 CFR 435.912). The hypothetical trust further provides that, once an eligibility determination has been made, the trustee must immediately distribute all property to the community spouse. See 42 USC 1396p(d)(2)(C)(ii) and (iii) (providing that the trust rules "shall apply without regard to . . . whether the trustees have or exercise any discretion under the trust [or] any restrictions on when or whether distributions may be made from the trust . . . ."). Such a trust would serve as a vehicle through which assets could be placed during the application, and then passed directly to the community spouse once an eligibility determination is made.

The plaintiffs argue that this transfer would not trigger a divestment penalty, because it would be for "for the sole benefit of" the community spouse. And there is no dispute that the distribution of assets to the community spouse would not be imputed to the institutionalized spouse; that part is settled. See 42 USC 1396r-5(b)(2) and (c)(4); *Blumer*, 534 US at 480-481. Thus, the value of the assets placed in the trust would be sheltered from the initial resource evaluation, and the distribution would not affect the institutionalized spouse's continued eligibility, nor would it change the level of financial

assistance provided by the Department. The only practical restriction is that the trust property would be inaccessible to the community spouse for the period it would take the Department to process the application. Aside from that minor inconvenience, a married applicant can evade virtually every restriction that Congress has placed on Medicaid financial assistance. There would be no limitation on the amount of assets that a Medicaid applicant could transfer penalty-free to her spouse, virtually immediately, not subject to the repayment requirements for (d)(4) trusts and trust-like devices such as annuities, and shielded from Medicaid's initial resource assessment. That result is inconsistent with the statute, especially given that Congress has already enacted complex rules that "shelter[] from diminution a standard amount of assets" (the CSRA). *Blumer*, 534 US at 478; see also *Breighner*, 471 Mich at 232. But our determination requires us to consider the entire text, not isolated parts lifted out of context. See Scalia & Garner, *Reading Law: The Interpretation of Legal Texts* (St. Paul: Thomson/West, 2012), p 167 ("Perhaps no interpretative fault is more common than the failure to follow the whole-text canon, which calls on the judicial interpreter to consider the entire text, in view of its structure and of the physical and logical relation of its many parts.").

II. CONCLUSION

In the Medicaid Act, Congress has balanced two competing policies: "protect[ing] community spouses from 'pauperization' while preventing financially secure couples from obtaining Medicaid assistance." *Blumer*, 534 US at 480. These policies are well reflected in the (admittedly complex) statutory scheme. I agree with the majority that "the individual" in 42 USC 1396p(d)(3)(B) refers to the Medicaid applicant. But if the

plaintiffs' transfers trigger the divestment penalty, it is not likely they will view this planning strategy as a success. The majority is correct to leave this question for a case in which it has been presented by the parties. I address it here only to caution individuals who might consider forming *irrevocable* trusts in an effort to achieve Medicaid eligibility, especially when other planning strategies are available, permission for which is well settled.

Bridget M. McCormack

CAVANAGH, J., did not participate in the disposition of this case because the Court considered it before she assumed office.

STATE OF MICHIGAN
IN THE SUPREME COURT

MARY ANN HEGADORN,

Plaintiff-Appellant,

vs.

DEPARTMENT OF HUMAN SERVICES DIRECTOR,

Defendant-Appellee

/

Supreme Court No. 156132
Court of Appeals No. 329508
Livingston CC: 2014-028394-AA

ESTATE OF DOROTHY LOLLAR, by DEBORAH D TRIM, Personal Representative

Plaintiff-Appellant,

vs.

DEPARTMENT OF HUMAN SERVICES DIRECTOR,

Defendant-Appellee

/

Supreme Court No. 156133
Court of Appeals No. 329511
Livingston CC: 2014-028395-AA

ROSELYN FORD,

Plaintiff-Appellant,

vs.

DEPARTMENT OF HUMAN SERVICES DIRECTOR,

Defendant-Appellee

/

Supreme Court No. 156134
Court of Appeals No. 331242
Washtenaw CC: 15-000488-AA

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STATEMENT OF CORPORATE DISCLOSURE

The National Academy of Elder Law Attorneys, Inc. (NAELA), is a non-profit membership organization without corporate stock and without a coorporate parent.

INTERESTS OF AMICUS CURIAE

NAELA is a professional organization of attorneys concerned with the rights of the elderly and disabled. It provides a professional center, including public interest advocacy, for attorneys whose work enhances the lives of people with special needs and of all people as they age.

RESTATEMENT OF QUESTIONS PRESENTED

I. **Does the statutory term "the individual" as used in 42 USC 1396p(d)(3)(B)(i) and (ii) mean the individual referenced in *id.* § 1396p(d)(1) whose application for Medicaid is governed by "the rules specified in paragraph (3)" [§ 1396p(d)(3)]?**

The Administrative Law Judge in effect answered this question no.
The Circuit Court's answer: Yes
Court of Appeal's answer: No
Appellant's answer: Yes
Appellee's answer: No

II. **Is treating a trust for the sole benefit of a community spouse under third party trust rules consistent with the general pattern of providing for the spouses of nursing home residents receiving Medicaid long term care benefits?**

The Administrative Law Judge in effect answered this question no.
The Circuit Court in effect answered this question yes.
Court of Appeal in effect answered this question no.
Appellant in effect answered this question yes.
Appellee in effect answered this question no.

STATEMENT OF THE CASE

This appeal involves three cases with a common fact pattern. A wife was admitted to a nursing home. Her husband then established and funded a trust for his sole benefit ("solely for the benefit of," or "SBO"), not to be counted for his wife's eligibility purposes, so that his remaining non-trust assets were less than the community spouse resource allowance (CSRA) in his case. Each then applied for Medicaid long term care benefits for the wife, the institutionalized spouse, and each application was denied by the local departments applying a new interpretation from the Department of Health and Human Services (the Department) of its manual paraphrasing the relevant federal statute. Two county circuit courts reversed the agency, but the Court of Appeals in turn reversed them and ruled in favor of the Department.

The Department argued that the community spouses' trusts were governed by the self-settled trust provision, subsection (3)(B)(i), of Section 1396p(d), which its guidelines paraphrase as providing "if there are any circumstances under which the assets can be [sic: distributed] to or for the benefit of *a* person, those are countable assets for the person" (emphasis added), not limited to the applicant, Brief for Department, *Hegadorn v. Department*, p. 17 (emphasis added). Given that premise, it could then argue logically that the spousal rules would require that these trust assets be considered in assessing eligibility.

The Court of Appeals accepted that argument, indeed did not even recognize that the applicants disagreed and that the theory was contested. "At the outset, it is undisputed that each trust at issue in this case was, in fact, a Medicaid trust. ..." Decision at 7. It then quoted from the state Medicaid manual the provision drawn from the federal statute, but more broadly worded:

> Count as the person's countable asset the value of the countable assets in the trust principal if there is any condition under which the principal could be paid to or on behalf of the person from an irrevocable trust,

applying 1396p(d) but not limited (as the statute is) to trusts for Medicaid applicants. With that premise, the court said the issue was to determine whether there were any such conditions allowing distribution.

SUMMARY OF ARGUMENT

The decision in this case turns entirely on the meaning of a federal statute. That statute, 42 U.S.C. § 1396p(d), exquisitely designed to frustrate Medicaid eligibility except where Congress intended, separates trusts by beneficiary and then provides clear and specific exceptions to its rules. A trust for the sole benefit of the spouse of Medicaid applicant, like the ones at issue here, is one of those exceptions.

The Department and the Court of Appeals come to a contrary result by analyzing a document that is not the statute and whose differences from the statute, if slight, are not trivial, like the difference between a horse chestnut and a chestnut

horse. Recognizing that the Medicaid statute does not support its position, the Department struggles to bring its case within the SSI trust statute, again with similar but not identical language, and where the difference goes to the very issue in dispute. The statutory language flatly rejects the Department's approach.

Finally, both of the federal agencies with responsibility for administering these trust statutes – the Social Security Administration and the Centers for Medicare and Medicaid Services – come to the opposite conclusion from the Department in how they analyze the statutes that apply.

ARGUMENT

To call something a "Medicaid trust" is not the end of analysis but the beginning.[1] It tells you nothing about what rules to apply. There are many types of trusts created by and/or for Medicaid applicants. Some thwart eligibility; some advance eligibility; some have little direct effect on eligibility. Who funded the trust, who is the beneficiary, the standards that guides the trustee, all of these and other factors can lead to diametrically different results under one provision or another. Many trusts, like the ones in this case, are the specific subject of federal legislation. In looking at Congress' action in this area, proper application of the

[1] By contrast, the notion of special needs trust as one designed to coordinate public benefits and private wealth is reasonably well understood. Ron M. Landsman, "Special Needs Trusts," in A Practical Guide to Estate Planning, ch. 14 (Jay Soled, ed., ABA 2012); see pp. 197-198. But even there, there is a wide variety of such trusts, first- or third-party, individual or pooled, SSI-complaint or not, and so forth.

law requires both appreciating the context in which any provision sits, while paying due attention to the specific language Congress used.

I. THE DEPARTMENT AND THE COURT OF APPEALS ERR IN ANALYZING A TRUST FOR THE SOLE BENEFIT OF THE COMMUNITY SPOUSE AS THOUGH IT WERE FOR THE BENEFIT OF THE APPLICANT.

The decision in these cases turns on the meaning of subsection (d) of 42 USC 1396p, "Treatment of trust amounts," which thoroughly and definitively addresses trusts funded by Medicaid applicants or their spouses. The question that divides the parties is whether subsection (d) directs that these "sole benefit" trusts for the husbands be treated as the self-settled trust for the wives/Medicaid applicants, as the Department argues, or whether they are to be treated as transferred for the benefit of the husbands and so subject to the transfer rules, as the husbands/community spouses argue. There appears to be little dispute beyond that. If not treated as self-settled trusts of the Medicaid applicant wives, the trusts are subject to analysis under the SSI resource rules, which undergird the spousal rules and control what constitutes an asset of the spouse for Spousal Impoverishment (SI) purposes.

A. The Federal Statute Comprehensively Governs Trusts Created or Funded by a Medicaid Applicant or his Spouse.

One cannot overstate how determined Congress was to stop the abusive use of trusts by Medicaid applicants when it enacted the Omnibus Budget Reconciliation

Act of 1993 (OBRA 1993).[2] A previous effort proved unsatisfactory.[3] State governors and Medicaid directors, supported by the long term care insurance industry, provided Congress with extensive descriptions of how "some non-poor elderly are using 'estate planning' techniques to shelter assets that otherwise would have kept them from becoming Medicaid eligible."[4] Many aspects of Medicaid planning were addressed, including the look-back date, how to calculate penalty periods, allocation of penalties involving married couples, treatment of jointly held assets, exemptions and affirmative defenses. But trusts were the focus, "the single most offensive Medicaid estate planning vehicle," whose use Congress "tried, in almost every manner short of criminalization, to inhibit ..." [5]

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[2] Pub.L. 103-66, Title XIII, §§ 13611-13612, 107 Stat. 622-626 (August 10, 1993).

[3] The "Medicaid qualifying trust" provision, 42 USC 1396a(k)(since repealed), provided that trust assets were available if the trustee had discretion to distribute them to the beneficiary. While one case allowed an applicant to avoid that rule by having distribution subject to consent of remainderman, *Pollak v. Department of Health and Rehabilitative Services*, 579 So 2d 786 (Fla 4th Dist App, 1991), most efforts to avoid the impact of the statute were usually rejected, e.g., *Gulick v. Department of Health and Rehabilitative Services*, 615 So 2d 192 (Fla 1st Dist App, 1993); but see *Trust Company of Oklahoma v. Department Human Services*, 825 P2d 1295 (Okla, 1992).

[4] National Governors Association, Proposed Policy on Medicaid Transfer of Assets (NGA, Tallahassee, Fla), July 1992, Preface, quoted in Ira Stewart Wiesner, *"OBRA '93 and Medicaid: Asset Transfers, Trust Availability, and Estate Recovery Statutory Analysis in Context,"* 19 Nova Law Review (No. 2), p. 679, 693 (1995).

[5] Wiesner, p. 703. It was not just those paying the bills, or the commercially interested insurance industry, who sought to limit the use of trusts in Medicaid planning. Advocates of Medicaid like Rep. Henry Waxman (D-CA), the primary sponsor of the initial administration bill, were sharply critical of those who sought to "tak[e] advantage of the Medicaid program ... to finance the transmission of wealth to their heirs at federal and state taxpayer expense." Harry Margolis, U.S. Rep. Waxman Explains Role in

Notwithstanding, at the same time Congress authorized the use of trusts for spouses and certain others, and these spousal SBO trust fall squarely within that carefully crafted system. As we will show, the Department's arguments should be directed to Congress if it wants to undo what Congress has specifically authorized.

The key provision implementing this new "anti-trust" policy – subsection (d) of 42 USC 1396p – is a marvel of effective draftsmanship, exquisitely designed to frustrate those who would try to use trusts to their advantage when seeking Medicaid benefits. It not only renders all such trusts ineffectual, it makes their use counter-productive except for narrow exceptions, all of which are written to prevent abuse as vehicles for family wealth transfer.

These rules are comprehensive and all-encompassing. The trust provisions "apply to any individual who establishes a trust and who is an applicant for or recipient of Medicaid." Centers for Medicare and Medicaid Services (CMS), State Medicaid Manual, § 3259.3, p. 3-3-109.26. Provisions concerning purpose, trustee discretion, or limitations are all irrelevant. §1396p(d)(2)(D).

The question, in any case, is which aspect of subsection (d) applies. It covers all trusts created by a Medicaid applicant or her spouse, but it does not treat all such trusts the same way, and the biggest single determinant is who is the beneficiary of

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Medicaid Changes," ElderLaw Report, July-Aug. 1993, p. 2, quoted in Wiesner, at 682 n. 8.

the trust. Congress divided trusts into two groups, both of which frustrate Medicaid eligibility, albeit it in opposite ways.

- ***Trusts for the Medicaid applicant*** – This comprises first-party trusts ***for*** the applicant, funded by the applicant or spouse. All assets in such trusts are deemed available "if there are any circumstances" allowing payment to or for the applicant. *Id.* §1396p(d)(3)(A)(i) and (3)(B)(i) ("available trusts"). These trusts thwart Medicaid eligibility by making all assets available as a matter of law. This is the provision which the Department would apply to these trusts.
- ***Trusts for anyone other than the applicant*** – These are trusts for others where the applicant can get no benefit. Where "no payment could under any circumstances be made to the individual" applicant, 42 USC 1396p(d)(3)(B)(ii)("unavailable trusts"), or distributions to or for others are made from otherwise available trusts, 42 USC 1396p(d)(3)(A)(iii) and (B)(i)(II), those are transfers. These trusts thwart eligibility by being treated as transfers subject to analysis and penalties under subsection (c). This is the provision the spouses of the Medicaid applicants say applies.

Each of these in turn has limited exceptions.

- Self-settled trusts that meet certain requirements are exempt. These are the first-party special needs trusts, which are exempt from all of these rules if they have pay back and meet other requirements. 42 USC 1396p(d)(4)(A)-(C).
- Trusts for others for whom Congress provided additional protections. These are primarily spouses and disabled children, but can include other disabled individuals under age 65. 42 USC 1396p(c)(2)(B)(i)-(iv).

Under this general federal rule, irrevocable self-settled trusts of Medicaid applicants, if not exempt, are thus to be read – notwithstanding anything in the trust document or state law to the contrary – as though they were support trusts, which have historically been available for SSI and Medicaid purposes, *Kryzsko v. Ramsey County Social Services*, 607 NW2d 237; ND (2000), but not otherwise; *Lang v. Commonwealth*, 515 PA 428; 528 A2d 1335 (1987); *Chenot v. Bordeleau*, 561 A2d 891 (RI, 1989); *Hecker v. Stark County Social Service Board*, 527 NW2d 228; 1994 ND (1994); *In the Matter of the Leona Carlisle Trust*, 498 NW2d 260 (Minn App, 1985); *Young v. Ohio Dept. Of Human Services*, 76 Ohio St 3d 547; 668 NE2d 908 (1996); *First National Bank of Maryland v. Dep't. of Health and Mental Hygiene,* 284 Md 720; 399 A2d 891 (1979). This rule applies, in the case of an individual's application for Medicaid eligibility, if she or her spouse

established or funded a trust, subsection (d)(2)(A)(i) and (ii); (h)(1)(A), where "there are any circumstances" allowing payment "to or for the benefit of the individual" who applied for Medicaid. Subsection (d)(3)(B)(i).

This rule, imposed by Congress on self-settled trusts for the benefit of the individual who applies for benefits, reflects Congress' choice to interfere, to a limited extent, in state trust law when federally funded Medicaid benefits are involved. In enacting OBRA 1993, Congress did not seek to establish a general body of federal trust law, *Lewis v. Alexander*, 685 F3d 325, 347 (CA 3, 2012), but it did intend to establish the rules to be applied to trusts in the Medicaid context. *Id.* at 343-344 and 347.

It bears repeating how comprehensive these provisions are. The earlier "Medicaid qualifying trust" statute attempted to define a specific group of trusts to be treated adversely. Subsequent litigation focused on whether any particular trust was within that group or not, and if not, the Medicaid planning applicant won.[6] Congress recognized the limits of that approach and, in OBRA 1993, went in the opposite direction, covering every dollar going into or coming out of any trust used by a Medicaid applicant. But for the exceptions – for certain self-settled trusts in subsection (d), for trusts for certain others in subsection (c) – no one who uses a trust can do better than just giving the assets away, and might do worse. And the

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[6] The cases cited above, in footnote 3, are typical.

exceptions all come with limits that protect Medicaid, either payback, (d)(4)(A)-(C), or "sole benefit" of the protected beneficiary, (c)(2)(B)(i)-(iv).

Congress chose its words with great care in reaching every trust created or funded by a person who later seeks Medicaid benefits, the applicant. It included as the self-settled trust of the applicant trusts all trusts for the applicant created *by* the spouse of the applicant, (d)(2)(A)(ii), and those funded *by* the spouse of the applicant, 42 USC 1396p(h)(1), and it subjected those trusts to its own unique availability rule.

What Congress did not do is apply these rules for self-settled trusts to trusts *for* the spouse of the applicant.

B. Subsection (d) treats a trust for a spouse differently than trust for the applicant; subsection (d)'s abrogation of state law to trusts for Medicaid applicants does not apply.

There are three compelling reasons why the self-settled trust rule of subsection (d)(3)(B)(i) does not apply to trusts for the spouse. First, the plain words of the statute say so. Second, an analogous statute was specifically drafted to achieve the result the Department seeks, which negates its argument that Congress achieved the same result without saying so. And third, reading the statute as a whole, as we must, the Department's reading renders other provisions nugatory, violating the most fundamental rules of statutory construction.

1. The plain words of the statute rebut the idea that 42 U.S.C. 1396p(d)(3)(B)(i) applies to trusts for the community spouse.

The statute by its plain terms applies to trusts funded by an applicant where the trustee may, under any possible circumstance, make payment to or for the benefit of the applicant. The community spouses who are the beneficiaries of these three trusts, however, are not applicants at this time.[7]

Subsection (d) provides that for "determining an individual's [Medicaid] eligibility," its provisions apply to trusts "established by such individual." Subsection (d)(1). The subsection is quite clear when the "individual" is to include the spouse. Thus, a trust with the individual's assets is "considered to [be] established" by the individual if established by "[t]he individual's spouse." 42 USC 1396p(d)(2)(A)(ii). Similarly, the term assets, "with respect to an individual[] includes all income and resources of the individual and of the individual's spouse ..." *Id.*, § 1396p(h)(1). This includes income and resources of either spouse that they do not receive because of action "by the individual or such individual's spouse." Id., § 1396p(h)(1) & (A).

By contrast, (d)(3)(B)(i) applies to trusts where payment may be made "to or for the benefit of *the* individual" who has applied for Medicaid benefits.

[7] These trusts will thwart eligibility under (d)(3)(B)(i) if and when the husbands later apply for Medicaid benefits, as Congress intended. See pages 21-22 below.

Subsection (d)(3)(B)(i)(emphasis added). Congress's not including the spouse here, when it did so elsewhere, requires the inference that it intended not to include the spouse. "Generally, when language is included in one section of a statute but omitted from another section, it is presumed that the drafters acted intentionally and purposely in their inclusion or exclusion." *People v. Peralta*, 489 Mich 174, 184; 803 NW2d 140, 146 (2011). "Where Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion." *Russello v. United States*, 464 US 16, 23; 104 S Ct 296, 300 (1983) (citations omitted).

Before this Court, the Department argues for reading the word "individual" broadly to include the community spouse, claiming that "[l]imiting the word 'individual' to mean only 'applicant' changes the meaning of the statute.'" Brief on Appeal, p. 23 (Brief). It says "individual" is an "undefined statutory term," and that in

> common usage[,] "*an* individual" is *not* an applicant for Medicaid benefits or an institutionalized individual – it is *any* individual, or *any* person.

Brief at 23 (emphasis in original). It asserts that this is in contradistinction to places elsewhere in the statutes where Congress, "when [it] intends to refer specifically to the applicant, ... uses clear and specific language." *Id.*, p. 22.

But the relevant provisions of the statute do not refer to "*an* individual."

They all – and there are numerous ones – refer to "*the* individual," (d)(3)(A)(i), (d)(3)(B)(i), (d)(3)(B)(i)(II), and (d)(3)(B)(ii)(emphasis added), and *the* individual to which they refer is the one who applied for benefits and whose eligibility for Medicaid benefits is being determined based on (d)(3)(B)(i). *See* (d)(1).

It is difficult to see how Congress could have been more clear. When Congress meant to include the spouse, it said so. When discussing to whom trust payments may be made, it refers to "the individual," (d)(3)(B)(i) and (d)(3)(B)(ii), not to "an individual," as the Department misquotes it, nor to "the individual and his spouse," as the Department would have the Court read it. Congress knew how to include the spouse, but it limited the "any circumstances" test to trusts payable to or for "the individual" whose application for benefits was at issue. See *Peralta and Russelo*, above, p. 11. The omission of "and the spouse," when used elsewhere in the same statute, precludes reading the term in as the Department have would this Court do. This is "a general principle of statutory construction..." *Barnhart v. Sigmon Coal Co.*, 534 US.436, 440; 122 S Ct 941, 944 (2002), To claim that limiting "the individual" to the individual applicant "changes the meaning of the statute" is to argue that black is white.

2. Closely related provisions underscore that Congress elected not to treat trusts for the benefit of the spouse as trusts for the benefit of the applicant.

When it enacted comparable trust provisions for the closely related Supplemental Security Income (SSI) program[8] six years later, Congress took a different approach, and that difference precludes a cavalier reading of the Medicaid trust provision as though it said the same thing.

The SSI trust statute provides that where a trust may "ma[k]e payment to or for the benefit of the individual *(or of the individual's spouse)*," the corpus from which such payment "could be made shall be considered a resource available to the individual." 42 USC 1382b(e)(3)(B) (emphasis added). There, Congress specifically chose to make the self-settled trust of the spouse a resource of the applicant. The SSI provision addresses what is available to the applicant, but it then brings in – as (d) does not – the trust for the benefit of the spouse of the applicant. Courts are not free to disregard such differences.

The Department would avoid the distinction by arguing that the SSI trust rules themselves apply in the face of a specific statutory provision that they do not. Brief at 18. The claim that this broadly worded trust exclusion, 42 USC 1396a(a)(10)(G), is limited to the "optional categorically needy" is utterly unsupported by legal authority. Eliminating intervening provisions, that sentence states in its entirety:

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[8] Eligibility for SSI and Medicaid are closely related. Except for those states that opted to freeze their Medicaid program in pre-SSI rules, so-called "209b States," SSI beneficiaries in all other states are entitled to community Medicaid benefits, so-called "SSI States." Michigan is an SSI State.

> (a) A State plan for medical assistance must – (10) provide – (G) that, in applying eligibility criteria of the [SSI program] for purposes of determining eligibility for medical assistance under the State plan of an individual who is not receiving [SSI], the State will disregard the provisions of subsections (c) and (e) of section 1392b of this title...

The statute and cases cited by the Department identify or elaborate on the meaning of categorical eligibility; they do not address the trust provisions or their application; indeed, *Herweg v. Ray*, 455 US 265 (1982), could hardly address the SSI trust provisions since it was decided 17 years before they were enacted; the CFR reference, 42 CFR 434.4 (2017), concerns State plan requirements for fiscal agents.

To the contrary, the general rule is that the specific controls over the general, which is in essence what 42 USC 1396a(a)(10)(G) does, making clear that the later-enacted SSI trust rules govern SSI eligibility, while the Medicaid-specific trust rules continue to govern Medicaid eligibility. While the SSI rules generally control for determination of Medicaid in SSI States like Michigan, this provision excludes the SSI trust rules in favor of the more specific Medicaid trust rules.

There is in the statute not a hint of a whisper of a clue that it is limited as the Department theorizes.

Perhaps the most serious problem with the Department's position is that while the Department thinks the SSI and Medicaid trust rules are identical, SSI does not. Most states, including Michigan, have agreements with SSI for the

federal agency to determine Medicaid eligibility for individuals who qualify for SSI (so-called "1634 states"). The POMS, which the Department says "warrant respect" (Brief at 25), directs its staff *not* to apply the SSI trust rules to Medicaid determinations. People may qualify for SSI, but they may still be affected by the different Medicaid trust provisions. POMS SI 01730.048E. Where there is a trust, "follow the procedures in SI 01.120.200 to determine if the trust is countable *for SSI purposes*." POMS SI 01730.048E, first unnumbered paragraph (emphasis added). These are the trust provisions that the Department says it should apply *because* it is a 1634 State. But SSI says the opposite (*id.*, emphasis in original):

> If the individual resides in a section 1634 State, do **not** attempt to determine whether the trust is countable or excludable for Medicaid purposes. ... Existence of a Medicaid trust will result in a referral of the case to the Medicaid State agency for a Medicaid eligibility decision.

For 1634 States, SSI is tasked with making the Medicaid eligibility decision. It *does* determine whether a trust satisfies the SSI requirements, but it does not determine whether the trust, under different rules, satisfies the Medicaid trust requirements; it leaves that to the State agency. If the standards were identical, as the Department claims, that referral would be pointless.[9]

[9] There are other reasons to make the referral to the State agency, e.g., determining hardship waiver, which is referred to separately *Id.*

For the same reasons, the reliance on the Social Security Administration's POMS, Brief at 24-27, is misplaced; they concern a different statute with different, indeed polar opposite, terms.

3. The exceptions for spousal trusts make no sense if (d) treats spousal trusts as trusts for the benefit of the applicant, rather than as transfers.

The broad reach of the OBRA 1993 trust rules – touching every single trust created or funded by Medicaid applicants – required that Congress also address which trusts would be exempt from those broad, comprehensive rules. Self-settled trusts were all treated as available – thus thwarting Medicaid eligibility – or exempt under subsection (d)(4). Trusts for others were all treated as transfers and referred to subsection (c), where its provisions come into play; it has its own distinct set of exemptions, aside from four affirmative defenses.[10] There are eight exemptions, four related to the applicant's home and four others. Subsection (c)(2)(A) and (B). Of the latter four, the first two are for the spouse; the latter two are for the applicant's disabled child or for a trust for other disabled individuals under age 65.

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[10] These are (1) the individual intended to get fair market value, (2) the assets were transferred exclusively for a reason other than Medicaid eligibility, (3) the assets were returned, or (4) imposition of a penalty would impose undue hardship. Subsections (c)(2)(C) and (D). There is also the fundamental question under (c)(1)(A) of whether the applicant received fair market value.

Thus, where a Medicaid applicant establishes a trust for her disabled child and can herself get no benefit under it, (d)(3)(B)(ii) applies and refers the case to subsection (c), which exempts it from the penalty provision. (c)(2)(B)(iii). Similarly, a transfer for the community spouse, from which the applicant can get no benefit, similarly falls within (d)(3)(B)(ii), which refers it to (c), which exempts from penalty transfers by either spouse "to another for the sole benefit of the individual's spouse." (c)(2)(B)(i) and (ii).

In arguing that (c)(2)(B)(i) and (ii) are irrelevant, because they concern transfers, and not availability, Brief at 13-14, the Department inadvertently concedes the point because the significance of the transfer exception is the opposite of what the Department claims. If putting money into a trust for a spouse is a transfer, as the Department concedes it is, then it must be analyzed as a transfer under (c)(3)(B)(ii) and not as the self-settled trust of the applicant under (c)(3)(B)(i). To be sure, Congress could have chosen, as it did with the SSI trust rules, to specifically apply an "any circumstance" test to trusts for spouses as well as applicants. But it did not do so. The Department cannot show otherwise.

The Department and the Court of Appeals relied on application of the "any circumstances" test of (d)(3)(B)(i) to find that the SBO trust assets were available to the community spouse. The foregoing shows that that was error. The question to be answered, then, is what standard does apply. Fortunately, the law in this area is clear and indeed there is little dispute between the parties.

II. SPOUSAL IMPOVERISHMENT DIRECTS THAT THE SSI RULES APPLY.

Having applied subsection (d) to render all trust assets available, the Court of Appeals then noted that the Spousal Impoverishment or SI rules plainly bring into the eligibility analysis the available assets of the community spouse. It is the premise that is wrong, as explained in Part I, so that the next question is what rules do apply in determining whether the SBO trust assets are an available resource.

Plaintiffs-Appellants correctly set out the SSI rules that show that the SBO trust assets are not available to the community spouse. Appellants' Brief on Appeal, pp. 18-21. The Spousal Impoverishment rules specifically incorporated existing rules, whether SSI or 209b, concerning what constituted resources or "the methodology and standards for determining and evaluating ... resources." 42 USC 1396r-5(a)(3)(A) and (B). Since existing underlying rules about assessing resources and availability are specifically incorporated into the Spousal Impoverishment rules, they are not inconsistent with the terms of SI. *Cf.*, 42 USC 1396r-5(a)(1). *Keip v. Wis. Dept. of Health and Family Services*, 232 Wis 2d 380, 397-398; 2000 WI App 13; 606 NW2d 543 (1999). This means that the existing SSI or the relevant pre-SSI rules in 209b states apply. This is underscored by the provision which adopts the SSI exclusion rules, overruling any contrary provision in 209b states. 42 USC 1396r-5(c)(5).

The Court of Appeals' reference to the general Spousal Impoverishment provisions on attribution at the time of application and the definitions, Decision at 10-11, elides the underlying, more fundamental rule, that the references to "resources" is controlled by other provisions drawn from SSI law. That oversight is error.

The Department agrees that the underlying SSI rules control in the spousal context, Department's Brief on Appeal, p. 12.

III. THE SBO TRUST RULES ARE PART OF A SYSTEM DESIGNED TO PROTECT THE COMMUNITY SPOUSE WITHOUT CREATING VEHICLES FOR FAMILY WEALTH TRANSFER.

The larger policy question standing behind this analysis is who are the intended beneficiaries of the Medicaid long-term care program. The Court of Appeals posits that the program is only for low-income individuals, in contradistinction to "wealthier individuals" taking advantage of loopholes to get government assistance for costs "they otherwise could afford." Decision at 2.

This is not an accurate dichotomy. For twenty years now, Congress has been adapting the Medicaid program to accommodate the needs and interests of decidedly non-poor spouses of individuals who need long term care. The provisions at issue here are part of that system, and their use as sought by the appellants' community spouses is well within the range of options Congress has offered to community spouses. Congress' goal has always been to protect the

community spouse, not to create a mechanism for family wealth transfer, and that is exactly what SBO spousal trusts are designed to do. This is part of the larger pattern, allowing transfers for disabled children and some others without loss of Medicaid long term care, provided that the trust meets the statutory requirements set by Congress designed to assure that the funds are used as intended. All of the trust provisions, including those at issue here, are designed to that end.

That is to say, one spouse may qualify for Medicaid, preserving assets for the community spouse. But if that community spouse himself later requires long term care, all of these mechanisms for protecting him then have the opposite effect of guaranteeing that he will not also qualify for benefits, or at least won't be able to pass significant assets onto the next generation (unless disabled). Everything said above to show the SBO trust is not the trust of the applicant when it is for the community spouse merely underscores that it is the trust of the Medicaid applicant if and when that spouse latter needs institutional care himself. "Sole benefit" guarantees that it is available for his or her care, forestalling Medicaid eligibility until those resources are spent. That is of course the very purpose of subsection (d) in making such trusts available as a matter of law. Subsection (c)(3)(A)(i) and (B)(i).

All of the excepted or exempt trusts serve to secure benefits for a protected individual, while limiting the benefits to the intended beneficiary, not other family

members.

The special needs trusts are probably the best known of the trusts authorized by Congress. All three of the self-settled first party special needs trusts require payback, that is, before a dollar is distributed to family members or other heirs or legatees, the Medicaid program must be reimbursed for all expenditures to the full extent of remaining trust assets at the death of the beneficiary. Subsections (d)(4)(A), (B)(ii) and (C)(iv). But even here, the provision goes beyond that, allowing pooled trusts to retain funds for their own charitable purposes in lieu of pay back. Subsection (d)(4)(C)(iv). *Lewis*, 685 F3d 325.

Similarly, the pattern for third party trusts is that they be for the sole benefit of the other person. This is true of trusts for disabled children of an applicant, for any other disabled person under age 65, and for the spouse of the Medicaid long term care applicant. Subsection (c)(2)(B)(i)-(iv). Part of the gloss on "sole benefit" is that the assets be distributed to the beneficiary on an actuarially sound basis. CMS, State Medicaid Manual, § 3258.9B, p. 3-3-109.15. That term was used in the annuity context to separate out those annuities that might be a hidden mechanism for getting assets to someone other than the beneficiary, *e.g.,* to children. An 85-year-old man might do this, for example, by purchasing a "life plus twenty years term certain"[11] annuity, when his life expectancy is only about 5.2 years. *Id.* p. 3-3-

[11] A life or "twenty years certain" annuity would pay for the period of the person's life but not less than 20 years. Where the term is longer than the person's life expectancy, the monthly payments are of course much less than they would be if the annuity were life

109.17 (Life Expectancy Tables – Male). That term, as used by CMS, means no longer than the life expectancy of the beneficiary. A transfer occurs if the person "is not reasonably expected to live longer than the guarantee period of the annuity," because they will not get back fair market value for what they paid out. That is when a transfer occurs, not otherwise. *Id.*, p. 3-3-109.16.

While the Department focuses on the limitations of the Spousal Impoverishment provisions, that section hardly defines the last word in what Congress authorized to protect community spouses. Indeed, SI itself includes provisions unheard of in other public benefits programs, *e.g.,* obtaining individual, case-specific judicial determinations allowing community spouses to retain or get additional income or resources beyond the standard allowances. 42 USC 1396r-5(d)(5)(income) and (f)(3)(resources). There are less expensive administrative mechanisms for obtaining like results. Section 1396r-5(e)(2)(B) and (C).

There are yet other ways in which SI is far more generous than the Department acknowledges. For example, there is no limit on the income of a community spouse before his or her institutionalized spouse can qualify. Many states disregard the retirement plans of community spouses, which reflects accumulated pre-tax income, and which was specifically required in *Keip v. Wis. Dept. of Health and Family Services*, above. While the institutionalized spouse's

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only, or life with a shorter term certain. The reduced current benefits are the mechanism by which the transfer is made to contingent beneficiaries.

income must go toward cost of care, and may be reduced for low income community spouses, 42 USC 1396r-5(d)(3)(A), it is never increased because of how high the community spouse's income is. *See* § 1396r-5(d)(1)(A), providing deductions from her income, but not additions, in determining the institutionalized spouse's cost of care.

Moreover, in the wake of Spousal Impoverishment, yet other ways to protect community spouses were developed with Congress' acquiescence or approval. Community spouses are allowed to annuitize what would otherwise be excess resources, converting them to income for their sole use. 42 USC 1396p(c)(1)(F) and (G). *Hughes v. McCarthy*, 734 F3d 473 (CA 6, 2013). They are also allowed to convert assets into income streams through promissory notes. *Id.*, § 1396r-5(c)(1)(I).

The common feature of all of these provisions is either pay back (in the case of special needs trusts), sole benefit, or actuarial soundness (in the case of annuities, but also including pay back), *Singleton v. Commonwealth of Kentucky*, 843 F3d 238, 240 (CA 6, 2016). *See* subsection (c)(I)(G)((ii)(II), (c)(1)(I)(i), (c)(2)(B)(i)-(iv).

CMS has acknowledged that SBO trusts like the ones at issue in this case are appropriate and *may* affect eligibility, as they were intended to. In discussing

transfers and the Spousal Impoverishment rules in its State Medicaid Manual, CMS noted that unlimited transfers between spouses

> should have little effect on the eligibility determination ... because resources belonging to both spouses are combined in determining eligibility for the institutionalized spouse [and] are still [to] be considered available to the institutionalized spouse for eligibility purposes.

Id., § 3258.11, p. 3-3-109.22. But, it said, this is not so with "transfers to a third party for the sole benefit of the spouse." Those do affect eligibility, "because resources may potentially be placed beyond the reach of either spouse and thus not be counted for eligibility purposes." *Id.*, p. 3-3-109.23. This goal, condoned by CMS, is achieved where the "sole benefit" requirement is "fully met":

> This definition is fairly restrictive, in that it requires that any funds transferred be spent for the benefit of the spouse within a time-frame actuarially commensurate with the spouse's life expectancy. *Id.*

The decision of the Court of Appeals, and the approach of the Department, requires that such trusts not affect eligibility. Indeed, that is the policy argument the Department makes. But it is flatly contradicted by CMS, in a considered document which is, as to these provisions, clear, consistent, and true to the statutory terms, without introducing inconsistences or odd results, and thus entitled to deference under the *Skidmore* doctrine, *United States v.Mead Corp., 533 US*

218, 228; 121 S Ct 2164; 150 L Ed 2d 292(2001) (citations omitted) (quoting *Skidmore v. Swift & Co.,* 323 US 134, 140; 65 S Ct 161; 89 L Ed 124 (1944), because it has "the power to persuade, if lacking power to control."

CONCLUSION

The decision in this case turns on the application of 42 USC 1396p(d) to the sole benefit trusts here. The Department's dissatisfaction with the results amounts to a policy argument with Congress about how generous Medicaid should be with married couples. The plain and clear language of the statute, as reasonably construed by the responsible federal agency, is flatly inconsistent with the Department's position and the decision of the Court of Appeals. That position should be rejected and the decision of the Court of Appeals reversed.

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EXHIBIT H

Colorado FH Decision, Arapahoe County, May 14, 2008

COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1570 Grant Street, Denver, CO 80203-1818 • (303) 866-5654 • (303) 866-3476 Fax • (303) 866-3883 TTY

Bill Ritter, Jr., Governor • Joan Henneberry, Executive Director

NOTICE OF INITIAL DECISION

In the matter of: Appellant: **Stanley Williams**
Appeal No: **SHP 2008-0092**

Enclosed is a true copy of the Initial Decision of the Administrative Law Judge regarding the above captioned matter. If you disagree with this Initial Decision, you have the right to ask for reversal or modification of the Initial Decision by filing written exceptions with the Office of Appeals. Section 24-4-105 (14) and (15), C.R.S.

Any of the parties listed on the attached Certificate of Mailing may file exceptions to the Initial Decision. Written exceptions must be received in the Office of Appeals by 5:00 p.m. on **June 06, 2008** unless this date falls on Saturday, Sunday, or a legal holiday, in which case exceptions will be due on the following business day. Please read the enclosed instructions carefully and follow each step. You will be notified by mail if any exceptions are filed by the other parties and given an opportunity to file a response. Failure to file exceptions may waive the right to seek judicial review of the Final Agency Decision.

If you have any questions, please contact me at the above address, attention Office of Appeals or at (303) 866-5654.

Sincerely,

Office of Appeals

Date: May 19, 2008
Enclosures

CERTIFICATE OF MAILING

I hereby certify that on May 19, 2008, I placed a true and correct copy of the Notice of the Initial Decision regarding Appeal Number **SHP 2008-0092** in the U.S. Mail, postage prepaid, addressed to the following:

Stanley Williams
c/o W. Eric Kuhn, Esq.
Law Office of Bradley J. Frigon
6500 S. Quebec Street, Suite 330
Englewood, CO 80111

Beate Fisk
Arapahoe County DHS
14980 E. Almeda Drive
Aurora, CO 80012

Carey Christie, Esq.
Arapahoe County Attorney's Office
14980 E. Almeda Drive
Aurora, CO 80012

and via Interdepartmental mail to:

Gary Ashby
Benefits Coordination Section
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Office of Appeals

APPELLANT INSTRUCTIONS FOR FILING EXCEPTIONS TO THE INITIAL DECISION

If you do not agree with the findings of fact or legal conclusions in the Initial Decision, you may file written Exceptions to the Initial Decision. Exceptions are your written arguments why you believe the Initial Decision is incorrect, based on either incorrect facts or incorrect conclusions of law. This is the last step in the Administrative appeal process before the Office of Appeals issues a Final Agency Decision.

- All Exceptions must be in writing, and they must be **received** in the Office of Appeals by the due date shown on the attached letter. A written statement may be submitted to the Office of Appeals if you feel you need more time to prepare your Exceptions. Your request for more time must be **received** in the Office of Appeals before the due date shown on the attached letter. The Office of Appeals will issue an Order with a new due date.

- Always include the Name and the Appeal Number shown on the top of the Initial Decision in your written Exceptions and all correspondence.

- State in your Exceptions the specific parts of the Initial Decision you disagree with, and the reasons why.

- **FOR THE RECIPIENT OR APPLICANT (Appellant)**: If you feel that a FINDING OF FACT is wrong, you must order a written transcript of the hearing. **There is no cost to you for the written transcript**. You do not need a written transcript if you disagree with the conclusion of law.

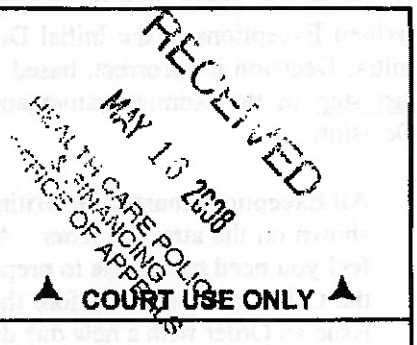
TO ORDER A WRITTEN TRANSCRIPT:

- 1) **Contact** the Office of Administrative Courts, 633 Seventeenth Street, Suite 1300, Denver, CO 80202, or call (303) 866-5626 and request a written transcript. The Court will submit the official recording of the hearing to A/V Tronics, a transcribing agency, to prepare the written transcript. The Department will pay A/V Tronics for the cost of the transcript and the cost of one copy for you.
- 2) **Notify** the Office of Appeals in writing that you ordered the written transcript, and need a new due date to file Exceptions. The Exceptions and written transcript must be received in the Office of Appeals by the due date. It is your responsibility to request a new due date to ensure timely filing of both your Exceptions and the transcript. Late filings will not be accepted.
- 3) A/V Tronics will submit the original written transcript directly to the Office of Appeals, and send one copy of the transcript to you.
- 4) If you have questions regarding the written transcript, contact A/V Tronics at (303) 634-2295. You must contact A/V Tronics to make sure the written transcript is submitted to the Office of Appeals by the due date for Exceptions.
- 5) **File** your written Exceptions with the Office of Appeals by the due date. The Exceptions shall state that a transcript has been requested.

MAIL, FAX, or HAND-DELIVER YOUR EXCEPTIONS TO:

Colorado Department of Health Care Policy & Financing
Office of Appeals
1570 Grant Street
Denver, CO 80203
Phone: (303) 866-5654 or by FAX at (303) 866-3476

The Office of Appeals will issue the Final Agency Decision after reviewing the hearing record and any other documents timely filed with the Office of Appeals. If you have questions, please contact us at the address or phone number above.

STATE OF COLORADO OFFICE OF ADMINISTRATIVE COURTS 633 17th Street, Suite 1300 Denver, Colorado 80202	 COURT USE ONLY
STANLEY WILLIAMS, Appellant, vs. **ARAPAHOE COUNTY DEPARTMENT OF HUMAN SERVICES,** Appellee.	**CASE NUMBER:** **SHP 2008-0092**
INITIAL DECISION	

This matter is before Administrative Law Judge (ALJ) Robert Spencer upon Appellant's appeal of the denial of his application for Medicaid long term care benefits. A hearing by telephone conference was held April 15, 2008. Supplemental briefs were submitted May 7, 2008, and the matter became ripe for decision at that time. Carey Christie, Assistant County Attorney, represented the Arapahoe County Department of Human Services (County Department). Appellant was represented by W. Eric Kuhn, Esq. and Alex Gury, Esq. of the Law Offices of Bradley J. Frigon.

Issue Presented

In September 2007, Appellant, as grantor, established an irrevocable trust in favor of his wife, Martha, who was the sole beneficiary. In October 2007, Appellant funded the trust with separate property in the form of shares of stock. The stock is the only trust asset.

Later in October 2007, Appellant applied for Medicaid long term care benefits. The County Department denied Appellant's application on the grounds that he was over-resourced. In so doing, the County Department relied upon the opinion of the Department of Health Care Policy & Financing (State Department) Trust Officer that because Appellant's wife was the trust beneficiary, the entire corpus of the trust was a resource countable against Appellant's financial eligibility. Because the value of the trust corpus exceeded the Community Spouse Resource Allowance plus Appellant's $2,000 eligibility threshold, Appellant was over-resourced and ineligible for Medicaid benefits.

Appellant disagrees with the County Department's determination. Appellant contends that because the trust was funded with his separate property and the corpus is owned by the trust, it is not owned by Martha. Furthermore, it is not owned by him because he irrevocably transferred it to the trust before he filed his Medicaid application.

Because the trust corpus, as of the date of Appellant's Medicaid application, was not owned by either spouse, it was not countable as a resource. Furthermore, Appellant argues that because the transfer of the stock to the trust was for the sole benefit of his spouse, and the terms of the trust complied with the State Department's regulations restricting transfers without fair consideration, the transfer did not trigger a period of ineligibility.

The County Department agrees that Appellant's transfer of stock to the trust complied with the State Department's rules regarding transfers without fair consideration and does not trigger a period of ineligibility. The sole issue, therefore, is whether the corpus of the trust is a countable resource because Martha is a beneficiary of that trust and receives payments from the trust corpus. For the reasons explained below, the ALJ concludes that it is not a countable resource, and therefore Appellant is not over-resourced for the purposes of eligibility for Medicaid long term care.

Findings of Fact

1. Appellant is 83 years old and currently resides in an assisted living facility in Arapahoe County.

2. On September 18, 2007, Appellant established a trust entitled *An Irrevocable Trust Agreement for the Sole Benefit of Martha M. Williams Pursuant to 42 U.S.C. § 1396p(c)(2)(B)(i) and the Colorado Medical Assistance Manual, Volume 8, Section 8.110.53.F(2)(a)* (hereafter referred to as "the Trust"). Exhibit B and Joint Exhibit I, ¶ 1.

3. On October 11, 2007, Appellant transferred 3,620 shares of Proctor & Gamble stock from his Scottrade account to Elizabeth Esterl as the trustee of the Trust. The stock was and is the sole asset of the Trust. Joint Exhibit I, ¶¶ 2, 3.

4. Prior to the transfer, the stock was Appellant's separate property. Joint Exhibit I, ¶ 4.

5. Appellant was the sole grantor of the Trust. This is clear from the provisions of the Trust:

   a. The preamble states that Appellant, referred to as "Stan," "desires to make an exempt transfer of his assets ... for the sole benefit of Martha." Exhibit B, p. 1.

   b. Appellant is the sole source of the Trust assets. Exhibit B, ¶ 1.2.

   c. Appellant is identified on the signature page as the grantor. Exhibit B, p. 8.

   d. The parties stipulate that Appellant executed the Trust "individually and as grantor." Joint Exhibit I, ¶ 1.

6. Martha is the sole beneficiary, but is not a grantor. This is clear from the provisions of the Trust:

a. Martha is not identified as contributing any property to the Trust. The only property that funds the Trust is Appellant's separate property. Exhibit B, ¶ 1.2.

b. Martha signed the Trust individually and as Appellant's agent and power of attorney, but she is not identified as a grantor. Exhibit B, p. 8.

c. The parties stipulate that Martha executed the Trust "individually as spouse." Joint Exhibit I, ¶ 1.

7. The Trust is irrevocable and is for the sole benefit of Martha. No other individual or entity other than Martha can receive payments from the Trust assets, either at the time of transfer or at any time in the future. The Trust is a written instrument that legally binds Appellant and Martha to a specified course of action, sets forth the conditions under which the transfer of assets is made, and contains a statement that only Martha can benefit from the assets transferred into the Trust. The Trust provides for the spending and use of the transferred assets on a basis that is actuarially sound based upon Martha's life expectancy. Exhibit B, Art. 3.

8. Although the Trust is set up for her sole benefit, Martha is not the owner of the Trust corpus. The Trust recites that, "the Trust [is] to be named as the sole owner of all ... assets, hereafter referred to as the 'Trust Estate.'" Exhibit B, ¶ 1.2. Furthermore, Martha is specifically deprived of any ability to anticipate, assign, pledge, mortgage, sell or transfer in any manner, voluntarily or involuntarily, her beneficial interest in the Trust. Exhibit B, ¶ 5.1. She also has no right or power to terminate the Trust. Exhibit B, ¶ 7.1. She has no legal right to make the Trust corpus available except as it is paid to her by monthly stipend.

9. On October 24, 2007, Appellant applied for Medicaid long term care benefits under the Home and Community Based Services (HCBS) program. The application was initially filed in Denver County, but transferred to Arapahoe County, where Appellant was residing, on November 9, 2007. Joint Exhibit I, ¶¶ 6, 8.

10. Appellant's transfer of stock to the Trust was without fair consideration and occurred less than a month before he applied for Medicaid. The County Department, however, concedes and the ALJ finds that because the Trust is established for the sole benefit of Martha and otherwise meets the requirements of the State Department's regulations related to transfers without fair consideration, no penalty period of ineligibility applies to Appellant's transfer of stock to the Trust.

11. Nevertheless, to be financially eligible for Medicaid, Appellant and his wife's pooled assets, less a Community Spouse Resource Allowance (CSRA), had to be less than $2,000. The CSRA at the time of application was $101,640, therefore Appellant and his wife's pooled assets had to be less than $103,640 for him to be eligible for Medicaid.

12. The County Department referred to the State Department the question of whether the Trust corpus was countable as a pooled asset. By letters dated January 2, 2008 and January 18, 2008, the State Department's Trust Officer opined that the Trust

corpus must be considered a countable resource because Martha was the beneficiary of the Trust. Exhibits 2 and 3. The Trust Officer relied upon § 8.110.52.B.4.a.1 of the State Department's regulations, which states that irrevocable trust assets are a countable resource "If there are any circumstances under which payments from the trust could be made to or for the benefit of the individual."[1] Exhibit 3.

13. The value of the Trust corpus as of the date of application was approximately $223,810. Exhibit B, p. 10. If countable as a pooled resource, the value of the Trust corpus exceeds Appellant's resource eligibility threshold.

14. Without consideration of the value of the Trust corpus, Appellant and his wife's pooled assets as of the date of his Medicaid application were less than $103,640, and therefore he would have met the resource requirement. Joint Exhibit I, ¶ 12.

15. On January 23, 2008, in reliance upon the State Department Trust Officer's opinion, the County Department issued a Notice of Proposed Action denying Appellant's application. Exhibit 1.

16. Appellant filed his appeal of the County Department's decision on January 31, 2008.

Discussion and Conclusions of Law

Burden of Proof

State Department regulation § 8.057.D states that hearings concerning Medicaid benefits are conducted according to the requirements of § 24-4-105, C.R.S. of the Administrative Procedure Act (APA). APA § 24-4-105(7) provides that the proponent of an order shall have the burden of proof. The proponent of an order is the party who seeks to change the *status quo*. *Orsinger Outdoor Advertising, Inc. v. Dept. of Highways*, 752 P.2d 55, 67 (Colo. 1988); *Renteria v. State Dept. of Personnel*, 811 P.2d 797, 803 (Colo. 1991). Here, Appellant is the party seeking to change the *status quo* by obtaining benefits he did not previously have. Appellant is therefore the proponent of the order and bears the burden of proof.

Resource Eligibility

To be eligible for Medicaid long term care, Appellant must have less than $2000 in "countable resources." Section 8.110.51. Countable resources include the current market value of stocks. Section 8.110.51.B.2.

When the spouse applying for Medicaid is seeking long term care benefits, resource eligibility is based upon the couple's combined or pooled assets. Per regulation § 8.112.1, an assessment of the total value of the couple's resources is completed "at the time of Medicaid application," and all non-exempt resources "owned by" the married couple at that time are counted, whether owned jointly or individually.

An assessment of the total value of the couple's resources shall be

[1] The State Department's regulations are published at 10 CCR 2505-10.

> completed *at the time of Medicaid application* or when requested by either spouse or a married couple. All non-exempt resources *owned by* a married couple are counted, whether owned jointly or individually. There are no exceptions for legal separation, pre-nuptial, or post-nuptial agreements.

Section 8.112.1, *italics* added.

In order to provide for the non-institutionalized or "community" spouse, a CSRA is allocated. Section 8.112.11.A. The CSRA at the time of Appellant's application was $101,640. The CSRA is then deducted from the total value of the pooled resources to determine the resources actually available to the Medicaid applicant. Per § 8.112.13, the applicant is resource eligible for Medicaid "when the total resources *owned by* the couple are at or below the amount of the [CSRA] plus the Medicaid resource allowance for an individual of $2000." *Italics* added.

In this case, the parties stipulate that, apart from the Trust corpus, the couple's resources do not exceed the CSRA plus $2,000, and therefore Appellant would be eligible if the Trust corpus is not counted. On the other hand, if the Trust corpus is counted, then the couple's resources exceed the CSRA plus $2,000, and Appellant would not be eligible. The issue, therefore, is whether "at the time of Medicaid application" the corpus of the trust was "owned by" either Appellant or his wife. The ALJ concludes that it was not owned by either individual at the time of application.

Ownership of the Trust Corpus

It is undisputed that the stock used to fund the Trust was initially Appellant's separate property. When Appellant irrevocably conveyed the stock to the Trust on October 11, 2007, the stock became the property of the Trust and Appellant no longer owned the property as of that date. Therefore, as of the date of Appellant's Medicaid application, October 24, 2007, he did not own the trust corpus.

The question of whether Martha owned, for purposes of Appellant's Medicaid eligibility, the trust corpus is less clear. The County Department, consistent with the opinion of the State Department's Trust Officer, argues that § 8.110.52.B.4.a.1 makes Martha an owner. Section § 8.110.52.B.4.a.1 reads as follows:

> If there are any circumstances under which payments from the [irrevocable] trust could be made to or for the benefit of the individual, the following shall apply:
>
> 1) The portion of the corpus of the trust, or the income on the corpus, from which payment to the individual could be made, shall be considered as resources available to the individual.

Applying § 8.110.52.B.4.a.1, the County Department argues that because Martha is the Trust beneficiary and therefore can receive payments from the Trust, the entire Trust corpus must be considered available to her. Appellant, on the other hand, argues that § 8.110.52.B.4.a.1 does not apply to Martha because she is not "the individual"

within the meaning of that section. The ALJ agrees with Appellant's interpretation.

The reference in § 8.110.52.B.4.a.1 to "the individual" is clearly to the trust grantor. This is apparent from § 8.110.52.A.1.a, which states that "the amount of the trust property considered available to the applicant/recipient *who established the trust* ... is the maximum amount that the trustee(s) is permitted under the trust to distribute *to the individual* ... "[2] *Italics* added. The interpretation that "the individual" is the grantor is confirmed by § 8.110.52.B.2.a, which states that, "An individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust." Because, as used in § 8.110.52, "the individual" is the grantor and Martha is not the grantor, that section cannot be used to constructively make Martha an owner of the trust.[3]

During her testimony, the State Department's Trust Officer agreed that "the individual," as that term is used in § 8.11.52.A, is the grantor, but opined that Martha was a grantor because her name was on the Trust and she signed the Trust. The facts, however, do not support that opinion. As noted in Findings of Fact 5 and 6, Appellant was the sole grantor and Martha the sole beneficiary. The fact that Martha signed the Trust as Appellant's power-of-attorney does not make her the grantor. *Water, Waste & Land v. Lanham*, 955 P.2d 997, 1001 (Colo. 1998)(an agent cannot be held responsible as the principal where the existence of the agency and identify of the principal are disclosed).

The question remains, however, whether any portion of the Trust corpus is nonetheless "owned by" Martha in view of the fact that she receives a portion of the Trust corpus each month. The ALJ believes not.

First, Martha is not the owner of the Trust corpus because the Trust clearly recites that, "the Trust [is] to be named as the sole owner of all ... assets, hereafter referred to as the 'Trust Estate.'" Exhibit B, ¶ 1.2. Martha is specifically deprived of any ability to anticipate, assign, pledge, mortgage, sell or transfer in any manner, voluntarily or involuntarily, her beneficial interest in the Trust. She has no right or power to terminate the Trust. That is to say, she has no legal right to make the Trust corpus available except as it is paid to her by monthly stipend upon an actuarially sound basis defined by the Trust.

Furthermore, under § 8.110.51.E.1, resources are not considered "available" when there is no "legal ability to make such sum available." Because Martha has no legal right to access the Trust corpus it is not available to her and therefore not a countable resource.

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[2] Although § 8.110.52.A applies to trusts established before August 11, 1993, the reference to "the individual" as being the grantor/applicant is consistent throughout § 8.110.52.

[3] Furthermore, "the individual" is not only the grantor but also the "applicant/recipient" of the Medicaid benefits. *See* Roger A. Mceowen, *Estate Planning for Farm and Ranch Families Facing Long-Term Health Care*, 73 Neb. L. Rev. 104 (1994), discussing the treatment of non-testamentary trusts after adoption of 42 U.S.C. § 1396p(d)(3)(B). "These assets will be considered available to the applicant and/or the applicant's spouse to the extent *the applicant* derives any benefit from them." *Id.* at 122, *italics* added. Because Martha is not the Medicaid applicant/recipient, she cannot be "the individual."

Finally, the ALJ considers whether the Trust's residuary distribution clause creates "any circumstance under which payments *from the trust* could be made to or for the benefit of" Appellant, such that the corpus must be counted as a resource under § 8.110.52.B.4.a.1 (*italics* added). The residuary distribution clause, Exhibit B, ¶ 3.4, decrees that upon Martha's death, the trustee shall distribute the remaining trust estate (if any) to Martha's estate. If Appellant survives Martha, he would be entitled to at least an elective share of her estate under the terms of Article 11 of the Colorado Probate Code, §§ 15-11-101, C.R.S. et seq. Although this would give Appellant access to at least a portion of the assets remaining at Martha's death, those assets would not be paid "from the trust" as required by § 8.110.52.B.4.a.1. Rather, those assets would be paid to Appellant from Martha's estate. Because the assets would not be paid to Appellant from the trust, the residuary clause does not trigger the "any circumstance" rule. Of course, any assets that were paid to Appellant at Martha's death would trigger a redetermination of his financial eligibility for continued long term care Medicaid benefits.

Deference to Agency Interpretation

Counsel for the County Department argues that the position of the State Department, as expressed by its Trust Officer, is entitled to "great deference" and the ALJ is therefore bound by that interpretation. Although the ALJ agrees that agency interpretations of their enabling statutes and regulations are entitled to deference, that deference normally applies upon judicial review of a final agency action. *Colo. Div. of Employment & Training v. Parkview Episcopal Hosp.*, 725 P.2d 787, 790 (Colo.1986) ("construction of a statute by an administrative agency charged with its enforcement should be given great deference by the courts.") Furthermore, even a court is not bound by an agency interpretation that misconstrues or misapplies the law. *Id.*

Because the Trust Officer's opinion is not a final agency decision, it is premature to give that opinion great deference. Doing so would be an abdication of the ALJ's duty to independently apply the State Department's regulations to the facts found, and thus arrive at the agency's initial decision.

Transfer Without Fair Consideration

Although the Trust corpus was not owned by either Appellant or Martha on the date of Appellant's Medicaid application, Appellant did fund the Trust with property transferred to the Trust without fair consideration. Transfers without fair consideration may trigger a period of ineligibility for Medicaid benefits, according to the rules in § 8.110.53.

Pursuant to § 8.110.53.F.2.a, even though a transfer is without fair consideration, no period of ineligibility will be imposed if the assets were transferred "to the individual's spouse or to another for the sole benefit of the individual's spouse." For a transfer to a trust to qualify as a "sole benefit" of the individual's spouse, certain limitations apply to the nature of the trust as specified in § 8.110.53.F.3. Those limitations include the requirement that the trust instrument be arranged in such a way that no one but the

spouse can benefit from the trust at the time of transfer or any time in the future, that the trust be in writing and legally bind the parties to a specified course of action, and that it provide for the spending of the trust assets "on a basis that is actuarially sound" based upon the spouse's life expectancy. *See* §§ 8.110.53.F.3.a, b(1) and b(2). The County Department concedes that the Trust meets these requirements, and therefore it seeks no transfer penalty.

Although § 8.110.53.F.2.a imposes no limit on the amount that may be transferred without penalty, the question arises whether such an unlimited transfer of assets subverts the intent of the Medicaid program to assist only needy applicants. In finding that it does, at least one state court has interpreted the federal Medicaid law to limit the amount the amount that may be transferred to the amount of the CSRA. The excess becomes a transfer without consideration subject to penalty. *McNamara v. Ohio Dept. of Human Serv.*, 139 Ohio App. 3d 551, 557-58 (2000).

In *McNamara*, the Ohio court of appeals held that the federal law which contains the unlimited transfer provision, 42 U.S.C. § 1396p(c)(2)(B), is superseded by 42 U.S.C. § 1396r-5, which contains the CSRA provision. That is to say, the limits of the CSRA provision trump the provision that allows unlimited transfers for the sole benefit of a spouse. The court arrived at this conclusion by noting that § 1396r-5(a) states, "In determining the eligibility for medical assistance of an institutionalized spouse ... the provisions of this section supersede any other provision of this subchapter ... which is inconsistent with them." Because the CSRA limit rule is found in § 1396r-5(f), it must supersede the unlimited spousal transfer exemption found in § 1396p(c)(2)(B). The court believed this construction was necessary because to construe the statute otherwise "would allow persons with unlimited resources to avail themselves of Medicaid nursing home benefits."[4] *McNamara*, 139 Ohio App. 3d at 558.

Regardless of the merit of the *McNamara* opinion, the ALJ is bound to apply the State Department's regulations as written and is not at liberty to disregard them. Section 8.057.8.E. Section 8.110.53.F.2.a plainly states that "no period of ineligibility will be imposed" upon a transfer of an individual's assets to another for the sole benefit of the individual's spouse, and it imposes no limitation upon the amount of money that may be transferred. To the contrary, the design of § 8.110.53.F.3, which defines the term "for the sole benefit of," contemplates that transfers of more than the CSRA may be made. This is apparent from the fact that although § 8.110.53.F.3.b(1) requires the trust document to be in writing, and b(2) requires that the trust corpus be paid to the spouse on a basis that is actuarially sound, § 8.110.53.F.3.b(4) eliminates those requirements if only a CSRA is transferred:

> 4) A community spouse to whom a Community Spouse Resource

[4] HCFA, the predecessor to CMS, recognized and accepted this possibility. In its State Medicaid Manual, General and Categorical Eligibility Requirements, "Transmittal 64," published in November 1994, HCFA acknowledged that the unlimited transfer exception of 42 U.S.C. § 1396p(c)(2)(B)(ii) "may have greater impact on eligibility because resources may potentially be placed beyond the reach of either spouse and thus not to be counted for eligibility purposes." *See* Transmittal 64, § 3258.11, found at www.sharinglaw.net/elder/Transmittal64.htm.

> Allowance has been transferred does not have to provide a written document or comply with the requirement that the transfer is actuarially sound. However, the Community Spouse Resource Allowance must be for the sole benefit of the community spouse to whom it is transferred. Upon the death of the community spouse, those resources shall be made available to the surviving spouse, at least up to the amount of the elective share of the augmented estate, the family allowance and the exempt property allowance.

Given the plain wording and design of § 8.110.53.F, by which the ALJ is bound, Appellant's transfer of stock to the Trust did not trigger a period of ineligibility even though the amount transferred exceeded the CSRA.

Summary

Because the Trust corpus was, as of the date of Appellant's Medicaid application, the sole property of the Trust and was not available to either Appellant or Martha, it was not owned by either of them on that date. Although Martha is the Trust beneficiary, she is not an "individual" for the purposes of applying the attribution rule of § 8.110.52.B.4.a.1. Because the Trust corpus was not owned by Appellant or his wife as of the date of Medicaid application, it was not a countable resource. Furthermore, because Appellant transferred his assets to the Trust for the sole benefit of his spouse, in compliance with State Department regulations, the transfer did not trigger a period of ineligibility. Appellant therefore meets the resource threshold and, according to the stipulation of the parties, is financially eligible for HCBS benefits.

Initial Decision

The County Department's decision to deny Appellant's Medicaid application due to being over-resourced is REVERSED.

Pursuant to §§ 25.5-1-107 and 24-4-105(14), C.R.S., this Initial Decision shall be reviewed by the Office of Appeals, State Department of Health Care Policy and Financing. The parties shall have 15 days from the date this Initial Decision is mailed, plus 3 days for mailing, to file written exceptions with the Office of Appeals at 1570 Grant Street, Denver, Colorado 80203, unless extended by the Office of Appeals. This Initial Decision will not be implemented while pending State Department review and final agency action. Pursuant to State Department rules, the failure to file exceptions to provisions of the Initial Decision will waive the right to seek judicial review of a final agency decision that affirms those provisions.

Done and Signed
May 14, 2008

ROBERT N. SPENCER
Administrative Law Judge

Digitally recorded
Exhibits admitted
For the County Department: exhibits 1 – 6
For the Appellant: exhibits A – G
Joint Exhibit I

ELDER LAW ASSOCIATES PA
We give families peace of mind.

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Special Needs Planning
Disability Planning
VA Planning
Wills & Trusts
Probate

EXHIBIT I

Massachusetts Fair Hearing

MOSCHELLA &WINSTON LLP

TO: Hearing Officer
Case Worker
FROM: Attorney Michael R. Couture, Esq.
DATE: July 25, 2011
RE: **Client, Appeal No. xxxx892**

POST FAIR HEARING MEMORANDUM

INTRODUCTION

This post-hearing memorandum is a response to the memorandum of law submitted by the Office of Medicaid on the date of the Fair Hearing, July 6, 2011. The Hearing Officer left the record open for the Appellant to provide supporting documentation until July 20, 2011. This deadline was extended pursuant to the Appellant's request until July 25, 2011.

I. PROCEDURAL HISTORY AND FACTS

The Appellant, Client, is a 79 year old woman who resides at the Radius Nursing Home in Lowell, Massachusetts. On November 14, 2010, Client established the Grandson Supplemental Needs Trust (the "Trust"). The Trust beneficiary is the disabled grandson of Client.

On December 6, 2010, the Office of Medicaid denied Client's MassHealth application based on the transfer of assets to the Trust. According to the MassHealth

memorandum of law, the reason for the denial was that the Appellant has not established that the Trust is permissible under federal Medicaid law and sub-regulatory guidance.

II. ISSUE PRESENTED

Whether the Appellant's transfer to the Trust is allowable pursuant to federal laws and regulations.

III. APPLICABLE LAW

MassHealth, also known as Medicaid, is a joint federal and state program established in 1965 by Title XIX of the Social Security Act, 42 U.S.C. §§1396 et seq. While administered by the states, state programs must comply with federal statutes and regulations to receive federal funding. Harris v. McRae, 448 U.S. 297 (1980). The Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Agency or "HCFA") issues federal guidelines which appear in the state Medicaid Manual. Massachusetts Hosp. Ass'n v. Department of Pub. Welfare, 419 Mass. 644 (1995). In Massachusetts, MassHealth provides coverage for long-term institutional care for individuals who meet the eligibility requirements found at 130 C.M.R. 520 *et seq.*

Generally, the MassHealth regulations impose a period of ineligibility for MassHealth when an applicant transfers assets for inadequate consideration. 130 C.M.R. 520.018. Exceptions to the transfer rules, however, are found at 130 C.M.R. 520.019(D). Specifically, permissible transfers include situations where:

The resources were transferred to a trust, a special needs trust, or a pooled trust created for the sole benefit of a permanently and totally disabled person who was under 65 year of age at the time the trust was created or funded. 130 C.M.R. 520.019(D)(4).

The federal statute permitting transfers to trusts for disabled individuals under 65 years of age states, in pertinent part:

An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that . . . the assets were transferred to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of an individual under 65 years of age who is disabled. 42 U.S.C §1396p(c)(2)(B)(iv).

IV. ARGUMENT

1. The transfer into the Trust is permissible because it meets the requirements set forth in "HCFA 64" as a Sole Benefit Trust

Client has demonstrated that she has transferred assets to a trust for the benefit of a disabled individual under the age of sixty-five. Therefore, the transfer to the Trust is permissible so long as the Trust is a "sole benefit" trust. The Centers for Medicare and Medicaid Services ("CMS") issued Transmittal 64 ("HCFA 64"), which illustrates the requirements of a sole benefit trust pursuant to federal law. The relevant language states the following:

> For the Sole Benefit of.--A transfer is considered to be for the sole benefit of a spouse, blind or disabled child, or a disabled individual if the transfer is arranged in such a way that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future.
>
> Similarly, a trust is considered to be established for the sole benefit of a spouse, blind or disabled child, or disabled individual if the trust benefits no one but that individual, whether at the time the trust is established or any time in the future....
>
> A transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is not the spouse, blind or disabled child, or disabled individual is not considered to be established for the sole benefit of one of these individuals. **In**

> **order for a transfer or trust to be considered to be for the sole benefit of one of these individuals, the instrument or document must provide for the spending of the funds involved for the benefit of the individual on a basis that is actuarially sound based on the life expectancy of the individual involved.** When the instrument or document does not so provide, any potential exemption from penalty or consideration for eligibility purposes is void.
>
> **An exception to this requirement exists for trusts discussed in §3259.7. Under these exceptions, the trust instrument must provide that any funds remaining in the trust upon the death of the individual must go to the State, up to the amount of Medicaid benefits paid on the individual's behalf. When these exceptions require that the trust be for the sole benefit of an individual, the restriction discussed in the previous paragraph does not apply when the trust instrument designates the State as the recipient of funds from the trust. Also, the trust may provide for disbursal of funds to other beneficiaries, provided the trust does not permit such disbursals until the State's claim is satisfied**...(Emphasis added).

State Medicaid Manual, HCFA 64 §3257(B).6.

A. The Trustee must make mandatory distributions to or for the benefit of the Beneficiary that are actuarially sound and the Trust is therefore compliant with the Sole Benefit requirements of HCFA 64.

First, the Trust contains express and specific language that provides for the spending of the funds for the benefit of the beneficiary, Grandson, on a basis that is actuarially sound based on his life expectancy. Article 7.2 of the Trust (Mandatory Distributions), expresses clear and unequivocal language that the Trustee "shall distribute to the Beneficiary or use on the Beneficiary's behalf principal and income on a basis that is considered an actuarially sound manner based on the Beneficiary's life expectancy."

The trust further explains how the Trustee shall calculate the life expectancy of the beneficiary, which references Social Security Administration tables referred to in 42 U.S.C.

§1396. The language in the Trust is clear in that the Trustee has no discretion to withhold payments to or for the benefit of the beneficiary.

The MassHealth memorandum incorrectly argues that these distributions are not mandatory, and therefore not actuarially sound, because Article 7.3 of the Trust ("Discretionary Distributions") provides discretionary language. This is a clear error by MassHealth because Article 7.3 is referring to any discretionary distributions to the beneficiary that are above any mandatory distributions that fall under Article 7.3. The first sentence of Article 7.3 states that "the making and the amount of any payment **above such amounts described in Article 7.2** shall be totally and solely within the discretion of the Trustee. (Emphasis added).

The MassHealth memorandum further erroneously states that the Trustee "impliedly" may not make any distributions at all because of Articles 3, 7.2, and 8 that the purpose of the trust is to supplement and not supplant public benefits…" The MassHealth memorandum has made the false assumption that the Trustee cannot make mandatory distributions without satisfying the purpose of the Trust, presumably because any payments will adversely affect public benefit eligibility. This is legally and factually incorrect because the Trustee must make the mandatory distributions and these distributions will not necessarily affect eligibility of any public benefit programs. Furthermore, the Trustee is not absolutely precluded to make payments that would affect Medicaid or SSI.

The Trustee is allowed to make payments to the beneficiary "in-kind", and according to federal regulations, in-kind payments made on behalf of the beneficiary that are not for food and shelter will not adversely affect SSI or Medicaid eligibility. It is entirely possible that the Trustee can make purchases up to and above the amount of the mandatory distributions without

reducing the beneficiary's SSI payments or risking any other public benefit program available to the beneficiary.

Further, Article 7.4 of the Trust expressly provides that the Trustee may reduce public benefits eligibility if it enhances the beneficiary's standard of living.[1] For example, the Trustee may make in-kind support payments on behalf of the beneficiary that "would reduce the Beneficiary's SSI benefit by a maximum of the monthly Presumed Maximum Value (PMV) amount, or such equivalent distribution as allowed by the state Medicaid Program."

The trust provisions are not contradictory, as MassHealth would argue, because the trustee's mandatory distributions do not violate the purpose or any express terms of the trust. The Appellant fully agrees with MassHealth that "if the Trustee makes distributions to Grandson, there is nothing to prevent the Social Security Administration from counting any money paid from the trust on Grandson's behalf as income that "can" be used for food or shelter." This is true, but only up to the PMV, which is why the Trustee has the discretion to make payments on behalf of Grandson that are not for food or shelter, OR, to make such in-kind payments that are for food and shelter and thereby reducing his SSI payments as provided in Article 7.4 of the Trust.[2]

B. The Trust provides that the State, up to the amount of Medicaid benefits paid on the individual's behalf, is the sole beneficiary after the death of Grandson, thereby satisfying the exception to the actuarially sound requirements of a Sole Benefit Trust

[1] Any allowable reduction in public benefits pursuant to Article 7.4 is "subject to the Provisions of Article 7.2, above". The mandatory distributions provided in Article 7.2, therefore, trump the discretion the Trustee has in reducing other benefits.

[2] MassHealth's statement that "any payments from the Trust on Grandson's behalf must necessarily be in small amounts in order to avoid supplanting SSI or MassHealth benefits" is, on the other hand, absolutely incorrect because as explained, the Trustee can either 1) make payments in-kind for non-food or shelter related items without reducing SSI, OR the Trustee can make payments for food and shelter and thereby reduce the SSI payments by the "presumed maximum value", which is expressly allowed pursuant to Article 7.4.

HCFA 64 provides that the restriction regarding mandatory distributions that are actuarially sound does not apply when the trust instrument designates the State as the recipient of funds from the trust. Therefore, as long as the trust has a beneficiary provision that "pays back" the government agency, the trust does not have to be actuarially sound. Article 10 of the Trust clearly provides such language where the state is paid back for Medicaid assistance provided to Grandson.

MassHealth has put forth the brief and confusing argument that the paragraph in HCFA 64 "is inapplicable" because according to MassHealth, "the issue in this case is not related to treatment of trust assets". The Appellant submits that this paragraph from HCFA is relevant because the sole issue in this case is whether transfers to this Trust are permissible according to federal law. Not only does the Trust meet the requirement distributions to the disabled beneficiary are actuarially sound, but it also contains a payback provision to the State, which alone would satisfy federal requirements. HCFA 64 mandates that in order to be an allowable trust, it must be actuarially sound or have a payback provision to the State agency and this trust contains both.

MassHealth also put forth the argument in a footnote that "the payback clause must be as to the person who is applying for or receiving Medicaid benefits and whose eligibility is sought to be established." This is incorrect. All federal laws and regulations provide that the payback clause in these trusts, whether it is a pooled trust, D4A trust, or to the sole benefit trusts, relate to the beneficiary of such a trust, not to the donor of the trust. MassHealth's conclusion is unsupported by common practice and the intent of the regulations.

The purpose of these sole benefit trusts is to preclude anyone other than the beneficiary from benefitting from the assets in any way. The solution to an untimely death by the beneficiary is to provide that the state is first paid back for all funds paid to the beneficiary. The language in HCFA 64 supports this reasoning by providing "the trust may provide for disbursal of funds to other beneficiaries, provided the trust does not permit such disbursals until the State's claim is satisfied." This sentence only makes sense if the claim is on the Medicaid funds paid to the beneficiary, and not to the donor of the trust.

V. CONCLUSION

For the foregoing reasons, Appellant Client respectfully requests that the Board of Hearings order the Respondent Office of Medicaid to treat the transfer to the Grandson Supplemental Needs Trust as a permissible transfer, to approve MassHealth eligibility, and to provide all other remedies it deems equitable and just.

Submitted on behalf of the Appellant Client, by his Attorney

Date:_____

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EXHIBIT J

NAELA Amicus Brief Filed in Hughes v. Colbert

Case No. 12-3765

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

Carole Hughes and Harry Hughes,
Plaintiff-Appellants,

v.

Michael Colbert, in his official capacity, as Director of the Ohio Department of Job & Family Services,
Defendant-Appellee.

APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO, EASTERN DIVISION

BRIEF *AMICI CURIAE* OF THE NATIONAL ACADEMY OF ELDER LAW ATTORNEYS AND THE OHIO STATE BAR ASSOCIATION IN SUPPORT OF THE PLAINTIFFS-APPELLANTS CAROLE HUGHES AND HARRY HUGHES AND IN SUPPORT OF REVERSAL OF THE LOWER COURT'S DECISION

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F.R.A.P. 26.1 CORPORATE DISCLOSURE STATEMENT

National Academy of Elder Law Attorneys ("NAELA")

The Internal Revenue Service has determined that NAELA is organized and operated pursuant to Section 501(c)(6) of the Internal Revenue Code and is exempt from income tax. NAELA is operated as a non-profit corporation under the laws of the State of Oregon. It does not issue stock and has no parent or subsidiary corporations.

Ohio State Bar Association ("OSBA")

The Internal Revenue Service has determined that the OSBA is organized and operated pursuant to Section 501(c)(6) of the Internal Revenue Code and is exempt from income tax. OSBA is operated as a not-for-profit unincorporated association under the laws of the State of Ohio. OSBA does not issue shares of stock and has no parent corporation.

Dated: September 5, 2012

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STATEMENT OF INTEREST OF *AMICI CURIAE*

The National Academy of Elder Law Attorneys ("NAELA") is a professional organization of attorneys concerned with legal issues affecting the elderly and disabled, including eligibility for medical assistance ("Medicaid") benefits. NAELA files this brief with the consent of both the Defendant-Appellee and the Plaintiff-Appellant. No counsel for any party authored this brief in whole or in part, and no money was contributed by anyone, other than the *amicus curiae* and its counsel, to fund preparing or submitting the brief.

NAELA's mission statement provides that its members provide legal advocacy, guidance and service to enhance the lives of people with

special needs and people as they age. Since its inception nearly twenty-five years ago, NAELA has grown to a current membership of over 4,400 attorneys in all fifty states, the District of Columbia and several foreign countries; it has almost 150 members in Ohio, in which this case arose, and nearly 350 members within the four states in the Sixth Circuit.

The Ohio State Bar Association ("OSBA") files this brief with the consent of both the Defendant-Appellee and the Plaintiff-Appellant. No counsel for any party authored this brief in whole or in part, and no money was contributed by anyone, other than the *amicus curae* and its counsel, to fund preparing or submitting the brief.

OSBA shares the concern of NAELA for the well-being of community spouses, often women with a lower fixed income, within the State of Ohio and throughout the country.

ISSUES OF LAW

1. The Statutes are Clear and Supported by the Views of the Centers for Medicare and Medicaid Services

The Centers for Medicare and Medicaid Services (the "CMS")[1], the component of the Department of Health and Human Services ("HHS") that oversees the administration of the Medicaid program by the states, has consistently and authoritatively advised that the limitation on the amount of transfers from an institutionalized spouse to a community spouse 42 U.S.C. § 1396r-5(f)(1) only applies in the post-eligibility context. The CMS has advised that prior to eligibility, such as in this case, that section does not apply; instead 42 U.S.C. § 1396p(c)(2)(B)(i) permits unlimited transfers to the community spouse. That is consistent with the terms of those statutes and the Medicaid eligibility process.

2. The Views of the CMS are Entitled to Substantial Deference

Those views of the CMS about the meaning of these statutes are entitled to substantial deference under *Skidmore v. Swift & Co.*, 323 U.S. 134 (1944) since they are well reasoned and consistent over time.

---

[1] Prior to July, 2001, the CMS was the Health Care Financing Administration. *See* 66 Fed. Reg. 35437 (2001). For consistency it will be referred to herein as the CMS.

3. Protecting the Community Spouse from Impoverishment is Federal Public Policy

In the "spousal impoverishment" statute, 42 U.S.C. § 1396r-5, Congress established the public policy that community spouses should have enhanced protections for their income and resources from being applied to the costs of care of their institutionalized spouses. It enacted restrictions on the use of annuities, including provisions requiring that the Medicaid program be named a remainder beneficiary, balancing the interests of community spouses and the Medicaid program.

SUMMARY OF ARGUMENT

The statutory construction applied by the court below, which substantially limits the ability of couples to provide for the needs of the community spouse when the elderly or disabled spouse enters a nursing home, is contrary to the terms of the relevant statutes, 42 U.S.C. §§ 1396p(c)(2)(B)(i) and 1396r-5(f)(1), the recent and only decision by a sister court of appeals on the issue, *Morris v. Okla. Dep't of Human Svcs.*, 685 F.3d 925 (10th Cir. 2012), and a series of letters from the CMS to several states which had been in the record in recent prior litigation on this issue in the same court but were not brought to the attention of the district court in this case.

Those letters from the CMS, well reasoned and consistent over time, should be considered by this court and given substantial deference.

The decision below is contrary to the intent of the statute to protect community spouses to provide for their own retirement needs, particularly in the context of this case, in which the funding of individual retirement account ("IRA") annuities resulted in the State Medicaid agency imposing a penalty period disqualifying the institutionalized spouse from Medicaid for having looked out for the needs of her husband in the community.

ARGUMENT

I. THE STATUTES ARE CLEAR AND SUPPORTED BY THE VIEWS OF THE CENTERS FOR MEDICARE AND MEDICAID SERVICES

The court below confused one statute, 42 U.S.C. § 1396r-5(f)(1) , which applies to transfers after one spouse has applied for Medicaid, and simply permits assets to be re-allocated from the institutionalized spouse to the community spouse to bring her up to the community spouse resource allowance (the "CSRA"), with another statute, 42 U.S.C. § 1396p(c)(2)(B)(i), which applies before the Medicaid application and permits unlimited transfers to the community spouse.

The Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, 102 Stat. 683, enacted the "spousal impoverishment" protections set forth in 42 U.S.C. § 1396r-5. They provide that, at the time of a Medicaid application, as a general rule the assets of both spouses shall be considered available to the institutionalized spouse. 42 U.S.C. § 1396r-5(c)(2)(A).

There is, however, one important exception. Resources are only considered available to the community spouse to the extent they exceed the community spouse resource allowance (the "CSRA"). 42 U.S.C. § 1396r-5(c)(2)(B). The CSRA is defined in 42 U.S.C. § 1396r-5(f)(2); it is, as its name implies, an allowance of resources for the community spouse that is substantially more than the allowance for the actual Medicaid applicant, which in most states is the same as the SSI resource allowance of $2,000.

Thus, depending on the way the couple's assets are titled at the time of the Medicaid application, the institutionalized spouse may have more than his allowance in his name while the community spouse has less than the CSRA in hers. For example, assume the CSRA is $50,000, and the institutionalized spouse has $40,000 in his name while the community spouse has just $5,000 in her name.

That is the circumstance, and the only circumstance, in which the provisions of 42 U.S.C. § 1396r-5(f)(1) come into play, and the court below erroneously applied the cap on spousal transfers in that statute because it has nothing to do with transfers prior to the Medicaid application like those here. Section 1396r-5(f)(1) merely permits a couple in a situation like that above to reallocate their resources "as soon as practicable after the date of the initial determination of eligibility" so that the institutionalized spouse has no more than his own individual resource allowance and the community spouse has been brought up closer to her CSRA.

What controls here is not that statute, but rather 42 U.S.C. § 1396p(c)(2)(B)(i), which permits unlimited transfers between spouses without there being any resulting penalty period of ineligibility. That makes perfect sense given that, for purposes of Medicaid eligibility, all the resources of both spouses in excess of the CSRA are attributed to the institutionalized spouse who is applying for Medicaid. 42 U.S.C. § 1396r-5(c)(2). The transfer of assets penalty rules are intended to address gifts to others because they artificially pauperize the applicant or spouse. Transfers to spouses, on the other hand, do not have that

consequence because Medicaid will count the assets irrespective of which one of the spouses holds the assets.

This critical distinction was missed by the court below, just like the district court in *Morris v. Okla. Dep't of Human Svcs.*, 758 F.Supp. 2d 1212 (W.D. Okla. 2010), on which the court below relied. That decision in *Morris* was reversed shortly after the decision below, 685 F.3d 925 (10th Cir. 2012), and the court of appeals corrected that error because it understood that the cap on spousal transfers in § 1396r-5(f)(1) did not apply to spousal transfers prior to the Medicaid application.

II. THE VIEWS OF THE CMS ARE ENTITLED TO SUBSTANTIAL DEFERENCE

The holding in *Morris* is buttressed by a series of letters issued to various states by the CMS about this very issue. These letters are available on PACER but were not part of the record below, although they were well known to the defendant since they had been introduced in the *Burkholder v. Lumpkin*[2] case involving the same defendant state Medicaid official and on which the court below relied. In the alternative

[2] 2010 U.S. Dist. LEXIS 11308 (N.D. Ohio 2010). These letters are in docket no. 23 for that case, 09-cv-1878, on PACER.

to merely referencing these letters we respectfully request that the court consider those references as being a motion to supplement the record by including them or for the court to take judicial notice of them as public records.

They represent a consistent and well thought out explanation of the differences between these two statutes, and as such they are entitled to substantial deference under *Skidmore v. Swift & Co., supra.* Both the Supreme Court and this court have given deference to such letters. *See Wis. Dep't of Health & Family Servs. v. Blumer*, 534 U.S. 473, 485, 496, 497 n. 14 (2002) [referring to several Regional State Letters]; *Chambers v. Ohio Dep't of Human Servs.*, 145 F.3d 793, 803 (6th Cir. 1998) ["given the unique nature of the statute and of HHS's power to interpret it we believe that courts may give even relatively informal interpretations by HHS some presumption of correctness."].

The earliest of these letters, to the Administrator of the Nevada State Welfare Division, sets forth a very detailed statutory analysis and explains why *McNamara v. Ohio Dep't of Human Servs.*, 139 Ohio App. 3d 551, 744 N.E.2d 1216 (2000), on which the court in *Burkholder* relied, 2010 U.S. Dist. LEXIS 11308, *17, 20-23, is incorrect. While that letter came from the Regional Office, it was copied to the

Administrator of the Division of Health Care Financing and Policy in the Central Office.

Another of the subsequent letters, to an attorney in Ohio, came directly from the Director of the Disabled and Elderly Health Programs Group in the Central Office of CMS in Baltimore. These are exactly the well reasoned and consistent policy interpretations that are entitled to deference.

The original Nevada letter also cites § 3262.4 of the State Medicaid Manual, the CMS manual that sets forth federal policy guidance for state Medicaid agencies. That section sets forth an example just like that described above, and makes clear that 42 U.S.C. § 1396r-5(f)(1), on which the court below relied, only applies to post-eligibility reallocation of resources, not the sort of pre-application transfers at issue here. The State Medicaid Manual also is entitled to *Skidmore* deference. *See Wong v. Doar*, 571 F.3d 247, 258 (2d Cir. 2009); *Dickson v. Hood*, 391 F.3d 581, 590 n. 6 (5th Cir. 2004).

In fact, a careful reading of the *Burkholder* decision indicates that it did not concern the situation in the instant case at all. In *Burkholder* the plaintiff had inherited money after Medicaid eligibility had been established; so it concerned a post-eligibility transfer, not a pre-

application transfer like the one in question here. Accordingly the court in *Burkholder* applied the post-eligibility statute, 42 U.S.C. § 1396r-5(f)(1), rather than the pre-application transfer statute, 42 U.S.C. § 1396p(c)(2)(B)(i). The court made this very clear in a subsequent Order, PACER docket no. 27, denying the plaintiff's motion for a new trial based on the newly discovered CMS letters, pointing out that they did not apply since the concerned pre-application transfers rather than the post-eligibility transfers in question there.

The court below in this action misapprehended the critical distinction between 42 U.S.C. § 1396p(c)(2)(B)(i), permitting unlimited transfers between spouses prior to applying for Medicaid, as in this case, and 42 U.S.C. § 1396r-5(f)(1) permitting otherwise eligible Medicaid recipients to make transfers re-allocating resources to bring the community spouse's resources up to the CSRA.

III. PROTECTING THE COMMUNITY SPOUSE FROM IMPOVERISHMENT IS FEDERAL PUBLIC POLICY

Each state which participates in the Medicaid program is required to provide coverage to certain categories of persons, often referred to as the "mandatory categorically needy." These persons are eligible for Medicaid because they receive some other form of public assistance,

such as Supplemental Security Income (SSI), or they fit into other specified groups of low-income persons. 42 U.S.C. §1396a(a)(10)(A)(i).

States may also elect, but are not required, to provide Medicaid coverage to other categories or groups of persons, including any group of individuals described in 42 U.S.C. §1396d(a) who are not mandatory categorically eligible or qualified Medicare beneficiaries. 42 U.S.C. §1396a(a)(10)(C). These groups of persons are commonly referred to as the "medically needy." One of the groups of individuals described in 42 U.S.C. §1396d(a) consists of adults who are 65 years of age or older, 42 U.S.C. §1396d(a)(iii), and Ohio has elected to provide Medicaid coverage to this group of individuals.

In determining income and resource eligibility for the medically needy, a state is required to use a methodology which is no more restrictive than the methodology used to determine eligibility for SSI. 42 U.S.C. §§1396a(a)(10)(C)(i)(III) and 1396a(r)(2)(A)(i). This means that the methodology used by the state may not result in persons in this category being ineligible for Medicaid if they would otherwise be eligible for SSI. 42 U.S.C. §1396a(r)(2)(B); *James v. Richman*, 547 F.3d 214, 218 (3d Cir. 2008); *Anna W. v. Bane*, 863 F.Supp. 125, 128-9 (W.D.N.Y.

1993). In addition, a state must use reasonable standards for determining eligibility which provide for taking into account only such income and resources as are available to the applicant or recipient and which would not be disregarded in determining eligibility for SSI. 42 U.S.C. §1396a(a)(17).

In the context of this statutory scheme, the state's implication that Mr. Hughes's purchase of an annuity is a "loophole" that the court should close should be rejected. For Medicaid purposes, an annuity generally counts as an "asset." *See* 42 U.S.C. § 1396p(c)(1)(G). Under 42 U.S.C. § 1396p(h)(1), "assets" include both income and resources, but an annuity that satisfies various conditions does not qualify as an available resource. *See* § 1396p(c)(1)(G).

The standards for what may be counted as a resource in determining eligibility for SSI (and therefore for determining Medicaid eligibility) are set forth in 20 C.F.R. §416.1201(a)(1): "[i]f a property right cannot be liquidated, the property will not be considered a resource of the individual (or spouse)." That the Medicaid provisions are read to treat an irrevocable and non-assignable annuity as the community spouse's income, rather than the couples' joint resource, is

the balance struck by Congress. *See* 42 U.S.C. §1396r-5. Such income would not affect Mrs. Hughes' eligibility because "no income of the community spouse shall be deemed available to the institutionalized spouse." 42 U.S.C. § 1396r-5(b)(1).

The weight of authority supports this interpretation. *See Hutcherson v. Ariz. Health Care Cost Containment Sys. Admin.*, 667 F.3d 1066, 1069 (9th Cir. 2012) (noting that the annuity provision "allow[s] the spouse to convert his or her assets, which are considered in determining the institutionalized spouse's eligibility, to income which is not considered"); *James v. Richman,* 465 F. Supp. 2d 395,403 (M.D. Pa. 2006), *aff'd*, 547 F.3d 214 (3d Cir. 2008) ("available assets may become unavailable assets and not countable in determining Medicaid eligibility for the institutionalized spouse when an irrevocable actuarially sound commercial annuity is purchased for the sole benefit of the community spouse"); *Mertz v. Houston*,155 F. Supp. 2d 415 (E.D. Pa. 2001) ("[A] couple may effectively convert countable resources into income of the community spouse which is not countable in determining Medicaid eligibility for the institutionalized spouse by purchasing an irrevocable actuarially sound commercial annuity for the sole benefit of

the community spouse."); *Vieth v. Ohio Dep't of Job & Family Servs.*, 2009 Ohio 3748 (Ct. App. 2009) (concluding that "funds used to purchase an actuarially sound, non-revocable, non-transferable commercial annuity, for the sole benefit of the community spouse, are not countable resources for Medicaid eligibility purposes"); *see also Estate of F.K. v. Div. of Med. Assistance & Health Servs.*, 374 N.J. Super. 126,142-143, 863 A.2d 1065, 1074-1075 (App. Div. 2005) (relying on the CMS State Medicaid Manual Transmittal 64 to strike down a New Jersey regulation that capped the amount a couple could spend on an annuity at the couple's CSRA). As noted above, this is also the reading of the statute adopted by the agency (CMS) charged with administering the Medicaid program.

Despite its presumed awareness of these judicial and administrative interpretations, Congress has not revised the Medicaid statute to foreclose this option. In fact, rather than close the annuity "loophole," Congress has twice amended the Medicaid statutes to specify the types of annuities capable of producing uncountable spousal income. *See* Tax Relief and Health Care Act of 2006, Pub. L. No. 109–432, 120 Stat. 2922, 2998; Deficit Reduction Act of 2005, Pub. L. No. 109–171,

120 Stat. 4, 62–64. "Congress provided a detailed set of rules governing transactions that it considered suspicious, and the purchase of an annuity is not among them." *James v. Richman,* 547 F. 3d at 219. There is nothing on its face suspicious, illegal, or otherwise contrary to the policy expressed in the Medicaid statutory scheme in treating an irrevocable, actuarially sound, non-assignable annuity as the community spouse's income rather than a resource attributable to the couple. A fair reading of the statutes, in fact, compels that result.

When Mrs. Hughes becomes eligible for Medicaid assistance, essentially all of her income will be required to be paid to the nursing home providing her care, with Medicaid payments making up the difference between the cost and her payments. 42 U.S.C. §§1396r-5(b)(1) and (d). Mr. Hughes receives $1,728.42 per month (R.E #1, Complaint, at ¶ 10) after using resources attributable to his marriage partnership to purchase a conforming annuity, in addition to his other retirement income, which would include, of course, his Social Security retirement benefits.

Therefore, the community spouse, Mr. Hughes, would not be eligible for an income allowance from his institutionalized spouse. 42

U.S.C. §1396r-5(d)(3)(A). So in the first instance, the state's payments to the nursing home on behalf of the institutionalized spouse would be reduced by the annuity payments to the community spouse. Thus, the public policy that permits a conforming annuity purchase to supplement the income of the community spouse is balanced by the institutionalized spouse's increased contribution to the cost of her nursing facility care.

The public policy balance struck by the Medicaid annuity provisions is also apparent in the restrictions governing such conforming annuities. Annuities are required to name, and Mr. Hughes did name, the institutionalized spouse as the remainder beneficiary if the community spouse does not survive the annuity's term. 42 U.S.C. 1396p(c)(1)(F)(ii); R.E. #1-2, Contract Data Page, p.2. If Mrs. Hughes survives her husband, for example, her income would increase by $1,728.42, essentially all of which would be paid for her nursing home care and offsetting the amount that the state would pay by $1,728.42. 42 U.S.C. 1396p(c)(1)(F).

If neither spouse survives the annuity's term, the state would be paid the remaining annuity payments up to the total amount of Medicaid assistance paid on behalf of the institutionalized spouse. 42

U.S.C. 1396p(c)(1)(F)(i). Thus, the benefit the community spouse realizes from the increased income produced by the purchase of the annuity prevents his impoverishment during his lifetime, but reduces the amount paid by Medicaid at his death because the annuity payments are either:

- consumed by the community spouse as support,
- used by the institutionalized survivor to meet the cost of nursing home care (and thereby reduce the state's outlay), or
- paid to the state to reimburse it for the Medicaid payments it made on behalf of the institutionalized spouse.

This public policy is perfectly consistent with the public policy of preventing spousal impoverishment, as the Department of Health and Human Services has pointed out in its *amicus* brief in the Second Circuit in the related *Lopes v. Starkowski* case, Docket No. 10-3741-CV (2d Cir. Dec., 2011). R.E. #15-4, Amicus Brief of HHS, pp. 19-22.

This annuity purchase was not an improper transfer of assets. Indeed, the treatment of the annuity purchase by Mr. Hughes, from his own funds, by definition could not have been a transfer from his wife, contrary to the position of the Defendant and the court below. In the

context in which it arose, the conversion of one form of IRA to another (the IRA annuity), the purchase was in furtherance of our express public policy to protect the marriage partnership from impoverishment in retirement. This is set out in the Medicaid statutory scheme expressly permitting IRA annuities that comply with certain requirements, as Mr. Hughes' annuity did.

CONCLUSION

For the foregoing reasons the judgment below should be reversed.

Dated: September 5, 2012

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH TYPEFACE AND LENGTH

Pursuant to Rule 32(a)(7)(C) of the Federal Rules of Appellate Procedure, I hereby certify that this brief complies with the limitations in Federal Rules of Appellate Procedure 29(d) and 32(a)(7)(B) because this brief contains 4764 words as determined by the word counting feature of Microsoft Word 2010. I also hereby certify that this brief complies with the typeface and typestyle requirements of Federal Rule of Appellate Procedure 32(a)(5)(A) because this brief has been prepared in a proportionally spaced typeface using 14-point Century font in Microsoft Word 2010.

Pursuant to Local Rule 25(f), I also hereby certify than an electronic version of this brief has been filed with the Clerk via the Court's CM/ECF system, the electronic version of the brief was generated by printing the original word processing file to PDF, and the file has been scanned for viruses and is virus-free.

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CERTIFICATE OF SERVICE

I hereby certify that on September 5, 2012, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Sixth Circuit by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

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NYSBA ELDER LAW & SPECIAL NEEDS SECTION SUMMER MEETING 2019

FAMILY LAW AND SPECIAL NEEDS ISSUES

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BASIC FACTS

Half of all marriages in America end in divorce.

Percentage increases when there is a child with disabilities.

Children with special needs require extra attention.

Unintended consequence is additional pressure in a marriage.

Stress of coping with the special needs of a child can:

- **Draw the couple closer together**
- **Pull them apart**

ISSUES AFFECTED BY A CHILD WITH SPECIAL NEEDS

- Custody and time sharing
- Child Support
- Alimony
- Private education
- Health Insurance
- Emancipation
- Life Insurance
- Dependency Exemptions
- Equitable Distribution

EDUCATING THE CLIENT

- Identify the special needs of the child
- Try to project into the future
- Discuss the divorce process and how the special needs of the child may be affected
- Governments Benefits
- Child Support

IMPORTANT DEFINITIONS

CHILD – an individual who is under 18, or under 22 attending school regularly who is not married or head of household (POMS SI 00501.010, SI 00501.020)

ADULT CHILD – a son or daughter who is no longer a child (POMS SI00830.420A.5)

CHILD SUPPORT - payment from a parent to or for the benefit of a child to meet the child's needs for food and shelter (POMS SI00830.420A.1)

CUSTODIAL PARENT – parent who has care, guardianship, or custody of the child (POMS SI00830.420A.6)

Child Support Whose Income is it?

Payments made on behalf of the child are unearned income to the child, which will reduce SSI payments dollar for dollar

Payments for an adult child received by the parent and not given to the child are considered income to the child

Payments made to an adult child are income to the child

Child Support as Income

What about in-kind support payments?

1/3 of the amount of child support that is received in the form of food and shelter is excluded from income

Remaining 2/3 is considered ISM (POMS SI00835.350C)

Any in-kind support payment that is not food or shelter would not be income to the child (POMS SI00830.420 B 2)

How to Protect Child Support

Assign child support to a Special Needs Trust

Must be a First Party SNT or a pooled trust

Assignment must be irrevocable

Have the assignment ordered by the Court

Notify Social Security and Medicaid of both the Court Order and SNT

LIFE INSURANCE

Divorce Agreement may mandate that one or both parents maintain a specific amount of life insurance to ensure financial support will be available to the couple's children in case of the death of a spouse

Consider how the death benefits are going to be paid

Use of Special Needs Trust

GUARDIANSHIP

What is the definition of emancipation?

- **Matrimonial attorney**
- **Special Needs attorney**
- **18 years vs. 21 years**

Other considerations:

- **Marriage**
- **Military service**
- **Full-time employment**
- **Change of permanent residence from parents' home**

GUARDIANSHIP

What if child is never emancipated?

- **Incorporate guardianship into divorce agreement**
- **Set forth who will be the guardian**
- **Provide a time frame for the commencement of the guardianship proceeding**
- **Put a safety net in place if an agreement is not reached**

AVOID THE NEED FOR A CONTESTED GUARDIANSHIP!

EDUCATIONAL DECISION MAKING

Services provided through local school districts

Consider who will be primarily responsible and who will have the authority to make these decisions

Avoid the denial of services if parents can't agree

Decide which primary residence will be used

School programs

Marriage

Capacity to enter into a marriage

Article 17- A of the Surrogate's Court Procedure Act

Article 81 of the Mental Hygiene Law

Marriage Ceremony vs. Marriage License

Marriage

Effect on government benefits

SSDI

If receive SSDI under your own work record – marriage won't effect benefits

If adult disabled child receiving benefits under parent's work record – marriage will cause SSDI benefits to stop

SSI

Spouse's income and resources may change SSI benefit

If both get SSI – benefit amount changes from individual to couple

Marriage

Effect on government benefits – cont'd

- **Medicaid – Spousal Refusal**
- **Medicaid Waiver Programs**
- **Gifts**
  - **tangible personal property**
  - **cash**
- **SNT**

ESTATE PLANNING

Review advance directives

Review Last Will and Testament and any Trusts

Confirm that bequests to child with special needs will be held in a SNT

Questions?

50 Misc.3d 666, 19 N.Y.S.3d
867, 2015 N.Y. Slip Op. 25364

**1 In the Matter of the
Appointment of a Guardian for D.D

Surrogate's Court, Kings County
2014-2185
October 28, 2015

CITE TITLE AS: Matter of D.D.

HEADNOTE

Incapacitated and Mentally Disabled Persons
Guardian for Mentally Retarded and Developmentally Disabled Persons
Requirement That Guardianship is Least Restrictive Alternative

In a guardianship proceeding pursuant to SCPA article 17-a, petitioners, the mother and brother of a 29-year-old man with "Down Syndrome with Low Mild" mental retardation, failed to demonstrate that the appointment of a guardian was necessary and in his best interest where he presented as a capable, thoughtful and engaging adult with mild intellectual disability who was high functioning, well integrated socially, able to work, to travel independently, to exercise self care and management, and to make decisions about his health and finances, albeit at times with assistance and supervision from his family and supportive programs. To support the immense loss of individual liberty which an article 17-a guardianship entails, the petitioner must prove that the appointment of a guardian is necessary and in the respondent's best interests and must exclude the possibility of the respondent's ability to live safely in the community supported by family, friends and mental health professionals. Here, respondent's needs could be met through supported, instead of substituted, decision-making. Alternate, less restrictive legal tools, such as a power of attorney and a health care proxy, could be utilized to allow family members to make financial and medical decisions for him when he was no longer able to do so, and a wide range of supportive services, some of which he already utilized, were offered by the Office for People with Developmental Disabilities. Moreover, the strong objection of respondent's mother, one of the proposed guardians, to his aspiration to one day marry and have a family raised concerns as the right to marry was central to his personal dignity and autonomy and his pursuit of happiness. The standard was not whether petitioners could make better decisions than respondent, but whether or not he had the capacity to make decisions for himself with support.

RESEARCH REFERENCES

Am Jur 2d, Guardian and Ward §§ 24–26, 30, 64–66.

Carmody-Wait 2d, Guardians and Guardianship §§ 155:115, 155:116, 155:121, 155:122, 155:125.

NY Jur 2d, Infants and Other Persons Under Legal Disability §§ 498–501, 507, 517.

ANNOTATION REFERENCE

See ALR Index under Guardian and Ward.

FIND SIMILAR CASES ON WESTLAW

Database: NY-ORCS

*667 Query: appoint! /4 guardian /p intellectual! /2 disab! & restrictive

APPEARANCES OF COUNSEL

Curtis, Mallet-Prevost, Colt & Mosle LLP, New York City (*Nancy Delaney* of counsel), for petitioners.
Advocates for Adults with Intellectual and Developmental Disabilities Legal Clinic, Brooklyn (*Natalie Chin* of counsel), guardian ad litem.

OPINION OF THE COURT

Margarita López Torres, S.

This is a proceeding brought by Ms. D. and M.D. (collectively, the petitioners) to be appointed the coguardians of the person of D.D. pursuant to article 17-a of the Surrogate's Court Procedure Act. Ms. D. is D.D.'s mother and M.D. is one of D.D.'s brothers. Petitioners also seek the appointment of W.D. and A.D., D.D.'s brothers, as standby guardian and alternate standby guardian, respectively. The petitioners are represented by counsel.

Statutory Framework

SCPA article 17-a governs guardianship of persons who are intellectually or developmentally disabled. This court uses the term "intellectual disability" in lieu of "mental retardation" even though SCPA utilizes the latter to describe the same condition. This change in terminology has been approved and used in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), one of the standard texts used by psychiatrists and mental health professionals in classifying mental disorders. (*See Hall v Florida*, 572 US —, —, 134 S Ct 1986, 1990 [2014], citing American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders at 33 [5th ed 2013].) [1]

An intellectually disabled person is defined by SCPA 1750 as one who is permanently or indefinitely incapable of managing oneself and/or one's own affairs because of an intellectual disability. *668 The condition must be certified by a licensed physician and a licensed psychologist or by two licensed physicians, one of whom has familiarity with or knowledge of the care and treatment of persons with intellectual disabilities. It must appear to the satisfaction of the court that the best interests of such person will be promoted by the appointment of a guardian. (SCPA 1754 [5].)

A developmentally disabled person is defined by SCPA 1750-a as one who has an impaired ability to understand and appreciate the nature and consequences of decisions which result in one's incapacity to manage oneself and/or one's own affairs. The developmental disability must be permanent or indefinite and attributable to cerebral palsy, epilepsy, neurological impairment, autism, traumatic brain injury, or any condition found to be closely related to intellectual disability. The condition must have originated before the age of 22, except for traumatic brain injury which has no age limit. As with SCPA 1750, the condition must be certified by a licensed physician and a licensed psychologist or by two licensed physicians, one of whom has familiarity with or knowledge of the care and treatment of persons with developmental disabilities. Also as with SCPA 1750, the court must determine that it is in such person's best interest that a guardian is appointed. (SCPA 1754 [5].)

The legal determination of the need for guardianship is functionally the same whether an individual's disability is categorized under section 1750 or 1750-a of SCPA and relies upon the same body of law. Under article 17-a, appointment of a guardian of the person of an intellectually disabled individual wholly removes that individual's legal right to make decisions over one's own affairs and vests in the guardian "virtually complete power over [such individual]" (*Matter of Mark C.H.*, 28 Misc 3d 765, 776 [Sur Ct, NY County 2010]). In order to support this immense loss of individual liberty, the petitioners bear the burden of proving, to the satisfaction of the court, that the appointment of a guardian is necessary and in the best interest of the person with intellectual disability or developmental disability. (SCPA 1750, 1750-a; *Matter of Maselli*, NYLJ, Mar. 29, 2000 at 28, col 4 [Sur Ct, Nassau County 2000].) The extreme remedy of guardianship should be the last resort for addressing an individual's needs because "it deprives the [individual] of so much power and control over his or her life" (*Matter of Dameris L.*, 38 Misc 3d 570, 577-578 [Sur Ct, NY County 2012] ["To the extent that New York courts have *669 recognized least restrictive alternative as a constitutional imperative, it must, of necessity, apply to guardianships sought pursuant to article 17-A" (citations omitted)]). If there are less restrictive alternatives that are sufficient and reliable to meet the needs of the person, guardianship is not warranted. (*Matter of Guardian for A.E.*, NYLJ, Aug. 17, 2015 at 22, col 4 [Sur Ct, Kings County 2015].)

The term "best interest" has been aptly described as "amorphous" (*see Matter of Chaim A.K.*, 26 Misc 3d 837, 844-845 [Sur Ct, NY County 2009]) and the criteria necessary to support a finding that appointment of a guardian is appropriate in a particular case are rarely articulated but frequently assumed. (*Matter of Udwin*, NYLJ, June 11, 2013 at 31 [Sur Ct, Kings County 2013].) Understanding the functional capacity of an individual with disability, what an individual can or cannot do, is a necessary inquiry in determining best interest and the necessity of guardianship. This is especially true in light of the emerging awareness that there is a wide range of functional capacity found among persons with diagnoses of intellectual disability and developmental disability. (*Chaim*, 26 Misc 3d 837.) As such, the perfunctory removal of decision-making rights from persons with cognitive limitations is increasingly disfavored. The New York State Legislature recognized this shift when it amended article 17-a in 1990, noting

> "[S]ince this statute was enacted in 1969, momentous changes have occurred in the care,

> treatment and understanding of these individuals. Deinstitutionalization and community-based care have increased the capacity of persons with mental retardation and developmental disabilities to function independently and make many of their own decisions. These . . . rights and activities which society has increasingly come to recognize should be exercised by such persons to the fullest extent possible."[2]

In order to identify "the least restrictive alternative [to guardianship] to achieve the State's goal of protecting a person with intellectual disabilities from harm connected to those disabilities," an inquiry into the availability of resources to assist the individual, including a support network of family, friends, ***670** and supportive services, is required. (*Matter of Dameris L.* at 579.) Indeed, "proof that a person with an intellectual disability *needs* a guardian must exclude the possibility of that person's ability to live safely in the community supported by family, friends and mental health professionals." (*Id.* at 578.)

> "SCPA article 17-A must be read to require that supported decision making must be explored and exhausted before guardianship can be imposed or, to put it another way, where a person with an intellectual disability has the 'other resource' of decision making support, that resource/ network constitutes the least restrictive alternative, precluding the imposition of a legal guardian." (*Id.* at 580.)

Before "the drastic judicial intervention of guardianship can be imposed," which completely supplants the decision-making ability of the individual with disability, guardianship "may be granted only if it is the least restrictive alternative to achieve the goal of protecting a person with a mental disability" (*Matter of Guardian for A.E.*, NYLJ, Aug. 17, 2015 at 22, col 4 [Sur Ct, Kings County 2015]).

Record Presented

Testimony was presented by both petitioners and D.D. during the hearings held on August 26, 2014, and March 27, 2015. In support of their petition, the petitioners submitted documentary evidence consisting of reports from a psychosocial assessment conducted on April 15, 2014, and a psychological evaluation conducted on October 31, 2013 (collectively, the reports), in addition to certifications from two licensed physicians (the certifications). A guardian ad litem was appointed and a report containing her findings and recommendations was filed.

The record reflects that D.D. is a 29-year-old adult and, according to a certification, diagnosed with "Down Syndrome with Low Mild MR." The psychological evaluation of D.D. revealed that on the Wechsler Adult Intelligence Scale—Fourth Edition, a test used to measure intellectual functioning, D.D. scored 68 in processing speed, 60 in working memory, 58 in verbal comprehension, and 56 in perceptual reasoning, for a composite full scale IQ score of 54, indicating cognitive ability in the mild range of intellectual disability. On the Vineland Adaptive Behavior Scales, which measure everyday living skills, D.D. has an Adaptive Behavior Composite score of 70. ***671** The two physicians' certifications[3] state, in a conclusory manner in a preprinted form, that by reason of his intellectual disability, D.D. is not capable of managing himself and appreciating the nature and consequences of health care decisions, and of reaching an informed decision to promote his own well being.

The comprehensive psychosocial report based on an evaluation of D.D. on April 15, 2014, reveals

> "[D.D.] is friendly, funny, engaging and charming man who presents as self confident and inquisitive . . . [D.D.] is a wonderful storyteller and has an excellent memory for detail . . . [D.D.] communicates effectively with good vocabulary and complex sentence structure . . . [He] displays a sensitivity towards others and expressed concern for those he loves . . . [D.D.]'s entire family embraces and supports him; they live fairly close by and see one another regularly . . . He shares a close relationship with his brothers . . . [D.D.] has three young nieces and enjoys spending time with them. Mrs. [D.] remarked on how good he is with assisting in the care of his nieces . . . [D.D.] was proud to tell me that he is the godfather for one of his nieces."[4]

During the evaluation, D.D. spoke often about his father, who died unexpectedly in 2011. D.D. stated he was "thick headed" like his father, but "I get my charm from my

father too!" D.D. is protective of his mother "and wants to make sure that she doesn't work too hard or do too much." The psychological report based on an evaluation of D.D. on October 31, 2013, concludes "[D.D.] appears to be doing well in his current program and current supports appear appropriate."[5] Said report recommended D.D.'s continued participation in his current work program and continued enhancement of his independent living skills and work skills. None of the reports specifically address D.D.'s capacity to engage in informed medical consent or to make medical decisions. No medical or mental health professionals testified.

*672 The record reflects that D.D. is able to work, both through enrollment in a supportive work program run by the Guild for Exceptional Children (the Guild) and at a restaurant in Brooklyn. Through the Guild program, D.D. works, under supervision, at various Petco stores and at Kingsborough Community College on a volunteer basis, where his responsibilities include cleaning tables, removing labels from shelves, collapsing cardboard boxes, and preparing for recycling and sanitation pickup. D.D. also works at Gargiulo's Restaurant in Brooklyn, where he has worked for several years mainly as a busboy. He has also served from the buffet table, passed hors d'oeuvres, and helped set up tables during catered functions. He works Saturday shifts "whenever they need me" and is paid in wages and in tips. According to other employees at the restaurant, D.D. is well liked, "is good at his job, does not need extra help, and never forgets a face." A supervisor at the restaurant opined that she believed "[D.D.] is capable of working there 20 to 30 hours a week because he has no physical impairments and works well." When asked if he would like to work more, D.D. seemed reluctant, testifying that he likes to do other things on Sundays.

D.D. has an active social schedule involving family, friends, and participation in recreational programs. D.D. bowls, takes karate lessons, plays sports, skis, and is an altar server at his church. In addition to Guild related activities, D.D. belongs to Rockaway Beach Special Athletes, an adaptive sports program that meets on Monday evenings.

D.D. is able to travel independently to familiar destinations using public transportation. On a daily basis he walks by himself to the Guild's Fischetti Center, an approximately 15-minute walk from his house. D.D. possesses and uses a phone and cell phone to make and receive calls. He knows what to do in the event of an emergency. He tells time and uses the computer for games and to access the Internet.

D.D. is independent in his personal care and hygiene. He is able to bathe, shave and dress himself. Ms. D. testified that D.D. sometimes needs to be reminded to brush his teeth, which he does not enjoy. He assists at home with different chores, including taking out the garbage, setting and clearing the table, loading and unloading the dishwasher, making his bed and keeping his room in order. He sets his alarm, gets himself up and ready in the morning. He packs his lunch, taking care to wrap his bottles of water and fruit in aluminum foil, but prefers *673 that his mother make his sandwich. Ms. D. does the cooking at home and, while she testified that she has not given D.D. the opportunity to cook, she felt he did have the capability. At the Guild, D.D. is provided training in food preparation.

D.D. is healthy, has had no medical complications or serious health issues, and does not take any prescription medication. D.D. does use a cream to treat foot fungus. Ms. D. believes he is not capable of making medical decisions. In support of her position that D.D. is in need of a guardian who will ensure he makes good medical decisions, she testified that one time, D.D. hurt his ankle and she took him to the orthopedist. The orthopedist recommended that D.D. wear an ankle brace for two to three weeks, which D.D. did. At the end of that period, D.D. continued to wear the ankle brace and did not want to take it off. Only after D.D.'s work supervisors at the Guild spoke with him did D.D. decide to remove the brace. There were no other medical incidents about which testimony was given.

D.D.'s main source of income is from Social Security, for which Ms. D. is his representative payee. She testified that she manages his finances and they have a joint checking account. D.D. contributes to the expenses of the household. D.D. also keeps some cash for spending money. He makes purchases and can identify money, but testified that he doesn't count his change. Ms. D. and M.D. testified that on two occasions a few years ago, they were concerned that D.D. would not tell them how he spent his spending money. They fear someone will take advantage of D.D. in a financial situation. When asked if he would sign a contract if a stranger offered him money, D.D. testified unequivocally that he would not. D.D. has

never been shown how to use the ATM machine or, aside from a lesson in high school, write a check. When D.D. wishes to spend money from his bank account, he and Ms. D. have a discussion and she will write a check for him. There was no testimony or evidence presented that D.D. is incapable of learning how to use an ATM machine or write a check.

D.D. testified he would someday like to get married and have a family. He has a girlfriend named Janice and is saving up for an engagement ring. Ms. D. does not support D.D.'s desire to marry Janice. At the hearing, Ms. D. testified adamantly that she is opposed to D.D. marrying at all. She testified "[i]f a child were to come of the union, that child would have Down syndrome. I have concerns about who would take care of that *674 child. I don't feel [D.] and Janice are capable of taking care of her." In the guardian ad litem report, it states, "Ms. [D.] thinks Janice is too pushy and said she would never give her blessing to a marriage between [D.D.] and Janice."

In court, D.D. testified that he wants Ms. D. and M.D. to be appointed his guardians. However, when the guardian ad litem interviewed D.D. outside the presence of his mother and M.D., D.D. declared that he did not want a guardian. The guardian ad litem reports, "[d]uring our home visit on March 2, 2015, [D.D.] expressed his desire to make his own decisions about healthcare, moving out on his own, and marriage." In any event, D.D.'s preference with respect to guardianship is not controlling on the issue of whether guardianship is appropriate and does not supplant the court's function to determine if a need for guardianship pursuant to SCPA article 17-a has been satisfactorily demonstrated and is in his best interest.

The guardian ad litem interviewed Ms. D., M.D., D.D.'s other two brothers, D.D.'s primary care physician, Medicaid service coordinator, social worker, psychologist, supervisor at the Guild, and employees of Gargiulo's Restaurant. As a result of her investigation, the guardian ad litem reports that D.D. appears to be capable of making his own decisions albeit with the help and support of his family, those close to him, and his supportive services. She further reports that given his history of consulting with family before making significant decisions, guardianship is not appropriate. It is the recommendation of the guardian ad litem that D.D. is not in need of a guardian. The guardian ad litem recommends alternatives to guardianship, such as a durable power of attorney and health care proxy, to meet any financial and health care concerns expressed by petitioners and if desired by D.D.

M.D. testified that they wish to protect D.D. with making health care decisions, finances, and "protecting him from somebody else, without his best interest at heart, having him do something that [is] not in his best interest." Ms. D. testified that D.D. needs help with finances and medical decisions and it would be good for him to have someone to talk to, that she was looking toward the future more than the present and worries that someone down the line will take advantage of him.

Based upon the documentary proof proferred, the oral testimony presented at the hearings, the report of the guardian ad litem, and the personal appearance and demeanor of D.D., the court finds that the petitioners have failed to sufficiently *675 demonstrate that the appointment of an article 17-a guardian for D.D. is necessary and in his best interest.

D.D. presents as a capable, thoughtful and engaging adult with mild intellectual disability who is high functioning, well integrated socially, able to work, to travel independently, to exercise self-care and management, and to make decisions about his own affairs, albeit at times with assistance and supervision from his family and supportive programs. The petitioners' contention that D.D. is unable to make medical decisions is unsupported by the record. On the contrary, it appears that D.D. makes decisions, including those affecting his health, in consultation with the people he trusts, and there is no evidence presented in the psychological and social evaluations of D.D. to substantiate petitioners' contention that D.D. is incapable of making medical decisions. There is also no evidence presented that D.D. is incapable of making financial decisions. There is no indication that, if taught, D.D. would not be able to use an ATM or write checks. To the extent that D.D. may require assistance with more complex fiscal matters, that need has been largely met by D.D.'s designation of Ms. D. as his representative payee. Ms. D. already manages D.D.'s primary source of income and their joint account.

To the extent needed, alternate, less restrictive legal tools, such as a power of attorney, may be utilized to handle other financial matters, and advance directives, such as a health care proxy, may be utilized to allow family

members to make medical decisions for D.D. when he is no longer able to do so. D.D. may also authorize his physicians to speak with his family and those he trusts to discuss his medical needs, which he appears to have already done. Furthermore, a wide range of services, some of which it appears D.D. already utilizes, are offered by the Office for People with Developmental Disabilities to support individuals with intellectual disabilities, such as supportive housing, including supervised semi-independent living options, adaptive skill development, adult educational programs, vocational training, community inclusion and relationship building, and self-advocacy, informed choice and behavioral skills development.[6] These alternative resources enable individuals with disabilities to maintain as much control over their own life decisions as they are capable to make in the least restrictive setting.

***676** Finally, D.D. presents as a young man who aspires to someday do what many people desire—to marry. The strong objection of the proposed guardian Ms. D. to D.D. ever marrying raises concerns. As most recently articulated by the United States Supreme Court in *Obergefell v Hodges*, "[r]ising from the most basic human needs, marriage is essential to our most profound hopes and aspirations" (576 US —, —, 135 S Ct 2584, 2594 [2015]). "[T]he right to marry is of fundamental importance for all individuals" (*Zablocki v Redhail*, 434 US 374, 384 [1978]) and "has long been recognized as one of the vital personal rights essential to the orderly pursuit of happiness by free [people]" (*Loving v Virginia*, 388 US 1, 12 [1967]). This is no less true for D.D., a young man who has expressed that, like his brothers, he wants to marry and have a family. The right "to marry, establish a home and bring up children" is a central part of liberty protected by the Due Process Clause. (*Meyer v Nebraska*, 262 US 390, 399 [1923].) "We deal with a right of privacy older than the Bill of Rights—older than our political parties, older than our school system. Marriage is a coming together for better or for worse, hopefully enduring, and intimate to the degree of being sacred" (*Griswold v Connecticut*, 381 US 479, 486 [1965]). The right to have children is "a right which is basic to the perpetuation of a race" (*Skinner v Oklahoma ex rel. Williamson*, 316 US 535, 536 [1942]). The right to have a family of one's own is not reserved only for persons with no disabilities, and the yearning for companionship, love, and intimacy is no less compelling for persons living with disabilities. D.D. desires to choose whom he loves, to marry, to establish a home, and, perhaps, to bring up children some day; these are choices central to his personal dignity and autonomy and his pursuit of happiness, and they are his to make.

The petitioners believe that they know what is best for D.D. and can provide him with excellent care and guidance in the event he needs it. There is no doubt that the petitioners deeply love and are devoted to D.D. and are motivated by what they believe is in his best interest. However, the standard here is not whether the petitioners can make better decisions than D.D., it is whether or not D.D. has the capacity to make decisions for himself with the support that he abundantly has. (*Matter of Rupper*, Sur Ct, Kings County, Dec. 9, 2011, López Torres, S., file No. 2011-783.)

***677 Conclusion**

The loving and supportive environment in which D.D. is enveloped has enabled him to thrive despite his limitations. It has not been demonstrated to the satisfaction of the court that guardianship pursuant to article 17-a is the least restrictive means to address D.D.'s needs where the presence of supported, instead of substituted, decision-making is available for D.D. It is evident that D.D. seeks advice and direction from his loving family before making significant decisions, and nothing in this court's ruling precludes D.D. from continuing to do so, nor does it preclude his family members from continuing to be involved in his medical and financial decisions. The network of supported decision-making provided D.D. that has characterized the past 11 years of his adulthood has yielded a safe and productive life where he has thrived and remained free from the need to wholly supplant the legal right to make his own decisions.

It has not been sufficiently demonstrated that D.D. is a person in need of a guardian pursuant to SCPA article 17-a and that it is in his best interest to have a guardian appointed for him. Accordingly, the petition for the appointment of a guardian of the person is dismissed.

FOOTNOTES

Footnotes

1 The shift away from usage of "mental retardation" is reflected in federal statutes (*see* Pub L 111-256, 124 US Stat 2643 [111th Cong, Oct. 5, 2010] [termed "Rosa's Law"] [all references in federal law to "mentally retarded individual" are changed to "individual with an intellectual disability"]). New York has renamed its "Office of Mental Retardation and Developmental Disabilities" to "Office for People With Developmental Disabilities."

2 L 1990, ch 516, § 1, reprinted in McKinney's Cons Laws of NY, Book 58A, SCPA 1750, Historical and Statutory Notes at 427 (2011 ed).

3 These certifications are boilerplate forms that include sections where the affirmant checks off preprinted conclusions relating to the decision making capabilities of an intellectually or developmentally disabled individual. The court has found the certifications wanting in useful information and requires, at a minimum, psychological and psychosocial evaluations as well as the individualized education program (IEP).

4 Comprehensive Social Evaluation of D.D., Guild for Exceptional Children.

5 Psychological Evaluation of D.D., Guild for Exceptional Children.

6 *See* New York State Office for People With Developmental Disabilities, http://www.opwdd.ny.gov/opwdd_services_supports (accessed Oct. 13, 2015), for a description of services available to persons with disabilities.

Social Security

Program Operations Manual System (POMS)

TN 74 (11-12)

SI 00835.350 Computation of In-Kind Support and Maintenance (ISM) from Outside a Household (Including Vendor Payments by a Third Party Outside the Household)

A. Actual Value (AV) Of ISM Provided From Outside The Household

The purpose of this ISM computation is to determine the AV of food and shelter someone outside a household provides to a recipient. The result of this computation is added to the result of the computation described in SI 00835.340 Computation of In-Kind Support and Maintenance from Within a Household if the recipient receives ISM both from outside the household and from within the household (other than the value of the one-third reduction (VTR)). The sum of the AV's of ISM from within, ISM from outside a household, and ISM benefiting only one person is subject to the presumed maximum value PMV, see SI 00835.400 In-Kind Support and Maintenance (ISM) to One Person.

NOTE: If a recipient alleges a loan for the value of food or shelter received from outside the household, the following instructions do not apply. Develop such a loan allegation per SI 00835.482 Loans of In-Kind Support and Maintenance.

B. Procedure For Determining Outside ISM

1. Who is a household member

To use this ISM computation, refer to the definitions in SI 00835.020 Definitions of Terms Used in Living Arrangements (LA) and In-Kind Support and Maintenance (ISM) Instructions. Consistent with the definition of "household," do not count persons who live under the same roof but who are not members of the recipient's

economic unit as household members. To be a household member, a person must reside in the household as of the first moment of the month.

2. Determine the current market value (CMV) of food and shelter

In computations of ISM from outside a household, use the CMV of the item of food and shelter after conversion (if necessary) as described in SI 00835.470 ISM and Households - Conversions.

Deduct from this amount the cash payment made by all members of the household toward that item, if any. The payment by the household toward the item of ISM is generally equal to the household operating expense for that item in the month(s) in which the household receives ISM from outside the household.

Occasionally, you must convert vendor charges for food and shelter shown on a bill or statement to monthly amounts, see SI 00835.470 ISM and Households - Conversions. If you convert a CMV for this reason, you must convert the household payment in the same manner.

EXAMPLE: If a household pays $600 of its annual $1,200 real property tax bill and a third party pays the remainder, divide the $1,200 CMV by 12; divide the $600 household payment by 12. Subtract the converted household payment from the converted property tax bill. Use the resulting $50 household payment in the computation of monthly outside ISM.

3. Rent-free shelter or prepayment of rent

See SI 00835.370 Rent Free Shelter, which explains special rules applicable to household payments in rent-free situations. Also, SI 00835.380 Rental Subsidies defines prepayments of rent (a type of household payment) and discusses situations in which a household prepays rent in both rent subsidy and other rental liability situations.

4. Allocate ISM to household members

The final step in the computation of ISM from outside a household is to allocate the ISM equally among all household members.

Use this formula to compute ISM from outside the household.

Enter Converted Current Market Value		_____
Deduct Household Payment Toward Item	-	_____
Balance		_____
Divide by Number of Household Members	÷	_____
Actual Value to Individual		_____

Compare the amount yielded by this computation to the PMV for the recipient. The lesser is "H" income if the recipient is not receiving any other ISM.

C. Procedure For Determining AV For A Couple Or Eligible Child

For eligible couples, the AV that results from the computation above is the AV of ISM to each member. Multiply this amount by 2 and compare the result to the PMV for a couple receiving no other ISM.

For an eligible child, when an absent parent provides the ISM, apply the one-third exclusion explained in SI 00830.420B.2. to the AV and then compare this amount to the PMV and charge the lesser amount.

EXAMPLE 1: Conversion of a bill and household payment

Bernie and Alex Bell are cousins who are both supplemental security income (SSI) recipients. They share the household operating expenses of the house in which they live. Bernie Bell has ownership interest in the house, and he receives a $1,300 real property tax bill for a prospective 12-month period beginning June 1. His sister, who lives elsewhere, pays $400 directly to the county in June; the cousins pay the remaining $900. After the claims representative (CR) converts the CMV to $108.33 ($1,300 divided by 12), the CR also converts the household payment to $75 ($900 divided by 12). The CR then computes the AV to them as follows:

Converted CMV $108.33

Less Converted Household Payment Toward Item - $75.00

Balance = $33.33

Divided by Two Household Members 2

Actual Value to Each beginning June 1 = $16.66

NOTE: The CR divides the household payment of $900 by 12, just as it divided the vendor charge by 12. It is immaterial whether Bernie and Alex split the household payment equally; both receive the same amount of outside ISM.

EXAMPLE 2: Computing AV of ISM to a Couple

Bruce O'Neill is an eligible recipient who lives with his eligible spouse, Gracie, in a home they own jointly. The only other household member is their 25-year-old daughter. Each March, an adult son (who lives elsewhere) pays all of their annual real property taxes. These taxes, due in March, are $1,300 and cover services for the following 12 months. Thus, the O'Neill's receive ISM from outside their household in each month of the year. (See SI 00835.474B. and SI 00835.360.) To compute the amount of ISM to charge the couple, the CR performs the following calculation for the period beginning April 1, 2010.

1. Vendor Charge (annual taxes) $1,300.00

2. Divide by 12 = Converted CMV of $108.33

3. Less Household Payment - 0 = $108.33

4. Divide by 3 household members = Actual Value to each $36.11

5. Multiply by 2 = Actual Value to couple $72.22

Since this AV is less than the couple's PMV, the couple's "H" income is $72.22.

EXAMPLE 3: Third Party Vendor Payment Involving an Arrearage

Bessie Marshall, an ineligible parent, has two eligible children, Karen and Jacob. She also has two ineligible children. They all live in an apartment, which Mrs. Marshall rents for $210 per month. In February 2010, Mrs. Marshall's brother (who lives elsewhere) pays part of Mrs. Marshall's rent ($150) to help her out. This payment is a gift, and he sends it directly to the landlord. Mrs. Marshall pays an additional $35 and

still owes $25. She elects rebuttal and furnishes evidence of these facts. The CR computes ISM from outside the household to the two eligible children as follows.

1.	Rent Due	$210.00
2.	Rent Arrearage	$25.00
3.	Converted CMV	$185.00
4.	Less Household Payment	- $35.00
5.	Balance (Paid by Third Party)	$150.00
6.	Divided by 5 Household Members	÷ 5
7.	Actual Value to Each	$30.00

Since $30 is less than the PMV for a recipient, we charge each disabled child "H" income of $30 for February, the month in which the third party makes the vendor payment.

EXAMPLE 4: Individual Receives both Inside and Outside ISM

Michael O'Keefe, an eligible recipient, lives in a household with three other persons. A third party outside the household pays the entire mortgage of $235, directly to the bank. The household expenses are $407. (**NOTE:** These expenses do not include the mortgage paid by the third party.) Mr. O'Keefe is not paying his pro rata share ($101.75) of all household operating expenses, but he is paying his share ($50) of the food expenses for the household ($200) with his earmarked contribution of $60. Therefore, Mr. O'Keefe is federal living arrangement (FLA-A) based on contributing an earmarked share of household food costs.

This case has issues of both ISM from within the household (in the form of shelter) and ISM from outside the household (in the form of a third party vendor payment resulting in shelter). The computation of ISM from within the household is as follows.

1.	Total Household Operating Expenses	$407.00
2.	Divided by Number of Household Members	÷ 4

3.	Mr. O'Keefe's Pro Rata Share	= $101.75
4.	Less Mr. Okeefe's Contribution	- $60.00
5.	Actual Value	= $41.75
6.	The computation of ISM from outside the household is: CMV of Mortgage	$235.00
7.	Less Household Payment	- 0
8.	Balance	= $235.00
9.	Divided by Number of Household Members	÷ 4
10	Actual Value	$58.75
11.	Add the two results:	
12.	Actual Value of ISM From Within	$41.75
13	Actual Value of ISM From Outside	+ $58.75
14.	Total Actual Value	$100.50

Since the total AV is less than the PMV for an individual, the CR charges Mr. O'Keefe "H" income of $100.50.

D. Develop And Document ISM From Outside The Household

1. When to develop ISM from outside a household

Develop ISM from outside a household when its receipt is alleged or otherwise indicated and the recipient is not subject to the VTR. See SI 00835.320 for instructions on when to offer a rebuttal and an explanation of the rebuttal rules. See SI 00835.370 and SI 00835.380 for additional development instructions for outside ISM in the form of rent-free shelter and rental subsidy.

2. When to obtain evidence of the AV of outside ISM

Obtain evidence of the AV of outside ISM whenever the recipient wishes to rebut the PMV or rental subsidy See SI 00835.320 for an explanation of the rebuttal rule. The following describes evidence of the factors that determine the AV of outside ISM.

a. Evidence of the CMV

We base the CMV of an item of food or shelter provided by someone outside the household on the vendor charge if there is a vendor charge associated with it or the provider's estimate of the CMV of the item if there is no vendor charge associated with it.

Obtain evidence of the CMV in accordance with the chart below.

Type of ISM	**Evidence (Signed Statement or DROC)**
Food	A statement from the person who paid for the food or a statement from the provider.
Shelter	A copy of the bill or receipt, or a statement from the person who paid the bill or a statement from the provider.

NOTE: If you cannot obtain the CMV from the provider, contact a knowledgeable source (e.g., a real estate or rental agent for the value of rent) and document the contact on a report of contact (DROC) screen or other form.

b. Evidence of the household payment

If the household makes any payment towards the item of food or shelter (e.g., the household pays part of its electric bill and a third party pays the rest), obtain evidence of the payment. Preferred evidence is a receipt, a cancelled check, or a corroborative statement from the third party who paid the rest of the bill or from the householder (if the recipient does not have ownership interest or rental liability). If no preferred evidence is available, accept the statement, signed or DROC screen, of the eligible recipient.

c. Evidence of household composition

Obtain a signed statement from the recipient, or a DROC, as to the number of household members in the month in which the recipient receives ISM (household membership always includes persons who are temporarily absent, see SI 00835.040). It is not necessary to corroborate this statement.

3. Breakpoints and a change in ISM

Breakpoints are certain identifiable events that may indicate that the ISM the recipient receives changed. (See SI 00835.510 for an explanation of breakpoints.) Report of breakpoints may be timely or they may come to our attention during a redetermination. We should evaluate breakpoints to see if they actually affect ISM and we should document any change in ISM according to the rules in SI 00835.350D.2. in this section. Changes due to breakpoints are effective with the breakpoint effective month.

See SI 00835.520C. for an explanation of when to redevelop outside ISM at a redetermination.

Social Security

Program Operations Manual System (POMS)

TN 50 (06-16)

SI 00501.010 Determining Child Status for Supplemental Security Income (SSI) Purposes

CITATIONS: Social Security Act, Sec. 1614

20 CFR 416.1101; 416.1160; 416.1165; 416.1851; 416.1856; 416.1866; 416.1872; 416.1881

A. Introduction To Determining Child Status For SSI Purposes

A child for SSI purposes, according to the Social Security Act, is neither married, nor the head of a household, as defined in SI 00501.010D in this section; and is either:

- under age 18, or
- under age 22 and a student regularly attending school, college, or training that is designed to prepare him or her for a paying job, according to instructions in SI 00501.020.

There are different requirements for determining SSI child status in particular situations, as follows:

1. When we use these instructions

Follow instructions in this section and in SI 00501.015 to determine if someone is a child who is in a parent-child relationship for purposes of:

- deeming parental income and resources;

- applying allocations for ineligible children in an SSI eligible individual's or an SSI eligible child's household; and

- excluding one-third of the child support received from a parent who is absent from the household.

2. When we do not use these instructions

Do **not** follow these instructions when you need to determine child status for certain purposes other than those specified in SI 00501.010A.1. in this section. Instead, follow instructions in:

- DI 11055.001 to apply the SSI childhood disability definition;

- DI 11005.016 to complete childhood disability forms and questionnaires;

- GN 00501.010 to determine whether someone is a parent for representative payment purposes;

- SI 00501.020 to apply the student earned income exclusion (SEIE);

- SI 00502.000 to determine the alien status of a child;

- SI 00515.004 to determine whether a "minor child" is required to give permission to contact financial institutions;

- SI 00830.314 to determine the portion of a veteran's augmented Veterans Affairs benefit attributable to a child;

- SI 00830.099 (income) and SI 01130.050 (resources) to exclude assistance to a child as specified by certain Federal statutes other than the Social Security Act;

- SI 01150.120 through SI 01150.123 to apply an exception to the ineligibility period for transferring a resource to a child at less than fair market value; and

- SI 02101.007 to determine if a parent may be paid SSI benefits due a deceased child.

B. Determining Child Status For Parent-Child Deeming, Applying The Ineligible Child Allocation, And Excluding One-Third Of The Income From Child Support

Use these instructions to determine SSI child status for the purposes listed in SI 00501.010A.1. in this section.

1. Determining SSI eligible child status for deeming of income and resources

For purposes of deeming of income and resources from an SSI ineligible parent or the current spouse of an ineligible parent (i.e., a stepparent), an SSI eligible child:

- is under age 18;

- is eligible for or applying for SSI disability or blindness payments;

- is neither married nor the head of a household; and

- is a member of the household of at least one ineligible parent. If the SSI eligible child's parent has permanently left the household, deeming from a stepparent does **not** apply.

2. Determining SSI ineligible child status for the ineligible child deeming allocation

For purposes of applying the ineligible child deeming allocation, an SSI ineligible child:

- is either under age 18, or under age 22 and regularly attending school, college, or training designed to prepare him or her for a paying job as described in SI 00501.020C.1.;
- is not eligible for SSI payments;
- is neither married nor the head of a household;
- is a member of the household of an SSI eligible individual/child who is subject to deeming of income; and
- is himself or herself the child of either:
  a. the SSI eligible individual;
  b. the living-with ineligible spouse of the SSI eligible individual;
  c. the SSI eligible child's living-with parent; or
  d. the SSI eligible child's stepparent. If an SSI eligible child's stepparent has permanently left the household, we continue to provide the ineligible child allocation for each of the stepparent's children remaining in the eligible child's household.

3. Determining SSI eligible child status for excluding one-third of the child support received from an absent parent

For purposes of applying the one-third exclusion of child support from countable income, a child:

- is either under age 18, or under age 22 and regularly attending school, college, or training designed to prepare him or her for a paying job as described in SI 00501.020C.1.;

- is eligible for or applying for SSI disability or blindness payments;

- is neither married nor the head of a household; and

- receives child support from an absent parent (according to instructions in SI 00830.420).

C. Determining When Child Status Ends

Status as an SSI child ceases effective with the month after the month he or she last meets the applicable requirements in SI 00501.010B.1. through SI 00501.010B.3. in this section.

D. Establishing Head Of Household

1. Determining whether someone is the head of his or her household

A head of household is someone who is no longer under his or her parent's or stepparent's control, and:

- has left his or her parent's or stepparent's home on a permanent basis to be responsible for the day-to-day decisions on the operation of his or her own household;

- has left his or her parental home on a permanent basis to live with others, where everyone has an equal voice in the decision-making (e.g., a group of students sharing off-campus housing); or

- lives with his or her parent(s) or stepparent and makes the day-to-day decisions of the household (e.g., due to parental illness).

2. Initial simultaneous development claim systems input instructions for head of household under age 18, not transitioning out of foster care

If you establish in MSSICS that a claimant under age 18 is head of household (claim ID of DI) before having transferred the case to the Disability Determination Services (DDS) for a medical decision, you will prevent case handling in the Electronic Disability Collect System (EDCS), because EDCS assigns the conflicting claim ID of DC.

Instead, do **not** answer the head of household question on the MSSICS Home Ownership and Rental Liability screen for a simultaneously developed case until you have first established the disability portion of the claim in EDCS for any claimant who is:

- under age 18 and
- the head of his or her household but
- **not** in the process of transitioning out of foster care (under Title IV-E).

Re-enter MSSICS to answer the head of household question after you have established the claim in EDCS.

3. Initial claim systems input instructions for head of household under age 18, transitioning out of foster care

See systems input instructions in SI 00601.011D for a claimant who is under age 18 and transitioning out of foster care (under Title IV-E).

E. Obtaining Evidence Of Child Status

1. Evidence of a child's age

Develop proof of age requirements according to instructions in GN 00302.290.

2. Evidence of a child's marital status

Generally accept an allegation regarding the marital status of a child; however, develop marital status according to instructions in SI 00501.150 and SI 00501.152, when:

- the individual is under age 22 and has been married but now alleges that the marriage has ended; or
- you have information contrary to the allegation regarding the individual's marital status.

F. References

- DI 11005.016 Forms Used in Disability Claims
- DI 11055.001 Title XVI Disability Claims
- GN 00302.290 Proof of Age Requirements for Supplemental Security Income (SSI)
- GN 00501.010 Definitions of Common Representative Payment Terms
- SI 00501.015 Determining Parent-Child Relationships for Supplemental Security Income (SSI) Purposes
- SI 00501.020 Student - SSI
- SI 00501.150 Determining Whether a Marital Relationship Exists
- SI 00501.152 Determining Whether Two Opposite-Sex Individuals Are Holding Themselves Out as a Married Couple
- SI 00502.000 SSI Alien Eligibility

- SI 00515.004 Good Cause — Minor Children
- SI 00601.011 Filing Supplemental Security Income (SSI) Applications for Disabled Youth Transitioning out of Foster Care
- SI 00820.510 Student Child Earned Income Exclusion
- SI 00830.099 Guide to Unearned Income Exclusions
- SI 00830.314 Augmented VA Benefits
- SI 00830.420 Child Support Payments
- SI 01130.050 Guide to Resources Exclusions
- SI 01150.120 Exceptions to the Ineligibility Period—General
- SI 02101.007 SSI Underpayment Due - Deceased Individual Was A Blind or Disabled Child When Underpayment Occurred - Payment to Parent(s) and/or Spouse

To Link to this section - Use this URL:
http://policy.ssa.gov/poms.nsf/lnx/0500501010

SI 00501.010 - Determining Child Status for Supplemental Security Income (SSI) Purposes - 02/08/2012
Batch run: 06/30/2016
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Social Security

Program Operations Manual System (POMS)

TN 123 (07-17)

SI 00830.420 Child Support Payments

Citations: Social Security Act, as amended, sections 1612(a)(2)(E) Meaning of Income and 1612(b)(9) Exclusions From Income; 20 Code of Federal Regulations 416.1121(b) Alimony and support payments and 416.1124(c)(11) Other unearned income we do not count.

A. Glossary Of Child Support Terms

1. Child support payment

A child support payment is a payment from a parent to meet the child's needs for food and shelter. Child support can be in cash or in-kind; it can be voluntary or court ordered.

2. Absent parent

An absent parent is a parent whose parental rights are not legally severed or is a stepparent currently married to a parent of the child who does not live in the same household as the child. We determine household status on the first of the month.

If the periods of living together are brief and the child remains independent or under the care and control of another person, agency, institution, or is living in the home of another, usually consider the parent absent unless such parent retains parental responsibility and control.

Do not consider a parent absent if such parent is away due to employment, intends to resume living with the child, and retains parental control and responsibility. Do not consider an "absent" military deemor "absent" for purposes of the child support exclusion.

For more information on deeming from an "absent" military deemor, see SI 01310.170.

Do not consider a child (or parent) who is a boarding student in an educational facility absent.

NOTE: This definition of an absent parent does not apply when determining "temporary absence" for deeming purposes.

When determining temporary absence from a deeming household, refer to SI 01310.165.

3. Supplemental Security Income (SSI) child

A child, for SSI purposes, according to the Social Security Act, is neither married, nor the head of a household and is either:

- under age 18, or
- under age 22 and a student regularly attending school, college, or training that is designed to prepare him or her for a paying job.

For more information on SSI child status, see SI 00501.010.

4. Student

A student is a child who is under age 22 and regularly attending school. For more information on SSI student child status, see SI 00501.020.

5. Adult child

An adult child is a number holder's son or daughter who no longer meets the definition of a child (e.g., is now head of a household). For more information on SSI child status, see SI 00501.010.

6. Custodial parent

A custodial parent is a parent who has care, guardianship, or custody of the child.

7. Other person

An "other person" is an individual, other than a parent who has care, guardianship, or custody of the child.

8. Child support arrearage payment

A child support arrearage payment is a payment that was due, but not paid in a timely manner for the appropriate period. The payment is paid to comply with an unfulfilled past obligation to support the child.

B. Child Support On Behalf Of An SSI Child

1. Treatment of child support as income

To treat child support payments made on behalf of an SSI child:

- When an eligible child receives child support payments (including arrearage payments), the payments are unearned income to the child. For information on an SSI child, see SI 00501.010.

- When an absent parent makes a child support payment for an eligible child, exclude one-third of the amount. This exclusion does not apply when determining the income of ineligible children in a deeming computation.

  For information on the ineligible child allocation, see SI 01310.110D.

To treat child-support payments made on behalf of a deceased SSI child:

- Child support payments (including arrearage payments) made on behalf of a deceased SSI child are unearned income to the parent or other person who receives them.

- The one-third child support exclusion does not apply.

2. Food or shelter received as in-kind child support

Exclude one-third of the amount of child support that an eligible child receives in the form of food or shelter from an absent parent as income. The remaining two-thirds are in-kind support and maintenance (ISM) subject to the presumed maximum value (PMV).

For more information on computing ISM from outside a household, see SI 00835.350C.

EXAMPLE: Absent parent provides ISM to child: Joe Smith's father provides all Joe's food as part of his child support agreement. In November 2011, Joe's father gives him food with a value of $600.

Exclude $200 of that amount from income. The remaining $400 is subject to the 2011 PMV, which is $224.66. Charge (the lesser of the two) $224.66 to Joe as ISM in the month of November.

Any in-kind child-support payment that is not for food or shelter (e.g., for health insurance) is not income to the child. However, deduct court-ordered support payments made for any purpose (e.g., for health insurance) from the deemor's income.

3. Child support and deeming

a. Treatment of child support for specific deemors

Exclude the income used by an ineligible spouse, ineligible parent, ineligible child, or eligible alien to make court-ordered or Title IV-D support payments. Deduct the court-ordered or Title IV-D support payments from the parent's income prior to deeming by selecting deductions on the parent's applicable Income Selection page (e.g., Child Support page) and enter the amount of the support on the page. The system deducts the support amount from the ineligible parent's countable income.

For more information on excluding the income used by specific deemors to make support payments, see SI 01320.145.

b. Treatment of child support when a child's household changes

The child may leave the home of the custodial parent, or begin living with an absent parent, or the absent parent may begin living in the household of the

child and custodial parent. For purposes of deeming, change of status is effective with the month following the month the change occurs. For more information on deeming policies when a child's household changes, see SI 01320.550.

If the child lives in a household and receives child support payments from a parent in that same household, do not consider the parent absent. The support is unearned income (type "SS") to the child. The one-third exclusion does not apply to these payments because the one-third child support exclusion only applies to payments from an absent parent. On the SSI Claims System Child Support page, "Court ordered-parent in household" and the system does not apply the one-third child support exclusion.

EXAMPLE 1: A parent who was absent moves into household with eligible child and custodial parent

A mother who was absent moves into the same household with the father and their children. She continues to give the father a child support payment each week as required by the court order.

The payments are type "SS" unearned income to the children. The one-third exclusion does not apply to these payments. On the Child Support page, select "Court ordered-parent in household" as the "Type" of income the person receives from the drop-down list. Begin deeming the mother's income in the month following the month the parent and children begin living in the same household. Deduct the court-ordered child support from the mother's income prior to deeming by selecting deductions on the mother's applicable income page and enter the amount of the court-ordered child support on the Child Support page. The system does not include the amount of the court-ordered child support in the deeming computation.

EXAMPLE 2: Child lives with both parents and father contributes to household

Both parents and their children live in the same household. The father works and gives the mother a money each week to help run the household and pay for the family's needs.

Do not charge income to the mother or children due to this exchange of money. However, include the support amount in the father's deemed income.

EXAMPLE 3: Child lives with both parents and mother contributes to household

Both parents and the child live in the same household. The mother works and uses her income to pay the rent, utilities, other bills, and provide for her family's other needs.

The amount of money the mother spends to support her family is included in her income that is subject to deeming. Do not charge the mother's contribution as support income to the father or child.

4. Child support paid to the State child support enforcement agency under Title IV-D

When a child is in the custody of the State (i.e., in foster care), and the State collects child support and keeps the money, the support payment from the parent is not income to the child. Consider the support payment a reimbursement to the State for the foster care payment. Also, child support collected and retained by the State, as reimbursement for prior Temporary Assistance for Needy Families (TANF) payments, is not income to the child.

A custodial parent or other person may ask the child support enforcement agency to collect child support payments from the absent parent, and the child support agency may give the custodial parent or other person the support they collect. Treat the support the same as if the non-custodial parent sends the support payment directly to the custodial parent or other person.

For more information on the treatment of child support as income, please see SI 00830.420B.1. in this section.

C. Child Support On Behalf Of An Adult Child

1. Current child support received on behalf of an adult child

When a parent or other person receives current child support payments for an adult child after the adult child stops meeting the definition of a child, the income belongs to the adult child. The support payments are income to the adult child even if he or she does not live with or receive any of the child support payment from the parent or other person. Such support payments are not subject to the SSI one-third child support exclusion.

When a parent or other person receives current child support payments on behalf of a deceased SSI adult child, consider it income to the parent or other person who receives the payments. Support payments are not subject to the SSI one-third child support exclusion.

2. Child support arrearages received on behalf of an adult child

a. Policy for child support arrearage payments effective June 1, 2002

Child support arrearage payments received on behalf of an adult child are not subject to the SSI one-third child support exclusion. The policy on the treatment of child support arrearage payments made on behalf of an adult child changed as a result of a court-approved settlement agreement. Effective June 1, 2002, when a parent or other person receives a child support arrearage payment on behalf of an adult child:

- Any amount of that payment that the parent or other person receives and does not give to the adult child is unearned income to the parent or other person in the month they receive it. The portion of the arrearage payment the parent or other person retains is not income to the adult child and does not affect the adult child's SSI eligibility or payment.

- Any amount of that payment that the parent or other person gives to the adult child is unearned income to the adult child in the month given, not income to the parent or other person.

- Any payment that a parent or other person receives on behalf of a deceased SSI adult child is unearned income to the parent or other person in the month they receive the payment.

- Any child support arrearage payment an adult child receives directly from the absent parent is unearned income to the adult child.

EXAMPLE: Child support paid for an adult child

A non-custodial father pays child support on behalf of his 19-year old disabled son who lives in his own apartment. Consider the son an adult child.

The former custodial mother receives a $100 child support payment. The $100 child support payment consists of both a current payment of $75 and $25 to pay for an arrearage. The mother keeps the child support arrearage payment of $25, and gives her son his current $75 child support payment.

If the mother is SSI eligible or a deemor, the arrearage payment is her income. The current child support payment of $75 is type "SS" unearned income to the adult child. The one-third child support exclusion does not apply.

b. Policy for child support arrearage payments prior to June 1, 2002

Prior to June 1, 2002, if a parent or other person received child support arrearage payments on behalf of an adult child, the income belongs to the adult child. The support payments are income to the child even if he or she does not live with or receive any of the child support payment from the parent or other person.

Child support arrearage payments are not subject to the one-third exclusion.

D. Verifying Child Support Payments

1. Procedure for developing and verifying child support payments effective June 1, 2002

- Verify the amount and frequency of child support payments.
- Unless you doubt the allegation, accept the individual's allegation of the relationship of the payer to the payee and type of payment (voluntary or court-ordered).
- Determine if any of the child support payments represent an arrearage.
- Develop and document dates and amounts retained by the parent or other person, or dispersed to the adult child when a parent or other person receives a child support arrearage payment on behalf of an adult child.

- Charge the arrearage payment as unearned income to the adult child when an adult child receives a child support arrearage payment directly from the absent parent.

- Post to the SSI record, the date and amount of the arrearage payment as unearned income to the adult child when a parent or other person who receives an arrearage payment gives the payment to the adult child.

- Post to the SSI record, the date and amount of the arrearage payment as unearned income to the parent or other person when the parent or other person retains the arrearage payment and he or she receives SSI (or is a deemor on an SSI record).

- Post to the SSI record, the date and amount of the child support payment (including arrearages) as unearned income to the parent or other person when the parent or other person receives the payment on behalf of a deceased SSI child or adult child and he or she receives SSI (or is a deemor on an SSI record).

- Use associated Remarks in MSSICS or a MSSICS Person Statement (DPST) screen to record a statement of retention or disbursement of child-support arrearage payments over the penalty clause.

2. Developing and verifying child support payments prior to June 1, 2002

- Verify the amount and frequency of child support payments.

- Accept the individual's allegation of relationship of the payer to the payee unless you doubt the allegation.

- Develop child support arrearage payments to an adult child depending on the month(s) he or she receives arrearage payments.

- Post the amount of the payment to the SSI record as income to the adult child who is receiving SSI payments. Do not charge any of the income to the parent or other person receiving the income on behalf of the adult child.

- Use associated Remarks in the Modernized Supplemental Security Income Claims System (MSSICS) or a MSSICS Person Statement (DPST) screen to record a statement of retention or disbursement of child support arrearage payments over the penalty clause.

3. Procedure when we make one payment for two or more recipients

Apply the procedures in this section when you make a single support payment (e.g., one check) for two or more recipients:

a. Review the legal document that describes the support payments:

   - If the legal document states the amount of each person's share, divide the payment according to the terms of the document.

   - If the legal document does not indicate the amount of each person's share, divide the payment equally.

b. If no legal document exists, contact the source of the payment to establish intent and allocate the support payment according to that intent.

   - If contact with the source is not successful, accept the payer's signed allegation about who the support is for and how to allocate the support. If the payer cannot tell you how he or she wants to allocate the support payment, divide the payment equally among the intended recipients.

   - Use associated Remarks in MSSICS or a MSSICS Person Statement (DPST) screen to record a statement of retention or disbursement of child support arrearage payments over the penalty clause.

4. Developing evidence for child support payments

Consider the following child support evidence:

- Court records (For information on accepting court orders, see GN 00301.030B.3.);
- Records of the agency that released the payments;
- Official documents in the recipient's possession (e.g., legal documents) that establish the amount and frequency of the support;
- Report of contact with the source of the payment containing the date, amount, and frequency of the support.

If none of the evidence in SI 00830.420D.4. is available, document the recipient's signed statement of the amount of the support, dates received, and the retention or disbursement of the payments on the DPST screen in MSSICS. In non-MSSICS cases, fax an SSA-795 (Statement of Claimant or Other Person) into the Electronic Disability Collect System (EDCS) or Non-Disability Repository for Evidentiary Documents (NDRed). Document the reason we did not obtain evidence (e.g., the documentation does not exist, the court or agency will not release the information, or the source refused to cooperate) in associated REMARKS or in COMMENTS on the EVID screen in MSOM EVID 001.003.

E. Procedure To Code SSI Claims System Claims

1. Payment on behalf of an SSI child when payer is an absent parent

Apply these procedures for a payment from an absent parent on behalf of an SSI child.

In the SSI Claims System:

Enter the date and the full amount of cash child support payment and income type on the Child Support (ICHS) page for the child.

For more information on the Child Support (ICHS) page, see INTRANETSSI.014.025 .

For information on deeming and the income used to comply with a court order, see SI 01320.145.

If the claimant meets the definition of "child," the system:

- posts the income to the Social Security Record (SSR) as type "N" unearned income,
- applies the one-third exclusion to the type "N" income, and
- uses only two-thirds of the support payment in the SSI payment computation.

Enter the total child support payment that is In-Kind Support and Maintenance (ISM) on the In-Kind Support and Maintenance (LISM) page.

For more information about the In-Kind Support and Maintenance page (LISM) page, see INTRANETSSI 010.015. Select "Yes" for question "DOES ANY PERSON (NOT LIVING WITH YOU) OR ANY AGENCY PAY FOR ANY OF YOUR FOOD OR SHELTER ITEMS, OR PROVIDE YOU OR YOUR HOUSEHOLD (IF APPLICABLE) WITH ANY FOOD OR SHELTER ITEMS." Click "Add ISM Source" button. A separate ISM Source window will be displayed. Select "Yes" for question "Payment from absent parent." The system applies the exclusion and determines the ISM amount based on the selections made.

2. Payment on behalf of a deceased SSI child when payer was an absent parent

If the parent or other person receives Social Supplemental Income (SSI), e.g., parent is a disabled recipient, enter the date and any child support payment (including arrearages) that he or she receives on behalf of a deceased SSI child on the Other Income (IOTH) page of the SSI eligible person's record. MSSICS posts this income as type "SO" unearned income to the Supplemental Security Record (SSR). Document in Remarks that the income is a child support payment or arrearage on behalf of a deceased SSI child.

3. Court-ordered payment on behalf of an SSI child when payer is NOT an absent parent

Enter the date and the full amount of cash child support payments and income type on the Child Support (ICHS) page for the SSI child.

For more information about the Child Support (ICHS) page, see MS INTRANETSSI 014.025.

MSSICS posts the income to the SSR as type "SS" unearned income. The one-third exclusion does not apply to these payments.

For information on deeming and the income used to comply with a court order, see SI 01320.145.

4. Court-ordered payment on behalf of a deceased SSI child when payer was NOT an absent parent

If the parent or other person receives SSI (e.g., parent is a disabled recipient), enter the date and any child support payment (including arrearages) that he or she receives on behalf of a deceased SSI child on the Other Income (IOTH) page. MSSICS posts this income as type "SO" unearned income to the SSR. Document in Remarks that the income is from a child support payment or arrearage from a deceased SSI child.

5. Payment on behalf of an adult child

Apply these procedures for a payment on behalf of an adult child:

- Enter the date and the full amount of cash child support payments (including arrearage payments received, if applicable) to an adult child on the Child Support (ICHS) page in MS INTRANETSSI 014.025.

If the claimant does not meet the definition of a "child," MSSICS posts this income to the SSR as type "SS" unearned income. The one-third exclusion does not apply to support payments received by an adult child. The system uses the entire support payment in the SSI payment computation.

- If the parent or other person receives SSI (e.g., parent is a disabled recipient), enter the date and any child support arrearage payment that he or she received and retained June 1, 2002 or later on the IOTH screen. MSSICS posts this income as type "SO" unearned income to the SSR. Document, in Remarks, that the income is from a child support arrearage.

6. Payment on behalf of a deceased adult child

If the parent or other person receives SSI (e.g., parent is a disabled recipient), enter the date and all child support payments (including arrearages) that he or she receives on behalf of a deceased SSI adult child on the Other Income (IOTH) page. MSSICS posts this income as type "SO" unearned income to the SSR. Document, in Remarks, that the income is from a child support payment or arrearage from a deceased SSI adult child.

F. Procedure To Code Non-SSI Claims System Claims

1. Payment on behalf of an SSI child when payer is an absent parent

Apply these procedures for a payment from an absent parent on behalf of an SSI child:

- Enter the date and the full amount of cash child support payments to a child as type "N" unearned income in the UM field on the SSA-1719-B, (SSI Post Eligibility Data Input) or the SSA-450-SI (SSI Data Input and Determination). The system applies the one-third exclusion when performing the SSI payment computation.

- For child-support payments that are ISM, first compute the amount of child support that is countable. For more information on food or shelter received as child support, see SI 00830.420B.2 in this section. Post the countable child support as type "H" income on the SSA-1719-B (SSI Posteligiblity Data Input) or SSA-450-SI (SSI Data Input and Determination). For more information on specific rules for in-kind support and maintenance (Type H) unearned income, see SM 01005.193.

2. Payment from an absent parent on behalf of a deceased SSI child

Post the full amount of the child support payments (including arrearages) to a parent or other person who received the payment on behalf of the deceased SSI child (and who receives SSI or is a deemor) as type "SS" unearned income in the UM field on the SSA-1719-B or SSA-450-SI. The one-third exclusion does not apply to these payments. Document, on a SSA-795, the payer's signed statement that the income is from a child support payment or arrearage from a deceased SSI child and fax it into Electronic Disability Collect System (EDCS) or Non-Disability Repository for Evidentiary Documents (NDRed).

3. Court-ordered payment on behalf of an SSI child when payer is NOT an absent parent

Post the full amount of cash child support payments to the child as type "SS" unearned income in the UM field on the SSA-1719-B or SSA-450-SI. The one-third exclusion does not apply to these payments. For information on deeming and the income used to comply with a court order, see SI 01305.330.

4. Court-ordered payment from parent who is not absent on behalf of a deceased SSI child

Post the full amount of child support payments (including arrearages) as income to the parent or other person who received the payment on behalf of the deceased SSI child. Post the income as type "SS" unearned income in the UM field on the SSA-1719-B or SSA-450-SI. The one-third exclusion does not apply to these payments. Document the recipient's signed statement that the income is from a child support payment or arrearage from a deceased SSI child on an SSA-795 and fax it into EDCS or NDRed.

5. Payment on behalf of an adult child

Apply these procedures for a payment on behalf of an adult child:

- Enter the date and the full amount of cash child support payments (including arrearages received, if applicable) to an adult child as type "SS" unearned income in the UM field on the SSA-1719-B or SSA-450-SI. The one-third exclusion does not apply to an adult child.

- Enter the date and any child support arrearage payments that are income (received June 1, 2002 or later) to a parent or other person who receives SSI as type "SS" unearned income in the UM field on the SSA-1719-B or SSA-450-SI.

6. Payment on behalf of a deceased SSI adult child

Enter the date and the full amount of the child support payments (including arrearages) to a parent or other person who received the payment on behalf of the deceased adult child (and who receives SSI or is a deemor) as type "SS" unearned income in the UM field on the SSA-1719-B or SSA-450-SI. The one-third exclusion does not apply to these payments. Document, on an SSA-795, the recipient's signed statement that the income is from a child support payment or arrearage from a deceased SSI adult child and fax it into EDCS or NDRed.

G. References

- MS INTRANETSSI 014.024 Child Support List
- MS INTRANETSSI 014.025 Child Support
- SI 00501.415 Blind or Disabled Children of Military Personnel Stationed Overseas - Overview
- SI 00501.010 Determining Child Status for Supplemental Security Income (SSI) Purposes
- SI 00501.020 Student - SSI
- SI 00830.005 General Rules for Developing Unearned Income
- SI 01320.550 Deeming - Change of Status - Parents/Children

- SI 01310.110 Deeming Concept - Allocation
- SI 00835.350 Computation of In-Kind Support and Maintenance (ISM) from Outside a Household (Including Vendor Payments by a Third Party Outside the Household)
- SI 00835.400 In-Kind Support and Maintenance (ISM) to One Person
- SI 00830.100 Expenses of Obtaining Income
- MS INTRANETSSI 010.015 In-Kind Support and Maintenance (ISM)

To Link to this section - Use this URL:
http://policy.ssa.gov/poms.nsf/lnx/0500830420

SI 00830.420 - Child Support Payments - 07/25/2016
Batch run: 07/13/2017
Rev:07/25/2016

SAMPLE LANGUAGE FOR SETTLEMENT AGREEMENTS

GUARDIANSHIP OF SON, JAKE

Should Wife need to apply for Guardianship of Jake before the age of 18, then Husband shall not object to same.

CHILD SUPPORT & EMANCIPATION

Once the ___ and _____ homes are sold, all debts are paid off, and the parties are able to separate their checking accounts, the Husband shall pay to the Wife as and for the children's support the sum of Three Thousand one hundred and twenty five dollars ($3,125.00) dollars every month payable to the Wife and Three Thousand one hundred and twenty-five dollars ($3,125.00) directly into the Jake First Party Special Needs Trust. The amount of basic support shall be adjusted upon the emancipation of any of the children of the marriage. The parties have mutually agreed that should either child be unable to be emancipated due to his special needs, then both parents will continue to equally support the child past the age of 22, with the husband continuing to fund the Special Needs Trust created for the benefit of the Special Needs Child;

MUTUAL RELEASE AND DISCHARGE

The Husband Agrees to execute a new Last Will and Testament which names daughter, Suzie and the "Jake First Party Special Needs Trust" as beneficiaries of a minimum of 50% of his net estate therein.

LIFE INSURANCE

(a) Both Wife and Husband agree to maintain in full force and effect their existing Term life insurance policies. The Husband currently owns two policies with _____. The first being policy number _____, face amount is one million dollars; and the second being policy number _____ whose face value is 2.4 million dollars. Suzie and Jake First Party Special Needs Trust shall be the irrevocable beneficiaries of such policy, and the Wife shall be the irrevocable trustee thereof.

(b) If the policy herein for the benefit of the Children as aforesaid is not in full force and effect at the time of the Husband's death, and the Children or Trustee does not receive the amount to which he or she is entitled, then the Children shall have a priority creditor's claim and a lien against the Husband's estate for the face amount of the policy.

(c) Husband shall submit to Wife a photocopy or other proof of payment receipt evidencing payment of premiums on the policy herein above described upon written request of the Wife. Should the Husband fail to pay a premium when due, the Wife shall have the right, but not the obligation, to make payment thereof and in such event, the Husband shall immediately reimburse the Wife for all premiums paid by her.

(d) The Wife currently owns a policy with _____. Policy number _____ face amount is one and a half million dollars. Wife shall be the owner of said policy, and Suzie and Jake First Party Special Needs Trust shall be the irrevocable beneficiaries of such policy, with Uncle Joe and Aunt Mary as the irrevocable co-trustees thereof.

(e) If the policy herein for the benefit of the Children as aforesaid is not in full force and effect at the time of the Wife's death, and the Children or Trustee does not receive the amount to which he or she is entitled, then the Children shall have a priority creditor's claim and a lien against the Wife's estate for the face amount of the policy.

(f) Wife shall submit to Husband a photocopy or other proof of payment receipt evidencing payment of premiums on the policy herein above described upon written request of the Husband. Should the Wife fail to pay a premium when due, the Husband shall have the right, but not the obligation, to make payment thereof and in such event, the Wife shall immediately reimburse the Husband for all premiums paid by him.

17-A Update

Kathryn E. Jerian, Esq.
NYSARC, Inc., Latham, NY

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17-A Guardianship Reform Update:

NYSBA Elder Law & Special Needs Section Summer Meeting 2019

Kathryn E. Jerian, Esq. – The Arc New York
Deputy Executive Director & General Counsel

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Roadmap of Presentation

- I – History of 17-A & Reform Efforts
- II - DRNY Lawsuit
- III – Law Revision Commission & OCA Efforts
- IV – Current Trends/Cases of Interest
- V – Questions/Comments

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Part I: History of 17-A Reform in a Nutshell

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Article 17-A of the Surrogate's Court Procedure Act

1969 – law originally enacted (mainly at behest of The Arc New York and its families) & applied only to persons with "mental retardation"

1989 – Original 17-A repealed and replaced with current version, applicable to those with developmental disabilities and the "mentally retarded"

1992 – Article 81 enacted – some overlap with Article 17-A but more complicated and costly

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Olmstead v. L.C. (U.S. Supreme Court, 1999)

- Held that States are required to provide community-based services for individual with disabilities (i.e., use of *the least restrictive setting*) as long as appropriate, the individual does not oppose the community based service, and it can be reasonably accommodated by the State
- Not until 2012…NY creates "Olmstead Plan Development and Implementation Cabinet" to advise Governor on compliance with Olmstead decision and to suggest changes in law to comply

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NY Olmstead Report

- Issued October 2013
- Identified 17-A guardianship as one of two areas requiring legal reform
- Found that Olmstead requires that guardianship only be imposed if necessary and in the least-restrictive manner possible
- Pointed out basis for 17-A is diagnosis driven (as opposed to functional capacity), hearings are not always required, and lack of decision-making standard for routine decisions that includes the point of view of the individual under guardianship

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17-A Workgroup

- As a result of Olmstead Report, Governor's Olmstead counsel formed a workgroup to discuss changes to 17-A
- Workgroup included a range of individuals: practitioners, a family member, DRNY, The Arc New York counsel, NYCLU counsel, PADD counsel, private attorneys, MHLS, and others
- Meetings held from Nov. 2013 - Feb. 2015 to draft proposal

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Legislative History

- 2015 - S. 4983 (came from "Olmstead workgroup")
  - Bill now "dead"
- Sept. 2016 – DRNY files suit alleging 17-A unconstitutional (unhappy with lack of progress in legislature)(more on this in a bit…)
- May 2017 – The Arc New York gets a bill introduced seeking changes (S. 5842) – stalled in legislative process
- June 2017 – More "onerous" version of The Arc bill introduced – also stalled
- 2019 Legislative Session – Nothing…..(also more on this in a bit)

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Part II: DRNY Challenge to Constitutionality of 17-A (dismissed 2/2019)

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What is Disability Rights New York (DRNY)?

- Non-profit seated in NY but federally funded under the DD Act
- Role is to advocate for individuals with I/DD
- Can file suit on variety of issues – *see* suit re: NYS failure to discharge adults from out-of-state residential schools, suit against landlords for not allowing service animals on premises, etc.
- https://www.drny.org/page/litigation-12.html

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What did the DRNY suit seek?

- Sept. 2016 – DRNY files suit in federal court alleging 17-A is unconstitutional & seeks:
  - Declaration that 17-A is unconstitutional
  - Injunction requiring notice to every individual who has a 17-A guardian telling them they have a right to terminate or modify their guardianship
  - If anyone takes up the offer in the notice, courts must hold a hearing using "clear and convincing evidence" and applying the substantive and procedural rights in Article 81
  - Disallow state courts from issuing any other 17-A decrees until the law is revised

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What was the basis of DRNYs lawsuit?

- Equal Protection Problems - federal constitution provides that no state can deny any person "equal protection of the law"
- DRNY claims because NYS has two different laws for guardianship Article 81 (for any disabilities) and Article 17-A (only for I/DD), that people with I/DD aren't equally protected by the law BECAUSE provisions are different
- Due Process Violation Problems – federal constitution again prohibits government from taking away life, liberty, or property w/o due process
- They claim granting guardianship removes "liberty" and that the process in 17-A doesn't meet constitutional safeguards

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Status of DRNY Suit

- Aug. 2017 – Defendants motion to dismiss the case was granted based on abstention
- Feb. 2019 – Appeal dismissed; lower court dismissal affirmed (https://casetext.com/case/york-v-new-york-1)
- Link to oral argument here: http://www.ca2.uscourts.gov/decisions/isysquery/a3fe6238-d548-4b77-8983-5c87a656f941/1/doc/17-2812.mp3

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Bottom Line

- No further action since February 2019 dismissal
- Informal comments from State Legislators indicate that they expect reform will be a long process…see next section!

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Part III: Current Reform Efforts by NYS Law Revision Commission & Office of Court Administration

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NYS Law Revision Commission

- Main concept is seeking to obtain consensus.
- Interviews of parents, MHLS, DRNY, attorneys from around the state and other professionals who work with individuals with disabilities as well as professionals from other states that have a two track system have been conducted.
- Draft of bill is completed, but no bill introduced yet this past session, which ended June 19, 2019.

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Law Revision Commission Bill Draft: Main Points

- Diagnosis alone cannot be basis for appointment – now based on functional level, adaptive behaviors
- G'ship to be last resort (considering all other decision-making alternatives) and tailored to the needs of each person (not plenary)
- Clear and convincing evidence of harm if guardian NOT appointed will be standard of proof absent consent by individual
- Mental Hygiene Legal Service (MHLS) to be appointed counsel unless respondent retains their own or MHLS has conflict
- Hearings only on contested issues of fact (by jury trial)
- Court must make findings, and decree must include duration of g'ship
- Process for removal, discharge, or modification of g'ship added
- Decision-making standard added (no longer best interests/substituted judgment as first step)

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OCA/Surrogate Judges' Work

- Some saw judges as the "missing voice" in prior reform efforts
- Cost to system/strain on staffing for new bills?
- How does it actually work now?
- Does it need reform?
- So…judges undertook to start at square one and craft their own bill
- Like LRC, nothing was introduced during 2019 session

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OCA/Surrogate Judges' Work: Main Points

- Clear and convincing evidence, imposed in least restrictive manner based on functional abilities that the individual is incapable of managing his/her affairs will be the standard
- MHLS to be appointed counsel as general default
- GAL may also be appointed, or respondent can proceed *pro se* if court allows it
- Tailoring is expected if warranted (in scope and duration)
- Includes new decision-making standard (best interests a last resort)

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Part IV: Current Trends/ Cases of Interest

- Sloane v. M.G. (NY County Supreme Court ➡ 1st Dep't)
- MG – 80 y/o man lived in CR for 25 years prior to hosp. admission
- Suffered heart attack, anoxic brain injury resulting in permanent vegetative state/dependent on ventilator
- Family member/guardian tried to remove life sustaining treatment under 1750-b and MHLS objected claiming: (1) 1750-b shouldn't be used because MG previously had capacity, and (2) using 1750-b violates equal protection
- Court held that equal protection isn't violated because people with ID/DD are differently situated since many of them never had capacity – unlike people who would normally use the Family Health Care Decisions Act
- M.G. died prior to the court's decision

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Part IV: Current Trends/ Cases of Interest

- In re: Anna F. (App. Div., 2nd Dept.)
- Parents of 51 y/o woman applied for 17-A g'ship – trial court denied the petition and parents appealed
- Anna has cerebral palsy, 24-hour supervision, can't feed herself – developmental age of ~ 4 mos.
- Appeals court held that Anna met the standard for 17-A guardianship and there was no reason the trial court should have denied the petition
- Court remanded and ordered trial court to issue decree naming the parents Anna's 17-A guardian
- Trial Court made decision that 17-A was not appropriate because Article 81 was an available option and was less restrictive, ignoring the fact that 17-A is on the books.

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Part IV: Current Trends/ Cases of Interest

- In re: Capurso (Westchester County, Surr. Ct. 3/26/19)
- DRNY repped individual with I/DD to revoke 17-A g'ship previously obtained by his parents when he was ~22 y/o
- Parents/guardians supported the relief sought
- Burden is on "ward" to demonstrate continued g'ship is not in his/her best interests
- Court found "ward" had gained independence, sustained employment, and demonstrated other ability to live and function independently
- Court recommended HCP and POA instead of g'ship

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Part IV: Current Trends/ Cases of Interest

- A host of other cases preceding *Anna F.* where Surrogates denied a 17-A application due to it not being appropriate or the least restrictive alternative and directing family to seek out an alternative.
- In at least one case, *Matter of Cronin*, Court sought to determine how a Trust was being utilized in the context of the life of an individual with a disability in the context of a 17-A proceeding.
- Continuing Communication and Education is required.

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Questions/Comments

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Docket No. 17-2812-cv
UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

Disability RIghts N.Y. v. New York

Decided Feb 15, 2019

CHIN, Circuit Judge

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK Before: CABRANES, LYNCH, and CHIN, *Circuit Judges*.

2 *2 Appeal from a judgment entered in the United States District Court for the Southern District of New York (Hellerstein, *J.)* granting defendants-appellees' motion for judgment on the pleadings and dismissing the complaint. Plaintiff-appellant Disability Rights New York ("DRNY") alleges constitutional and other deficiencies in the manner in which guardianship proceedings are conducted in New York Surrogate's Court under Article 17A of the Surrogate's Court Procedure Act. Relying on *Younger v. Harris*, 401 U.S. 37 (1971), and *O'Shea v. Littleton*, 414 U.S. 488 (1974), the district court determined that it was required to abstain from hearing the case. On appeal, DRNY contends that the district court erred in abstaining.

AFFIRMED. JENNIFER J. MONTHIE (Lara H. Weissman, *on the brief)*, Disability Rights New York, Albany, New York, *for Plaintiff-Appellant*. MARK S. GRUBE, Assistant Solicitor General (Barbara D. Underwood, Solicitor General, Steven C. Wu, Deputy Solicitor General, *on the brief*), *for* Letitia James, Attorney General for the State of New York, New York, New York, *for Defendants-*
3 *Appellants*. *3 CHIN, *Circuit Judge*:

Article 17A of the New York Surrogate's Court Procedure Act (the "SCPA") governs guardianship proceedings in New York State Surrogate's Court for individuals with intellectual and developmental disabilities. The statute was enacted in 1969 to permit the appointment of parents or other interested persons as guardians for individuals unable to care for themselves. Plaintiff-appellant Disability Rights New York ("DRNY") brought this action below contending that the statute is unconstitutional because it does not provide adequate protection for these individuals, and seeking declaratory and injunctive relief to compel defendants-appellees -- the State of New York, its court system, and its Chief Judge and Chief Administrative Judge ("Defendants") -- to alter the manner in which guardianship proceedings are conducted.

The district court did not reach the merits of DRNY's claims as it granted Defendants' motion for judgment on the pleadings, abstaining pursuant to *Younger v. Harris*, 401 U.S. 37 (1971), and *O'Shea v. Littleton*, 414 U.S. 488 (1974).

For the reasons set forth below, we affirm the judgment of the district court.

1 [1] As we affirm on abstention grounds, we do not reach the issue of standing raised by Defendants on appeal because we may "decide a case under *Younger* without addressing [DRNY's] constitutional standing to bring suit." *Spargo v. N.Y. State Comm'n on Judicial Conduct*, 351 F.3d 65, 74 (2d Cir. 2003); *see also Ruhrgas AG v. Marathon Oil Co.*, 526 U.S. 574, 585 (1999) (reaffirming the inherent flexibility that federal courts exercise "to choose among threshold grounds" for disposing of a case without reaching the merits).

BACKGROUND

A. *Relevant Statutory Provisions*

New York State utilizes two primary procedures related to legal guardianships: Article 17A of the Surrogate's Court Procedure Act (the "SCPA") and Article 81 of the New York Mental Hygiene Law (the "MHL").

1. ***Article 17A***

Article 17A governs guardianship proceedings in New York State Surrogate's Court for individuals with intellectual and developmental disabilities. it was designed primarily to allow parents to serve as long-term guardians of children who cannot care for themselves. *See In re Chaim A.K.*, 885 N.Y.S.2d 582, 586 (Sur. Ct. New York County 2009). Guardianships are not limited, however, to parent-child relationships, and guardianship can be obtained by any "interested person," including certain non-profit organizations. *See* SCPA §§ 1751, 1760.

5 *5 Article 17A guardianships, which allocate broad decision-making authority to the petitioner over the individual with alleged disabilities, are obtained through judicial proceedings before the New York Surrogate's Court. *See In re Chaim A.K.*, 885 N.Y.S.2d at 585. These procedures are designed to be accessible to lay people. *See id.* "Virtually all" Article 17A proceedings are uncontested and devoid of controversy. *See In re Derek*, 821 N.Y.S.2d 387, 390 (Sur. Ct. Broome County 2006).

An Article 17A proceeding commences with service of notice by the person seeking guardianship to a wide range of interested parties. *See* SCPA § 1753. The court then conducts a hearing at "which [the potential ward] shall have the right to a jury trial." *Id.* § 1754(1). The court can dispense with a hearing with the consent of both parents. *Id.* The individual with an alleged disability shall be present at the hearing, unless the court is satisfied that such person is "medically incapable of being present" or that her presence would not be in her best interest. *Id.* § 1754(3). Though Article 17A does not provide for the right to an attorney, courts have sometimes appointed attorneys in difficult cases. *See*, *e.g.*, *In re Zhuo*, 42 N.Y.S.3d 530, 532 (Sur. Ct. Kings County 2016). To obtain an Article 17A guardianship, a

6 petitioner must present proof that two *6 physicians (or a physician and a psychologist) have certified that (1) the individual has an intellectual or developmental disability that makes managing her own life impractical, (2) the situation is "permanent" or "likely to continue indefinitely," and (3) guardianship is in the individual's best interests. *See* SCPA §§ 1750, 1750-a. Courts have recognized that the "best interests" standard is a lower standard of proof than the clear and convincing evidence standard. *In re Mueller*, 887 N.Y.S.2d 768, 769 (Sur. Ct. Dutchess County 2009). Once a petition is granted, the court retains jurisdiction over the guardianship and may modify it at the request of the ward or anyone acting on her behalf. *See* SCPA §§ 1755, 1758.

2. ***Article 81***

Article 81 governs guardianship proceedings in New York State Supreme Court. Unlike Article 17A, Article 81 is designed primarily to deal with elderly, disabled adults. *In re Lavecchia*, 170 Misc. 3d 211, 213 (Sup. Ct. Rockland County 1996). Article 81 is not limited to individuals diagnosed with specific disabilities, but instead is designed for adults with "functional limitations" that impede their ability to provide for their own personal needs. MHL § 81.02.

7 *7 Article 81 has different requirements than Article 17A. For example, under Article 81 the court must hold a hearing, at which the prospective ward must be present. *Id.* § 81.11(a), (c). At the hearing, the petitioner has the burden of establishing the need for guardianship by "clear and convincing evidence." *Id.* §§ 81.02(b), 81.12(a). And once a petition has been granted, guardians have ongoing disclosure requirements. *See*, *e.g.*, *id.* § 81.31 (requiring the guardian to file an annual report with the supervising court). In sum, Article 81 proceedings contain more checks and oversight than Article 17A proceedings: They require more detailed pleadings, proof, and notice, and they provide appointed counsel, a hearing that the potential ward must attend, ongoing

supervision and reporting, and narrowly tailored guardianship powers. These more robust standards form the basis for DRNY's argument on the merits. **B.** ***Procedural Background***

On September 21, 2016, DRNY brought this action to, *inter alia*, enjoin defendants from appointing legal guardians pursuant to Article 17A. DRNY alleges that Article 17A proceedings, as currently administered, do not meet the standards of due process and equal protection. Rather than citing the circumstances of specific
8 individuals subject to Article 17A proceedings, *8 however, DRNY's complaint relies primarily on a comparison of the two New York State guardianship schemes -- Article 71A of the SCPA and Article 81 of the MHL.

DRNY brought suit pursuant to (1) 42 U.S.C. § 1983, (2) Section 504 of the Rehabilitation Act of 1973 (the "Rehabilitation Act"), 29 U.S.C. § 794, and (3) Title II of the Americans with Disabilities Act (the "ADA"), 42 U.S.C. § 12132. DRNY asked for a declaration that Article 17A violates the Constitution, the ADA, and the Rehabilitation Act. It also sought an injunction requiring defendants to take certain actions in Article 17A guardianship proceedings, such as providing notice, applying a certain burden of proof, and providing substantive and procedural rights equal to those provided in Article 81 proceedings. App'x at 41-42.

Defendants answered the complaint and moved for judgment on the pleadings. On August 16, 2017, the district court granted defendants' motion on abstention grounds pursuant to *Younger v. Harris*, 401 U.S. 37 (1971), and *O'Shea v. Littleton*, 414 U.S. 488 (1974). The district court held that DRNY's claims fell "squarely" under the third of the three categories of cases in which *Younger* principles require a federal court to refuse to
9 exercise its jurisdiction in deference *9 to state courts. *Disability Rights N.Y. v. New York*, No. 16-cv-7363, 2017 WL 6388949, at *2 (S.D.N.Y. Aug. 16, 2017) (citing *Sprint Commc'ns, Inc. v. Jacobs*, 571 U.S. 69, 78 (2013)). The district court also relied on *O'Shea*, holding that the proposed injunction would impose "standards on state court proceedings that 'would require for their enforcement the continuous supervision by the federal court over the conduct of' those proceedings." *Id.* (quoting *O'Shea*, 414 U.S. at 501 (alteration omitted)). DRNY timely appealed.

[2] [2] " [A]n order of abstention is considered final for purposes of appeal, at least when the order applies to the entire complaint." *Pathways, Inc. v. Dunne*, 329 F.3d 108, 113 (2d Cir. 2003).

DISCUSSION

DRNY argues that the district court erred in abstaining from exercising its jurisdiction. In particular, DRNY argues that the district court erred in holding that the third *Younger* category applies. It also argues that the district court's reliance on *O'Shea* is misplaced. For the reasons set forth below, we conclude that the district court correctly abstained under *O'Shea*.

I. *Applicable Law*

We review *de novo* the "essentially" legal determination of whether the requirements for abstention have been met. *Diamond "D" Constr.*
10 *Corp. v.* *10 *McGowan*, 282 F.3d 191, 197-98 (2d Cir. 2002); *accord Schlager v. Phillips*, 166 F.3d 439, 441 (2d Cir. 1999).

In general, "federal courts are obliged to decide cases within the scope of federal jurisdiction." *Sprint*, 571 U.S. at 72. The Supreme Court, however, has recognized "certain instances in which the prospect of undue interference with state proceedings counsels against federal relief." *Id.*

Federal courts must abstain where a party seeks to enjoin an ongoing, parallel state criminal proceeding, to preserve the "longstanding public policy against federal court interference with state court proceedings" based on principles of federalism and comity. *Younger*, 401 U.S. at 43-44. The *Younger* doctrine has been extended beyond ongoing criminal cases to include particular state civil proceedings akin to criminal prosecutions, *see Huffman v. Pursue, Ltd.*, 420

U.S. 592 (1975), or that implicate a state's interest in enforcing the orders and judgments of its courts, *see Pennzoil Co. v. Texaco, Inc.*, 481 U.S. 1 (1987). In *Sprint*, the Supreme Court held that *Younger*'s scope is limited to these three "exceptional" categories -- "ongoing state criminal prosecution," "certain civil enforcement proceedings," and "civil proceedings involving
11 certain orders *11 uniquely in furtherance of the state courts' ability to perform their judicial functions." *Sprint*, 571 U.S. at 78.

Here, only the third category is at issue: civil proceedings involving certain orders uniquely in furtherance of the state courts' ability to perform their judicial functions. Civil contempt orders and orders requiring the posting of bonds on appeal fall into this category. *See NOPSI v. Council of City of New Orleans*, 491 U.S. 350, 368 (1989) (citing *Juidice v. Vail*, 430 U.S. 327, 336 n.12 (1977); *Pennzoil Co.*, 481 U.S. at 13). In *Juidice*, the Supreme Court abstained from interfering with the ability of New York state courts to issue contempt decrees because "[t]he contempt power lies at the core of the administration of a State's judicial system," and "stands in aid of the authority of the judicial system, so that its orders and judgments are not rendered nugatory." 430 U.S. at 335, 336 n.12. In *Pennzoil*, the Supreme Court abstained from interfering with the ability of Texas state courts to require the posting of appeal bonds because of the "importance to the States of enforcing the orders and judgments of their courts." 481 U.S. at 13. We recently followed this line of cases in finding that abstention was appropriate in a case seeking to enjoin New York
12 courts from ordering *12 attorneys' fees in child custody cases. *See Falco v. Justices of Matrimonial Parts of Supreme Court of Suffolk Cty.*, 805 F.3d 425, 428 (2d Cir. 2015).

Although *Younger* mandates abstention only when the plaintiff seeks to enjoin ongoing state proceedings and only in the three instances identified in *Sprint*, the Supreme Court has also held that even where no state proceedings are pending, federal courts must abstain where failure to do so would result in "an ongoing federal audit of state criminal proceedings." *O'Shea*, 414 U.S. at 500. In *O'Shea*, the plaintiffs sought to enjoin state court judges from carrying out allegedly unconstitutional policies and practices relating to bond setting, sentencing, and jury fees in criminal cases. *Id.* at 491-92. The Court held that "an injunction aimed at controlling or preventing the occurrence of specific events that might take place in the course of future state criminal trials" would amount to "nothing less than an ongoing federal audit of state . . . proceedings which would indirectly accomplish the kind of interference that [*Younger*] and related cases sought to prevent." *Id.* at 500. Thus, to avoid effecting "a major continuing intrusion of the equitable power of the federal courts into the daily conduct of state criminal proceedings," which is "antipathetic to established principles of comity," *id.* at 501-02, federal courts must be constantly mindful of the
13 "special *13 delicacy of the adjustment to be preserved between federal equitable power and State administration of its own law," *id.* at 500 (quoting *Stefanelli v. Minard*, 342 U.S. 117, 120 (1951)). Hence, *O'Shea* is an extension of the principles set forth in *Younger*, and although *Younger* does not apply in the absence of pending proceedings, *see Ankenbrandt v. Richards*, 504 U.S. 689, 705 (1992) ("Absent any *pending* proceeding in state tribunals, therefore, application by the lower courts of *Younger* abstention was clearly erroneous." (emphasis in original)), the considerations underlying *Younger* are still very much at play even when a suit is filed prior to the onset of state proceedings, *see O'Shea*, 414 U.S. at 500; *see also Courthouse News Serv. v. Brown*, 908 F.3d 1063, 1072 (7th Cir. 2018) ("While this case does not fit neatly into the *Younger* doctrine, it fits better into the Supreme Court's extension of the *Younger* principles in *O'Shea* . . . .").

Like *Younger*, *O'Shea* has also been applied in certain civil contexts involving the operations of state courts. *See Kaufman v. Kaye*, 466 F.3d 83, 86 (2d Cir. 2006) (abstaining under *O'Shea* from enjoining internal state court judicial assignment procedures). Many of our sister circuits have abstained in similar situations. *See Courthouse*

News Serv., 908 F.3d at 1065-66 (abstaining under *O'Shea*, and the principles of federalism and
14 comity that underly it, from *14 enjoining the Clerk of the Circuit Court of Cook County to release newly filed complaints at the moment of receipt); *Oglala Sioux Tribe v. Fleming*, 904 F.3d 603, 612 (8th Cir. 2018) (abstaining under *O'Shea* from enjoining allegedly unconstitutional child custody proceedings because "[t]he relief requested would interfere with the state judicial proceedings by requiring the defendants to comply with numerous procedural requirements" and "failure to comply with the district court's injunction would subject state officials to potential sanctions"); *Miles v. Wesley*, 801 F.3d 1060, 1064, 1066 (9th Cir. 2015) (abstaining under *O'Shea* from enjoining the Los Angeles Supreme Court from reducing the number of courthouses used for unlawful detainer actions); *Hall v. Valeska*, 509 F. App'x 834, 835-36 (11th Cir. 2012) (per curiam) (abstaining under *O'Shea* from enjoining allegedly discriminatory jury selection procedures); *Parker v. Turner*, 626 F.2d 1, 8 & n.18 (6th Cir. 1980) (providing that *O'Shea* establishes a rule of "near-absolute restraint . . . to situations where the relief sought would interfere with the day-to-day conduct of state trials").

3 [3] While the Supreme Court in *Sprint* made clear that *Younger*'s scope should be limited to the three specified categories, 134 S. Ct. at 591, 594, the Court did not suggest that abstention under *O'Shea* should be circumscribed. Indeed, courts have continued to apply *O'Shea* even after *Sprint*. *See, e.g.*, *Courthouse News Serv.*, 908 F.3d at 1072; *Oglala Sioux Tribe*, 904 F.3d at 612; *Miles*, 801 F.3d at 1064-65.

II. *Application*

DRNY first argues that the third category of *Younger* does not apply to this case because there is no pending, parallel state court action. Indeed, DRNY is not seeking to enjoin any specific pending action, but it is instead seeking to affect the manner in which all Article 17A proceedings -- present and future -- are conducted.[4] Mindful of the Supreme Court's admonition that the three "exceptional" categories under *Younger* are to be narrowly construed, *Sprint*, 571 U.S. at 73, 78, 82 (noting that the three categories "define *Younger*'s scope," that *Younger* extends "no further," and that it has not "applied *Younger* outside these three 'exceptional' categories"), we do not decide whether this case fits within the third *Younger* category, for we conclude that it falls squarely within *O'Shea*'s abstention framework.

4 We note that DRNY's complaint lacks nearly any specificity in its pleading. The complaint itself merely compares the aspects of two pieces of legislation and fails to mention a single individual by name. Indeed, DRNY "tenders 'naked assertions' devoid of 'further factual enhancement.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (alteration omitted) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 557 (2007)). As drafted, DRNY's pleading "give[s] no indication of the circumstances that support the conclusory allegation of unlawfulness." *Drimal v. Tai*, 786 F.3d 219, 224 (2d Cir. 2015). --------

Our decision in *Kaufman v. Kaye* is instructive. There, we abstained under *O'Shea* from declaring that New York State's system for assigning cases
16 *16 among panels of appellate judges violated the Constitution and we refused to order the state legislature to establish a new procedure for assigning appeals. *Kaufman*, 466 F.3d at 84-85, 87. Doing so, we held, would "raise compliance issues under the putative federal injunction" as well as claims that "the state court's chosen remedy violated the Constitution or the terms of that injunction," which "would inevitably lead to precisely the kind of piecemeal interruptions of state proceedings condemned in *O'Shea*." *Id.* at 87 (internal quotation marks and ellipsis omitted). A recent decision of the Ninth Circuit is also helpful. In *Miles v. Wesley*, the Ninth Circuit abstained under *O'Shea* from enjoining the Los Angeles Supreme Court from, *inter alia*, eliminating any courthouses that heard unlawful detainer actions. 801 F.3d at 1064. The court held that the requested injunction would result in "heavy federal interference in such sensitive state activities as

administration of the judicial system." *Id*. at 1063 (quoting *L.A. Cty. Bar Ass'n v. Eu*, 979 F.2d 697, 703 (9th Cir. 1992)).

In seeking the injunction in this case, DRNY asked the district court (and asks this Court now) to direct the New York State Unified Court System, the Chief Judge of the State of New York, and the Chief Administrative Judge for the Courts of New York to (1) notify all current Article 17A
17 wards of their right to *17 request modification or termination of their guardianship order, (2) hold proceedings that provide augmented substantive and procedural rights "no less than" those of Article 81 proceedings, and (3) cease future Article 17A adjudications "until defendants ensure that the proceedings provide substantive and procedural rights" on par with those of Article 81 proceedings. App'x at 42.

As in *O'Shea*, DRNY's requested relief would effect a continuing, impermissible "audit" of New York Surrogate's Court proceedings, which would offend the principles of comity and federalism. Simply put, DRNY seeks to "control[] or prevent[] the occurrence of specific events that might take place in the court of future state [Article 17A proceedings.]" *O'Shea*, 414 U.S. at 500. With such an injunction in place, anyone seeking or objecting to Article 17A guardianship in the future would be able to "raise compliance issues under the putative federal injunction claiming that the state court's chosen remedy violated the Constitution or the terms of that injunction." *Kaufman*, 466 F.3d at 87; *see also id*. ("[A]ny remedy fashioned by the state would then be subject to future challenges in the district court."). Ongoing, case-by-case oversight of state courts, like the New York Surrogate's Court, is exactly the sort of interference *O'Shea* seeks to avoid. *Kaufman*, 466
18 F.3d at 86 ("[F]ederal courts may not entertain *18 actions . . . that seek to impose 'an ongoing federal audit of state . . . proceedings.'" (quoting *O'Shea*, 414 U.S. at 500)). Indeed, such "monitoring of the operation of state court functions . . . is antipathetic to established principles of comity." *O'Shea*, 414 U.S. at 501-02. Because this Court has "no power to intervene in the internal procedures of the state courts" and cannot "legislate and engraft new procedures upon existing state . . . practices," the district court correctly abstained from exercising jurisdiction in this case. *See Kaufman*, 466 F.3d at 86 (quoting *Wallace v. Kern*, 520 F.2d 400, 404-05 (2d Cir. 1975)).

DRNY argues that federal courts have often found state statutes unconstitutional, including statutes resulting in the issuance of state court orders. It cites landmark decisions such as *Obergefell v. Hodges*, 135 S. Ct. 2584 (2015) (holding that Michigan's law prohibiting same-sex marriage violated equal protection and due process rights), and *Blakely v. Washington*, 542 U.S. 296 (2004) (holding that Washington's sentencing law violates the Sixth Amendment). But those cases did not implicate *Younger*. Plaintiffs in *Obergefell* challenged substantive state statutes, and plaintiffs in *Blakely* simply appealed a final judgment of the state courts. Here, DRNY seeks a far more substantial invasion of state courts' domain; it would have federal courts conduct a preemptive
19 *19 review of state court procedure in guardianship proceedings, an area in which states have an especially strong interest. *See Falco*, 805 F.3d at 427. Such review would directly impede "the normal course of . . . proceedings in the state courts." *O'Shea*, 414 U.S. at 500; *see also Sprint*, 571 U.S. at 73 (noting that abstention is proper where relief would impede "the state courts' ability to perform their judicial functions." (quoting *NOPSI*, 491 U.S. at 368)).

DRNY also seeks to have Article 17A declared unconstitutional and violative of the Americans with Disability Act and Section 504 of the Rehabilitation Act of 1973. DRNY argues that its request for declaratory relief is not subject to abstention, as a declaratory judgment would not order the state courts to take certain actions. We are not persuaded. In *Samuels v. Mackell*, the Supreme Court held that "ordinarily a declaratory judgment will result in precisely the same interference with and disruption of state proceedings that the longstanding policy limiting injunctions was designed to avoid." 401 U.S. 66,

72 (1971); *see also Miles*, 801 F.3d at 1063-64 (noting that where *O'Shea* is implicated, even where plaintiffs narrow their request only to declaratory relief, abstention is proper where the relief sought "would inevitably set up the precise basis for *future intervention* condemned in
20 *O'Shea*" because "the question of defendants' *20 compliance with any remedy imposed could be the subject of future court challenges" (internal citations omitted)); *Kaufman*, 466 F.3d at 85 (abstaining under *O'Shea* from hearing Kaufman's complaint seeking injunctive and declaratory relief). Thus, the district court properly abstained from exercising jurisdiction even as to DRNY's request for declaratory relief.

We conclude by noting that abstention here is supported by the "availability of other avenues of relief." *O'Shea*, 414 U.S. at 504. DRNY may still avail itself of the state courts to challenge the constitutionality of Article 17A proceedings. *See Foxhall Realty Law Offices, Inc. v. Telecomms. Premium Servs., Ltd.*, 156 F.3d 432, 435 (2d Cir. 1998) ("State courts are courts of general jurisdiction and are accordingly presumed to have jurisdiction over federally-created causes of action unless Congress indicates otherwise."). DRNY and any aggrieved individuals will be able to obtain sufficient review in state court and, if needed, the Supreme Court of the United States. *See Allen v. McCurry*, 449 U.S. 90, 105 (1980) (noting the Supreme Court's confidence in state courts to adjudicate constitutional issues); *Kaufman*, 466 F.3d at 87-88. Indeed, New York state courts have been diligent in reviewing the sufficiency of Article 17A proceedings, *see*, *e.g.*, *In re Mark C.H.*, 906 N.Y.S.2d 419, 427 (Sur. Ct.
21 New York County 2010); *In re* *21 *D.D.*, 19 N.Y.S.3d 867, 869-71 (Sur. Ct. Kings County 2015), and understand well the differences between Article 17A proceedings and Article 81 proceedings, *see In re Chaim A.K.*, 885 N.Y.S.2d at 584-90.

CONCLUSION

Accordingly, for the reasons set forth above, the judgment of the district court is **AFFIRMED.**

STATE OF NEW YORK

8171--A

2017-2018 Regular Sessions

IN ASSEMBLY

June 1, 2017

Introduced by M. of A. LAVINE, WEINSTEIN -- read once and referred to the Committee on Judiciary -- reported and referred to the Committee on Codes -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the surrogate's court procedure act and the judiciary law, in relation to replacing the term intellectually disabled with developmentally disabled; and guardianship and health care decisions of persons with developmental disabilities; and to repeal section 1750-a of the surrogate's court procedure act relating thereto

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Section 1750 of the surrogate's court procedure act, as amended by chapter 198 of the laws of 2016, is amended to read as follows:

§ 1750. Guardianship of persons [~~who are intellectually disabled~~] **with developmental disabilities**

1. When it shall appear to the satisfaction of the court that a person is a person [~~who is intellectually disabled~~] **with a developmental disability within the meaning of subdivision twenty-two of section 1.03 of the mental hygiene law, and that such person, as a result of such developmental disability, exhibits significant impairment of general or specific areas of intellectual functioning and/or adaptive behaviors in specified domains as enumerated in subdivision eight of section seventeen hundred fifty-two of this article**, the court is authorized to appoint a guardian of the person or of the property or of both if such appointment of a guardian or guardians is [~~in the best interest of~~] **shown by clear and convincing evidence that** the person [~~who is intellectually disabled~~] **with a developmental disability is likely to suffer harm or is unable to provide for personal needs and/or property management needs or cannot adequately understand and appreciate the nature and consequences of such inability, and where the respondent has unmet**

EXPLANATION--Matter in *italics* (underscored) is new; matter in brackets [-] is old law to be omitted.

LBD10185-05-7

needs. Such appointment shall be made pursuant to the provisions of this article[~~, provided however that the provisions of section seventeen hundred fifty-a of this article shall not apply to the appointment of a guardian or guardians of a person who is intellectually disabled~~]. The nature and duration of the guardianship must bear a reasonable relation to the purpose for which the person is appointed a guardian.

[~~1. For the purposes of this article, a person who is intellectually disabled is a person who has been certified by one licensed physician and one licensed psychologist, or by two licensed physicians at least one of whom is familiar with or has professional knowledge in the care and treatment of persons with an intellectual disability, having qualifications to make such certification, as being incapable to manage him or herself and/or his or her affairs by reason of intellectual disability and that such condition is permanent in nature or likely to continue indefinitely.~~]

2. Every guardianship entered into pursuant to this article prior to the effective date of this subdivision, including orders and decrees pursuant to section seventeen hundred fifty-seven of this article, shall remain in full force and effect thereafter, except as amended pursuant to section seventeen hundred fifty-five of this article or as ordered by the court; and any such guardianship shall be administered consistent with the substantive and procedural requirements set forth in this article.

3. Every [~~such certification pursuant to subdivision one of this section,~~] order and decree made on or after the effective date of this subdivision, shall include a specific determination by [~~such physician and psychologist, or by such physicians,~~] the issuing court as to whether the person [~~who is intellectually disabled~~] with a developmental disability has the capacity to make health care decisions, as defined by subdivision three of section twenty-nine hundred eighty of the public health law, for himself or herself. A determination that the person [~~who is intellectually disabled~~] with a developmental disability has the capacity to make health care decisions shall not preclude the appointment of a guardian pursuant to this section to make other decisions on behalf of the person [~~who is intellectually disabled~~] with a developmental disability. The absence of this determination in the case of guardians appointed prior to [~~the effective date of this subdivision~~] March sixteenth, two thousand three, shall not preclude such guardians from making health care decisions. Further, guardians appointed by orders and/or decrees issued prior to the effective date of this subdivision shall have authority in all areas, unless otherwise stated.

§ 2. Section 1750-a of the surrogate's court procedure act is REPEALED.

§ 3. Section 1750-b of the surrogate's court procedure act, as amended by chapter 198 of the laws of 2016, is amended to read as follows:

§ 1750-b. Health care decisions for persons [~~who are intellectually disabled~~] with developmental disabilities

1. Scope of authority. As used in this section the term "developmental disability" shall have the same meaning as defined in subdivision twenty-two of section 1.03 of the mental hygiene law. Unless specifically prohibited by the court after consideration of [~~the determination, if any, regarding~~] a person [~~who is intellectually disabled's~~] with a developmental disability's capacity to make health care decisions, which is required by section seventeen hundred fifty of this article, the guardian of such person appointed pursuant to section seventeen hundred fifty of this article shall have the authority to make

any and all health care decisions, as defined by subdivision six of section twenty-nine hundred eighty of the public health law, on behalf of the person [~~who is intellectually disabled~~] **with a developmental disability** that such person could make if such person had capacity. Such decisions may include decisions to withhold or withdraw life-sustaining treatment. For purposes of this section, "life-sustaining treatment" means medical treatment, including cardiopulmonary resuscitation and nutrition and hydration provided by means of medical treatment, which is sustaining life functions and without which, according to reasonable medical judgment, the patient will die within a relatively short time period. Cardiopulmonary resuscitation is presumed to be life-sustaining treatment without the necessity of a medical judgment by an attending physician. The provisions of this article are not intended to permit or promote suicide, assisted suicide or euthanasia; accordingly, nothing in this section shall be construed to permit a guardian to consent to any act or omission to which the person [~~who is intellectually disabled~~] **with a developmental disability** could not consent if such person had capacity.

(a) For the purposes of making a decision to withhold or withdraw life-sustaining treatment pursuant to this section, in the case of a person for whom no guardian has been appointed pursuant to section seventeen hundred fifty [~~or seventeen hundred fifty-a~~] of this article, a "guardian" shall also mean a family member of a person who [~~(i) has intellectual disability, or (ii)~~] has a developmental disability, as defined in **subdivision twenty-two of** section 1.03 of the mental hygiene law, [~~which (A) includes intellectual disability, or (B) results in a similar impairment of general intellectual functioning or adaptive behavior so that such person is incapable of managing himself or herself, and/or his or her affairs by reason of such developmental disability~~] **and that such person, as a result of such developmental disability, exhibits significant impairment of the ability to make his or her own health care decisions**. Qualified family members shall be included in a prioritized list of said family members pursuant to regulations established by the commissioner of the office for people with developmental disabilities. Such family members must have a significant and ongoing involvement in a person's life so as to have sufficient knowledge of their needs and, when reasonably known or ascertainable, the person's wishes, including moral and religious beliefs. In the case of a person who was a resident of the former Willowbrook state school on March seventeenth, nineteen hundred seventy-two and those individuals who were in community care status on that date and subsequently returned to Willowbrook or a related facility, who are fully represented by the consumer advisory board and who have no guardians appointed pursuant to this article or have no qualified family members to make such a decision, then a "guardian" shall also mean the Willowbrook consumer advisory board. A decision of such family member or the Willowbrook consumer advisory board to withhold or withdraw life-sustaining treatment shall be subject to all of the protections, procedures and safeguards which apply to the decision of a guardian to withhold or withdraw life-sustaining treatment pursuant to this section.

In the case of a person for whom no guardian has been appointed pursuant to this article or for whom there is no qualified family member or the Willowbrook consumer advisory board available to make such a decision, a "guardian" shall also mean, notwithstanding the definitions in section 80.03 of the mental hygiene law, a surrogate decision-making committee, as defined in article eighty of the mental hygiene law. All

declarations and procedures, including expedited procedures, to comply with this section shall be established by regulations promulgated by the [~~commission on quality of care and advocacy for persons with disabilities~~] **justice center for the protection of people with special needs, as established by article twenty of the executive law**.

(b) Regulations establishing the prioritized list of qualified family members required by paragraph (a) of this subdivision shall be developed by the commissioner of the office for people with developmental disabilities in conjunction with parents, advocates and family members of persons [~~who are intellectually disabled~~] **with developmental disabilities**. Regulations to implement the authority of the Willowbrook consumer advisory board pursuant to paragraph (a) of this subdivision may be promulgated by the commissioner of the office for people with developmental disabilities with advice from the Willowbrook consumer advisory board.

(c) Notwithstanding any provision of law to the contrary, the formal determinations required pursuant to section seventeen hundred fifty of this article shall only apply to guardians appointed pursuant to section seventeen hundred fifty [~~or seventeen hundred fifty-a~~] of this article.

2. Decision-making standard. (a) The guardian shall base all advocacy and health care decision-making solely and exclusively on the best interests of the person [~~who is intellectually disabled~~] **with a developmental disability** and, when reasonably known or ascertainable with reasonable diligence, on [~~the person who is intellectually disabled's~~] **such person's** wishes, including moral and religious beliefs.

(b) An assessment of the person [~~who is intellectually disabled's~~] **with a developmental disability's** best interests shall include consideration of:

(i) the dignity and uniqueness of every person;

(ii) the preservation, improvement or restoration of the person [~~who is intellectually disabled's~~] **with a developmental disability's** health;

(iii) the relief of the person [~~who is intellectually disabled's~~] **with a developmental disability's** suffering by means of palliative care and pain management;

(iv) the unique nature of artificially provided nutrition or hydration, and the effect it may have on the person [~~who is intellectually disabled~~] **with a developmental disability**; and

(v) the entire medical condition of the person.

(c) No health care decision shall be influenced in any way by:

(i) a presumption that persons [~~who are intellectually disabled~~] **with developmental disabilities** are not entitled to the full and equal rights, equal protection, respect, medical care and dignity afforded to persons without [~~an intellectual disability or a~~] developmental [~~disability~~] **disabilities**; or

(ii) financial considerations of the guardian, as such considerations affect the guardian, a health care provider or any other party.

3. Right to receive information. Subject to the provisions of sections 33.13 and 33.16 of the mental hygiene law, the guardian shall have the right to receive all medical information and medical and clinical records necessary to make informed decisions regarding the person [~~who is intellectually disabled's~~] **with a developmental disability's** health care.

4. Life-sustaining treatment. The guardian shall have the affirmative obligation to advocate for the full and efficacious provision of health care, including life-sustaining treatment. In the event that a guardian makes a decision to withdraw or withhold life-sustaining treatment from

a person [~~who is intellectually disabled~~] **with a developmental disability**:

(a) The attending physician, as defined in subdivision two of section twenty-nine hundred eighty of the public health law, must confirm to a reasonable degree of medical certainty that the person [~~who is intellectually disabled~~] **with a developmental disability** lacks capacity to make health care decisions. The determination thereof shall be included in the person [~~who is intellectually disabled's~~] **with a developmental disability's** medical record, and shall contain such attending physician's opinion regarding the cause and nature of the person [~~who is intellectually disabled's~~] **with a developmental disability's** incapacity as well as its extent and probable duration. The attending physician who makes the confirmation shall consult with another physician, or a licensed psychologist, to further confirm the person [~~who is intellectually disabled's~~] **with a developmental disability's** lack of capacity. The attending physician who makes the confirmation, or the physician or licensed psychologist with whom the attending physician consults, must (i) be employed by a developmental disabilities services office named in section 13.17 of the mental hygiene law or employed by the office for people with developmental disabilities to provide treatment and care to people with developmental disabilities, or (ii) have been employed for a minimum of two years to render care and service in a facility or program operated, licensed or authorized by the office for people with developmental disabilities, or (iii) have been approved by the commissioner of the office for people with developmental disabilities in accordance with regulations promulgated by such commissioner. Such regulations shall require that a physician or licensed psychologist possess specialized training or three years experience in treating [~~intellectual disability~~] **persons with developmental disabilities**. A record of such consultation shall be included in the person [~~who is intellectually disabled's~~] **with developmental disability's** medical record.

(b) The attending physician, as defined in subdivision two of section twenty-nine hundred eighty of the public health law, with the concurrence of another physician with whom such attending physician shall consult, must determine to a reasonable degree of medical certainty and note on the person [~~who is intellectually disabled's~~] **with a developmental disability's** chart that:

(i) the person [~~who is intellectually disabled~~] **with a developmental disability** has a medical condition as follows:

A. a terminal condition, as defined in subdivision twenty-three of section twenty-nine hundred sixty-one of the public health law; or

B. permanent unconsciousness; or

C. a medical condition other than such person's [~~intellectual disability~~] **developmental disability** which requires life-sustaining treatment, is irreversible and which will continue indefinitely; and

(ii) the life-sustaining treatment would impose an extraordinary burden on such person, in light of:

A. such person's medical condition, other than such person's [~~intellectual disability~~] **developmental disability**; and

B. the expected outcome of the life-sustaining treatment, notwithstanding such person's [~~intellectual disability~~] **developmental disability**; and

(iii) in the case of a decision to withdraw or withhold artificially provided nutrition or hydration:

A. there is no reasonable hope of maintaining life; or

B. the artificially provided nutrition or hydration poses an extraordinary burden.

(c) The guardian shall express a decision to withhold or withdraw life-sustaining treatment either:

(i) in writing, dated and signed in the presence of one witness eighteen years of age or older who shall sign the decision, and presented to the attending physician, as defined in subdivision two of section twenty-nine hundred eighty of the public health law; or

(ii) orally, to two persons eighteen years of age or older, at least one of whom is the person [~~who is intellectually disabled's~~] **with a developmental disability's** attending physician, as defined in subdivision two of section twenty-nine hundred eighty of the public health law.

(d) The attending physician, as defined in subdivision two of section twenty-nine hundred eighty of the public health law, who is provided with the decision of a guardian shall include the decision in the person [~~who is intellectually disabled's~~] **with a developmental disability's** medical chart, and shall either:

(i) promptly issue an order to withhold or withdraw life-sustaining treatment from the person [~~who is intellectually disabled~~] **with a developmental disability**, and inform the staff responsible for such person's care, if any, of the order; or

(ii) promptly object to such decision, in accordance with subdivision five of this section.

(e) At least forty-eight hours prior to the implementation of a decision to withdraw life-sustaining treatment, or at the earliest possible time prior to the implementation of a decision to withhold life-sustaining treatment, the attending physician shall notify:

(i) the person [~~who is intellectually disabled~~] **with a developmental disability**, except if the attending physician determines, in writing and in consultation with another physician or a licensed psychologist, that, to a reasonable degree of medical certainty, the person would suffer immediate and severe injury from such notification. The attending physician who makes the confirmation, or the physician or licensed psychologist with whom the attending physician consults, shall:

A. be employed by a developmental disabilities services office named in section 13.17 of the mental hygiene law or employed by the office for people with developmental disabilities to provide treatment and care to people with developmental disabilities, or

B. have been employed for a minimum of two years to render care and service in a facility operated, licensed or authorized by the office for people with developmental disabilities, or

C. have been approved by the commissioner of the office for people with developmental disabilities in accordance with regulations promulgated by such commissioner. Such regulations shall require that a physician or licensed psychologist possess specialized training or three years experience in treating [~~intellectual disability~~] **developmental disabilities**. A record of such consultation shall be included in the person [~~who is intellectually disabled's~~] **with a developmental disability's** medical record;

(ii) if the person is in or was transferred from a residential facility operated, licensed or authorized by the office for people with developmental disabilities, the chief executive officer of the agency or organization operating such facility and the mental hygiene legal service; and

(iii) if the person is not in and was not transferred from such a facility or program, the commissioner of the office for people with developmental disabilities, or his or her designee.

5. Objection to health care decision. (a) Suspension. A health care decision made pursuant to subdivision four of this section shall be suspended, pending judicial review, except if the suspension would in reasonable medical judgment be likely to result in the death of the person [~~who is intellectually disabled~~] with a developmental disability, in the event of an objection to that decision at any time by:

(i) the person [~~who is intellectually disabled~~] with a developmental disability on whose behalf such decision was made; or

(ii) a parent or adult sibling who either resides with or has maintained substantial and continuous contact with the person [~~who is intellectually disabled~~] with a developmental disability; or

(iii) the attending physician, as defined in subdivision two of section twenty-nine hundred eighty of the public health law; or

(iv) any other health care practitioner providing services to the person [~~who is intellectually disabled~~] with a developmental disability, who is licensed pursuant to article one hundred thirty-one, one hundred thirty-one-B, one hundred thirty-two, one hundred thirty-three, one hundred thirty-six, one hundred thirty-nine, one hundred forty-one, one hundred forty-three, one hundred forty-four, one hundred fifty-three, one hundred fifty-four, one hundred fifty-six, one hundred fifty-nine or one hundred sixty-four of the education law; or

(v) the chief executive officer identified in subparagraph (ii) of paragraph (e) of subdivision four of this section; or

(vi) if the person is in or was transferred from a residential facility or program operated, approved or licensed by the office for people with developmental disabilities, the mental hygiene legal service; or

(vii) if the person is not in and was not transferred from such a facility or program, the commissioner of the office for people with developmental disabilities, or his or her designee.

(b) Form of objection. Such objection shall occur orally or in writing.

(c) Notification. In the event of the suspension of a health care decision pursuant to this subdivision, the objecting party shall promptly notify the guardian and the other parties identified in paragraph (a) of this subdivision, and the attending physician shall record such suspension in the person [~~who is intellectually disabled's~~] with a developmental disability's medical chart.

(d) Dispute mediation. In the event of an objection pursuant to this subdivision, at the request of the objecting party or person or entity authorized to act as a guardian under this section, except a surrogate decision making committee established pursuant to article eighty of the mental hygiene law, such objection shall be referred to a dispute mediation system, established pursuant to section two thousand nine hundred seventy-two of the public health law or similar entity for mediating disputes in a hospice, such as a patient's advocate's office, hospital chaplain's office or ethics committee, as described in writing and adopted by the governing authority of such hospice, for non-binding mediation. In the event that such dispute cannot be resolved within seventy-two hours or no such mediation entity exists or is reasonably available for mediation of a dispute, the objection shall proceed to judicial review pursuant to this subdivision. The party requesting mediation shall provide notification to those parties entitled to notice pursuant to paragraph (a) of this subdivision.

6. Special proceeding authorized. The guardian, the attending physician, as defined in subdivision two of section twenty-nine hundred eighty of the public health law, the chief executive officer identified in subparagraph (ii) of paragraph (e) of subdivision four of this section, the mental hygiene legal service (if the person is in or was transferred from a residential facility or program operated, approved or licensed by the office for people with developmental disabilities) or the commissioner of the office for people with developmental disabilities or his or her designee (if the person is not in and was not transferred from such a facility or program) may commence a special proceeding in a court of competent jurisdiction with respect to any dispute arising under this section, including objecting to the withdrawal or withholding of life-sustaining treatment because such withdrawal or withholding is not in accord with the criteria set forth in this section.

7. Provider's obligations. (a) A health care provider shall comply with the health care decisions made by a guardian in good faith pursuant to this section, to the same extent as if such decisions had been made by the person [~~who is intellectually disabled~~] **with a developmental disability**, if such person had capacity.

(b) Notwithstanding paragraph (a) of this subdivision, nothing in this section shall be construed to require a private hospital to honor a guardian's health care decision that the hospital would not honor if the decision had been made by the person [~~who is intellectually disabled~~] **with a developmental disability**, if such person had capacity, because the decision is contrary to a formally adopted written policy of the hospital expressly based on religious beliefs or sincerely held moral convictions central to the hospital's operating principles, and the hospital would be permitted by law to refuse to honor the decision if made by such person, provided:

(i) the hospital has informed the guardian of such policy prior to or upon admission, if reasonably possible; and

(ii) the person [~~who is intellectually disabled~~] **with a developmental disability** is transferred promptly to another hospital that is reasonably accessible under the circumstances and is willing to honor the guardian's decision. If the guardian is unable or unwilling to arrange such a transfer, the hospital's refusal to honor the decision of the guardian shall constitute an objection pursuant to subdivision five of this section.

(c) Notwithstanding paragraph (a) of this subdivision, nothing in this section shall be construed to require an individual health care provider to honor a guardian's health care decision that the individual would not honor if the decision had been made by the person [~~who is intellectually disabled~~] **with a developmental disability**, if such person had capacity, because the decision is contrary to the individual's religious beliefs or sincerely held moral convictions, provided the individual health care provider promptly informs the guardian and the facility, if any, of his or her refusal to honor the guardian's decision. In such event, the facility shall promptly transfer responsibility for the person [~~who is intellectually disabled~~] **with a developmental disability** to another individual health care provider willing to honor the guardian's decision. The individual health care provider shall cooperate in facilitating such transfer of the patient.

(d) Notwithstanding the provisions of any other paragraph of this subdivision, if a guardian directs the provision of life-sustaining treatment, the denial of which in reasonable medical judgment would be

likely to result in the death of the person [~~who is intellectually disabled~~] with a developmental disability, a hospital or individual health care provider that does not wish to provide such treatment shall nonetheless comply with the guardian's decision pending either transfer of the person [~~who is intellectually disabled~~] with a developmental disability to a willing hospital or individual health care provider, or judicial review.

(e) Nothing in this section shall affect or diminish the authority of a surrogate decision-making panel to render decisions regarding major medical treatment pursuant to article eighty of the mental hygiene law.

8. Immunity. (a) Provider immunity. 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 reasonably and in good faith a health care decision by a guardian, or for other actions taken reasonably and in good faith pursuant to this section.

(b) Guardian immunity. No guardian shall be subjected to criminal or civil liability for making a health care decision reasonably and in good faith pursuant to this section.

§ 4. Section 1751 of the surrogate's court procedure act, as amended by chapter 198 of the laws of 2016, is amended to read as follows:

§ 1751. Petition for appointment; by whom made

(a) A petition for the appointment of a guardian [~~of the person or property, or both,~~] of a person [~~who is intellectually disabled or a person who is developmentally disabled~~] with a developmental disability pursuant to this article may be made by the person with a developmental disability when such person is eighteen years of age or older, a parent, spouse, sibling, adult child or any other interested person eighteen years of age or older on behalf of the person [~~who is intellectually disabled or a person who is developmentally disabled~~] with a developmental disability including a corporation authorized to serve as a guardian as provided for by this article[~~, or by the person who is intellectually disabled or a person who is developmentally disabled when such person is eighteen years of age or older~~].

(b) A person with a developmental disability may knowingly and voluntarily consent to the appointment of a guardian pursuant to this article.

§ 5. The surrogate's court procedure act is amended by adding a new section 1751-a to read as follows:

§ 1751-a. Petition for appointment; where made (venue)

1. A proceeding under this article shall be brought in the surrogate's court within the county in which the person with a developmental disability resides, or is physically present at the time the proceeding is commenced. If the person with a developmental disability alleged to be in need of a guardian is being cared for as a resident in a facility, the residence of that person shall be deemed to be in the county where the facility is located and the proceeding shall be brought in that county, subject to application by an interested party for a change in venue to another county due to inconvenience to the parties or witnesses, or due to the condition of the person alleged to be in need of a guardian.

2. After the appointment of a guardian, any proceeding to modify a prior order shall be brought in the surrogate's court which granted the prior order, unless at the time of the application to modify the order the person with a developmental disability resides elsewhere, in which case the proceeding shall be brought in the county where the person with

a developmental disability resides, without the need for a motion to transfer venue.

§ 6. Section 1752 of the surrogate's court procedure act, as amended by chapter 198 of the laws of 2016, is amended to read as follows:

§ 1752. Petition for appointment; contents

The petition for the appointment of a guardian shall be filed with the court on forms to be prescribed by the state chief administrator of the courts. Such petition for a guardian of a person [~~who is intellectually disabled or a person who is developmentally disabled~~] with a developmental disability shall include, but not be limited to, the following information:

1. the full name, date of birth and residence of the person [~~who is intellectually disabled or a person who is developmentally disabled~~] with a developmental disability;

2. the name, age, address and relationship or interest of the petitioner to the person [~~who is intellectually disabled or a person who is developmentally disabled~~] with a developmental disability;

3. the names and addresses, if known, of the father, the mother, adult children, adult siblings [~~if eighteen years of age or older,~~] and the spouse [~~and primary care physician if other than a physician having submitted a certification with the petition, if any,~~] of the person [~~who is intellectually disabled or a person who is developmentally disabled~~] with a developmental disability and whether or not they are living, and if living, their addresses and the names and addresses of the nearest distributees of full age who are domiciliaries, if both parents are dead;

4. the name and address of the person [~~with whom the person who is intellectually disabled or a~~] caring for the person [~~who is developmentally disabled~~] with a developmental disability, or with whom the person with a developmental disability resides if other than the parents or spouse;

5. the name and address of any person with significant and ongoing involvement in the life of the person with a developmental disability so as to have sufficient knowledge of their needs, if such persons are known to the petitioner;

6. the name, age, address, education and other qualifications, and consent of the proposed guardian, standby and alternate guardian, if other than the parent, spouse, adult child if eighteen years of age or older or adult sibling if eighteen years of age or older, and if such parent, spouse or adult child be living, why any of them should not be appointed guardian;

[~~6.~~] 7. the estimated value of real and personal property and the annual income therefrom and any other income including governmental entitlements to which the person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability is entitled; [~~and~~

~~7. any circumstances which the court should consider in determining whether it is in the best interests of the person who is intellectually disabled or person who is developmentally disabled to not be present at the hearing if conducted.~~]

8. factual allegations forming the basis for the petition, including facts relating to the person's functional limitations which impair his or her ability to provide for personal and/or property management needs, and the person's lack of understanding and appreciation of the nature and consequences of his or her functional limitations;

9. the particular powers being sought under their relationship to the functional level and needs of the person with a developmental disability;

10. an enumeration of the specific domains in which the person with a developmental disability is alleged to be in need of a guardian or a statement that full guardianship is sought. Specific domains may be included which may include:

(i) consent to or refusal to consent to health care or other professional care;

(ii) management of money or other income, assets or property;

(iii) access to confidential and other sensitive information;

(iv) choices involving education, training, employment, supports and services;

(v) requesting advocacy, legal or other professional services;

(vi) choice of residence and shared living arrangements;

(vii) choices as to social and recreational activity;

(viii) decisions concerning travel; and

(ix) application for government-sponsored or private insurance and benefits; and

11. a statement of the alternatives to guardianship considered, including but not limited to the execution of a health care proxy, power of attorney, representative payee, service coordination, and/or other social support services, other available supported or shared decision-making, and surrogate decision-making committee, and reasons for the declination of such alternatives.

§ 7. Section 1753 of the surrogate's court procedure act, as amended by chapter 198 of the laws of 2016, is amended to read as follows:

§ 1753. Persons to be served and noticed

1. Upon [~~presentation~~] filing of the petition, process shall issue to[~~:~~

~~(a) the parent or parents, adult children, if the petitioner is other than a parent, adult siblings, if the petitioner is other than a parent, and if the person who is intellectually disabled or person who is developmentally disabled is married, to the spouse, if their residences are known;~~

~~(b) the person having care and custody of the person who is intellectually disabled or person who is developmentally disabled, or with whom such person resides if other than the parents or spouse; and~~

~~(c) the person who is intellectually disabled or person who is developmentally disabled if fourteen years of age or older for whom an application has been made in such person's behalf.~~

~~2. Upon presentation of the petition, notice of such petition shall be served by certified mail to:~~

~~(a) the adult siblings if the petitioner is a parent, and adult children if the petitioner is a parent;~~

~~(b) the mental hygiene legal service in the judicial department where the facility, as defined in subdivision (a) of section 47.01 of the mental hygiene law, is located if the person who is intellectually disabled or person who is developmentally disabled resides in such a facility;~~

~~(c) in all cases, to the director in charge of a facility licensed or operated by an agency of the state of New York, if the person who is intellectually disabled or person who is developmentally disabled resides in such facility;~~

~~(d) one other person if designated in writing by the person who is intellectually disabled or person who is developmentally disabled; and~~

[~~(e) such other persons as the court may deem proper~~] the person with a developmental disability, if the petitioner is other than the person with a developmental disability alleged to be in need of a guardian. Any process served upon the person with a developmental disability shall be accompanied by a simplified, clear and easily readable form statement, developed by the office of court administration, including the right of the person to contest the appointment of the guardian to be present at hearings related to the proceeding, to be represented by an attorney and a statement about the nature and implications of the proceedings.

2. Upon filing of the petition, notice of the petition shall be sent by certified mail to the last known address of the following, except if any of the following is also the petitioner:

(a) parents, spouse, adult children, and adult siblings of the person alleged to be in need of the guardian;

(b) individuals listed in the petition pursuant to section seventeen hundred fifty-two of this article and subdivisions four and five of this section;

(c) mental hygiene legal service in the judicial department where the person with a developmental disability resides;

(d) the director in charge of a facility licensed or operated by an agency of the state of New York, if the person with a developmental disability resides in such facility;

(e) any other person if designated in writing by the person with a developmental disability; and

(f) such other persons as the court may deem proper.

3. Within five days of the filing of the petition, a full copy of said petition shall be served by certified mail to the mental hygiene legal service in the judicial department in which the petition was filed. A copy of proof of mailing shall be thereafter filed with the court.

4. For petitions to modify an existing guardianship pursuant to section seventeen hundred fifty-five of this article and/or to appoint a standby guardian pursuant to section seventeen hundred fifty-seven of this article, written notice must be given to all standby guardians currently in succession for a person with a developmental disability who is the subject of the petition by regular mail unless such standby guardians have consented to the petition. An affidavit of service by mail shall be filed with the court. A copy of such petition to modify shall also be served by certified mail upon the mental hygiene legal service in the judicial department in which the petition was filed.

[~~3.~~] 5. No process or notice shall be necessary to [~~a parent, adult child, adult sibling, or spouse of the person who is intellectually disabled or person who is developmentally disabled who has been declared by a court as being incompetent. In addition, no process or notice shall be necessary to a spouse who is divorced from the person who is intellectually disabled or person who is developmentally disabled, and to~~] a parent, adult child, or adult sibling when it shall appear to the satisfaction of the court, based on evidence submitted to the court, that such person or persons have abandoned the person who [~~is intellectually disabled or person who is developmentally disabled~~] has a developmental disability. In addition, no process or notice shall be necessary to any individual who cannot, after due diligence, reasonably be located. The petitioner shall submit an affidavit to such effect.

§ 8. Section 1754 of the surrogate's court procedure act, as amended by chapter 198 of the laws of 2016, is amended to read as follows:

§ 1754. [~~Hearing and trial~~] Proceedings upon petition

1. Upon a petition for the appointment of a guardian of a person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability eighteen years of age or older, the court shall [~~conduct a hearing at which such person shall have the right to jury trial. The right to a jury trial shall be deemed waived by failure to make a demand therefor. The court may in its discretion dispense with a hearing for the appointment of a guardian, and may in its discretion appoint a guardian ad litem, or the mental hygiene legal service if such person is a resident of a mental hygiene facility as defined in subdivision (a) of section 47.01 of the mental hygiene law, to recommend whether the appointment of a guardian as proposed in the application is in the best interest of the person who is intellectually disabled or person who is developmentally disabled, provided however, that such application has been made by:~~

~~(a) both parents or the survivor; or~~

~~(b) one parent and the consent of the other parent; or~~

~~(c) any interested party and the consent of each parent.~~], not later than forty-five days following the filing of proof of mailing upon the mental hygiene legal service, schedule an appearance in the matter.

(a) The mental hygiene legal service shall ascertain whether the person with a developmental disability alleged to need a guardian has any objection to the relief sought in the petition and whether the service is unable to represent the interests of the person in the proceeding due to conflict of interest.

(b) If the service reports that the person with a developmental disability alleged to need a guardian objects to the relief sought in the petition, the court shall appoint the service as counsel for the person. If the service is not available to serve as the person's counsel and the person does not otherwise have counsel of his or her own choice, the court shall appoint counsel for the person from among attorneys eligible for such appointment pursuant to section thirty-five of the judiciary law. The court shall ensure that the individual's counsel, whether it be the service or appointed counsel, have demonstrated experience with and knowledge of representing individuals with developmental disabilities. The appointment of such counsel shall be at no cost to the petitioner.

(c) If the service reports that the person with a developmental disability alleged to need a guardian does not object to relief sought in the petition, the person's interests shall continue to be represented by the service, if available. The service shall conduct an examination into the allegations of fact contained in the petition and file with the court and serve upon the petitioner or their counsel, no later than ten days prior to the appearance date, an answer confirming or denying the allegations in the petition and report as to whether the service finds grounds to object to the relief sought in the petition. If appropriate and upon consent of the person with a developmental disability, the service may nominate a person or entity of the respondent's choosing to serve as guardian. The service will otherwise perform its functions consistent with uniform regulations promulgated by the appellate division of the supreme court.

(d) If a person with a developmental disability alleged to need a guardian does not object and does not otherwise appear by the service or other counsel, the court shall appoint a guardian ad litem to such person pursuant to this section and section four hundred three of this act. Any guardian ad litem appointed pursuant to this section shall conduct an investigation into the allegations of fact contained in the

petition and file with the court and serve no later than ten days prior to the appearance date, a report of its findings confirming or disconfirming said allegations, and if appropriate and upon consent of the person with a developmental disability nominate a person or entity of the respondent's choosing to serve as guardian, as well as any other matter which could assist the court's consideration of the matter, and serve a copy of the report upon the petitioner upon consent of the person with the developmental disability.

(e) The service, any other counsel for the person with a developmental disability alleged to need a guardian, or the guardian ad litem may apply to the court for permission to inspect the clinical records pertaining to the person with a developmental disability alleged to need a guardian in accordance with state and federal laws. The service, any other counsel for the person with a developmental disability and the guardian ad litem, if any, shall be afforded access to the person's clinical records without a court order to the extent that such access is otherwise authorized by state and federal laws.

(f) The service, any other counsel for the person with a developmental disability alleged to need a guardian, and the guardian ad litem, if any, may request the court for further evaluation of the person by a physician, psychiatrist or certified psychologist. In the event that further evaluations are required, the court may grant appropriate adjournments of the initial appearance date and may direct, in the case of a person determined to be indigent, that any further court authorized evaluations be paid for out of funds available pursuant to section thirty-five of the judiciary law. Such evaluation shall be at no cost to the petitioner.

2. [~~When it shall appear to the satisfaction of the court that a parent or parents not joining in or consenting to the application have abandoned the person who is intellectually disabled or person who is developmentally disabled or are not otherwise required to receive notice, the court may dispense with such parent's consent in determining the need to conduct a hearing for a person under the age of eighteen. However, if the consent of both parents or the surviving parent is dispensed with by the court, a hearing shall be held on the application~~] At the first appearance, the respondent shall be present unless such presence is excused by the court upon recommendation of the service, respondent's counsel, or the guardian ad litem if the respondent does not have counsel and upon consent of the respondent. The petitioner shall also be present and may be represented by counsel. Any other party required to be served or noticed with process in the matter may be present.

(a) Prior to such appearance, the petitioner, either personally or by counsel, may confer with the service, respondent's counsel and the guardian ad litem if respondent does not have counsel and agree to amend any part of its petition and allegations of fact therein. Any such amended petition shall be filed with the court prior to the date of the first appearance.

(b) At the first appearance, the court shall examine the answer of the service, respondent's counsel, and the report of the guardian ad litem, if any, and shall hear from the petitioner and the service, respondent's counsel and the guardian ad litem, if any, on the contents of the said answer or report and any amended petition filed.

(c) The court may direct that an order and decree of guardianship be issued, including the authority of the guardian to act on behalf of the respondent with respect to any matter in which petitioner, the service,

respondent's counsel, and the guardian ad litem, if any, all agree on the record that the respondent requires the requested relief and does not object to such relief.

(d) In the event that the petition cannot be disposed of by the agreement of the court and all of the parties, the court shall forthwith schedule a hearing on the matter at which the respondent shall be present unless the court determines, based on clear and convincing evidence, that the respondent's presence is medically contraindicated, in that it would be likely to cause harm to the respondent, or that the respondent is completely unable to participate in the hearing or where no meaningful participation will result from the respondent's presence at the hearing. Provided, however, that the respondent's presence shall not be waived over the objection of the service, respondent's counsel, or a guardian ad litem, if any. If the respondent physically cannot come or be brought to the courthouse, or the court determines, based on clear and convincing evidence that the respondent's presence would be harmful to the respondent, the hearing must be conducted where the respondent resides.

3. [~~If a hearing is conducted, the person who is intellectually disabled or person who is developmentally disabled shall be present unless it shall appear to the satisfaction of the court on the certification of the certifying physician that the person who is intellectually disabled or person who is developmentally disabled is medically incapable of being present to the extent that attendance is likely to result in physical harm to such person who is intellectually disabled or person who is developmentally disabled, or under such other circumstances which the court finds would not be in the best interest of the person who is intellectually disabled or person who is developmentally disabled~~] If there are any objections to the relief sought by the petitioner, the respondent has a right to a hearing or jury trial, if demanded by the respondent. In addition, the court may conduct a hearing at the request of any party or on its own motion. At any such hearing or trial, the petitioner must establish by clear and convincing evidence any facts alleged in the petition or amended petition which are controverted and are relevant to whether respondent has a developmental disability, and if so, whether appointment of a guardian is required as provided under subdivision one of section seventeen hundred fifty of this article and the scope of the guardian's powers.

4. [~~If either a hearing is dispensed with pursuant to subdivisions one and two of this section or the person who is intellectually disabled or person who is developmentally disabled is not present at the hearing pursuant to subdivision three of this section, the court may appoint a guardian ad litem if no mental hygiene legal service attorney is authorized to act on behalf of the person who is intellectually disabled or person who is developmentally disabled. The guardian ad litem or mental hygiene legal service attorney, if appointed, shall personally interview the person who is intellectually disabled or person who is developmentally disabled and shall submit a written report to the court.~~

~~5. If, upon conclusion of such hearing or jury trial or if none be held upon the application, the court is satisfied that the best interests of the person who is intellectually disabled or person who is developmentally disabled will be promoted by the appointment of a guardian of the person or property, or both, it shall make a decree naming such person or persons to serve as such guardians.~~] If, upon conclusion of such hearing or jury trial, if any, the court is satisfied, based on the standard outlined in this section and in subdivision one of section

seventeen hundred fifty of this article that the respondent has a developmental disability and requires the appointment of a guardian of the person or property, or both, it shall make a decree naming such person or persons to serve as such guardians. The court decree shall be designed to accomplish the least restrictive form of intervention by appointing a guardian with powers limited to those which the court has found necessary to assist the respondent in providing for personal needs and/or property management. The powers of the guardian shall be tailored to the needs of the respondent.

5. If the respondent is found to have agreed to the appointment of a guardian and the court determines that the appointment of a guardian is necessary, the court decree shall be designed to accomplish the least restrictive form of intervention by appointing a guardian with powers limited to those which the court has found necessary to assist the respondent in providing for personal needs and/or property management. The powers of the guardian shall be tailored to the needs of the respondent.

6. If the respondent is found to be a person with a developmental disability and the court determines that the appointment of a guardian is necessary, the court decree shall be designed to accomplish the least restrictive form of intervention by appointing a guardian with powers limited to those which the court has found necessary to assist the respondent in providing for personal needs and/or property management. The powers of the guardian shall be tailored to the needs of the respondent.

7. Where the court directs the appointment of a guardian pursuant to this section, the court shall make the following findings of fact on the record:

(a) the respondent's functional limitations which impair the respondent's ability to provide for personal and/or property management needs;

(b) the respondent's lack of understanding and appreciation of the nature and consequences of his or her functional limitations;

(c) the likelihood that the respondent will suffer harm because of the respondent's functional limitations and inability to adequately understand and appreciate the nature and consequences of such functional limitations;

(d) the necessity of the appointment of a guardian to prevent such harm;

(e) the specific powers of the guardian which constitute the least restrictive form of intervention consistent with the findings of this subdivision; and

(f) the duration of the appointment.

8. If the hearing is conducted without the respondent and the court appoints a guardian, the order of appointment shall set forth the factual basis for conducting the hearing without the presence of the respondent.

9. If the hearing is conducted in the presence of the respondent and the respondent is not represented by counsel, the court shall explain to the respondent, on the record, the purpose and possible consequences of the proceeding, the right to be represented by counsel of the respondent's own choice and the respondent's right to have counsel appointed if the respondent wishes to be represented by counsel and is unable to afford one, and shall inquire of the respondent whether he or she wishes to have an attorney appointed. If the respondent refuses the assistance of counsel, the court may nevertheless appoint counsel for the person from among the attorneys eligible for such appointment pursuant to

section thirty-five of the judiciary law, if the court is not satisfied that the respondent is capable of making an informed decision regarding the appointment of counsel. The appointment of such counsel shall be at no cost to the petitioner. The court shall ensure that the individual's counsel, whether it be the service or appointed counsel, has demonstrated experience with and knowledge of representing individuals with developmental disabilities.

10. The court shall direct that a decree be entered determining the rights of the parties.

11. The order and judgment must be entered and served within ten days of the signing of the order.

12. A copy of the order and decree shall be personally served upon and explained to the respondent in a manner which the respondent can reasonably be expected to understand by the counsel for the person, or by the guardian or the guardian ad litem.

§ 9. The surrogate's court procedure act is amended by adding a new section 1754-a to read as follows:

§ 1754-a. Decision making standard

Decisions made by a guardian on behalf of a person with a developmental disability shall be made in accordance with the following standards.

1. A guardian shall exercise authority only as necessitated by the person with a developmental disability's limitations, and, to the extent possible, shall encourage the person with a developmental disability to participate in decisions and to act on his or her own behalf.

2. A guardian shall consider the expressed desires and personal values of the person with a developmental disability to the extent known and shall afford the person with a developmental disability the greatest amount of independence and self-determination, when making decisions and shall consult with the person with a developmental disability whenever meaningful communication is possible.

3. If the person's wishes are unknown and remain unknown after reasonable efforts to discern them, the decision shall be made on the basis of the best interests of the person with a developmental disability as determined by the guardian. In determining the best interests of the person with a developmental disability, the guardian shall afford the person with a developmental disability the greatest amount of independence and self-determination, and shall weigh the reason for and nature of the proposed action; the benefit or necessity of the action, the possible risks and other consequences of the proposed action; and any available alternatives and their risks, consequences and benefits. The guardian shall take into account any other information, including the views of family and friends, that the guardian believes the person with a developmental disability would have considered if able to act for himself or herself.

§ 10. Section 1755 of the surrogate's court procedure act, as amended by chapter 198 of the laws of 2016, is amended to read as follows:

§ 1755. Modification order

1. Any person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability eighteen years of age or older, or any person on behalf of any person [~~who is intellectually disabled or person who is developmental disabled~~] with a developmental disability for whom a guardian has been appointed, may apply to the court [~~having jurisdiction over the guardianship order~~] pursuant to section seventeen hundred fifty-one-a of this article, requesting modification of such order in order to protect the [~~person who is intel-~~

~~lectually disabled's, or person who is developmentally disabled's~~] person with a developmental disability's financial situation and/or his or her personal interests.

2. The court [~~may~~] shall, upon receipt of any such request to modify the guardianship order, appoint the mental hygiene legal service, assigned counsel, or a guardian ad litem, as provided in paragraphs (a) through (f) of subdivision one of section seventeen hundred fifty-four of this article. The court shall so modify the guardianship order if in its judgment the guardianship is no longer needed or the interests of the guardian are adverse to those of the person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability or if the interests of justice will be best served including, but not limited to, facts showing the necessity for protecting the personal and/or financial interests of the person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability.

3. To the extent that relief sought under this section would terminate the guardianship or restore certain powers to the person with a developmental disability, the burden of proof shall be on the person objecting to such relief. To the extent that relief sought under this section would further limit the powers of the person with a developmental disability, the burden shall be on the person seeking such relief.

§ 11. Section 1756 of the surrogate's court procedure act, as amended by chapter 198 of the laws of 2016, is amended to read as follows:

§ 1756. Limited [~~guardian of the property~~] purpose and/or limited duration guardianship

1. When it shall appear to the satisfaction of the court that such person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability for whom an application for guardianship is made is eighteen years of age or older and is wholly or substantially self-supporting by means of his or her wages or earnings from employment, the court is authorized and empowered to appoint a limited guardian of the property of such person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability who shall receive, manage, disburse and account for only such property of said person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability as shall be received from other than the wages or earnings of said person.

The person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability for whom a limited guardian of the property has been appointed shall have the right to receive and expend any and all wages or other earnings of his or her employment and shall have the power to contract or legally bind himself or herself for such sum of money not exceeding one month's wages or earnings from such employment or three hundred dollars, whichever is greater, or as otherwise authorized by the court.

2. When it shall appear to the satisfaction of the court, either upon a petition for guardianship filed as permitted by sections seventeen hundred fifty-one and seventeen hundred fifty-two of this article or upon a petition filed pursuant to this section in a simplified format to be established by the office of court administration in consultation with the office for people with developmental disabilities and other interested stakeholders, that a person with a developmental disability needs the assistance of a guardian of the person and/or property for the purpose of making a single decision or for a brief stated period of transition in such person's life, the court may appoint a limited-pur-

pose guardian of the person and/or property to effectuate such a decision or transition. In any such case, the provisions of section seventeen hundred fifty-four of this article shall apply, except that the period for the rendering of a report by the mental hygiene legal service or other respondent's counsel may be shortened as may be reasonably necessary to meet the needs of the respondent under the circumstances presented. An order appointing and empowering such a limited-purpose guardian of the person and/or property shall state specifically the duration and scope of such guardian's authority. The nature and duration of the guardianship must bear a reasonable relation to the purpose for which the person is appointed a guardian.

§ 12. Section 1757 of the surrogate's court procedure act, as amended by chapter 198 of the laws of 2016, is amended to read as follows:

§ 1757. Standby guardian of a person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability

1. Upon application, a standby guardian of the person or property or both of a person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability may be appointed by the court. Any such application shall be made upon notice to the mental hygiene legal service. The court may also, upon application, appoint an alternate and/or successive alternates to such standby guardian, to act if such standby guardian shall die, or become incapacitated, or shall renounce. Such appointments by the court shall be made in accordance with the provisions of this article.

2. Such standby guardian, or alternate in the event of such standby guardian's death, incapacity or renunciation, shall without further proceedings be empowered to assume the duties of his or her office immediately upon death, renunciation or adjudication of incompetency of the guardian or standby guardian appointed pursuant to this article, subject only to the filing of an application for confirmation of his or her appointment by the court within one hundred eighty days following assumption of his or her duties of such office. Before confirming the appointment of the standby guardian or alternate guardian, the court may conduct a hearing pursuant to section seventeen hundred fifty-four of this article upon petition by anyone on behalf of the person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability or the person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability if such person is eighteen years of age or older, or upon its discretion.

3. Failure of a standby or alternate standby guardian to assume the duties of guardian, seek court confirmation or to renounce the guardianship within sixty days of written notice by certified mail or personal delivery given by or on behalf of the person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability of a prior guardian's inability to serve and the standby or alternate standby guardian's duty to serve, seek court confirmation or renounce such role shall allow the court to:

(a) deem the failure an implied renunciation of guardianship, and

(b) authorize, notwithstanding the time period provided for in subdivision two of this section to seek court confirmation, any remaining standby or alternate standby guardian to serve in such capacity provided (i) an application for confirmation and appropriate notices pursuant to subdivision one of section seventeen hundred fifty-three of this article are filed, or (ii) an application for modification of the guardianship

order pursuant to section seventeen hundred fifty-five of this article is filed.

§ 13. Subdivision 2 of section 1758 of the surrogate's court procedure act, as amended by chapter 198 of the laws of 2016, is amended to read as follows:

2. After the appointment of a guardian, standby guardian or alternate guardians, the court shall have and retain general jurisdiction over the person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability for whom such guardian shall have been appointed, to take of its own motion or to entertain and adjudicate such steps and proceedings relating to such guardian, standby, or alternate guardianship as may be deemed necessary or proper for the welfare of such person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability.

§ 14. Section 1759 of the surrogate's court procedure act, as amended by chapter 198 of the laws of 2016, is amended to read as follows:

§ 1759. Duration of guardianship

1. Such guardianship shall not terminate at the age of majority or marriage of such person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability but shall continue during the life of such person, during the period specified in a limited purpose or limited duration guardianship, or until terminated by the court.

2. A person eighteen years or older for whom such a guardian has been previously appointed or anyone, including the guardian, on behalf of a person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability for whom a guardian has been appointed may petition the court which made such appointment or the court in his or her county of residence to have the guardian discharged and a successor appointed, or to have the guardian of the property designated as a limited guardian of the property, or to have the guardianship order modified, dissolved or otherwise amended. Upon such a petition for review, the court shall conduct a hearing pursuant to section seventeen hundred fifty-four of this article, and shall apply all applicable standards outlined in this article, including those outlined in sections seventeen hundred fifty, seventeen hundred fifty-five, seventeen hundred fifty-six and seventeen hundred fifty-seven of this article.

3. Upon marriage of such person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability for whom such a guardian has been appointed, the court shall, upon request of the person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability, spouse, or any other person acting on behalf of the person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability, review the need, if any, to modify, dissolve or otherwise amend the guardianship order including, but not limited to, the appointment of the spouse as standby guardian. The court, in its discretion, may conduct such review pursuant to [~~section~~] the standards laid out in sections seventeen hundred fifty,seventeen hundred fifty-four, seventeen hundred fifty-five, seventeen hundred fifty-six and seventeen hundred fifty seven of this article.

§ 15. Section 1760 of the surrogate's court procedure act, as amended by chapter 198 of the laws of 2016, is amended to read as follows:

§ 1760. Corporate guardianship

No corporation may be appointed guardian of the person under the provisions of this article, except that a non-profit corporation organized and existing under the laws of the state of New York and having the corporate power to act as guardian of a person [~~who is intellectually disabled or person who is developmentally disabled~~] **with a developmental disability** may be appointed as the guardian of the person only of such person [~~who is intellectually disabled or person who is developmentally disabled~~] **with a developmental disability**.

§ 16. Section 1761 of the surrogate's court procedure act, as amended by chapter 198 of the laws of 2016, is amended to read as follows:

§ 1761. Application of other provisions

To the extent that the context thereof shall admit, the provisions of article seventeen of this act shall apply to all proceedings under this article with the same force and effect as if an "infant", as therein referred to, were a "person [~~who is intellectually disabled" or "person who is developmentally disabled"~~] **with a developmental disability"** as herein defined, and a "guardian" as therein referred to were a "guardian of the person [~~who is intellectually disabled or a "guardian of a person who is developmentally disabled"~~] **with a developmental disability**" as herein provided for.

§ 17. The surrogate's court procedure act is amended by adding a new section 1762 to read as follows:

§ 1762. Annual report of personal needs guardian

1. For the purposes of this article, the guardian of a person with a developmental disability shall submit a simplified report regarding the status of the person with a developmental disability annually on the anniversary of his or her appointment or at such other interval as ordered by the court.

2. The simplified report shall be on a form prescribed by the office of court administration and shall be reviewed by the court.

3. A corporate guardian appointed pursuant to section seventeen hundred sixty of this article may submit in lieu of the form prescribed by the office of court administration in subdivision two of this section its own internal report provided the information required by the office of court administration to be contained in the report is included in the corporate annual report.

4. The guardianship report form shall be filed with the court and mailed to standby guardians and alternate standby guardians, and, where applicable, the director of mental hygiene legal service in the department in which the person with a developmental disability resides and the director of the residence of the person with a developmental disability or the person with whom the person with a developmental disability resides.

§ 18. Paragraph a of subdivision 1 of section 35 of the judiciary law, as amended by chapter 817 of the laws of 1986, is amended to read as follows:

a. When a court orders a hearing in a proceeding upon a writ of habeas corpus to inquire into the cause of detention of a person in custody in a state institution, or when it orders a hearing in a civil proceeding to commit or transfer a person to or retain him in a state institution when such person is alleged to be mentally ill, mentally defective or a narcotic addict, or when it orders a hearing for the commitment of the guardianship and custody of a child to an authorized agency by reason of the mental illness or [~~mental retardation~~] **developmental disability** of a parent, **or when it orders a hearing for guardianship under article seventeen-A of the surrogate's court procedure act,** or when it orders a

hearing to determine whether consent to the adoption of a child shall be required of a parent who is alleged to be mentally ill or [~~mentally retarded~~] **have a developmental disability**, or when it orders a hearing to determine the best interests of a child when the parent of the child revokes a consent to the adoption of such child and such revocation is opposed or in any adoption or custody proceeding if it determines that assignment of counsel in such cases is mandated by the constitution of this state or of the United States, the court may assign counsel to represent such person if it is satisfied that he is financially unable to obtain counsel. Upon an appeal taken from an order entered in any such proceeding, the appellate court may assign counsel to represent such person upon the appeal if it is satisfied that he is financially unable to obtain counsel.

§ 19. Subdivision 4 of section 35 of the judiciary law, as amended by chapter 706 of the laws of 1975 and as renumbered by chapter 315 of the laws of 1985, is amended to read as follows:

4. In any proceeding described in paragraph (a) of subdivision one of this section, when a person is alleged to **be a person with a developmental disability in need of a guardian pursuant to article seventeen-A of the surrogate's court procedure act,** be mentally ill, mentally defective or a narcotic addict, the court which ordered the hearing may appoint no more than two psychiatrists, certified psychologists or physicians to examine and testify at the hearing upon the condition of such person. A psychiatrist, psychologist or physician so appointed shall, upon completion of his services, receive reimbursement for expenses reasonably incurred and reasonable compensation for such services, to be fixed by the court. Such compensation shall not exceed two hundred dollars if one psychiatrist, psychologist or physician is appointed, or an aggregate sum of three hundred dollars if two psychiatrists, psychologists or physicians are appointed, except that in extraordinary circumstances the court may provide for compensation in excess of the foregoing limits.

§ 20. This act shall take effect on the one hundred eightieth day after it shall have become a law.

S T A T E O F N E W Y O R K

4983

2015-2016 Regular Sessions

I N S E N A T E

April 27, 2015

Introduced by Sen. ORTT -- (at request of the Office for People with Developmental Disabilities) -- read twice and ordered printed, and when printed to be committed to the Committee on Judiciary

AN ACT to amend the surrogate's court procedure act, in relation to guardianship and health care decisions of persons with developmental disabilities; and to repeal certain provisions of such law relating thereto

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Section 1750 of the surrogate's court procedure act, as amended by chapter 500 of the laws of 2002, is amended to read as follows:

S 1750. Guardianship of [mentally retarded] persons WITH DEVELOPMENTAL DISABILITIES

1. When it shall appear to the satisfaction of the court that a person is a [mentally retarded] person WITH A DEVELOPMENTAL DISABILITY WITHIN THE MEANING OF SUBDIVISION TWENTY-TWO OF SECTION 1.03 OF THE MENTAL HYGIENE LAW AND THAT SUCH PERSON, AS A RESULT OF SUCH DEVELOPMENTAL DISABILITY, EXHIBITS SIGNIFICANT IMPAIRMENT OF GENERAL OR SPECIFIC AREAS OF INTELLECTUAL FUNCTIONING AND/OR ADAPTIVE BEHAVIORS IN SPECIFIED DOMAINS AS ENUMERATED IN SUBDIVISION EIGHT OF SECTION SEVENTEEN HUNDRED FIFTY-TWO OF THIS ARTICLE, the court is authorized to appoint a guardian of the person or of the property or of both if such appointment of a guardian or guardians is in the best interest of the [mentally retarded] person WITH A DEVELOPMENTAL DISABILITY. Such appointment shall be made pursuant to the provisions of this article[, provided however that the provisions of section seventeen hundred fifty-a of this article shall not apply to the appointment of a guardian or guardians of a mentally retarded person].

[1. For the purposes of this article, a mentally retarded person is a person who has been certified by one licensed physician and one licensed

EXPLANATION--Matter in ITALICS (underscored) is new; matter in brackets [ ] is old law to be omitted.

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psychologist, or by two licensed physicians at least one of whom is familiar with or has professional knowledge in the care and treatment of persons with mental retardation, having qualifications to make such certification, as being incapable to manage him or herself and/or his or her affairs by reason of mental retardation and that such condition is permanent in nature or likely to continue indefinitely.]

2. EVERY GUARDIANSHIP ENTERED INTO PURSUANT TO THIS ARTICLE PRIOR TO THE EFFECTIVE DATE OF THIS SUBDIVISION, INCLUDING ORDERS AND DECREES PURSUANT TO SECTION SEVENTEEN HUNDRED FIFTY-SEVEN OF THIS ARTICLE, SHALL REMAIN IN FULL FORCE AND EFFECT THEREAFTER, EXCEPT AS AMENDED PURSUANT TO SECTION SEVENTEEN HUNDRED FIFTY-FIVE OF THIS ARTICLE OR AS ORDERED BY THE COURT; AND ANY SUCH GUARDIANSHIP SHALL BE ADMINISTERED CONSISTENT WITH THE SUBSTANTIVE AND PROCEDURAL REQUIREMENTS SET FORTH IN THIS ARTICLE.

[2.] 3. Every [such certification pursuant to subdivision one of this section,] ORDER AND DECREE made on or after the effective date of this subdivision, shall include a specific determination by [such physician and psychologist, or by such physicians,] THE ISSUING COURT as to whether the [mentally retarded] person WITH A DEVELOPMENTAL DISABILITY has the capacity to make health care decisions, as defined by subdivision three of section twenty-nine hundred eighty of the public health law, for himself or herself. A determination that the [mentally retarded] person WITH A DEVELOPMENTAL DISABILITY has the capacity to make health care decisions shall not preclude the appointment of a guardian pursuant to this section to make other decisions on behalf of the [mentally retarded] person WITH A DEVELOPMENTAL DISABILITY. The absence of this determination in the case of guardians appointed prior to [the effective date of this subdivision] MARCH 16, 2003, shall not preclude such guardians from making health care decisions. FURTHER, GUARDIANS APPOINTED BY ORDERS AND/OR DECREES ISSUED PRIOR TO THE EFFECTIVE DATE OF THIS SUBDIVISION SHALL HAVE AUTHORITY IN ALL AREAS, UNLESS OTHERWISE STATED.

S 2. Section 1750-a of the surrogate's court procedure act is REPEALED.

S 3. Section 1750-b of the surrogate's court procedure act, as added by chapter 500 of the laws of 2002, subdivision 1 as amended by chapter 105 of the laws of 2007, the opening paragraph, paragraphs (a) and (b) of subdivision 1 and the opening paragraph of subdivision 4 as amended by chapter 8 of the laws of 2010, subparagraph (i) of paragraph (a) and clause A of subparagraph (i) of paragraph (e) of subdivision 4 as amended by section 18 of part J of chapter 56 of the laws of 2012, and paragraph (d) of subdivision 5 as added by chapter 262 of the laws of 2008, is amended to read as follows:

S 1750-b. Health care decisions for [mentally retarded] persons WITH DEVELOPMENTAL DISABILITIES

1. Scope of authority. AS USED IN THIS SECTION, THE TERM "DEVELOPMENTAL DISABILITY" IS AS DEFINED BY SUBDIVISION TWENTY-TWO OF SECTION 1.03 OF THE MENTAL HYGIENE LAW. Unless specifically prohibited by the court after consideration of [the determination, if any, regarding a mentally retarded person's] A PERSON WITH A DEVELOPMENTAL DISABILITY'S capacity to make health care decisions, which is required by section seventeen hundred fifty of this article, the guardian of such person appointed pursuant to section seventeen hundred fifty of this article shall have the authority to make any and all health care decisions, as defined by subdivision six of section twenty-nine hundred eighty of the public health law, on behalf of the [mentally retarded] person WITH A DEVELOPMENTAL DISABILITY that such person could make if such person had

capacity. Such decisions may include decisions to withhold or withdraw life-sustaining treatment. For purposes of this section, "life-sustaining treatment" means medical treatment, including cardiopulmonary resuscitation and nutrition and hydration provided by means of medical treatment, which is sustaining life functions and without which, according to reasonable medical judgment, the patient will die within a relatively short time period. Cardiopulmonary resuscitation is presumed to be life-sustaining treatment without the necessity of a medical judgment by an attending physician. The provisions of this article are not intended to permit or promote suicide, assisted suicide or euthanasia; accordingly, nothing in this section shall be construed to permit a guardian to consent to any act or omission to which the [mentally retarded] person WITH A DEVELOPMENTAL DISABILITY could not consent if such person had capacity.

(a) For the purposes of making a decision to withhold or withdraw life-sustaining treatment pursuant to this section, in the case of a person for whom no guardian has been appointed pursuant to section seventeen hundred fifty [or seventeen hundred fifty-a] of this article, a "guardian" shall also mean a family member of a person who [(i) has mental retardation, or (ii)] has a developmental disability, as defined in SUBDIVISION TWENTY-TWO OF section 1.03 of the mental hygiene law, [which (A) includes mental retardation, or (B) results in a similar impairment of general intellectual functioning or adaptive behavior so that such person is incapable of managing himself or herself, and/or his or her affairs by reason of such developmental disability] AND THAT SUCH PERSON, AS A RESULT OF SUCH DEVELOPMENTAL DISABILITY, EXHIBITS SIGNIFICANT IMPAIRMENT OF GENERAL OR SPECIFIC AREAS OF INTELLECTUAL FUNCTIONING AND/OR ADAPTIVE BEHAVIORS IN SPECIFIED DOMAINS AS ENUMERATED IN SUBDIVISION EIGHT OF SECTION SEVENTEEN HUNDRED FIFTY-TWO OF THIS ARTICLE. Qualified family members shall be included in a prioritized list of said family members pursuant to regulations established by the commissioner of [mental retardation and] developmental disabilities. Such family members must have a significant and ongoing involvement in a person's life so as to have sufficient knowledge of their needs and, when reasonably known or ascertainable, the person's wishes, including moral and religious beliefs. In the case of a person who was a resident of the former Willowbrook state school on March seventeenth, nineteen hundred seventy-two and those individuals who were in community care status on that date and subsequently returned to Willowbrook or a related facility, who are fully represented by the consumer advisory board and who have no guardians appointed pursuant to this article or have no qualified family members to make such a decision, then a "guardian" shall also mean the Willowbrook consumer advisory board. A decision of such family member or the Willowbrook consumer advisory board to withhold or withdraw life-sustaining treatment shall be subject to all of the protections, procedures and safeguards which apply to the decision of a guardian to withhold or withdraw life-sustaining treatment pursuant to this section.

In the case of a person for whom no guardian has been appointed pursuant to this article or for whom there is no qualified family member or the Willowbrook consumer advisory board available to make such a decision, a "guardian" shall also mean, notwithstanding the definitions in section 80.03 of the mental hygiene law, a surrogate decision-making committee, as defined in article eighty of the mental hygiene law. All declarations and procedures, including expedited procedures, to comply with this section shall be established by regulations promulgated by the

[commission on quality of care and advocacy for persons with disabilities] JUSTICE CENTER FOR THE PROTECTION OF PEOPLE WITH SPECIAL NEEDS, AS ESTABLISHED BY ARTICLE TWENTY OF THE EXECUTIVE LAW.

(b) Regulations establishing the prioritized list of qualified family members required by paragraph (a) of this subdivision shall be developed by the commissioner of [mental retardation and] developmental disabilities in conjunction with parents, advocates and family members of persons [who are mentally retarded] WITH DEVELOPMENTAL DISABILITIES. Regulations to implement the authority of the Willowbrook consumer advisory board pursuant to paragraph (a) of this subdivision may be promulgated by the commissioner of the office of [mental retardation and] developmental disabilities with advice from the Willowbrook consumer advisory board.

(c) Notwithstanding any provision of law to the contrary, the formal determinations required pursuant to section seventeen hundred fifty of this article shall only apply to guardians appointed pursuant to section seventeen hundred fifty [or seventeen hundred fifty-a] of this article.

2. Decision-making standard. (a) The guardian shall base all advocacy and health care decision-making solely and exclusively on the best interests of the [mentally retarded] person WITH A DEVELOPMENTAL DISABILITY and, when reasonably known or ascertainable with reasonable diligence, on [the mentally retarded] SUCH person's wishes, including moral and religious beliefs.

(b) An assessment of the [mentally retarded person's] PERSON WITH A DEVELOPMENTAL DISABILITY'S best interests shall include consideration of:

(i) the dignity and uniqueness of every person;

(ii) the preservation, improvement or restoration of the [mentally retarded person's] PERSON WITH A DEVELOPMENTAL DISABILITY'S health;

(iii) the relief of the [mentally retarded person's] PERSON WITH A DEVELOPMENTAL DISABILITY'S suffering by means of palliative care and pain management;

(iv) the unique nature of [artificially provided] nutrition or hydration PROVIDED BY MEANS OF MEDICAL TREATMENT, and the effect it may have on the [mentally retarded] person WITH A DEVELOPMENTAL DISABILITY; and

(v) the entire medical condition of the person.

(c) No health care decision shall be influenced in any way by:

(i) a presumption that persons with [mental retardation] DEVELOPMENTAL DISABILITIES are not entitled to the full and equal rights, equal protection, respect, medical care and dignity afforded to persons without [mental retardation or] developmental disabilities; or

(ii) financial considerations of the guardian, as such considerations affect the guardian, a health care provider or any other party.

3. Right to receive information. Subject to the provisions of sections 33.13 and 33.16 of the mental hygiene law, the guardian shall have the right to receive all medical information and medical and clinical records necessary to make informed decisions regarding the [mentally retarded person's] PERSON WITH A DEVELOPMENTAL DISABILITY'S health care.

4. Life-sustaining treatment. The guardian shall have the affirmative obligation to advocate for the full and efficacious provision of health care, including life-sustaining treatment. In the event that a guardian makes a decision to withdraw or withhold life-sustaining treatment from a [mentally retarded] person WITH A DEVELOPMENTAL DISABILITY:

(a) The attending physician, as defined in subdivision two of section twenty-nine hundred eighty of the public health law, must confirm to a

reasonable degree of medical certainty that the [mentally retarded] person WITH A DEVELOPMENTAL DISABILITY lacks capacity to make health care decisions. The determination thereof shall be included in the [mentally retarded person's] PERSON WITH A DEVELOPMENTAL DISABILITY'S medical record, and shall contain such attending physician's opinion regarding the cause and nature of the [mentally retarded] person's incapacity as well as its extent and probable duration. The attending physician who makes the confirmation shall consult with another physician, or a [licensed] psychologist, to further confirm the [mentally retarded] person's lack of capacity. The attending physician who makes the confirmation, or the physician or licensed psychologist with whom the attending physician consults, must (i) be employed by a developmental disabilities services office named in section 13.17 of the mental hygiene law or employed by the office for people with developmental disabilities to provide treatment and care to people with developmental disabilities, or

(ii) have been employed for a minimum of two years to render care and service in a facility or program operated, licensed or authorized by the office [of mental retardation and] FOR PEOPLE WITH developmental disabilities, or

(iii) have been approved by the commissioner of [mental retardation and] developmental disabilities in accordance with regulations promulgated by such commissioner. Such regulations shall require that a physician or licensed psychologist possess specialized training or three years experience in treating [mental retardation] PEOPLE WITH DEVELOPMENTAL DISABILITIES. A record of such consultation shall be included in the [mentally retarded person's] PERSON WITH A DEVELOPMENTAL DISABILITY'S medical record.

(b) The attending physician, as defined in subdivision two of section twenty-nine hundred eighty of the public health law, with the concurrence of another physician with whom such attending physician shall consult, must determine to a reasonable degree of medical certainty and note on the [mentally retarded person's] PERSON WITH A DEVELOPMENTAL DISABILITY'S chart that:

(i) the [mentally retarded] person has a medical condition as follows:

A. a terminal condition, as defined in subdivision twenty-three of section twenty-nine hundred sixty-one of the public health law; or

B. permanent unconsciousness; or

C. a medical condition other than such person's [mental retardation] DEVELOPMENTAL DISABILITY which requires life-sustaining treatment, is irreversible and which will continue indefinitely; and

(ii) the life-sustaining treatment would impose an extraordinary burden on such person, in light of:

A. such person's medical condition, other than such person's [mental retardation] DEVELOPMENTAL DISABILITY; and

B. the expected outcome of the life-sustaining treatment, notwithstanding such person's [mental retardation] DEVELOPMENTAL DISABILITY; and

(iii) in the case of a decision to withdraw or withhold artificially provided nutrition or hydration:

A. there is no reasonable hope of maintaining life; or

B. the artificially provided nutrition or hydration poses an extraordinary burden.

(c) The guardian shall express a decision to withhold or withdraw life-sustaining treatment either:

(i) in writing, dated and signed in the presence of one witness eighteen years of age or older who shall sign the decision, and presented to

the attending physician, as defined in subdivision two of section twenty-nine hundred eighty of the public health law; or

(ii) orally, to two persons eighteen years of age or older, at least one of whom is the [mentally retarded person's] PERSON WITH A DEVELOPMENTAL DISABILITY'S attending physician, as defined in subdivision two of section twenty-nine hundred eighty of the public health law.

(d) The attending physician, as defined in subdivision two of section twenty-nine hundred eighty of the public health law, who is provided with the decision of a guardian shall include the decision in the [mentally retarded person's] PERSON WITH A DEVELOPMENTAL DISABILITY'S medical chart, and shall either:

(i) promptly issue an order to withhold or withdraw life-sustaining treatment from the [mentally retarded] person, and inform the staff responsible for such person's care, if any, of the order; or

(ii) promptly object to such decision, in accordance with subdivision five of this section.

(e) At least forty-eight hours prior to the implementation of a decision to withdraw life-sustaining treatment, or at the earliest possible time prior to the implementation of a decision to withhold life-sustaining treatment, the attending physician shall notify:

(i) the [mentally retarded] person WITH A DEVELOPMENTAL DISABILITY, except if the attending physician determines, in writing and in consultation with another physician or a licensed psychologist, that, to a reasonable degree of medical certainty, the person would suffer immediate and severe injury from such notification. The attending physician who makes the confirmation, or the physician or licensed psychologist with whom the attending physician consults, shall:

A. be employed by a developmental disabilities services office named in section 13.17 of the mental hygiene law or employed by the office for people with developmental disabilities to provide treatment and care to people with developmental disabilities, or

B. have been employed for a minimum of two years to render care and service in a facility operated, licensed or authorized by the office [of mental retardation and] FOR PEOPLE WITH developmental disabilities, or

C. have been approved by the commissioner of [mental retardation and] developmental disabilities in accordance with regulations promulgated by such commissioner. Such regulations shall require that a physician or licensed psychologist possess specialized training or three years experience in treating mental retardation. A record of such consultation shall be included in the [mentally retarded] person's medical record;

(ii) if the person is in or was transferred from a residential facility operated, licensed or authorized by the office [of mental retardation and] FOR PEOPLE WITH developmental disabilities, the chief executive officer of the agency or organization operating such facility and the mental hygiene legal service; and

(iii) if the person is not in and was not transferred from such a facility or program, the commissioner of [mental retardation and] developmental disabilities, or his or her designee.

5. Objection to health care decision. (a) Suspension. A health care decision made pursuant to subdivision four of this section shall be suspended, pending judicial review, except if the suspension would in reasonable medical judgment be likely to result in the death of the [mentally retarded] person WITH A DEVELOPMENTAL DISABILITY, in the event of an objection to that decision at any time by:

(i) the [mentally retarded] person on whose behalf such decision was made; or

(ii) a parent or adult sibling who either resides with or has maintained substantial and continuous contact with the [mentally retarded] person; or

(iii) the attending physician, as defined in subdivision two of section twenty-nine hundred eighty of the public health law; or

(iv) any other health care practitioner providing services to the [mentally retarded] person WITH A DEVELOPMENTAL DISABILITY, who is licensed pursuant to article one hundred thirty-one, one hundred thirty-one-B, one hundred thirty-two, one hundred thirty-three, one hundred thirty-six, one hundred thirty-nine, one hundred forty-one, one hundred forty-three, one hundred forty-four, one hundred fifty-three, one hundred fifty-four, one hundred fifty-six, one hundred fifty-nine or one hundred sixty-four of the education law; or

(v) the chief executive officer identified in subparagraph (ii) of paragraph (e) of subdivision four of this section; or

(vi) if the person is in or was transferred from a residential facility or program operated, approved or licensed by the office [of mental retardation and] FOR PEOPLE WITH developmental disabilities, the mental hygiene legal service; or

(vii) if the person is not in and was not transferred from such a facility or program, the commissioner of [mental retardation and] developmental disabilities, or his or her designee.

(b) Form of objection. Such objection shall occur orally or in writing.

(c) Notification. In the event of the suspension of a health care decision pursuant to this subdivision, the objecting party shall promptly notify the guardian and the other parties identified in paragraph (a) of this subdivision, and the attending physician shall record such suspension in the [mentally retarded person's] PERSON WITH A DEVELOPMENTAL DISABILITY'S medical chart.

(d) Dispute mediation. In the event of an objection pursuant to this subdivision, at the request of the objecting party or person or entity authorized to act as a guardian under this section, except a surrogate decision making committee established pursuant to article eighty of the mental hygiene law, such objection shall be referred to a dispute mediation system, established pursuant to section two thousand nine hundred seventy-two of the public health law or similar entity for mediating disputes in a hospice, such as a patient's advocate's office, hospital chaplain's office or ethics committee, as described in writing and adopted by the governing authority of such hospice, for non-binding mediation. In the event that such dispute cannot be resolved within seventy-two hours or no such mediation entity exists or is reasonably available for mediation of a dispute, the objection shall proceed to judicial review pursuant to this subdivision. The party requesting mediation shall provide notification to those parties entitled to notice pursuant to paragraph (a) of this subdivision.

6. Special proceeding authorized. The guardian, the attending physician, as defined in subdivision two of section twenty-nine hundred eighty of the public health law, the chief executive officer identified in subparagraph (ii) of paragraph (e) of subdivision four of this section, the mental hygiene legal service (if the person is in or was transferred from a residential facility or program operated, approved or licensed by the office [of mental retardation and] FOR PEOPLE WITH developmental disabilities) or the commissioner of [mental retardation and] developmental disabilities or his or her designee (if the person is not in and was not transferred from such a facility or program) may

commence a special proceeding in a court of competent jurisdiction with respect to any dispute arising under this section, including objecting to the withdrawal or withholding of life-sustaining treatment because such withdrawal or withholding is not in accord with the criteria set forth in this section.

7. Provider's obligations. (a) A health care provider shall comply with the health care decisions made by a guardian in good faith pursuant to this section, to the same extent as if such decisions had been made by the [mentally retarded] person WITH A DEVELOPMENTAL DISABILITY, if such person had capacity.

(b) Notwithstanding paragraph (a) of this subdivision, nothing in this section shall be construed to require a private hospital to honor a guardian's health care decision that the hospital would not honor if the decision had been made by the [mentally retarded] person WITH A DEVELOPMENTAL DISABILITY, if such person had capacity, because the decision is contrary to a formally adopted written policy of the hospital expressly based on religious beliefs or sincerely held moral convictions central to the hospital's operating principles, and the hospital would be permitted by law to refuse to honor the decision if made by such person, provided:

(i) the hospital has informed the guardian of such policy prior to or upon admission, if reasonably possible; and

(ii) the [mentally retarded] person WITH A DEVELOPMENTAL DISABILITY is transferred promptly to another hospital that is reasonably accessible under the circumstances and is willing to honor the guardian's decision. If the guardian is unable or unwilling to arrange such a transfer, the hospital's refusal to honor the decision of the guardian shall constitute an objection pursuant to subdivision five of this section.

(c) Notwithstanding paragraph (a) of this subdivision, nothing in this section shall be construed to require an individual health care provider to honor a guardian's health care decision that the individual would not honor if the decision had been made by the [mentally retarded] person WITH A DEVELOPMENTAL DISABILITY, if such person had capacity, because the decision is contrary to the individual's religious beliefs or sincerely held moral convictions, provided the individual health care provider promptly informs the guardian and the facility, if any, of his or her refusal to honor the guardian's decision. In such event, the facility shall promptly transfer responsibility for the [mentally retarded] person WITH A DEVELOPMENTAL DISABILITY to another individual health care provider willing to honor the guardian's decision. The individual health care provider shall cooperate in facilitating such transfer of the patient.

(d) Notwithstanding the provisions of any other paragraph of this subdivision, if a guardian directs the provision of life-sustaining treatment, the denial of which in reasonable medical judgment would be likely to result in the death of the [mentally retarded] person WITH A DEVELOPMENTAL DISABILITY, a hospital or individual health care provider that does not wish to provide such treatment shall nonetheless comply with the guardian's decision pending either transfer of the mentally retarded person to a willing hospital or individual health care provider, or judicial review.

(e) Nothing in this section shall affect or diminish the authority of a surrogate decision-making panel to render decisions regarding major medical treatment pursuant to article eighty of the mental hygiene law.

8. Immunity. (a) Provider immunity. 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 reasonably and in good faith a health care decision by a guardian, or for other actions taken reasonably and in good faith pursuant to this section.

(b) Guardian immunity. No guardian shall be subjected to criminal or civil liability for making a health care decision reasonably and in good faith pursuant to this section.

S 4. Section 1751 of the surrogate's court procedure act, as added by chapter 675 of the laws of 1989, is amended to read as follows:

S 1751. Petition for appointment; by whom made

(A) A petition for the appointment of a guardian [of the person or property, or both,] of a [mentally retarded or developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY PURSUANT TO THIS ARTICLE may be made by THE PERSON WITH A DEVELOPMENTAL DISABILITY WHEN SUCH PERSON IS EIGHTEEN YEARS OF AGE OR OLDER, a parent, SPOUSE, SIBLING, ADULT CHILD OR any OTHER interested person eighteen years of age or older on behalf of the [mentally retarded or developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY including a corporation authorized to serve as a guardian as provided for by this article[, or by the mentally retarded or developmentally disabled person when such person is eighteen years of age or older].

(B) A PERSON WITH A DEVELOPMENTAL DISABILITY MAY KNOWINGLY AND VOLUNTARILY CONSENT TO THE APPOINTMENT OF A GUARDIAN PURSUANT TO THIS ARTICLE.

S 5. The surrogate's court procedure act is amended by adding a new section 1751-a to read as follows:

S 1751-A. PETITION FOR APPOINTMENT; WHERE MADE (VENUE)

1. A PROCEEDING UNDER THIS ARTICLE SHALL BE BROUGHT IN THE SURROGATE'S COURT WITHIN THE COUNTY IN WHICH THE PERSON WITH A DEVELOPMENTAL DISABILITY RESIDES, OR IS PHYSICALLY PRESENT AT THE TIME THE PROCEEDING IS COMMENCED. IF THE PERSON WITH A DEVELOPMENTAL DISABILITY ALLEGED TO BE IN NEED OF A GUARDIAN IS BEING CARED FOR AS A RESIDENT IN A FACILITY, THE RESIDENCE OF THAT PERSON SHALL BE DEEMED TO BE IN THE COUNTY WHERE THE FACILITY IS LOCATED AND THE PROCEEDING SHALL BE BROUGHT IN THAT COUNTY, SUBJECT TO APPLICATION BY AN INTERESTED PARTY FOR A CHANGE IN VENUE TO ANOTHER COUNTY BECAUSE OF THE INCONVENIENCE OF THE PARTIES OR WITNESSES OR THE CONDITION OF THE PERSON ALLEGED TO BE IN NEED OF A GUARDIAN.

2. AFTER THE APPOINTMENT OF A GUARDIAN, ANY PROCEEDING TO MODIFY A PRIOR ORDER SHALL BE BROUGHT IN THE SURROGATE'S COURT WHICH GRANTED THE PRIOR ORDER, UNLESS AT THE TIME OF THE APPLICATION TO MODIFY THE ORDER THE PERSON WITH A DEVELOPMENTAL DISABILITY RESIDES ELSEWHERE, IN WHICH CASE THE PROCEEDING SHALL BE BROUGHT IN THE COUNTY WHERE THE PERSON WITH A DEVELOPMENTAL DISABILITY RESIDES, WITHOUT THE NEED FOR A MOTION TO TRANSFER VENUE.

S 6. Section 1752 of the surrogate's court procedure act, as added by chapter 675 of the laws of 1989, is amended to read as follows:

S 1752. Petition for appointment; contents

The petition for the appointment of a guardian shall be filed with the court on forms to be prescribed by the state chief administrator of the courts. Such petition for a guardian of a [mentally retarded or developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY shall include, but not be limited to, the following information:

1. the full name, date of birth and residence of the [mentally retarded or developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY;

2. the name, age, address and relationship or interest of the petitioner to the [mentally retarded or developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY;

3. the names AND ADDRESSES, IF KNOWN, of the father, the mother, ADULT children, adult siblings [if eighteen years of age or older,] AND the spouse [and primary care physician if other than a physician having submitted a certification with the petition, if any,] of the [mentally retarded or developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY and whether or not they are living, and if living, their addresses and the names and addresses of the nearest distributees of full age who are domiciliaries, if both parents are dead;

4. the name and address of the person [with whom the mentally retarded or developmentally disabled] CARING FOR THE person WITH A DEVELOPMENTAL DISABILITY, OR WITH WHOM THE PERSON WITH A DEVELOPMENTAL DISABILITY resides if other than the parents or spouse;

5. THE NAME AND ADDRESS OF ANY PERSON WITH SIGNIFICANT AND ONGOING INVOLVEMENT IN THE LIFE OF THE PERSON WITH A DEVELOPMENTAL DISABILITY SO AS TO HAVE SUFFICIENT KNOWLEDGE OF THEIR NEEDS, IF SUCH PERSONS ARE KNOWN TO THE PETITIONER;

6. the name, age, address, education and other qualifications, and consent of the proposed guardian, standby and alternate guardian, if other than the parent, spouse, adult child if eighteen years of age or older or adult sibling if eighteen years of age or older, and if such parent, spouse or adult child be living, why any of them should not be appointed guardian;

[6.] 7. the estimated value of real and personal property and the annual income therefrom and any other income including governmental entitlements to which the [mentally retarded or developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY is entitled; and

[7. any circumstances which the court should consider in determining whether it is in the best interests of the mentally retarded or developmentally disabled person not be be present at the hearing if conducted.]

8. AN ENUMERATION OF THE SPECIFIC DOMAINS IN WHICH THE PERSON WITH A DEVELOPMENTAL DISABILITY IS ALLEGED TO BE IN NEED OF A GUARDIAN OR A STATEMENT THAT FULL GUARDIANSHIP IS SOUGHT. SPECIFIC DOMAINS MAY BE INCLUDED WHICH MAY INCLUDE:

(I) CONSENT TO OR REFUSAL TO CONSENT TO HEALTH CARE OR OTHER PROFESSIONAL CARE;

(II) MANAGEMENT OF MONEY OR OTHER INCOME, ASSETS OR PROPERTY;

(III) ACCESS TO CONFIDENTIAL AND OTHER SENSITIVE INFORMATION;

(IV) CHOICES INVOLVING EDUCATION, TRAINING, EMPLOYMENT, SUPPORTS AND SERVICES;

(V) REQUESTING ADVOCACY, LEGAL OR OTHER PROFESSIONAL SERVICES;

(VI) CHOICE OF RESIDENCE AND SHARED LIVING ARRANGEMENTS;

(VII) CHOICES AS TO SOCIAL AND RECREATIONAL ACTIVITY;

(VIII) DECISIONS CONCERNING TRAVEL; AND

(IX) APPLICATION FOR GOVERNMENT-SPONSORED OR PRIVATE INSURANCE AND BENEFITS.

9. A STATEMENT OF THE ALTERNATIVES TO GUARDIANSHIP CONSIDERED, INCLUDING BUT NOT LIMITED TO THE EXECUTION OF A HEALTH CARE PROXY, POWER OF ATTORNEY, REPRESENTATIVE PAYEE, SERVICE COORDINATION, AND/OR OTHER SOCIAL SUPPORT SERVICES, OTHER AVAILABLE SUPPORTED OR SHARED DECISION MAKING, AND SURROGATE DECISION-MAKING COMMITTEE, AND REASONS FOR THE DECLINATION OF SUCH ALTERNATIVES.

S 7. Section 1753 of the surrogate's court procedure act, as added by chapter 675 of the laws of 1989, is amended to read as follows:

S 1753. Persons to be served AND NOTICED

1. Upon [presentation] FILING of the petition, process shall issue to[:

(a) the parent or parents, adult children, if the petitioner is other than a parent, adult siblings, if the petitioner is other than a parent, and if the mentally retarded or developmentally disabled person is married, to the spouse, if their residences are known;

(b) the person having care and custody of the mentally retarded or developmentally disabled person, or with whom such person resides if other than the parents or spouse; and

(c) the mentally retarded or developmentally disabled person if fourteen years of age or older for whom an application has been made in such person's behalf.

2. Upon presentation of the petition, notice of such petition shall be served by certified mail to:

(a) the adult siblings if the petitioner is a parent, and adult children if the petitioner is a parent;

(b) the mental hygiene legal service in the judicial department where the facility, as defined in subdivision (a) of section 47.01 of the mental hygiene law, is located if the mentally retarded or developmentally disabled person resides in such a facility;

(c) in all cases, to the director in charge of a facility licensed or operated by an agency of the state of New York, if the mentally retarded or developmentally disabled person resides in such facility;

(d) one other person if designated in writing by the mentally retarded or developmentally disabled person; and

(e) such other persons as the court may deem proper.] THE PERSON WITH A DEVELOPMENTAL DISABILITY, IF PETITIONER IS OTHER THAN THE PERSON WITH A DEVELOPMENTAL DISABILITY ALLEGED TO BE IN NEED OF A GUARDIAN.

2. UPON FILING OF THE PETITION, NOTICE OF THE PETITION SHALL BE SENT BY CERTIFIED MAIL, RETURN RECEIPT REQUESTED TO THE LAST KNOWN ADDRESS OF THE:

(A) PARENTS, SPOUSE, ADULT CHILDREN, AND ADULT SIBLINGS OF THE PERSON ALLEGED TO BE IN NEED OF THE GUARDIAN;

(B) INDIVIDUALS LISTED IN THE PETITION PURSUANT TO SECTION SEVENTEEN HUNDRED FIFTY-TWO OF THIS ARTICLE AND SUBDIVISIONS FOUR AND FIVE OF THIS SECTION;

(C) MENTAL HYGIENE LEGAL SERVICE IN THE JUDICIAL DEPARTMENT WHERE THE PERSON WITH A DEVELOPMENTAL DISABILITY RESIDES;

(D) THE DIRECTOR IN CHARGE OF A FACILITY LICENSED OR OPERATED BY AN AGENCY OF THE STATE OF NEW YORK, IF THE PERSON WITH A DEVELOPMENTAL DISABILITY RESIDES IN SUCH FACILITY;

(E) ANY OTHER PERSON IF DESIGNATED IN WRITING BY THE PERSON WITH A DEVELOPMENTAL DISABILITY; AND

(F) SUCH OTHER PERSONS AS THE COURT MAY DEEM PROPER.

3. WITHIN FIVE DAYS OF THE FILING OF THE PETITION, A FULL COPY OF SAID PETITION SHALL BE SERVED BY CERTIFIED MAIL TO THE MENTAL HYGIENE LEGAL SERVICE IN THE JUDICIAL DEPARTMENT IN WHICH THE PETITION WAS FILED. A COPY OF PROOF OF MAILING SHALL BE THEREAFTER FILED WITH THE COURT.

4. FOR PETITIONS TO MODIFY AN EXISTING GUARDIANSHIP PURSUANT TO SECTION SEVENTEEN HUNDRED FIFTY-FIVE OF THIS ARTICLE AND/OR TO APPOINT A STANDBY GUARDIAN PURSUANT TO SUBDIVISION SEVENTEEN HUNDRED FIFTY-SEVEN OF THIS ARTICLE, WRITTEN NOTICE MUST BE GIVEN TO ALL STANDBY GUARDIANS CURRENTLY IN SUCCESSION FOR A PERSON WITH A DEVELOPMENTAL DISABILITY WHO IS THE SUBJECT OF THE PETITION.

5. No process or notice shall be necessary to [a parent, adult child, adult sibling, or spouse of the mentally retarded or developmentally disabled person who has been declared by a court as being incompetent. In addition, no process or notice shall be necessary to a spouse who is divorced from the mentally retarded or developmentally disabled person, and to a parent, adult child, adult sibling when it shall appear to the satisfaction of the court that such person or persons have abandoned the mentally retarded or developmentally disabled person] ANY INDIVIDUAL WHO CANNOT, AFTER DUE DILIGENCE, REASONABLY BE LOCATED. THE PETITIONER SHALL SUBMIT AN AFFIDAVIT TO SUCH EFFECT.

S 8. Section 1754 of the surrogate's court procedure act, as added by chapter 675 of the laws of 1989, is amended to read as follows:

S 1754. [Hearing and trial] PROCEEDINGS UPON PETITION

1. Upon a petition for the appointment of a guardian of a [mentally retarded or developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY eighteen years of age or older, the court shall [conduct a hearing at which such person shall have the right to jury trial. The right to a jury trial shall be deemed waived by failure to make a demand therefor. The court may in its discretion dispense with a hearing for the appointment of a guardian, and may in its discretion appoint a guardian ad litem, or the mental hygiene legal service if such person is a resident of a mental hygiene facility as defined in subdivision (a) of section 47.01 of the mental hygiene law, to recommend whether the appointment of a guardian as proposed in the application is in the best interest of the mentally retarded or developmentally disabled person, provided however, that such application has been made by:

(a) both parents or the survivor; or

(b) one parent and the consent of the other parent; or

(c) any interested party and the consent of each parent.], NOT LATER THAN FORTY-FIVE DAYS FOLLOWING THE FILING OF PROOF OF MAILING UPON THE MENTAL HYGIENE LEGAL SERVICE, SCHEDULE AN APPEARANCE IN THE MATTER.

(A) THE MENTAL HYGIENE LEGAL SERVICE SHALL ASCERTAIN WHETHER THE PERSON WITH A DEVELOPMENTAL DISABILITY ALLEGED TO NEED A GUARDIAN HAS ANY OBJECTION TO THE RELIEF SOUGHT IN THE PETITION AND WHETHER THE SERVICE IS ABLE TO REPRESENT THE INTERESTS OF THE PERSON IN THE PROCEEDING.

(B) IF THE SERVICE REPORTS THAT THE PERSON WITH A DEVELOPMENTAL DISABILITY ALLEGED TO NEED A GUARDIAN OBJECTS TO THE RELIEF SOUGHT IN THE PETITION, THE COURT SHALL APPOINT THE SERVICE AS COUNSEL FOR THE PERSON. IF THE SERVICE IS NOT AVAILABLE TO SERVE AS THE PERSON'S COUNSEL AND THE PERSON DOES NOT OTHERWISE HAVE COUNSEL, THE COURT SHALL APPOINT COUNSEL FOR THE PERSON FROM AMONG ATTORNEYS ELIGIBLE FOR SUCH APPOINTMENT PURSUANT TO SECTION THIRTY-FIVE OF THE JUDICIARY LAW.

(C) IF THE SERVICE REPORTS THAT THE PERSON WITH A DEVELOPMENTAL DISABILITY ALLEGED TO NEED A GUARDIAN DOES NOT OBJECT TO RELIEF SOUGHT IN THE PETITION, THE PERSON'S INTERESTS SHALL CONTINUE TO BE REPRESENTED BY THE SERVICE, IF AVAILABLE, AND THE SERVICE SHALL CONDUCT AN EXAMINATION INTO THE ALLEGATIONS OF FACT CONTAINED IN THE PETITION AND FILE WITH THE COURT AND SERVE NO LATER THAN TEN DAYS PRIOR TO THE APPEARANCE DATE AN ANSWER CONFIRMING OR DENYING THE ALLEGATIONS IN THE PETITION AND REPORT AS TO WHETHER THE SERVICE FINDS GROUNDS TO OBJECT TO THE RELIEF SOUGHT IN THE PETITION. THE SERVICE WILL OTHERWISE PERFORM ITS FUNCTIONS CONSISTENT WITH UNIFORM REGULATIONS PROMULGATED BY THE APPELLATE DIVISION OF THE SUPREME COURT.

(D) IF A PERSON WITH A DEVELOPMENTAL DISABILITY ALLEGED TO NEED A GUARDIAN WHO DOES NOT OBJECT DOES NOT OTHERWISE APPEAR BY THE SERVICE OR

OTHER COUNSEL, THE COURT SHALL APPOINT A GUARDIAN AD LITEM PURSUANT TO THIS SECTION AND SECTION FOUR HUNDRED THREE OF THIS ACT. ANY GUARDIAN AD LITEM APPOINTED PURSUANT TO THIS SECTION SHALL CONDUCT AN INVESTIGATION INTO THE ALLEGATIONS OF FACT CONTAINED IN THE PETITION AND FILE WITH THE COURT AND SERVE NO LATER THAN TEN DAYS PRIOR TO THE APPEARANCE DATE, A REPORT OF ITS FINDINGS CONFIRMING OR DISCONFIRMING SAID ALLEGATIONS, AND IF APPROPRIATE AND UPON CONSENT OF THE PERSON WITH A DEVELOPMENTAL DISABILITY NOMINATE A PERSON OR ENTITY OF THE RESPONDENT'S CHOOSING TO SERVE AS GUARDIAN, AS WELL AS ANY OTHER MATTER WHICH COULD ASSIST THE COURT'S CONSIDERATION OF THE MATTER, AND SERVE A COPY OF THE REPORT UPON THE PETITIONER.

(E) THE SERVICE, ANY OTHER COUNSEL FOR THE PERSON WITH A DEVELOPMENTAL DISABILITY ALLEGED TO NEED A GUARDIAN, OR THE GUARDIAN AD LITEM MAY APPLY TO THE COURT FOR PERMISSION TO INSPECT THE CLINICAL RECORDS PERTAINING TO THE PERSON WITH A DEVELOPMENTAL DISABILITY ALLEGED TO NEED A GUARDIAN IN ACCORDANCE WITH STATE AND FEDERAL LAWS. THE SERVICE, ANY OTHER COUNSEL FOR THE PERSON WITH A DEVELOPMENTAL DISABILITY AND THE GUARDIAN AD LITEM, IF ANY, SHALL BE AFFORDED ACCESS TO THE PERSON'S CLINICAL RECORDS WITHOUT A COURT ORDER TO THE EXTENT THAT SUCH ACCESS IS OTHERWISE AUTHORIZED BY STATE AND FEDERAL LAWS.

(F) THE SERVICE, ANY OTHER COUNSEL FOR THE PERSON WITH A DEVELOPMENTAL DISABILITY ALLEGED TO NEED A GUARDIAN, AND THE GUARDIAN AD LITEM, IF ANY, MAY REQUEST THE COURT FOR FURTHER EVALUATION OF THE PERSON BY A PHYSICIAN, PSYCHIATRIST OR CERTIFIED PSYCHOLOGIST. IN THE EVENT THAT FURTHER EVALUATIONS ARE REQUIRED, THE COURT MAY GRANT APPROPRIATE ADJOURNMENTS OF THE INITIAL APPEARANCE DATE AND MAY DIRECT, IN THE CASE OF A PERSON DETERMINED TO BE INDIGENT, THAT ANY FURTHER COURT AUTHORIZED EVALUATIONS BE PAID FOR OUT OF FUNDS AVAILABLE PURSUANT TO SECTION THIRTY-FIVE OF THE JUDICIARY LAW.

2. [When it shall appear to the satisfaction of the court that a parent or parents not joining in or consenting to the application have abandoned the mentally retarded or developmentally disabled person or are not otherwise required to receive notice, the court may dispense with such parent's consent in determining the need to conduct a hearing for a person under the age of eighteen. However, if the consent of both parents or the surviving parent is dispensed with by the court, a hearing shall be held on the application.] AT THE FIRST APPEARANCE, THE RESPONDENT SHALL BE PRESENT UNLESS SUCH PRESENCE IS EXCUSED BY THE COURT UPON RECOMMENDATION OF THE SERVICE, RESPONDENT'S COUNSEL, OR THE GUARDIAN AD LITEM IF THE RESPONDENT DOES NOT HAVE COUNSEL. THE PETITIONER SHALL ALSO BE PRESENT AND MAY BE REPRESENTED BY COUNSEL. ANY OTHER PARTY REQUIRED TO BE SERVED OR NOTICED WITH PROCESS IN THE MATTER MAY BE PRESENT.

(A) PRIOR TO SUCH APPEARANCE, THE PETITIONER, EITHER PERSONALLY OR BY COUNSEL, MAY CONFER WITH THE SERVICE, RESPONDENT'S COUNSEL AND THE GUARDIAN AD LITEM IF RESPONDENT DOES NOT HAVE COUNSEL AND AGREE TO AMEND ANY PART OF ITS PETITION AND ALLEGATIONS OF FACT THEREIN. ANY SUCH AMENDED PETITION SHALL BE FILED WITH THE COURT PRIOR TO THE DATE OF THE FIRST APPEARANCE.

(B) AT THE FIRST APPEARANCE, THE COURT SHALL EXAMINE THE ANSWER OF THE SERVICE, RESPONDENT'S COUNSEL, OR THE REPORT OF THE GUARDIAN AD LITEM, IF ANY, AND MAY HEAR FROM THE PETITIONER AND THE SERVICE, RESPONDENT'S COUNSEL AND THE GUARDIAN AD LITEM, IF ANY, ON THE CONTENTS OF THE SAID ANSWER OR REPORT AND ANY AMENDED PETITION FILED.

(C) THE COURT MAY DIRECT THAT AN ORDER AND DECREE OF GUARDIANSHIP ISSUE, INCLUDING THE AUTHORITY OF THE GUARDIAN TO ACT ON BEHALF OF THE

RESPONDENT WITH RESPECT TO ANY MATTER IN WHICH PETITIONER, THE SERVICE, RESPONDENT'S COUNSEL, AND THE GUARDIAN AD LITEM, IF ANY, ALL AGREE ON THE RECORD THAT THE RESPONDENT REQUIRES THE REQUESTED RELIEF AND DOES NOT OBJECT TO SUCH RELIEF.

(D) IN THE EVENT THAT THE PETITION CANNOT BE DISPOSED OF BY THE AGREEMENT OF THE COURT AND ALL OF THE PARTIES, THE COURT SHALL FORTHWITH SCHEDULE A HEARING IN THE MATTER AT WHICH THE RESPONDENT SHALL BE PRESENT UNLESS IT SHALL APPEAR TO THE COURT THAT THE RESPONDENT'S PRESENCE IS MEDICALLY CONTRAINDICATED, IN THAT IT WOULD BE LIKELY TO CAUSE HARM TO THE RESPONDENT, OR UNDER SUCH OTHER CIRCUMSTANCES RAISED BY OR ON BEHALF OF THE RESPONDENT AS THE COURT AGREES THAT THE RESPONDENT'S PRESENCE WOULD NOT BE IN HIS OR HER BEST INTERESTS, PROVIDED HOWEVER THAT THE RESPONDENT'S PRESENCE SHALL NOT BE WAIVED OVER THE OBJECTION OF THE SERVICE, RESPONDENT'S COUNSEL, OR A GUARDIAN AD LITEM, IF ANY, IN WHICH CASE THE COURT SHALL CONDUCT THE HEARING WHERE THE RESPONDENT RESIDES, IF THE COURT IS SATISFIED THAT THE RESPONDENT'S PRESENCE WOULD BE HARMFUL TO THE RESPONDENT.

3. [If a hearing is conducted, the mentally retarded or developmentally disabled person shall be present unless it shall appear to the satisfaction of the court on the certification of the certifying physician that the mentally retarded or developmentally disabled person is medically incapable of being present to the extent that attendance is likely to result in physical harm to such mentally retarded or developmentally disabled person, or under such other circumstances which the court finds would not be in the best interest of the mentally retarded or developmentally disabled person.] IF THERE ARE ANY OBJECTIONS TO THE RELIEF SOUGHT BY THE PETITIONER, THE RESPONDENT HAS A RIGHT TO A HEARING OR JURY TRIAL, IF DEMANDED BY THE RESPONDENT. IN ADDITION, THE COURT MAY CONDUCT A HEARING AT THE REQUEST OF ANY PARTY OR ON ITS OWN MOTION. AT ANY SUCH HEARING OR TRIAL, THE PETITIONER MUST ESTABLISH BY CLEAR AND CONVINCING EVIDENCE ANY FACTS ALLEGED IN THE PETITION OR AMENDED PETITION WHICH ARE CONTROVERTED AND ARE RELEVANT TO WHETHER RESPONDENT HAS A DEVELOPMENTAL DISABILITY, AND IF SO, WHETHER APPOINTMENT OF A GUARDIAN IS REQUIRED AND THE SCOPE OF THE GUARDIAN'S POWERS. ANY OTHER MATTER MUST BE PROVEN BY THE FAIR PREPONDERANCE OF THE EVIDENCE PRESENTED AND ADMITTED.

4. [If either a hearing is dispensed with pursuant to subdivisions one and two of this section or the mentally retarded or developmentally disabled person is not present at the hearing pursuant to subdivision three of this section, the court may appoint a guardian ad litem if no mental hygiene legal service attorney is authorized to act on behalf of the mentally retarded or developmentally disabled person. The guardian ad litem or mental hygiene legal service attorney, if appointed, shall personally interview the mentally retarded or developmentally disabled person and shall submit a written report to the court.

5. If, upon conclusion of such hearing or jury trial or if none be held upon the application, the court is satisfied that the best interests of the mentally retarded or developmentally disabled person will be promoted by the appointment of a guardian of the person or property, or both, it shall make a decree naming such person or persons to serve as such guardians.] IF, UPON CONCLUSION OF SUCH HEARING OR JURY TRIAL, IF ANY, THE COURT IS SATISFIED THAT THE RESPONDENT HAS A DEVELOPMENTAL DISABILITY AND REQUIRES THE APPOINTMENT OF A GUARDIAN OF THE PERSON OR PROPERTY, OR BOTH, IT SHALL MAKE A DECREE NAMING SUCH PERSON OR PERSONS TO SERVE AS SUCH GUARDIANS. THE POWERS OF THE GUARDIAN SHALL BE TAILORED TO THE NEEDS OF THE RESPONDENT.

S 9. The surrogate's court procedure act is amended by adding a new section 1754-a to read as follows:

S 1754-A. DECISION MAKING STANDARD

DECISIONS MADE BY A GUARDIAN ON BEHALF OF A PERSON WITH A DEVELOPMENTAL DISABILITY SHALL BE MADE IN ACCORDANCE WITH THE FOLLOWING STANDARDS.

1. A GUARDIAN SHALL EXERCISE AUTHORITY ONLY AS NECESSITATED BY THE PERSON WITH A DEVELOPMENTAL DISABILITY'S LIMITATIONS, AND, TO THE EXTENT POSSIBLE, SHALL ENCOURAGE THE PERSON WITH A DEVELOPMENTAL DISABILITY TO PARTICIPATE IN DECISIONS AND TO ACT ON HIS OR HER OWN BEHALF.

2. A GUARDIAN SHALL CONSIDER THE EXPRESSED DESIRES AND PERSONAL VALUES OF THE PERSON WITH A DEVELOPMENTAL DISABILITY TO THE EXTENT KNOWN, WHEN MAKING DECISIONS AND SHALL CONSULT WITH THE PERSON WITH A DEVELOPMENTAL DISABILITY WHENEVER MEANINGFUL COMMUNICATION IS POSSIBLE.

3. IF THE PERSON'S WISHES ARE UNKNOWN AND REMAIN UNKNOWN AFTER REASONABLE EFFORTS TO DISCERN THEM, THE DECISION SHALL BE MADE ON THE BASIS OF THE BEST INTERESTS OF THE PERSON WITH A DEVELOPMENTAL DISABILITY AS DETERMINED BY THE GUARDIAN. IN DETERMINING THE BEST INTERESTS OF THE PERSON WITH A DEVELOPMENTAL DISABILITY, THE GUARDIAN SHALL WEIGH THE REASON FOR AND NATURE OF THE PROPOSED ACTION; THE BENEFIT OR NECESSITY OF THE ACTION, THE POSSIBLE RISKS AND OTHER CONSEQUENCES OF THE PROPOSED ACTION; AND ANY AVAILABLE ALTERNATIVES AND THEIR RISKS, CONSEQUENCES AND BENEFITS. THE GUARDIAN SHALL TAKE INTO ACCOUNT ANY OTHER INFORMATION, INCLUDING THE VIEWS OF FAMILY AND FRIENDS, THAT THE GUARDIAN BELIEVES THE PERSON WITH A DEVELOPMENTAL DISABILITY WOULD HAVE CONSIDERED IF ABLE TO ACT FOR HERSELF OR HIMSELF.

S 10. Section 1755 of the surrogate's court procedure act, as added by chapter 675 of the laws of 1989, is amended to read as follows:

S 1755. Modification order

Any [mentally retarded or developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY eighteen years of age or older, or any person on behalf of any [mentally retarded or developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY for whom a guardian has been appointed, may apply to the court [having jurisdiction over the guardianship order] PURSUANT TO SECTION 1751-A OF THIS ARTICLE requesting modification of such order in order to protect the [mentally retarded or developmentally disabled person's] PERSON WITH A DEVELOPMENTAL DISABILITY'S financial situation and/or his or her personal interests. The court may, upon receipt of any such request to modify the guardianship order, appoint a guardian ad litem. The court shall so modify the guardianship order if in its judgment the interests of the guardian are adverse to those of the [mentally retarded or developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY or if the interests of justice will be best served including, but not limited to, facts showing the necessity for protecting the personal and/or financial interests of the [mentally retarded or developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY.

S 11. Section 1756 of the surrogate's court procedure act, as added by chapter 675 of the laws of 1989, is amended to read as follows:

S 1756. Limited [guardian of the property] PURPOSE AND/OR LIMITED DURATION GUARDIANSHIP

1. When it shall appear to the satisfaction of the court that such [mentally retarded or developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY for whom an application for guardianship is made is eighteen years of age or older and is wholly or substantially self-supporting by means of his or her wages or earnings from employment, the court is authorized and empowered to appoint a limited guardian of the

property of such [mentally retarded or developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY who shall receive, manage, disburse and account for only such property of said [mentally retarded or developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY as shall be received from other than the wages or earnings of said person.

The [mentally retarded or developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY for whom a limited guardian of the property has been appointed shall have the right to receive and expend any and all wages or other earnings of his or her employment and shall have the power to contract or legally bind himself or herself for such sum of money not exceeding one month's wages or earnings from such employment or three hundred dollars, whichever is greater, or as otherwise authorized by the court.

2. WHEN IT SHALL APPEAR TO THE SATISFACTION OF THE COURT, EITHER UPON A PETITION FOR GUARDIANSHIP FILED AS PERMITTED BY SECTIONS 1751 AND 1752 OF THIS ARTICLE OR UPON A PETITION FILED PURSUANT TO THIS SECTION IN A SIMPLIFIED FORMAT TO BE ESTABLISHED BY THE OFFICE OF COURT ADMINISTRATION IN CONSULTATION WITH THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES AND OTHER INTERESTED STAKEHOLDERS, THAT A PERSON WITH A DEVELOPMENTAL DISABILITY NEEDS THE ASSISTANCE OF A GUARDIAN OF THE PERSON AND/OR PROPERTY FOR THE PURPOSE OF MAKING A SINGLE DECISION OR FOR A BRIEF STATED PERIOD OF TRANSITION IN SUCH PERSON'S LIFE, THE COURT MAY APPOINT A LIMITED-PURPOSE GUARDIAN OF THE PERSON AND/OR PROPERTY TO EFFECTUATE SUCH A DECISION OR TRANSITION. IN ANY SUCH CASE, THE PROVISIONS OF SECTION 1754 SHALL APPLY, EXCEPT THAT THE PERIOD FOR THE RENDERING OF A REPORT BY THE MENTAL HYGIENE LEGAL SERVICE OR OTHER RESPONDENT'S COUNSEL MAY BE SHORTENED AS MAY BE REASONABLY NECESSARY TO MEET THE NEEDS OF THE RESPONDENT UNDER THE CIRCUMSTANCES PRESENTED. AN ORDER APPOINTING AND EMPOWERING SUCH A LIMITED-PURPOSE GUARDIAN OF THE PERSON AND/OR PROPERTY SHALL STATE SPECIFICALLY THE DURATION AND SCOPE OF SUCH GUARDIAN'S AUTHORITY.

S 12. Section 1757 of the surrogate's court procedure act, as added by chapter 675 of the laws of 1989, the section heading as amended by chapter 290 of the laws of 1992, subdivision 2 as amended by chapter 260 of the laws of 2009, subdivision 3 as added by chapter 294 of the laws of 2012, is amended to read as follows:

S 1757. Standby guardian of a [mentally retarded or developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY

1. Upon application, a standby guardian of the person or property or both of a [mentally retarded or developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY may be appointed by the court. ANY SUCH APPLICATION SHALL BE MADE UPON NOTICE TO THE MENTAL HYGIENE LEGAL SERVICE. The court may also, upon application, appoint an alternate and/or successive alternates to such standby guardian, to act if such standby guardian shall die, or become incapacitated, or shall renounce. Such appointments by the court shall be made in accordance with the provisions of this article.

2. Such standby guardian, or alternate in the event of such standby guardian's death, incapacity or renunciation, shall without further proceedings be empowered to assume the duties of his or her office immediately upon death, renunciation or adjudication of incompetency of the guardian or standby guardian appointed pursuant to this article, subject only to THE FILING OF AN APPLICATION FOR confirmation of his or her appointment by the court within one hundred eighty days following assumption of his or her duties of such office. Before confirming the appointment of the standby guardian or alternate guardian, the court may

conduct a hearing pursuant to section seventeen hundred fifty-four of this article upon petition by anyone on behalf of the [mentally retarded or developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY or the [mentally retarded or developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY if such person is eighteen years of age or older, or upon its discretion.

3. Failure of a standby or alternate standby guardian to assume the duties of guardian, seek court confirmation or to renounce the guardianship within sixty days of written notice by certified mail or personal delivery given by or on behalf of the [mentally retarded or developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY of a prior guardian's inability to serve and the standby or alternate standby guardian's duty to serve, seek court confirmation or renounce such role shall allow the court to:

(a) deem the failure an implied renunciation of guardianship, and

(b) authorize, notwithstanding the time period provided for in subdivision two of this section to seek court confirmation, any remaining standby or alternate standby guardian to serve in such capacity provided (i) an application for confirmation and appropriate notices pursuant to subdivision one of section seventeen hundred fifty-three of this article are filed, or (ii) an application for modification of the guardianship order pursuant to section seventeen hundred fifty-five of this article is filed.

S 13. Subdivision 2 of section 1758 of the surrogate's court procedure act, as amended by chapter 427 of the laws of 2013, is amended to read as follows:

2. After the appointment of a guardian, standby guardian or alternate guardians, the court shall have and retain general jurisdiction over the [mentally retarded or developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY for whom such guardian shall have been appointed, to take of its own motion or to entertain and adjudicate such steps and proceedings relating to such guardian, standby, or alternate guardianship as may be deemed necessary or proper for the welfare of such [mentally retarded or developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY.

S 14. Section 1759 of the surrogate's court procedure act, as added by chapter 675 of the laws of 1989, is amended to read as follows:

S 1759. Duration of guardianship

1. Such guardianship shall not terminate at the age of majority or marriage of such [mentally retarded or developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY but shall continue during the life of such person, DURING THE PERIOD SPECIFIED IN A LIMITED PURPOSE OR LIMITED DURATION GUARDIANSHIP, or until terminated by the court.

2. A person eighteen years or older for whom such a guardian has been previously appointed or anyone, including the guardian, on behalf of a [mentally retarded or developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY for whom a guardian has been appointed may petition the court which made such appointment or the court in his or her county of residence to have the guardian discharged and a successor appointed, or to have the guardian of the property designated as a limited guardian of the property, or to have the guardianship order modified, dissolved or otherwise amended. Upon such a petition for review, the court shall conduct a hearing pursuant to section seventeen hundred fifty-four of this article.

3. Upon marriage of such [mentally retarded or developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY for whom such a guardian

has been appointed, the court shall, upon request of the [mentally retarded or developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY, spouse, or any other person acting on behalf of the [mentally retarded or developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY, review the need, if any, to modify, dissolve or otherwise amend the guardianship order including, but not limited to, the appointment of the spouse as standby guardian. The court, in its discretion, may conduct such review pursuant to section seventeen hundred fifty-four of this article.

S 15. Section 1760 of the surrogate's court procedure act, as added by chapter 675 of the laws of 1989, is amended to read as follows:

S 1760. Corporate guardianship

No corporation may be appointed guardian of the person under the provisions of this article, except that a non-profit corporation organized and existing under the laws of the state of New York and having the corporate power to act as guardian of [mentally retarded or developmentally disabled] persons WITH DEVELOPMENTAL DISABILITIES may be appointed as the guardian of the person only of such [mentally retarded or developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY.

S 16. Section 1761 of the surrogate's court procedure act, as added by chapter 675 of the laws of 1989, is amended to read as follows:

S 1761. Application of other provisions

To the extent that the context thereof shall admit, the provisions of article seventeen of this act shall apply to all proceedings under this article with the same force and [affect] EFFECT as if an "infant", as therein referred to, were a "[mentally retarded" or "developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY" as herein defined, and a "guardian" as therein referred to were a "guardian of the [mentally retarded person" or a "guardian of a developmentally disabled] person WITH A DEVELOPMENTAL DISABILITY" as herein provided for.

S 17. The surrogate's court procedure act is amended by adding a new section 1762 to read as follows:

S 1762. ANNUAL REPORT OF PERSONAL NEEDS GUARDIAN

1. FOR THE PURPOSES OF THIS ARTICLE, THE GUARDIAN OF A PERSON WITH A DEVELOPMENTAL DISABILITY SHALL SUBMIT A REPORT REGARDING THE STATUS OF THE PERSON WITH A DEVELOPMENTAL DISABILITY ANNUALLY ON THE ANNIVERSARY OF HIS OR HER APPOINTMENT OR AT SUCH OTHER INTERVAL AS ORDERED BY THE COURT.

2. THE REPORT SHALL BE ON A FORM PRESCRIBED BY THE OFFICE OF COURT ADMINISTRATION.

3. A CORPORATE GUARDIAN APPOINTED PURSUANT TO SECTION 1760 OF THIS ARTICLE MAY SUBMIT IN LIEU OF THE FORM PRESCRIBED BY THE OFFICE OF COURT ADMINISTRATION IN SUBDIVISION TWO OF THIS SECTION ITS OWN INTERNAL REPORT PROVIDED THE INFORMATION REQUIRED TO BE CONTAINED IN THE REPORT IS INCLUDED IN THE CORPORATE ANNUAL REPORT.

4. THE GUARDIANSHIP REPORT FORM SHALL BE FILED WITH THE COURT AND MAILED TO STANDBY GUARDIANS AND ALTERNATE STANDBY GUARDIANS, AND, WHERE APPLICABLE, THE DIRECTOR OF MENTAL HYGIENE LEGAL SERVICE IN THE DEPARTMENT IN WHICH THE PERSON WITH A DEVELOPMENTAL DISABILITY RESIDES AND THE DIRECTOR OF THE RESIDENCE OF THE PERSON WITH A DEVELOPMENTAL DISABILITY OR THE PERSON WITH WHOM THE PERSON WITH A DEVELOPMENTAL DISABILITY RESIDES.

S 18. This act shall take effect on the one hundred eightieth day after it shall have become a law.

STATE OF NEW YORK

5842

2017-2018 Regular Sessions

IN SENATE

May 2, 2017

Introduced by Sen. HANNON -- read twice and ordered printed, and when printed to be committed to the Committee on Judiciary

AN ACT to amend the surrogate's court procedure act and the judiciary law, in relation to guardianship and health care decisions of persons with developmental disabilities; and to repeal certain provisions of the surrogate's court procedure act relating thereto

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Section 1750 of the surrogate's court procedure act, as amended by chapter 198 of the laws of 2016, is amended to read as follows:

§ 1750. Guardianship of persons [~~who are intellectually disabled~~] **with developmental disabilities**

1. When it shall appear to the satisfaction of the court that a person is a person [~~who is intellectually disabled~~] **with a developmental disability within the meaning of subdivision twenty-two of section 1.03 of the mental hygiene law or a person with traumatic brain injury within the meaning of subdivision one of section two thousand seven hundred forty-one of the public health law, except that no age of origination shall apply for purposes of this article to a person with traumatic head injury, and that such person, as a result of such developmental disability or traumatic brain injury, exhibits significant impairment of general or specific areas of intellectual functioning and/or adaptive behaviors in specified domains as enumerated in subdivision eight of section seventeen hundred fifty-two of this article**, the court is authorized to appoint a guardian of the person or of the property or of both if such appointment of a guardian or guardians is in the best interest of the person [~~who is intellectually disabled~~]. Such appointment shall be made pursuant to the provisions of this article[~~, provided however that the provisions of section seventeen hundred fifty-a of this article shall~~

EXPLANATION--Matter in *italics* (underscored) is new; matter in brackets [-] is old law to be omitted.

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~~not apply to the appointment of a guardian or guardians of a person who is intellectually disabled.~~

~~1. For the purposes of this article, a person who is intellectually disabled is a person who has been certified by one licensed physician and one licensed psychologist, or by two licensed physicians at least one of whom is familiar with or has professional knowledge in the care and treatment of persons with an intellectual disability, having qualifications to make such certification, as being incapable to manage him or herself and/or his or her affairs by reason of intellectual disability and that such condition is permanent in nature or likely to continue indefinitely~~].

2. Every guardianship entered into pursuant to this article prior to the effective date of this subdivision, including orders and decrees pursuant to section seventeen hundred fifty-seven of this article, shall remain in full force and effect thereafter, except as amended pursuant to section seventeen hundred fifty-five of this article or as ordered by the court; and any such guardianship shall be administered consistent with the substantive and procedural requirements set forth in this article, except that the provisions of section seventeen hundred six-two of this article shall only apply to guardianships entered into on or after the effective date of this subdivision. Further, guardianships entered into prior to the effective date of the chapter of the laws of two thousand seventeen which amended this subdivision, upon petition for amendment pursuant to section seventeen hundred fifty-five and section seventeen hundred fifty-seven of this article, shall not be required to resubmit proof of the continued need for guardianship.

3. Every [~~such certification pursuant to subdivision one of this section,~~] order and decree made on or after the effective date of this subdivision, shall include a specific determination by [~~such physician and psychologist, or by such physicians,~~] the issuing court as to whether the person [~~who is intellectually disabled~~] has the capacity to make health care decisions, as defined by subdivision three of section twenty-nine hundred eighty of the public health law, for himself or herself. A determination that the person [~~who is intellectually disabled~~] has the capacity to make health care decisions shall not preclude the appointment of a guardian pursuant to this section to make other decisions on behalf of the person [~~who is intellectually disabled~~]. The absence of this determination in the case of guardians appointed prior to [~~the effective date of this subdivision~~] March sixteenth, two thousand three shall not preclude such guardians from making health care decisions. Further, guardians appointed by orders and/or decrees issued prior to the effective date of the chapter of the laws of two thousand seventeen which amended this subdivision shall have authority in all areas, unless otherwise stated in said order or decree.

§ 2. Section 1750-a of the surrogate's court procedure act is REPEALED.

§ 3. Section 1750-b of the surrogate's court procedure act, as amended by chapter 198 of the laws of 2016, is amended to read as follows:

§ 1750-b. Health care decisions for persons [~~who are intellectually disabled~~] with developmental disabilities

1. Scope of authority. As used in this section, the term "developmental disability" is as defined by subdivision twenty-two of section 1.03 of the mental hygiene law and shall also include individuals with traumatic brain injury as defined by subdivision one of section two thousand seven hundred forty-one of the public health law. Unless specifically prohibited by the court after consideration of [~~the deter-~~

~~mination, if any, regarding a person who is intellectually disabled's~~] a person with a developmental disability's capacity to make health care decisions, which is required by section seventeen hundred fifty of this article, the guardian of such person appointed pursuant to section seventeen hundred fifty of this article shall have the authority to make any and all health care decisions, as defined by subdivision six of section twenty-nine hundred eighty of the public health law, on behalf of the person [~~who is intellectually disabled~~] with a developmental disability, that such person could make if such person had capacity. Such decisions may include decisions to withhold or withdraw life-sustaining treatment. For purposes of this section, "life-sustaining treatment" means medical treatment, including cardiopulmonary resuscitation and nutrition and hydration provided by means of medical treatment, which is sustaining life functions and without which, according to reasonable medical judgment, the patient will die within a relatively short time period. Cardiopulmonary resuscitation is presumed to be life-sustaining treatment without the necessity of a medical judgment by an attending physician. The provisions of this article are not intended to permit or promote suicide, assisted suicide or euthanasia; accordingly, nothing in this section shall be construed to permit a guardian to consent to any act or omission to which the person [~~who is intellectually disabled~~] with a developmental disability could not consent if such person had capacity.

(a) For the purposes of making a decision to withhold or withdraw life-sustaining treatment pursuant to this section, in the case of a person for whom no guardian has been appointed pursuant to [~~section seventeen hundred fifty or seventeen hundred fifty-a of~~] this article, a "guardian" shall also mean a family member of a person who [~~(i) has intellectual disability, or (ii)~~] has a developmental disability, as defined in [~~section 1.03 of the mental hygiene law, which (A) includes intellectual disability, or (B) results in a similar impairment of general intellectual functioning or adaptive behavior so that such person is incapable of managing himself or herself, and/or his or her affairs by reason of such developmental disability~~] this subdivision and that such person, as a result of such developmental disability, exhibits significant impairment of general or specific areas of intellectual functioning and/or adaptive behaviors in specified domains as enumerated in subdivision eight of section seventeen hundred fifty-two of this article. Qualified family members shall be included in a prioritized list of said family members pursuant to regulations established by the commissioner of the office for people with developmental disabilities. Such family members must have a significant and ongoing involvement in a person's life so as to have sufficient knowledge of their needs and, when reasonably known or ascertainable, the person's wishes, including moral and religious beliefs. In the case of a person who was a resident of the former Willowbrook state school on March seventeenth, nineteen hundred seventy-two and those individuals who were in community care status on that date and subsequently returned to Willowbrook or a related facility, who are fully represented by the consumer advisory board and who have no guardians appointed pursuant to this article or have no qualified family members to make such a decision, then a "guardian" shall also mean the Willowbrook consumer advisory board. A decision of such family member or the Willowbrook consumer advisory board to withhold or withdraw life-sustaining treatment shall be subject to all of the protections, procedures and safeguards which apply to the deci-

sion of a guardian to withhold or withdraw life-sustaining treatment pursuant to this section.

In the case of a person for whom no guardian has been appointed pursuant to this article or for whom there is no qualified family member or the Willowbrook consumer advisory board available to make such a decision, a "guardian" shall also mean, notwithstanding the definitions in section 80.03 of the mental hygiene law, a surrogate decision-making committee, as defined in article eighty of the mental hygiene law. All declarations and procedures, including expedited procedures, to comply with this section shall be established by regulations promulgated by the [~~commission on quality of care and advocacy for persons with disabilities~~] **justice center for the protection of people with special needs, as established by article twenty of the executive law**.

(b) Regulations establishing the prioritized list of qualified family members required by paragraph (a) of this subdivision shall be developed by the commissioner of the office for people with developmental disabilities in conjunction with parents, advocates and family members of persons [~~who are intellectually disabled~~] **with developmental disabilities**. Regulations to implement the authority of the Willowbrook consumer advisory board pursuant to paragraph (a) of this subdivision may be promulgated by the commissioner of the office for people with developmental disabilities with advice from the Willowbrook consumer advisory board.

(c) Notwithstanding any provision of law to the contrary, the formal determinations required pursuant to section seventeen hundred fifty of this article shall only apply to guardians appointed pursuant to section seventeen hundred fifty [~~or seventeen hundred fifty-a~~] of this article.

2. Decision-making standard. (a) The guardian shall base all advocacy and health care decision-making solely and exclusively on the best interests of the person [~~who is intellectually disabled~~] **with a developmental disability** and, when reasonably known or ascertainable with reasonable diligence, on [~~the person who is intellectually disabled's~~] **such person's** wishes, including moral and religious beliefs.

(b) An assessment of the person [~~who is intellectually disabled's~~] **with a developmental disability's** best interests shall include consideration of:

(i) the dignity and uniqueness of every person;

(ii) the preservation, improvement or restoration of the person [~~who is intellectually disabled's~~] **with a developmental disability's** health **and well being**;

(iii) the relief of the person [~~who is intellectually disabled's~~] **with a developmental disability's** suffering by means of palliative care and pain management;

(iv) the unique nature of [~~artificially provided~~] nutrition or hydration **provided by medical treatment**, and the effect it may have on the person [~~who is intellectually disabled~~] **with a developmental disability**; and

(v) the entire medical condition of the person.

(c) No health care decision shall be influenced in any way by:

(i) a presumption that persons [~~who are intellectually disabled~~] **with a developmental disability** are not entitled to the full and equal rights, equal protection, respect, medical care and dignity afforded to persons without [~~an intellectual disability or a~~] developmental [~~disability~~] **disabilities**; or

(ii) financial considerations of the guardian, as such considerations affect the guardian, a health care provider or any other party**;**

provided, however that the guardian shall have no financial obligation for the care of the person with developmental disabilities.

3. Right to receive information. Subject to the provisions of sections 33.13 and 33.16 of the mental hygiene law, the guardian shall have the right to receive all medical information and medical and clinical records necessary to make informed decisions regarding the person [~~who is intellectually disabled's~~] **with a developmental disability's** health care.

4. Life-sustaining treatment. The guardian shall have the affirmative obligation to advocate for the full and efficacious provision of health care, including life-sustaining treatment. In the event that a guardian makes a decision to withdraw or withhold life-sustaining treatment from a person [~~who is intellectually disabled~~] **with a developmental disability**:

(a) The attending physician, as defined in subdivision two of section twenty-nine hundred eighty of the public health law, must confirm to a reasonable degree of medical certainty that the person [~~who is intellectually disabled~~] **with a developmental disability** lacks capacity to make health care decisions. The determination thereof shall be included in the person [~~who is intellectually disabled's~~] **with a developmental disability's** medical record, and shall contain such attending physician's opinion regarding the cause and nature of the [~~person who is intellectually disabled's~~] **person's** incapacity as well as its extent and probable duration. The attending physician who makes the confirmation shall consult with another physician, or a [~~licensed~~] psychologist, to further confirm the [~~person who is intellectually disabled's~~] **person's** lack of capacity. The attending physician who makes the confirmation, or the physician or [~~licensed~~] psychologist with whom the attending physician consults, must (i) be employed by a developmental disabilities services office named in section 13.17 of the mental hygiene law or employed by the office for people with developmental disabilities to provide treatment and care to people with developmental disabilities, or (ii) have been employed for a minimum of two years to render care and service in a facility or program operated, licensed or authorized by the office for people with developmental disabilities, or (iii) have been approved by the commissioner of the office for people with developmental disabilities in accordance with regulations promulgated by such commissioner. Such regulations shall require that a physician or licensed psychologist possess specialized training or three years experience in treating [~~intellectual disability~~] **people with developmental disabilities**. A record of such consultation shall be included in the person [~~who is intellectually disabled's~~] **with a developmental disability's** medical record.

(b) The attending physician, as defined in subdivision two of section twenty-nine hundred eighty of the public health law, with the concurrence of another physician with whom such attending physician shall consult, must determine to a reasonable degree of medical certainty and note on the person [~~who is intellectually disabled's~~] **with a developmental disability's** chart that:

(i) the person [~~who is intellectually disabled~~] has a medical condition as follows:

A. a terminal condition, as defined in subdivision twenty-three of section twenty-nine hundred sixty-one of the public health law; or

B. permanent unconsciousness; or

C. a medical condition other than such person's [~~intellectual~~] **developmental** disability which requires life-sustaining treatment, is irreversible and which will continue indefinitely; and

(ii) the life-sustaining treatment would impose an extraordinary burden on such person, in light of:

A. such person's medical condition, other than such person's [~~intellectual~~] **developmental** disability; and

B. the expected outcome of the life-sustaining treatment, notwithstanding such person's [~~intellectual~~] **developmental** disability; and

(iii) in the case of a decision to withdraw or withhold artificially provided nutrition or hydration:

A. there is no reasonable hope of maintaining life; or

B. the artificially provided nutrition or hydration poses an extraordinary burden.

(c) The guardian shall express a decision to withhold or withdraw life-sustaining treatment either:

(i) in writing, dated and signed in the presence of one witness eighteen years of age or older who shall sign the decision, and presented to the attending physician, as defined in subdivision two of section twenty-nine hundred eighty of the public health law; or

(ii) orally, to two persons eighteen years of age or older, at least one of whom is the person [~~who is intellectually disabled's~~] **with a developmental disability's** attending physician, as defined in subdivision two of section twenty-nine hundred eighty of the public health law.

(d) The attending physician, as defined in subdivision two of section twenty-nine hundred eighty of the public health law, who is provided with the decision of a guardian shall include the decision in the person [~~who is intellectually disabled's~~] **with a developmental disability's** medical chart, and shall either:

(i) promptly issue an order to withhold or withdraw life-sustaining treatment from the person [~~who is intellectually disabled~~], and inform the staff responsible for such person's care, if any, of the order; or

(ii) promptly object to such decision, in accordance with subdivision five of this section.

(e) At least forty-eight hours prior to the implementation of a decision to withdraw life-sustaining treatment, or at the earliest possible time prior to the implementation of a decision to withhold life-sustaining treatment, the attending physician shall notify:

(i) the person [~~who is intellectually disabled~~] **with a developmental disability**, except if the attending physician determines, in writing and in consultation with another physician or a licensed psychologist, that, to a reasonable degree of medical certainty, the person would suffer immediate and severe injury from such notification. The attending physician who makes the confirmation, or the physician or licensed psychologist with whom the attending physician consults, shall:

A. be employed by a developmental disabilities services office named in section 13.17 of the mental hygiene law or employed by the office for people with developmental disabilities to provide treatment and care to people with developmental disabilities, or

B. have been employed for a minimum of two years to render care and service in a facility operated, licensed or authorized by the office for people with developmental disabilities, or

C. have been approved by the commissioner of the office for people with developmental disabilities in accordance with regulations promulgated by such commissioner. Such regulations shall require that a physician or licensed psychologist possess specialized training or three

years experience in treating [~~intellectual disability~~] **persons with developmental disabilities**. A record of such consultation shall be included in the [~~person who is intellectually disabled's~~] **person's** medical record;

(ii) if the person is in or was transferred from a residential facility operated, licensed or authorized by the office for people with developmental disabilities, the chief executive officer of the agency or organization operating such facility and the mental hygiene legal service; and

(iii) if the person is not in and was not transferred from such a facility or program, the commissioner of the office for people with developmental disabilities, or his or her designee.

5. Objection to health care decision. (a) Suspension. A health care decision made pursuant to subdivision four of this section shall be suspended, pending judicial review, except if the suspension would in reasonable medical judgment be likely to result in the death of the person [~~who is intellectually disabled~~] **with a developmental disability**, in the event of an objection to that decision at any time by:

(i) the person [~~who is intellectually disabled~~] on whose behalf such decision was made; or

(ii) a parent or adult sibling who either resides with or has maintained substantial and continuous contact with the person [~~who is intellectually disabled~~]; or

(iii) the attending physician, as defined in subdivision two of section twenty-nine hundred eighty of the public health law; or

(iv) any other health care practitioner providing services to the person [~~who is intellectually disabled~~] **with a developmental disability**, who is licensed pursuant to article one hundred thirty-one, one hundred thirty-one-B, one hundred thirty-two, one hundred thirty-three, one hundred thirty-six, one hundred thirty-nine, one hundred forty-one, one hundred forty-three, one hundred forty-four, one hundred fifty-three, one hundred fifty-four, one hundred fifty-six, one hundred fifty-nine or one hundred sixty-four of the education law; or

(v) the chief executive officer identified in subparagraph (ii) of paragraph (e) of subdivision four of this section; or

(vi) if the person is in or was transferred from a residential facility or program operated, approved or licensed by the office for people with developmental disabilities, the mental hygiene legal service; or

(vii) if the person is not in and was not transferred from such a facility or program, the commissioner of the office for people with developmental disabilities, or his or her designee.

(b) Form of objection. Such objection shall occur orally or in writing.

(c) Notification. In the event of the suspension of a health care decision pursuant to this subdivision, the objecting party shall promptly notify the guardian and the other parties identified in paragraph (a) of this subdivision, and the attending physician shall record such suspension in the person [~~who is intellectually disabled's~~] **with a developmental disability's** medical chart.

(d) Dispute mediation. In the event of an objection pursuant to this subdivision, at the request of the objecting party or person or entity authorized to act as a guardian under this section, except a surrogate decision making committee established pursuant to article eighty of the mental hygiene law, such objection shall be referred to a dispute mediation system, established pursuant to section two thousand nine hundred seventy-two of the public health law or similar entity for mediating

disputes in a hospice, such as a patient's advocate's office, hospital chaplain's office or ethics committee, as described in writing and adopted by the governing authority of such hospice, for non-binding mediation. In the event that such dispute cannot be resolved within seventy-two hours or no such mediation entity exists or is reasonably available for mediation of a dispute, the objection shall proceed to judicial review pursuant to this subdivision. The party requesting mediation shall provide notification to those parties entitled to notice pursuant to paragraph (a) of this subdivision.

6. Special proceeding authorized. The guardian, the attending physician, as defined in subdivision two of section twenty-nine hundred eighty of the public health law, the chief executive officer identified in subparagraph (ii) of paragraph (e) of subdivision four of this section, the mental hygiene legal service (if the person is in or was transferred from a residential facility or program operated, approved or licensed by the office for people with developmental disabilities) or the commissioner of the office for people with developmental disabilities or his or her designee (if the person is not in and was not transferred from such a facility or program) may commence a special proceeding in a court of competent jurisdiction with respect to any dispute arising under this section, including objecting to the withdrawal or withholding of life-sustaining treatment because such withdrawal or withholding is not in accord with the criteria set forth in this section.

7. Provider's obligations. (a) A health care provider shall comply with the health care decisions made by a guardian in good faith pursuant to this section, to the same extent as if such decisions had been made by the person [~~who is intellectually disabled~~] **with a developmental disability**, if such person had capacity.

(b) Notwithstanding paragraph (a) of this subdivision, nothing in this section shall be construed to require a private hospital to honor a guardian's health care decision that the hospital would not honor if the decision had been made by the person [~~who is intellectually disabled~~] **with a developmental disability**, if such person had capacity, because the decision is contrary to a formally adopted written policy of the hospital expressly based on religious beliefs or sincerely held moral convictions central to the hospital's operating principles, and the hospital would be permitted by law to refuse to honor the decision if made by such person, provided:

(i) the hospital has informed the guardian of such policy prior to or upon admission, if reasonably possible; and

(ii) the person [~~who is intellectually disabled~~] **with a developmental disability** is transferred promptly to another hospital that is reasonably accessible under the circumstances and is willing to honor the guardian's decision. If the guardian is unable or unwilling to arrange such a transfer, the hospital's refusal to honor the decision of the guardian shall constitute an objection pursuant to subdivision five of this section.

(c) Notwithstanding paragraph (a) of this subdivision, nothing in this section shall be construed to require an individual health care provider to honor a guardian's health care decision that the individual would not honor if the decision had been made by the person [~~who is intellectually disabled~~] **with a developmental disability**, if such person had capacity, because the decision is contrary to the individual's religious beliefs or sincerely held moral convictions, provided the individual health care provider promptly informs the guardian and the facility, if any, of his

or her refusal to honor the guardian's decision. In such event, the facility shall promptly transfer responsibility for the person [~~who is intellectually disabled~~] with a developmental disability to another individual health care provider willing to honor the guardian's decision. The individual health care provider shall cooperate in facilitating such transfer of the patient.

(d) Notwithstanding the provisions of any other paragraph of this subdivision, if a guardian directs the provision of life-sustaining treatment, the denial of which in reasonable medical judgment would be likely to result in the death of the person [~~who is intellectually disabled~~] with a developmental disability, a hospital or individual health care provider that does not wish to provide such treatment shall nonetheless comply with the guardian's decision pending either transfer of the person [~~who is intellectually disabled~~] with a developmental disability to a willing hospital or individual health care provider, or judicial review.

(e) Nothing in this section shall affect or diminish the authority of a surrogate decision-making panel to render decisions regarding major medical treatment pursuant to article eighty of the mental hygiene law.

8. Immunity. (a) Provider immunity. 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 reasonably and in good faith a health care decision by a guardian, or for other actions taken reasonably and in good faith pursuant to this section.

(b) Guardian immunity. No guardian shall be subjected to criminal or civil liability for making a health care decision reasonably and in good faith pursuant to this section.

§ 4. Section 1751 of the surrogate's court procedure act, as amended by chapter 198 of the laws of 2016, is amended to read as follows:

§ 1751. Petition for appointment; by whom made

1. A petition for the appointment of a guardian [~~of the person or property, or both, of a person who is intellectually disabled or a person who is developmentally disabled may be made by a parent, any~~] pursuant to this article may be made by the person with a developmental disability or traumatic brain injury when such person is eighteen years of age or older, a parent, spouse, sibling, adult child or any other interested person eighteen years of age or older on behalf of the person [~~who is intellectually disabled or a person who is developmentally disabled~~] with a developmental disability or traumatic brain injury including a corporation authorized to serve as a guardian as provided for by this article[~~, or by the person who is intellectually disabled or a person who is developmentally disabled when such person is eighteen years of age or older~~].

2. A person with a developmental disability or traumatic brain injury may knowingly and voluntarily consent to the appointment of a guardian pursuant to this article.

§ 5. The surrogate's court procedure act is amended by adding a new section 1751-a to read as follows:

§ 1751-a. Petition for appointment; where made (venue)

1. A proceeding under this article shall be brought in the surrogate's court within the county in which the person with a developmental disability resides, or is physically present at the time the proceeding is commenced, subject to an application to change venue pursuant to this subdivision. If the person with a developmental disability alleged to be in need of a guardian is being cared for as a resident in a facility,

the residence of that person shall be deemed to be in the county where the facility is located and the proceeding may be brought in that county, subject to application by an interested party for a change in venue to another county because of the inconvenience of the parties or witnesses or the condition of the person alleged to be in need of a guardian.

2. After the appointment of a guardian, at the option of the petitioner, any proceeding to modify a prior order may be brought in the surrogate's court which granted the prior order, unless at the time of the application to modify the order the person with a developmental disability resides elsewhere, in which case the proceeding may be brought in the county where the person with a developmental disability resides or is physically present at the time the proceeding is commenced, without the need for a motion to transfer venue.

§ 6. Section 1752 of the surrogate's court procedure act, as amended by chapter 198 of the laws of 2016, is amended to read as follows:

§ 1752. Petition for appointment; contents

The petition for the appointment of a guardian shall be filed with the court on forms to be prescribed by the state chief administrator of the courts. Such petition for a guardian [~~of a person who is intellectually disabled or a person who is developmentally disabled~~] pursuant to this article shall include, but not be limited to, the following information:

1. the full name, date of birth and residence of the person [~~who is intellectually disabled or a person who is developmentally disabled~~] with a developmental disability or a traumatic brain injury;

2. the name, age, address and relationship or interest of the petitioner to the person [~~who is intellectually disabled or a person who is developmentally disabled~~] with a developmental disability;

3. the names and addresses, if known of the father, the mother, adult children, adult siblings [~~if eighteen years of age or older, the spouse and primary care physician if other than a physician having submitted a certification with the petition, if any,~~] of the person [~~who is intellectually disabled or a person who is developmentally disabled~~] with a developmental disability or traumatic brain injury and whether or not they are living, and if living, their addresses and the names and addresses of the nearest distributees of full age who are domiciliaries, if both parents are dead;

4. the name and address of the person with whom the person [~~who is intellectually disabled or a person who is developmentally disabled~~] with a developmental disability or traumatic brain injury resides if other than the parents or spouse;

5. the name and address of any person with significant and ongoing involvement in the life of the person with a developmental disability or traumatic brain injury so as to have sufficient knowledge of their needs, if such persons are known to the petitioner;

6. the name, age, address, education and other qualifications, and consent of the proposed guardian, standby and alternate guardian, if other than the parent, spouse, adult child if eighteen years of age or older or adult sibling if eighteen years of age or older, and if such parent, spouse or adult child be living, why any of them should not be appointed guardian;

[~~6.~~] 7. the estimated value of real and personal property and the annual income therefrom and any other income including governmental entitlements to which the person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability or traumatic brain injury is entitled; and

[~~7. any circumstances which the court should consider in determining whether it is in the best interests of the person who is intellectually disabled or person who is developmentally disabled to not be present at the hearing if conducted.~~]

8. An enumeration of the specific domains in which the person is alleged to be in need of a guardian or a statement that full guardianship is sought. Specific domains may include:

(a) informed consent health care or other professional care;

(b) management of money or other income, assets or property;

(c) access to confidential and other sensitive information;

(d) choices involving education, training, employment, supports and services;

(e) requesting advocacy, legal or other professional services;

(f) choice of residence and shared living arrangements;

(g) choices as to social and recreational activity;

(h) decisions concerning travel; and

(i) application for government-sponsored or private insurance and benefits.

9. A statement of the alternatives to guardianship considered, including but not limited to the execution of a health care proxy, power of attorney, representative payee, service coordination, and/or other social support services, other available supported or shared decision making, and surrogate decision-making committee, and reasons for the declination of such alternatives.

§ 7. Section 1753 of the surrogate's court procedure act, as amended by chapter 198 of the laws of 2016, is amended to read as follows:

§ 1753. Persons to be served and noticed

1. Upon [~~presentation~~] filing of the petition, process shall issue to:

(a) [~~the parent or parents, adult children, if the petitioner is other than a parent, adult siblings, if the petitioner is other than a parent, and if the person who is intellectually disabled or person who is developmentally disabled is married, to the spouse, if their residences are known;~~

~~(b) the person having care and custody of the person who is intellectually disabled or person who is developmentally disabled, or with whom such person resides if other than the parents or spouse; and~~

~~(c) the person who is intellectually disabled or person who is developmentally disabled if fourteen years of age or older for whom an application has been made in such person's behalf.~~

~~2. Upon presentation of the petition, notice of such petition shall be served by certified mail to:~~

~~(a) the adult siblings if the petitioner is a parent, and adult children if the petitioner is a parent;~~

~~(b) the mental hygiene legal service in the judicial department where the facility, as defined in subdivision (a) of section 47.01 of the mental hygiene law, is located if the person who is intellectually disabled or person who is developmentally disabled resides in such a facility;~~

~~(c) in all cases, to the director in charge of a facility licensed or operated by an agency of the state of New York, if the person who is intellectually disabled or person who is developmentally disabled resides in such facility;~~

~~(d) one other person if designated in writing by the person who is intellectually disabled or person who is developmentally disabled; and~~

~~(e) such other persons as the court may deem proper.~~

~~3. No process or notice shall be necessary to a parent, adult child, adult sibling, or spouse of the person who is intellectually disabled or person who is developmentally disabled who has been declared by a court as being incompetent. In addition, no process or notice shall be necessary to a spouse who is divorced from the person who is intellectually disabled or person who is developmentally disabled, and to a parent, adult child, adult sibling when it shall appear to the satisfaction of the court that such person or persons have abandoned the person who is intellectually disabled or person who is developmentally disabled.~~] the person with a developmental disability, if petitioner is other than the person with a developmental disability alleged to be in need of a guardian; and

(b) the parent or parents of the individual if the petitioner is other than the parents.

2. Upon filing of the petition, notice of the petition and the citation along with notice of the date, time, and location of the first appearance shall be sent by certified mail, return receipt requested to the last known address of the following, except if any of the following is also the petitioner:

(a) individuals listed in the petition pursuant to section seventeen hundred fifty-two of this article and subdivisions four and five of this section;

(b) the director in charge of a facility licensed or operated by an agency of the state of New York or their designee, if the person with a developmental disability resides in such facility;

(c) any other person if designated in writing by the person with a developmental disability; and

(d) such other persons as the court may deem proper.

3. Within five days of the filing of the petition, a full copy of said petition shall be served by certified mail upon the mental hygiene legal service in the judicial department in which the petition was filed. A copy of proof of mailing shall be thereafter filed with the court.

4. For petitions to modify an existing guardianship pursuant to section seventeen hundred fifty-five of this article and/or to appoint a standby or alternate standby guardian pursuant to subdivision seventeen hundred fifty-seven of this article, written notice must be given to all standby and alternate standby guardians currently in succession for a person with a developmental disability who is the subject of the petition by regular mail unless such standby and alternate standby guardians have consented to the petition. An affidavit of service by mail shall be filed with the court.

5. In addition, no process or notice shall be necessary to any individual who has evinced an intent to forgo his or her relationship to the individual as manifested by his or her failure to visit and communicate with the person alleged to be in need of guardianship, although able to do so and not prevented or discouraged from doing so. No process or notice shall be necessary for any individual who cannot, after due diligence, reasonably be located. The petitioner shall submit an affidavit to such effect.

§ 8. Section 1754 of the surrogate's court procedure act is REPEALED and a new section 1754 is added to read as follows:

§ 1754. Proceedings upon petition

1. Upon a petition for the appointment of a guardian of a person with a developmental disability eighteen years of age or older, the court shall not later than forty-five days following the filing of proof of

mailing upon the mental hygiene legal service, schedule an appearance in the matter.

(a) The mental hygiene legal service shall ascertain whether the person with a developmental disability alleged to need a guardian has any objection to the relief sought in the petition and whether the service is able to represent the interests of the person in the proceeding.

(b) If the mental hygiene service reports that the person with a developmental disability alleged to need a guardian objects to the relief sought in the petition, the court shall appoint the service as counsel for the person. If the service is not available to serve as the person's counsel and the person does not otherwise have counsel, the court shall appoint counsel for the person from among attorneys eligible for such appointment pursuant to section thirty-five of the judiciary law. The court shall ensure that the individual's counsel, whether it be the service or appointed counsel, have demonstrated experience with and knowledge of representing individuals with developmental disabilities. The appointment of such counsel shall be at no cost to the petitioners.

(c) If the mental hygiene legal service reports that the person with a developmental disability alleged to need a guardian does not object to relief sought in the petition, the person's interests shall continue to be represented by the service, if available, and the service shall conduct an examination into the allegations of fact contained in the petition and file with the court and serve upon the petitioner or their counsel no later than ten days prior to the appearance date an answer confirming or denying the allegations in the petition and report as to whether the service finds grounds to object to the relief sought in the petition. If the service objects to the relief sought in the petition, the service shall, along with its answer, serve a copy of its underlying report and findings upon the petitioner and/or their counsel. The service will otherwise perform its functions consistent with uniform regulations promulgated by the appellate division of the supreme court.

(d) If a person with a developmental disability alleged to need a guardian who does not object, does not otherwise appear by the service or other counsel, the court shall appoint a guardian ad litem pursuant to this section and section four hundred three of this act. Any guardian ad litem appointed pursuant to this section shall conduct an investigation into the allegations of fact contained in the petition and file with the court and serve no later than ten days prior to the appearance date, a report of its findings confirming or disconfirming said allegations, and if appropriate and upon consent of the person with a developmental disability nominate a person or entity of the respondent's choosing to serve as guardian, as well as any other matter which could assist the court's consideration of the matter, and serve a copy of the report upon the petitioner and petitioner's counsel. The court shall ensure that the individual's counsel, whether it be the service or appointed counsel, have demonstrated experience with and knowledge of representing individuals with developmental disabilities. The appointment of such guardian ad litem shall be at no cost to the petitioner.

(e) The mental hygiene legal service, any other counsel for the person with a developmental disability alleged to need a guardian, or the guardian ad litem may apply to the court for permission to inspect the clinical records pertaining to the person with a developmental disability alleged to need a guardian in accordance with state and federal laws. The service, any other counsel for the person with a developmental disability and the guardian ad litem, if any, shall be afforded access to

the person's clinical records without a court order to the extent that such access is otherwise authorized by state and federal laws.

(f) The petitioner, the mental hygiene legal service, any other counsel for the person with a developmental disability alleged to need a guardian, and the guardian ad litem, if any, may request the court for further evaluation of the person by a physician, psychiatrist or certified psychologist who has demonstrated experience with and knowledge of persons with developmental disabilities. In the event that further evaluations are required, the court may grant appropriate adjournments of the initial appearance date and may direct, in the case of a person determined to be indigent, that any further court authorized evaluations be paid for out of funds available pursuant to section thirty-five of the judiciary law. Such evaluation shall be at no cost to the petitioner.

2. At the first appearance, the respondent shall be present unless such presence is excused by the court based upon the standard set forth in paragraph (d) of this subdivision and upon recommendation of petitioner and/or petitioner's counsel, the mental hygiene legal service, respondent's counsel, or the guardian ad litem if the respondent does not have counsel. The petitioner shall also be present and may be represented by counsel. Any other party required to be served or noticed with process in the matter may be present.

(a) Prior to such appearance, the petitioner, either personally or by counsel, may confer with the service, respondent's counsel and the guardian ad litem if respondent does not have counsel and agree to amend any part of its petition and allegations of fact therein. Any such amended petition shall be filed with the court prior to the date of the first appearance.

(b) At the first appearance, the court shall examine the answer of the service, respondent's counsel, or the report of the guardian ad litem, if any, and may hear from the petitioner and the service, respondent's counsel and the guardian ad litem, if any, on the contents of the said answer or report and any amended petition filed.

(c) The court may direct that an order and decree of guardianship issue, including the authority of the guardian to act on behalf of the respondent with respect to any matter in which petitioner, the service, respondent's counsel, and the guardian ad litem, if any, all agree on the record that the respondent requires the requested relief and does not object to such relief.

(d) In the event that the petition cannot be disposed of by the agreement of the court and all of the parties, the court shall schedule a hearing in the matter within forty-five days of the first appearance at which the respondent shall be present unless it shall appear to the court that the respondent's presence is medically contraindicated, in that it would be likely to cause harm to the respondent, or under such other circumstances raised by or on behalf of the respondent as the court agrees that the respondent's presence would not be in his or her best interests, provided however that the respondent's presence shall not be waived over the objection of the service, respondent's counsel, or a guardian ad litem, if any, in which case the court shall conduct the hearing where the respondent resides, if the court is satisfied that the respondent's presence would be harmful to the respondent.

3. If there are any objections to the relief sought by the petitioner, the respondent has a right to a hearing or jury trial, if demanded by the respondent. In addition, the court may conduct a hearing at the request of any party or on its own motion. At any such hearing or trial,

the petitioner must establish by clear and convincing evidence any facts alleged in the petition or amended petition which are controverted and are relevant to whether respondent has a developmental disability, and if so, whether appointment of a guardian is required and the scope of the guardian's powers. Any other matter must be proven by the fair preponderance of the evidence presented and admitted.

4. If, upon conclusion of such hearing or jury trial, if any, the court is satisfied that the respondent has a developmental disability and requires the appointment of a guardian of the person or property, or both, it shall make a decree naming such person or persons to serve as such guardians. The powers of the guardian shall be tailored to the needs of the respondent.

§ 9. The surrogate's court procedure act is amended by adding a new section 1754-a to read as follows:

§ 1754-a. Decision making standard

Decisions made by a guardian appointed pursuant to this article shall be made in accordance with the following standards:

1. A guardian shall exercise authority only as necessitated by the person with a developmental disability's limitations, and, to the extent possible, shall encourage the person with a developmental disability to participate in decisions and to act on his or her own behalf.

2. A guardian shall consider the expressed desires and personal values of the person with a developmental disability to the extent known, when making decisions and shall consult with the person with a developmental disability whenever meaningful communication is possible.

3. If the person's wishes are unknown and remain unknown after reasonable efforts to discern them, the decision shall be made on the basis of the best interests of the person with a developmental disability as determined by the guardian. In determining the best interests of the person with a developmental disability, the guardian shall weigh the reason for and nature of the proposed action; the benefit or necessity of the action, the possible risks and other consequences of the proposed action; and any available alternatives and their risks, consequences and benefits. The guardian shall take into account any other information, including the views of family and friends, that the guardian believes the person with a developmental disability would have considered if able to act for herself or himself.

§ 10. Section 1755 of the surrogate's court procedure act, as amended by chapter 198 of the laws of 2016, is amended to read as follows:

§ 1755. Modification order

Any person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability eighteen years of age or older, or any person on behalf of any person [~~who is intellectually disabled or person who is developmental disabled~~] with a developmental disability for whom a guardian has been appointed, may apply to the court [~~having jurisdiction over the guardianship order~~] pursuant to section seventeen hundred fifty-one-a of this article requesting modification of such order in order to protect the person [~~who is intellectually disabled's, or person who is developmentally disabled's~~] with a developmental disability's financial situation and/or his or her personal interests. The court may, upon receipt of any such request to modify the guardianship order, appoint a guardian ad litem. Such guardian ad litem shall have demonstrated experience with and knowledge of persons with developmental disabilities. The court shall so modify the guardianship order if in its judgment the interests of the guardian are adverse to those of the person [~~who is intellectually disabled or person~~

~~who is developmentally disabled~~] with a developmental disability or if the interests of justice will be best served including, but not limited to, facts showing the necessity for protecting the personal and/or financial interests of the person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability.

§ 11. Section 1756 of the surrogate's court procedure act, as amended by chapter 198 of the laws of 2016, is amended to read as follows:

§ 1756. Limited [~~guardian of the property~~] purpose and/or limited duration guardianship

1. a. When it shall appear to the satisfaction of the court that such person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability for whom an application for guardianship is made pursuant to this article is eighteen years of age or older and is wholly or substantially self-supporting by means of his or her wages or earnings from employment, the court is authorized and empowered to appoint a limited guardian of the property of such person [~~who is intellectually disabled or person who is developmentally disabled~~] who shall receive, manage, disburse and account for only such property of said person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability as shall be received from other than the wages or earnings of said person.

b. The person [~~who is intellectually disabled or person who is developmentally disabled~~] who is developmentally disabled for whom a limited guardian of the property has been appointed shall have the right to receive and expend any and all wages or other earnings of his or her employment and shall have the power to contract or legally bind himself or herself for such sum of money not exceeding one month's wages or earnings from such employment or three hundred dollars, whichever is greater, or as otherwise authorized by the court.

2. When it shall appear to the satisfaction of the court, either upon a petition for guardianship filed as permitted by sections seventeen hundred fifty-one and seventeen hundred fifty-two of this article or upon a petition filed pursuant to this section in a simplified format to be established by the office of court administration in consultation with the office for people with developmental disabilities and other interested stakeholders, that a person with a developmental disability needs the assistance of a guardian of the person and/or property for the purpose of making a single decision or for a brief stated period of transition in such person's life, the court may appoint a limited-purpose guardian of the person and/or property to effectuate such a decision or transition. In any such case, the provisions of section seventeen hundred fifty-four of this article shall apply, except that the period for the rendering of a report by the mental hygiene legal service or other respondent's counsel may be shortened as may be reasonably necessary to meet the needs of the respondent under the circumstances presented. An order appointing and empowering such a limited-purpose guardian of the person and/or property shall state specifically the duration and scope of such guardian's authority.

§ 12. Section 1757 of the surrogate's court procedure act, as amended by chapter 198 of the laws of 2016, is amended to read as follows:

§ 1757. Standby guardian of a person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability

1. Upon application, a standby guardian of the person or property or both of a person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability may be appointed by

the court. **Any such application shall be made upon notice to the mental hygiene legal service.** The court may also, upon application, appoint an alternate and/or successive alternates to such standby guardian, to act if such standby guardian shall die, or become incapacitated, or shall renounce. Such appointments by the court shall be made in accordance with the provisions of this article**, except that the court shall not require the petitioner to resubmit proof of the need for guardianship**.

2. Such standby guardian, or alternate in the event of such standby guardian's death, incapacity or renunciation, shall without further proceedings be empowered to assume the duties of his or her office immediately upon death, renunciation or adjudication of incompetency of the guardian or standby guardian appointed pursuant to this article, subject only to **the filing of an application for** confirmation of his or her appointment by the court within one hundred eighty days following assumption of his or her duties of such office. Before confirming the appointment of the standby guardian or alternate guardian, the court may conduct a hearing pursuant to section seventeen hundred fifty-four of this article upon petition by anyone on behalf of the person [~~who is intellectually disabled or person who is developmentally disabled~~] **with a developmental disability** or the person [~~who is intellectually disabled or person who is developmentally disabled~~] **with a developmental disability** if such person is eighteen years of age or older, or upon its discretion**, except that the court shall not require the petitioner to resubmit proof of the need for guardianship**.

3. Failure of a standby or alternate standby guardian to assume the duties of guardian, seek court confirmation or to renounce the guardianship within sixty days of written notice by certified mail or personal delivery given by or on behalf of the person [~~who is intellectually disabled or person who is developmentally disabled~~] **with a developmental disability** of a prior guardian's inability to serve and the standby or alternate standby guardian's duty to serve, seek court confirmation or renounce such role shall allow the court to:

(a) deem the failure an implied renunciation of guardianship, and

(b) authorize, notwithstanding the time period provided for in subdivision two of this section to seek court confirmation, any remaining standby or alternate standby guardian to serve in such capacity provided (i) an application for confirmation and appropriate notices pursuant to subdivision one of section seventeen hundred fifty-three of this article are filed, or (ii) an application for modification of the guardianship order pursuant to section seventeen hundred fifty-five of this article is filed**, except that the court shall not require the petitioner to resubmit proof of the need for guardianship**.

§ 13. Section 1758 of the surrogate's court procedure act, as amended by chapter 198 of the laws of 2016, is amended to read as follows:

§ 1758. Court jurisdiction

1. The jurisdiction of the court to hear proceedings pursuant to this article shall be subject to article eighty-three of the mental hygiene law.

2. After the appointment of a guardian, standby guardian or alternate guardians, the court shall have and retain general jurisdiction over the person [~~who is intellectually disabled or person who is developmentally disabled~~] **with a developmental disability** for whom such guardian shall have been appointed, to take of its own motion or to entertain and adjudicate such steps and proceedings relating to such guardian, standby, or alternate guardianship as may be deemed necessary or proper for the

welfare of such person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability.

§ 14. Section 1759 of the surrogate's court procedure act, as amended by chapter 198 of the laws of 2016, is amended to read as follows:

§ 1759. Duration of guardianship

1. Such guardianship shall not terminate at the age of majority or marriage of such person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability but shall continue during the life of such person, or until terminated by the court.

2. A person eighteen years or older for whom such a guardian has been previously appointed or anyone, including the guardian, on behalf of a person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability for whom a guardian has been appointed may petition the court which made such appointment or the court in his or her county of residence to have the guardian discharged and a successor appointed, or to have the guardian of the property designated as a limited guardian of the property, or to have the guardianship order modified, dissolved or otherwise amended. Upon such a petition for review, the court shall conduct a hearing pursuant to section seventeen hundred fifty-four of this article except that the court shall not require the petitioner to resubmit proof of the need for guardianship.

3. Upon marriage of such person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability for whom such a guardian has been appointed, the court shall, upon request of the person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability, spouse, or any other person acting on behalf of the person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability, review the need, if any, to modify, dissolve or otherwise amend the guardianship order including, but not limited to, the appointment of the spouse as standby guardian. The court, in its discretion, may conduct such review pursuant to section seventeen hundred fifty-four of this article except that the court shall not require the petitioner to resubmit proof of the need for guardianship.

§ 15. Section 1760 of the surrogate's court procedure act, as amended by chapter 198 of the laws of 2016, is amended to read as follows:

§ 1760. Corporate guardianship

No corporation may be appointed guardian of the person under the provisions of this article, except that a non-profit corporation organized and existing under the laws of the state of New York and having the corporate power to act as guardian of a person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability, may be appointed as the guardian of the person only of such person [~~who is intellectually disabled or person who is developmentally disabled~~] with a developmental disability. Upon specific request to and approval by the court, such authority of a not-for-profit corporation as guardian of the person with developmental disabilities shall include the authority to establish a supplemental needs trust account for the benefit of the person with a developmental disability, if necessary.

§ 16. Section 1761 of the surrogate's court procedure act, as amended by chapter 198 of the laws of 2016, is amended to read as follows:

§ 1761. Application of other provisions

To the extent that the context thereof shall admit, the provisions of article seventeen of this act shall apply to all proceedings under this

article with the same force and effect as if an "infant", as therein referred to, were a "person [~~who is intellectually disabled" or "person who is developmentally disabled~~] with a developmental disability" as herein defined, and a "guardian" as therein referred to were a "guardian of the person [~~who is intellectually disabled" or a "guardian of a person who is developmentally disabled~~] with a developmental disability" as herein provided for.

§ 17. The surrogate's court procedure act is amended by adding a new section 1762 to read as follows:

§ 1762. Annual account and asset verification form

1. A guardian of the property of a person with a developmental disability must, within the counties within the city of New York and within the counties of Nassau, Orange, Suffolk and Westchester, annually within thirty days after the anniversary of his or her appointment and within every other county in the month of January of each year, as long as any of the person with a developmental disability's property of the proceeds thereof remains under the guardian's control, file in the court the model guardianship account and asset verification form annexed hereto. A copy of the annual guardianship account and asset verification form is also to be sent by regular mail to all standby and alternate standby guardians then named in the court's decree to their last known address.

2. The model guardianship account and asset verification form shall be as follows:

GUARDIANSHIP ACCOUNT AND ASSET VERIFICATION FORM

*The original of this form is to be filed with the Surrogate Court Clerk where guardianship was originally obtained. A copy of this form is to be sent to all standby guardians and alternate standby guardians by regular mail.

I. Guardianship Data

GUARDIAN INFORMATION

_____

Guardian's Name Home Phone #: _____

Mobile Phone #: _____

Work Phone#: _____

E-mail Address (if any): _____

Street Address

_____

City State Zip

WARD INFORMATION

_____

Ward's Name & Date of Birth

_____

Street Address

_____

City State Zip

If the Ward lives in a residential facility or other setting under someone's care, please provide the following information:

Name/Address: _____

Contact Person: _____

Phone #: _____

E-mail Address (if any): _____

II. Guardianship Account and Asset Verification Form

Note: Absolutely NO WITHDRAWALS are permitted from a guardianship account without a prior written court order from the _____ County Surrogate's court.

Please have the financial institution complete this section if a Guardianship Account exists for the individual for whom you serve as guardian.
This is to certify that the records of (Name & Address of institution holding assets indicated herein) show that (Name & Address of Guardian), as Guardian of (Name of Ward) had a balance as of December 31, (insert year) of $(Insert amount) in Account # , which is in a Court Restricted Guardianship Account with this Financial Institution.
This account earned interest in the amount of $ in (year), as will be reported on the 1099 for this Account.
In witness whereof, the Financial Institution has hereunto set its hand and corporate seal the day and year noted herein.
By:
Official Title:
****
If you are not holding funds for your Ward, please sign below in the presence of a Notary Public.
I certify under penalty of perjury that I am not holding any funds in any financial institution or otherwise for my Ward, (Name of Ward).
Guardian Signature :
Print Name:
Sworn to and subscribed before me:

Notary Public

§ 18. Paragraph a of subdivision 1 and subdivision 4 of section 35 of the judiciary law, paragraph a of subdivision 1 as amended by chapter 817 of the laws of 1986, subdivision 4 as amended by chapter 706 of the laws of 1975 and as renumbered by chapter 315 of the laws of 1985, are amended to read as follows:

a. When a court orders a hearing in a proceeding upon a writ of habeas corpus to inquire into the cause of detention of a person in custody in a state institution, or when it orders a hearing in a civil proceeding to commit or transfer a person to or retain him in a state institution when such person is alleged to be mentally ill, mentally defective or a narcotic addict, or when it orders a hearing for the commitment of the guardianship and custody of a child to an authorized agency by reason of the mental illness or [~~mental retardation~~] developmental disability of a parent, or when it orders a hearing for guardianship under article seventeen-a of the surrogate's court procedure act or when it orders a hearing to determine whether consent to the adoption of a child shall be required of a parent who is alleged to be mentally ill or [~~mentally retarded~~] have a developmental disability, or when it orders a hearing to determine the best interests of a child when the parent of the child revokes a consent to the adoption of such child and such revocation is opposed or in any adoption or custody proceeding if it determines that assignment of counsel in such cases is mandated by the constitution of this state or of the United States, the court may assign counsel to represent such person if it is satisfied that he is financially unable to obtain counsel. Upon an appeal taken from an order entered in any such proceeding, the appellate court may assign counsel to represent such person upon the appeal if it is satisfied that he is financially unable to obtain counsel.

4. In any proceeding described in paragraph (a) of subdivision one of this section, when a person is alleged to be a person with a developmental disability or traumatic brain injury in need of a guardian pursuant to article seventeen-a of the surrogate's court procedure act, be mentally ill, mentally defective or a narcotic addict, the court which

ordered the hearing may appoint no more than two psychiatrists, certified psychologists or physicians to examine and testify at the hearing upon the condition of such person. A psychiatrist, psychologist or physician so appointed shall, upon completion of his services, receive reimbursement for expenses reasonably incurred and reasonable compensation for such services, to be fixed by the court. Such compensation shall not exceed two hundred dollars if one psychiatrist, psychologist or physician is appointed, or an aggregate sum of three hundred dollars if two psychiatrists, psychologists or physicians are appointed, except that in extraordinary circumstances the court may provide for compensation in excess of the foregoing limits.

§ 19. This act shall take effect on the one hundred eightieth day after it shall have become a law.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

DISABILITY RIGHTS NEW YORK

Plaintiff,

-against-

COMPLAINT

CV:

NEW YORK STATE, UNIFIED COURT SYSTEM OF THE STATE OF NEW YORK, Honorable JANET DIFIORE, as Chief Judge of the New York State Unified Court System, Honorable LAWRENCE K. MARKS, as Chief Administrative Judge of the New York State Unified Court System.

Defendants.

PRELIMINARY STATEMENT

1. For decades, individuals with intellectual and developmental disabilities have been deprived of their constitutional rights and discriminated against because of their disabilities by New York State's Unified Court System through the appointment of plenary guardians pursuant to Article 17A of the Surrogate Court Procedure Act (Article 17A).

2. Through the application of Article 17A, defendants permit the termination of all decision making rights including, the right to decide where to live, whom to associate with, what medical treatment to seek and receive, whether to marry and have children, whether to vote, and where to work.

3. DRNY brings this action to defend the rights guaranteed by the United States Constitution, the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973 for New Yorkers with intellectual disabilities and developmental disabilities.

JURISDICTION AND VENUE

4. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. § 1331.

5. Plaintiff brings this civil rights action under the United States Constitution and 42 U.S.C. § 1983 to challenge the constitutionality of Article 17A of the Surrogates Court Procedure Act.

6. Plaintiff's additional federal claims are made pursuant to 42 U.S.C. § 1983, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794; and Title II of the Americans with Disabilities Act 42 U.S.C. § 12132.

7. This Court has the authority to grant declaratory and injunctive relief under 28 U.S.C §§ 2201, 2202.

8. Venue is appropriate in this District pursuant to 28 U.S.C. § 1391(b)(1)-(2).

PARTIES

Plaintiff

9. DISABILITY ADVOCATES, INC. is an independent non-profit corporation organized under the laws of the State of New York. It does business and has sued under the name DISABILITY RIGHTS NEW YORK (DRNY).

10. Under the Developmental Disabilities Assistance and Bill of Rights Act (DD Act), Congress gives significant federal funding to states for services to individuals with disabilities, provided that the state establishes a Protection and Advocacy (P&A) system that meets certain specified conditions. 42 U.S.C. § 15041 *et seq*.

11. DRNY is New York State's P&A system. N.Y. Exec. Law § 558(b).

12. DRNY is specifically authorized to pursue legal, administrative, and other appropriate remedies or approaches to ensure the protection of, and advocacy for, the rights of individuals with intellectual and developmental disabilities. 42 U.S.C. § 15043(a)(2)(A)(i).

13. DRNY has offices located at 25 Chapel Street, Suite 1005, Brooklyn, NY 11201; 725 Broadway, Suite 450, Albany, NY 12208; and, 44 Exchange Blvd, Suite 110, Rochester, NY 14614.

Defendants

14. New York State is a public entity as defined by 42 U.S.C § 12131(1)(A).

15. New York State operates the Unified Court System of the State of New York.

16. The Unified Court System of the State of New York is a program or activity pursuant to 29 U.S.C. § 794(b)(1)(A)

17. The Unified Court System of the State of New York has all the powers and duties set forth in Article VI of the New York State Constitution and as otherwise prescribed by law, statute, rules and regulations.

18. The Unified Court System of the State of New York has Surrogate Courts which have taken, and continue to take, action which plaintiff complains of in this lawsuit.

19. The Unified Court System Office of Court Administration is located at 25 Beaver Street - Rm. 852 New York, NY 10004

20. Janet DiFiore, is the Chief Judge of the State of New York, with all powers and duties set forth in Article VI of the New York State Constitution and as otherwise prescribed by law, statute, rules and regulations.

21. Chief Judge DiFiore serves as the Chief Judicial Officer of the State and the Chief Judge of the Court of Appeals.

22. The Chief Judge of the Unified Court System establishes statewide standards and administrative policies for the Unified Court System in the State of New York.

23. Judge DiFiore is sued in her official capacity.

24. While under Chief Judge DiFiore's control, Surrogate Courts have taken, and continue to take, action which plaintiff complains of in this lawsuit.

25. Lawrence K. Marks, is the Chief Administrative Judge for the Courts of New York State, with all powers and duties set forth in Article VI of the New York State Constitution and as otherwise prescribed by law, statute, rules and regulations.

26. Judge Marks is sued in his official capacity.

27. While under Chief Administrative Judge Marks' control, Surrogate Courts have taken, and continue to take, action which plaintiff complains of in this lawsuit.

28. Pursuant to the powers vested in the Chief Administrative Judge, on August 1, 2016 defendant Marks rescinded eight forms used in Surrogate's Court guardianship proceedings and prescribed eight new forms for use in Surrogate's Court guardianship proceedings in the courts of the State of New York. See http://www.nycourts.gov/courts/7jd/monroe/Surrogate/PDFs/SCPA_Changes_Petition.pdf

FACTUAL ALLEGATIONS

29. The imposition of a guardianship is a significant deprivation of personal liberty.

30. In New York State, guardianship of individuals with intellectual disabilities and developmental disabilities may be sought pursuant to Article 17A or Mental Hygiene Law Article 81 (Article 81).

31. A guardianship proceeding under Article 81 tailors any deprivation of rights to an individual's functional limitations rather than a diagnosis.

32. Article 81 explicitly requires the court to impose the least restrictive form of intervention, taking into account community supports, resources and existing advance directives that render a guardianship unnecessary. See MHL § 81.02 (a) (2); 81.03 (e).

33. By contrast, under Article 17A, the basis for appointing a guardian is diagnosis driven, that is, whether a person has an intellectual or developmental disability.

34. Article 17A provides only for the appointment of a plenary guardianship of the person, property or person and property and it is not individually tailored to meet the individual's needs or provide the least restrictive level of guardianship.

History of MHL Article 81 and SCPA Article 17A

35. In 1990, the Legislature directed the New York State Law Revision Commission to study and re-evaluate Article 17A and committee and conservatorship proceedings under Mental Hygiene Law (MHL) Article 77 and 78 in light of "momentous changes [which] have occurred in the care, treatment, and understanding of individuals [with disabilities]…" L. 1990, ch. 516 § 1

36. A study of Article 17A was conducted but not presented to the Legislature.

37. Instead, the Law Revision Commission submitted a report to the Legislature only on MHL Article 77 and 78.

38. Rejecting global adjudications of incapacity, the Legislature determined that New York's former conservatorship and committee laws, MHL Article 77 and 78, were not flexible enough to meet the diverse and complex needs of persons with disabilities that impact capacity.

39. After the Law Revision Commission's study was completed, the Legislature found that, "Conservatorship which traditionally compromises a person's right only with respect to property frequently is insufficient to provide necessary relief. On the other hand, a committee, with its judicial finding of incompetence and the accompanying stigma and loss of civil rights, traditionally involves a

depravation that is often excessive and unnecessary. Moreover, certain persons require some form of assistance in meeting their personal and property management needs but do not require either of these drastic remedies." MHL § 81.01

40. In response, the Legislature enacted MHL Article 81 in 1992 declaring, "it is the purpose of this act to promote the public welfare by establishing a guardianship system which is appropriate to satisfy either personal or property management needs of an incapacitated person in a manner tailored to the individual needs of that person, which takes in account the personal wishes, preferences and desires of the person, and which affords the person the greatest amount of independence and self-determination and participation in all the decisions affecting such person's life." MHL § 81.01

41. Article 81 applies to all persons with disabilities which impact capacity.

42. Article 81 does not distinguish between individuals with mental illness, intellectual disabilities, developmental disabilities, or any other disability.

43. Instead, Article 81 requires courts to assess the alleged incapacitated person's "functional limitations which impair the person's ability to provide for personal needs or property management" regardless of the origin of the functional limitation. MHL § 81.02(c)

44. In contrast, Article 17A, which was enacted in 1969, authorizes a Surrogate Judge to appoint a guardian over the person, property or person and property of a person with mental retardation.

45. Article 17A was placed within Surrogate Court Procedures Act (SCPA) Article 17 which governs the appointment of a guardian over a minor child.

46. The practice commentaries for Article 17A state "[t]he guardianship of a mentally retarded or developmentally disabled person is very much like the guardianship of a child…" SCPA § 1761.

47. The term, "mental retardation" was replaced with "intellectual disability" in Article 17A in 2016. SCPA § 1750(2016).

48. Under Article 17A, a "person who is intellectually disabled is a person who has been certified by one licensed physician and one licensed psychologist, or by two licensed physicians at least one of whom is familiar with or has professional knowledge in the care and treatment of persons with an intellectual disability, having qualifications to make such certification, as being incapable to manage him or herself and/or his or her affairs by reason of intellectual disability and that such condition is permanent in nature or likely to continue indefinitely." SCPA § 1750.

49. In 1986, Article 17A was expanded to include other "developmental disabilities." 1989 N.Y. Sess. Law 675 § 2 (McKinney).

50. For the purposes of Article 17A, "a person who is developmentally disabled is a person who has been certified by one licensed physician and one licensed psychologist, or by two licensed physicians at least one of whom is familiar with or has professional knowledge in the care and treatment of persons with developmental disabilities, having qualifications to make such certification, as having an impaired ability to understand and appreciate the nature and consequences of decisions which result in such person being incapable of managing himself or herself and/or his or her affairs by reason of developmental disability and that such condition is permanent in nature or likely to continue indefinitely, and whose disability: (a) is attributable to cerebral palsy, epilepsy, neurological impairment, autism or traumatic head injury; (b) is attributable to any other condition of a person found to be closely related to intellectual disability because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of persons with intellectual disabilities; or (c) is attributable to dyslexia resulting from a disability described in subdivision one or two of this section or from intellectual disability; and (d) originates before such person attains age twenty-two, provided, however, that no such age of origination shall apply for the purposes of this article to a person with traumatic head injury." SCPA § 1750-a.

51. The practice commentary following MHL § 81.01 describes the significant distinctions between Article 81 and Article 17A:

> Although the enactment of Article 81 has had a profound impact on guardianship law in New York, it has not effected any change in Article 17-A of the Surrogate's Court Procedure Act which governs guardianship for persons with mental retardation or developmental disabilities. Article 17-A is markedly different from Article 81. The proceeding can only be brought in Surrogate's court; it is limited to persons with mental retardation and developmental disabilities; the petition must be accompanied by certificates of one licensed physician and one licensed psychologist or two licensed physicians; the appointment can be made without a hearing or the presence of the person alleged to need a 17A guardian; and it does not provide the same due process protections, the limited or tailored authority of the guardian, nor the detailed accountability of the guardian as Article 81.

See Law Revision Commission Comment MHL § 81.01

52. Unlike, Article 81, Article 17A does not require the court to make any findings of fact with regard to the nature or extent of the powers requested by the petitioner, the allegedly incapacitated person's functional abilities and limitations, alternatives to guardianship, or why it is necessary for a guardian to be appointed.

53. Defendants' Surrogate Judges use Article 17A to grant all-encompassing powers of unlimited duration over the person and property of people with intellectual and developmental disabilities.

54. The appointment of a 17A guardianship limits the fundamental rights of individuals with intellectual and developmental disabilities by removing a person's legal authority and control over their decisions.

New York State's Olmstead Cabinet and Article 17A

55. In October 2013, New York State issued the Report and Recommendations of the Olmstead Cabinet pursuant to Executive Order Number 84. See http://www.governor.ny.gov/sites/governor.ny.gov/files/archive/assets/documents/olmstead-cabinet-report101013.pdf

56. New York's Olmstead Cabinet concluded that "[u]nder Article 17A, the basis for appointing a guardian is diagnosis driven and is not based upon the functional capacity of the person with disability." Id at 28

57. In contrast, MHL Article 81, "imposes guardianship based upon a functional analysis of a person's disability…" Id.

58. To meet the State's responsibility under the American with Disabilities Act, the Olmstead Cabinet recommended that Article 17A be amended to include an examination of functional capacity and consideration of choice and preference in decision making. Id.

59. As of the filing of this action, Article 17A has not been so amended.

Procedural and Substantive Standards for the Appointment of a Guardian

The Petition

60. The pleading requirements of Article 17A and Article 81 differ dramatically.

61. Article 81 requires the petition to include, "a description of the alleged incapacitated person's functional level including that person's ability to manage the activities of daily living, behavior, and understanding and appreciation of the nature and consequences of any inability to manage the activities of daily living." MHL § 81.08(3)

62. Article 81 also requires the petition to include, "specific factual allegations as to the personal actions or other actual occurrences involving the person alleged to be incapacitated which are

claimed to demonstrate that the person is likely to suffer harm because he or she cannot adequately understand and appreciate the nature and consequences of his or her inability to provide for personal needs." MHL § 81.08(4)

63. Article 81 further requires the petition to include, "specific factual allegations as to the financial transactions or other actual occurrences involving the person alleged to be incapacitated which are claimed to demonstrate that the person is likely to suffer harm because he or she cannot adequately understand and appreciate the nature and consequences of his or her inability to provide for property management." MHL § 81.08(5)

64. Additionally, Article 81 requires the petition to include, "the particular powers being sought and their relationship to the functional level and needs of the person alleged to be incapacitated." MHL § 81.08(6).

65. In contrast, Article 17A does not require any specific factual allegations about the person's ability to understand the nature and consequences of his or her ability to provide for personal needs or property management.

66. Instead, Article 17A requires that the petition be filed with the court on forms prescribed by the defendants. SCPA § 1752

67. Defendant Marks has issued these forms. See https://www.nycourts.gov/forms/surrogates/guardianship.shtml.

68. The defendants' forms require a petitioner to submit certifications of two physicians or one licensed psychologist and one physician with the petition. Id.

69. The physician or psychologist must opine whether the person is incapable of managing himself or herself and/or his or her affairs by reason of an intellectual or developmental disability and whether such condition is permanent in nature or likely to continue indefinitely. Id.

70. The defendants' forms allow the physician or psychologist to check boxes regarding these fundamental conclusions. Id.

71. The physician or psychologist are not directed to describe in detail how the existence of an intellectual or developmental disability makes the person incapable of managing himself or herself or his or her affairs.

72. Instead, the physician or psychologist must "describe, in detail, the nature, degree and origin of the disability." See http://www.nycourts.gov/courts/7jd/monroe/Surrogate/PDFs/SCPA_Changes_Petition.pdf

73. The defendants' forms specifically permit the courts' use of uncontested affidavits which are attached to the petition.

74. If the alleged incapacitated person is a minor, the physician or psychologist can provide this privileged information without the minor's knowledge or consent.

75. Unlike Article 81, Article 17A does not require a petitioner to state the specific powers requested and the relationship between the powers sought and the individual's functional limitations. See and compare, SCPA §1752 and MHL §81.08.

76. Unlike Article 81, Article 17A does not require a petitioner to state why the person would likely suffer harm if the court did not appoint a guardian. Id.

77. The petition under Article 17A does not put an allegedly incapacitated person on actual notice of the reasons why the guardianship is sought, the extent of the powers sought, the right to contest the proceeding at a hearing, or to be represented by an attorney.

Notice

78. Article 81 requires a notice to the allegedly incapacitated person which includes a clear and easily readable statement of the rights of the person in twelve point or larger bold face double spaced type as follows:

IMPORTANT

> An application has been filed in court by _____ who believes you may be unable to take care of your personal needs or financial affairs. _____ is asking that someone be appointed to make decisions for you. With this paper is a copy of the application to the court showing why _____ believes you may be unable to take care of your personal needs or financial affairs. Before the court makes the appointment of someone to make decisions for you the court holds a hearing at which you are entitled to be present and to tell the judge if you do not want anyone appointed. This paper tells you when the court hearing will take place. If you do not appear in court, your rights may be seriously affected.
>
> You have the right to demand a trial by jury. You must tell the court if you wish to have a trial by jury. If you do not tell the court, the hearing will be conducted without a jury. The name and address, and telephone number of the clerk of the court are:
>
> The court has appointed a court evaluator to explain this proceeding to you and to investigate the claims made in the application. The court may give the court evaluator permission to inspect your medical, psychological, or psychiatric records. You have the right to tell the judge if you do not want the court evaluator to be given that permission. The court evaluator's name, address, and telephone number are:
>
> You are entitled to have a lawyer of your choice represent you. If you want the court to appoint a lawyer to help you and represent you, the court will appoint a lawyer for you. You will be required to pay that lawyer unless you do not have the money to do so. MHL § 81.07.

79. The Article 81 notice must inform the individual of the right to a hearing, to present evidence, call witnesses, cross examine witnesses and be represented by counsel of his or her choice. MHL § 81.07 and MHL § 81.11

80. The Article 81 court must also appoints a person to explain "to the person alleged to be incapacitated, in a manner which the person can reasonably be expected to understand, the nature and possible consequences of the proceeding, the general powers and duties of a guardian, available resources, and the rights to which the person is entitled, including the right to counsel." MHL § 81.09

81. Article 17A does not require that the individual with intellectual or developmental disabilities be notified of his or her rights to contest the appointment of a guardianship, be present at a hearing, or be represented by an attorney.

82. Article 17A makes no provision to tailor notice requirements to ensure that the individual with intellectual or developmental disabilities is fully informed of the nature and implications of the proceeding.

Necessity of Guardianship

83. Since the appointment of a guardian results in a deprivation of fundamental rights, there must be a clear and compelling need for the appointment. See Rivers v. Katz, 67 N.Y.2d 485 (1986) *re-argument den.*, 68 N.Y.2d 808 (1986); Addington v. Texas, 441 U.S. 418 (1979).

84. The presence of a particular medical or psychiatric condition does not necessarily preclude a person from functioning effectively. See In re Grinker (Rose), 77 N.Y.2d 703 (1991); Rivers v. Katz, 67 N.Y.2d 485 (1986).

85. Under Article 81, a guardianship can only be imposed when:

a. The person is likely to suffer harm; and

b. The person is unable to provide for personal needs and/or property management; and

c. The person cannot adequately understand and appreciate the nature and consequences of such inability. MHL § 81.02(s)(b)(1)-(2).

86. Even if the alleged incapacitated person is found to lack capacity, Article 81 mandates a showing of unmet needs before a guardian can be appointed. MHL §§ 81.02(a)(1) and (2); 81.03(d).

87. Under Article 81, a guardian may be appointed only where it has been established by clear and convincing evidence that a guardian is needed and there are no lesser restrictive options. See MHL § 81.02; 81.03(d)(e).

88. In contrast with Article 81, Article 17A specifically directs that where "the court is satisfied that the best interests of the person who is intellectually disabled or person who is developmentally disabled will be promoted by the appointment of a guardian of the person or property, or both, it shall make a decree naming such person or persons to serve as such guardians." SCPA § 1754(5).

89. Surrogate Courts routinely terminate an individual's decision making authority in every aspect of life and deprive the individual of fundamental liberty interests simply because the court has determined it is in the person's "best interest" to do so.

The Hearing and Presence of a Person Subject to Guardianship

90. Article 17A directs the court to conduct a hearing but also permits the court, "in its discretion to dispense with a hearing for the appointment of a guardian" where the application has been made by (a) both parents or the survivor; or (b) one parent and the consent of the other parent; or (c) any interested party and the consent of each parent. SCPA § 1754 (1)(a)-(c).

91. Indeed, SCPA § 1752 (7) and the forms promulgated by defendants direct the petitioner to identify "any circumstances which the court should consider in determining whether it is in the best interest of the [alleged incapacitated] person … to not be present at the hearing."

92. The statutory standard for determining whether a person subjected to an Article 17A proceeding must be present are delineated in SCPA § 1754(3) which states:

> If a hearing is conducted, the person who is intellectually disabled or person who is developmentally disabled shall be present unless it shall appear to the satisfaction of the court on the certification of the certifying physician that the person who is intellectually disabled or person who is developmentally disabled is medically incapable of being present to the extent that attendance is likely to result in physical harm to such person who is intellectually disabled or person who is developmentally disabled, or under such other circumstances which the court finds would not be in the best interest of the person who is intellectually disabled or person who is developmentally disabled.

93. By contrast, Article 81 requires the court to conduct a hearing before the appointment of a guardianship; the hearing may be waived only if the alleged incapacitated person consents to the appointment of a guardian. MHL §§ 81.11, 81.02(a)(2).

94. Under Article 81, "the hearing must be conducted in the presence of the person alleged to be incapacitated…so as to permit the court to obtain its own impression of the person's incapacity. If the person alleged to be incapacitated physically cannot come or be brought to the courthouse, the hearing must be conducted where the person alleged to be incapacitated resides unless…all information before the court clearly establishes that (i) the person alleged to be incapacitated is completely unable to participate in the hearing or (ii) no meaningful participation will result from the person's presence at the hearing." MHL § 81.11(c)

95. The Law Revision Commission stressed the importance of having the person present at the hearing because "seeing the person allowed the court to draw a carefully crafted and nuanced order which takes into account the person's dignity, autonomy and abilities, because the judge has had the opportunity to learn more about the person as an individual rather than a case description in a report." The Law Revision Commission Comment MHL § 81.11.

Evidentiary Standard For Appointment of Guardian

96. Article 17A does not specifically set forth any evidentiary standards for the appointment of a guardian.

97. Surrogate Courts apply the preponderance of the evidence standard in Article 17A proceedings.

98. By contrast, MHL Article 81 expressly requires courts to apply a clear and convincing evidence standard of proof, with the burden of proof on the petitioner. MHL § 81.12(a)

Right to Counsel

99. Article 17A makes no provision for the appointment of an attorney to represent the alleged incapacitated person.

100. Instead, Article 17A states that a court, "may in its discretion appoint a guardian ad litem, or the mental hygiene legal service if such person is a resident of a mental hygiene facility… to recommend whether the appointment of a guardian as proposed in the application is in the best interest of the person who is intellectually disabled or person who is developmentally disabled." SCPA § 1754(1).

101. Article 81 requires the appointment of a court evaluator rather than a guardian ad litem. MHL § 81.09(a).

102. The court evaluator has a duty to ensure the alleged incapacitated person understands petition and the nature and potential consequences of the proceeding. MHL § 81.09

103. The court evaluator must also educate the person about their legal rights and assess whether legal counsel should be appointed. MHL §81.09

104. In addition, the court evaluator is required to conduct a thorough investigation to aid the court in reaching a determination about the person's capacity, the availability and reliability of alternative

resources, and assigning the proper powers to the guardian, and selecting the guardian. MHL § 81.09 (a); See also Law Revision Commission comment MHL § 81.10.

105. The appointment of a court evaluator is mandatory in every case, with one exception. The court may dispense with or suspend the appointment of the court evaluator only when the court appoints counsel under MHL § 81.10.

106. Article 81 also grants the alleged incapacitated person "the right to choose and engage legal counsel of the person's choice." MHL § 81.10(a).

107. MHL Article 81 requires the appointment of an attorney when the alleged incapacitated person : (1) requests counsel; (2) wishes to contest the proceeding; (3) does not consent to the authority requested in the petition; or when (4) the petition alleges the person is in need of major medical or dental treatment; (4) is being transferred to a nursing home or other residential facility; or (5) where the court determines that a possible conflict exists between the court evaluator's role and the advocacy needs of the person alleged to be incapacitated. MHL § 81.10(c)

108. In Article 81 proceedings, where the person is indigent, the state, or its appropriate subdivision, is required to pay for assigned counsel. MHL § 81.10(f); See also Matter of St. Luke's-Roosevelt Hosp. Ctr., 89 N.Y.2d 889, 892 (1996)

109. The Law Revision Commission explained why the appointment of counsel is absolute, and the difference between the appointment of a guardian ad litem and an attorney: "[i]n the past it often has not been clear whether the guardians ad litem appointed pursuant to Article 77 and 78 were acting as advocates for the person who was the subject of the proceeding or as a neutral "eyes and ears" of the court. In order to alleviate the confusion, Article 81 distinguishes between the two roles of counsel and that of guardian ad litem, now known as court evaluator, and creates separate rules to govern each…The role of counsel…is to represent the person alleged to be incapacitated and ensure that the point of view of

the person alleged to be incapacitated is presented to the court. At minimum that representation should include conducting personal interviews with the person; explaining to the person his or her rights and counseling the person regarding the nature and consequences of the proceeding; securing and presenting evidence and testimony; providing vigorous cross-examination; and offering arguments to protect the rights of the allegedly incapacitated person." Law Revision Commission comment under MHL § 81.10(f)

Powers of the Guardian: Plenary or Limited

110. The defendants' Unified Court Administration's guidance on Article 17A states, "[a]n Article 17A Guardianship is very broad and covers most decisions that are usually made by a parent for a child such as financial and healthcare decisions." See www.nycourts.gove/courthelp/Guardianship/17A.shtml.

111. The defendants' guidance states that the Surrogate's Court can appoint a guardian of the person, the property or both person and property. Id.

112. The defendants' guidance states that "a guardian of the person can make life decisions for the ward like health care, education and welfare decisions." Id.

113. The defendants' guidance states that "a guardian of the property handles decisions about the ward's money, investments and savings." Id.

114. The defendants' guidance states that a "guardian of the person and property has responsibility of both the ward's life decisions and the ward's property." Id.

115. Under Article 17A there is no provision for a lesser restrictive option than the appointment of a plenary guardian of the person.

116. Article 17A makes for provision for the Surrogate Court to limit or tailor the guardianship.

117. By contrast, Article 81 requires the court to limit or tailor the guardianship to "the least restrictive form of intervention by appointing a guardian with powers limited to those which the court has found necessary to assist the incapacitated person in providing for personal needs and/or property management." MHL § 81.16(c)(2).

118. The Legislature specifically declared that the purpose of Article 81 was to create a "guardianship system which is appropriate to satisfy either personal or property management needs of an incapacitated person in a manner tailored to the individuals needs of that person which…affords the person the greatest amount of independence and self-determination and participation in all the decisions affecting such person's life." MHL § 81.01.

119. The order from the court for an Article 81 guardianship must accomplish, "the least restrictive form of intervention by appointing a guardian with powers limited to those which the court has found necessary to assist the incapacitated person in providing for personal needs and/or property management." MHL § 81.16(c)(2).

120. Article 17A, in contrast, simply provides "[i]f the court is satisfied that the best interests of the person who is intellectually disabled or person who is developmentally disabled will be promoted by the appointment of a guardian of the person or property, or both, it shall make a decree naming such person or persons to serve as such guardians." SCPA § 1754(5).

121. The State's Olmstead Cabinet found that "Article 17A does not limit guardianship rights to the individual's specific incapacities, which is inconsistent with the least-restrictive philosophy of Olmstead. Once guardianship is granted, Article 17A instructs the guardian to make decisions based upon the 'best interests' of the person with a disability and does not require the guardian to examine the choice and preference of the person with a disability." Olmstead Report p. 28

Selection of Guardian; Powers and Oversight

122. Article 17A permits any person over the age of 18 not otherwise subjected to guardianship to be appointed as a guardian. SCPA § 1752 (5).

123. By contrast, Article 81 provides detailed consideration for who should be appointed a guardian, including consideration of the alleged incapacitated person's preferences and nomination. MHL § 81.19.

124. Article 81 requires the court to consider:

a. Any appointment or delegation made by the person alleged to be incapacitated;

b. The social relationship between the incapacitated person and the proposed guardian;

c. The care and services being provided to the incapacitated person at the time of the proceeding;

d. The educational, professional and business experience of the proposed guardian;

e. The nature of the financial resources involved;

f. The unique requirements of the incapacitated person; and

g. Any conflicts of interests between the person proposed as guardian and the incapacitated person.

MHL § 81.19(d)

Eligibility and Qualification of Guardian

125. Article 81 requires court-appointed guardians to visit the person under guardianship a minimum of four times per year, MHL § 81.20(a)(5), but Article 17A does not.

126. The purpose of this requirement is to assist the guardian in her capacity as a person who is obligated to exercise care and diligence in actions on behalf of the person under the guardianship.

127. The Law Revision Commission stated: "Decision making is a fundamental part of the guardian's role. In order to carry out this responsibility in the most careful and diligent manner, the guardian should develop a personal relationship to the ward, in the event one does not exist, so that the guardian can understand the decision's impacted from the incapacitated person's perspective and involve the incapacitated person in the decisions to the greatest extent possible." Law Revision Comments under MHL § 81.20,

Reporting and Review

128. Article 81 imposes rigorous reporting and oversight provisions upon the appointment of a guardian. See MHL §§ 81.30, 81.31, 81.32, 81.33.

129. The court is also required under Article 81 to specifically enumerate the powers regarding both property management and personal needs, with which the guardian will be vested. See MHL §§ 81.21, 81.22.

130. In contrast, Article 17A contains no requirement that guardians report annually as to the personal or property status of the person under guardianship.

131. Reporting requirements such as those contained in MHL §§ 81.30 and 81.31, allow the court to determine whether a guardian is fulfilling his or her fiduciary responsibility, and to ensure that the individual's autonomy is being preserved to the maximum extent possible.

132. MHL §§ 81.30 and 81.31 require the guardian to submit written initial and annual reports describing, "the social and personal services that are to be provided for the welfare of the incapacitated person," [MHL § 81.30(c)(2)] and "information concerning the social condition of the incapacitated person, including: the social and personal services currently utilized by the incapacitated person; the social skills of the incapacitated person; and the social needs of the incapacitated person." MHL § 81.31(b)(6)(iv).

133. The reporting requirement of Article 81 also includes information concerning the incapacitated person's medical and residential needs, and requires the guardian to submit in his or her report any and all facts indicating a need to terminate, or modify the terms of the guardianship. Preservation of the alleged incapacitated person's autonomy to the fullest extent possible is one of the avowed purposes of the reporting requirements. See Law Revision Commission Comments MHL § 81.31

Modification, Termination & Restoration of Rights

134. Under Article 17A, a guardianship continues over the entire life of the person under guardianship; there is no limit on duration or subsequent review of the need for continued guardianship. SCPA § 1759(1)

135. Modification or termination of an Article 17A guardianship requires the person under guardianship or another person on behalf of the person under guardianship to petition the court to modify, dissolve or amend the guardianship order. SCPA § 1759(2)

136. This proceeding is subject to the same limitations as set forth in SCPA § 1754 which permits the court to dispense with the hearing at the request of the parent.

137. Article 17A is silent as to the evidentiary standard for when a guardianship is to be modified; however, Surrogate Courts apply the preponderance of the evidence standard to the proceedings.

138. Article 17A is silent as to which party has the burden when petitioning for modification or dissolution of the guardianship and thus Surrogate Courts place this burden on the party moving for the modification.

139. MHL Article 81, by contrast, specifically contemplates removal of the guardian or powers where the guardian or the power is no longer necessary. MHL § 81.36 (a).

140. Article 81 requires a hearing when a petition for modification or termination is initiated, as well as the right to a jury trial upon request. MHL § 81.36(c)

141. Significantly, under Article 81, the party opposing the termination of guardianship bears the burden of proving by clear and convincing evidence that the grounds for guardianship continue to exist. MHL § 81.36(d)

142. Under Article 81, where a petition seeks to increase the powers of a guardian, the petitioner has the burden of proving by clear and convincing evidence that such an increase in power in necessary. MHL § 81.36 (d)

Right to Vote

143. Anyone who has been adjudicated incompetent by order of a court of competent judicial authority loses the right to register for or vote at any election in New York State. See NY Elec. Law 5-106

144. The imposition of a plenary guardianship pursuant to Article 17A adjudicates a person as incompetent without a specific finding that the person is incapable of voting.

CLAIMS FOR RELIEF

First Claim for Relief – 42 U.S.C. § 1983 - Substantive Due Process

145. Plaintiff reasserts and incorporates paragraphs 1 to 144 as though fully set forth herein.

146. The Fifth and Fourteenth Amendments of the U.S. Constitution provide that neither the federal nor state government shall deprive any person "of life, liberty, or property without due process of law."

147. The Supreme Court has defined liberty broadly to include "the right of the individual to contract, to engage in any of the common occupations of life, to acquire useful knowledge, to marry, establish a home and bring up children, to worship God…and generally enjoy those privileges long

recognized…as essential to the orderly pursuit of happiness by free men." Roth v. Board of Regents, 408 U.S. 564, 572 (1972) citing Meyer v. Nebraska, 262 U.S. 390, 399 (1923).

148. The appointment of a plenary guardianship of the person under Article 17A deprives persons of the power to make decisions about where they live, with whom they associate, whether to seek and receive medical treatment, whether to marry and have children, and where they work. See In re Mark C.H., 28 Misc. 3d 765, 776 (N.Y. Surr. Ct. 2010) citing Matter of Chaim A.K., 26 Misc. 3d 837 (N.Y. Surr. Ct. 2009); In re D.D., 50 Misc. 3d 666 (N.Y. Surr. Ct. 2015).

149. Substantive Due Process under the Fifth and Fourteenth Amendments of the U.S. Constitution forbid the government from infringing on a fundamental liberty interest where the matter is not narrowly tailored to serve a compelling governmental interest.

150. Guardianship imposed under Article 17A infringes on a person's fundamental rights, liberties and privileges, including:

a. a fundamental right to privacy to engage in personal conduct without intervention from state government. Lawrence v. Texas, 539 U.S. 558, 578 (2003).

b. a fundamental right to refuse unwanted medical treatment. Cruzan by Cruzan v. Dir., Missouri Dep't of Health, 497 U.S. 261, 278 (1990); and

c. a fundamental right to make personal decisions regarding marriage, procreation, contraception, family relationships, child rearing, and education. Planned Parenthood of Se. Pennsylvania v. Casey, 505 U.S. 833, 851, (1992) citing Casey v. Population Services International, 431 U.S. 678, 685 (1977).

151. Where personal liberty is being deprived courts must apply only the least restrictive form of intervention consistent with the clinical condition of a given individual. See Jackson v. Indiana, 406 U.S. 715, 738 (1972).

152. Article 17A is unnecessarily broad because it imposes a plenary guardianship of the person, property or person and property that terminates all decision making authority without conducting a functional assessment of the person's ability to care for himself and without narrowly tailoring the guardian's powers to those areas of need.

153. There is no compelling governmental interest to continue to allow the imposition of Article 17A guardianships.

Second Claim for Relief – 42 U.S.C. § 1983 - Procedural Due Process

154. Plaintiff reasserts and incorporates paragraphs 1 to 153 as though fully set forth herein.

155. The Fifth and Fourteenth Amendments of the U.S. Constitution provide that neither the federal nor state government shall deprive any person "of life, liberty, or property without due process of law."

156. The continued authorization of Article 17A guardianships violates a person's right to procedural due process.

157. Courts look at three factors to determine whether a taking of liberty or property violated a person's rights to procedural due process: "First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail." Matthews v. Eldridge, 424 U.S. 319, 335 (1976).

158. The appointment of a guardianship over people with disabilities pursuant to Article 17A is an official action of State of New York through the Unified Court System.

159. The risk of erroneously depriving individuals with disabilities of liberty and property interests through the process of an Article 17A guardianship proceeding is high because,

a. the notice afforded the person does not reasonably ensure the person is informed of the nature and possible consequences of the proceeding or the right to contest the proceeding;

b. the person is not entitled to legal representation;

c. the certifications of two physicians or a physician and psychologist is the primary evidence relied to determine if guardianship should be imposed;

d. said certifications can be obtained without the knowledge or consent of persons who are minors;

e. the guardianship is imposed without considering the functional capacity of the person to make decisions;

f. the court may dispense with the person's presence in court;

g. the court may dispense with the hearing;

h. the decision is made upon a mere preponderance of the evidence;

i. the statute only permits the appointment of a plenary guardianship;

j. the court does not need to examine lesser restrictive alternatives to plenary guardianship;

k. the statute does not require reporting and review of the need for the guardianship;

l. there are no procedures for the regular review of guardianships or even the termination of the guardianship; and

m. the process for removal of guardianship places the burden on a person seeking to remove the guardianship.

160. Further, the probative value of additional or substitute procedural safeguards is high as demonstrated by the due process protections afforded by Article 81 including:

a. the notice must inform the allegedly incapacitated person of the nature and possible consequences of the proceeding and the right to contest the proceeding;

b. the person is entitled to legal representation;

c. appointment of guardianship based upon the functional capacity of the person to make decisions;

d. procedures for ensuring the person's presence at the hearing;

e. the court may not dispense with the hearing without the allegedly incapacitated individual's consent;

f. a decision made upon clear and convincing evidence;

g. the court must examine lesser restrictive alternatives to guardianship;

h. the statute directs that if a guardian is appointed it is tailored to the person's needs;

i. procedures for the regular review of guardianships and the termination of the guardianship;

j. requires reporting and review of the need for the guardianship; and

k. the process for removal of guardianship places the burden on a person seeking to continue the guardianship.

161. Individuals with disabilities subject to Article 17A guardianship orders routinely go their entire lives without anyone reviewing the continued necessity for the guardianship order.

162. The nature and duration of the guardianship must bear some reasonable relation to the purpose for which the individual is committed to guardianship. See Jackson v. Indiana, 406 U.S. 715, 731(1972) (Supreme Court has held that a law permitting indefinite commitment of a criminal defendant solely on account of his incompetency to stand trial violates the guarantee of proper procedural due process).

163. The Government's interest for appointing guardianship over a person under Article 17A is to protect the person with a disability. The appointment of guardianship without procedural due process protections is contrary to this governmental interest.

164. One of New York State's courts administered by defendants Chief Judge DiFiore and Chief Administrative Judge Marks has already concluded that the failure to periodically review Article 17A guardianships is unconstitutional. See In re Mark C.H., 28 Misc.3d 765 (N.Y. Surr. Ct. 2010) (holding that periodic reporting is required so that " . . . the court can ascertain whether the deprivation of liberty resulting from guardianship is still justified by the ward's disabilities, or whether she has progressed to a level where she can live and function on her own.")

165. The New York State Unified Court System is already equipped to provide the procedural protections needed to address the lack of due process in Article 17A because the Supreme Courts, which defendants Chief Judge DiFiore and Chief Administrative Judge Marks also administers, already provide procedural due process protections to persons with developmental and intellectual disabilities brought under MHL Article 81.

Third Claim for Relief - 42 U.S.C. § 1983 – Equal Protection

166. Plaintiff reasserts and incorporates paragraphs 1 to 165 as though fully set forth herein.

167. Under the Fourteenth Amendment of the U.S. Constitution, individuals subjected to Article 17A guardianship proceedings are entitled to Equal Protection of the laws and should not be subject to a statute which denies them Equal Protection in comparison to others similarly situated.

168. The Fourteenth Amendment requires that where a person's fundamental rights and liberties are implicated, "classification which might invade or restrain them must be closely scrutinized and carefully confined." See Harper v. Virginia State Bd. of Elections, 383 U.S. 663, 670 (1966).

169. Fundamental liberty interests protected by the U.S. Constitution encompass "not merely freedom from bodily restraint but also the right of the individual to contract, to engage in any of the common occupations of life, to acquire useful knowledge, to marry, establish a home and bring up children ... and generally to enjoy those privileges long recognized at common law as essential to the orderly pursuit of happiness by free men." Meyer v. Nebraska, 262 U.S. 390, 399 (1923).

170. Courts within New York State's Unified Court System have already ruled that guardianship constitutes a significant taking of liberty which implicates fundamental freedoms. See In re Mark C.H., 28 Misc. 3d 765, 775-777 (N.Y. Surr. Ct. 2010); In re D.D., 50 Misc. 3d 666, 668 (N.Y. Surr. Ct. 2015).

171. In cases involving deprivations of personal liberty, courts are required to impose only the least restrictive form of intervention consistent with the clinical condition of a given individual. See Jackson v. Indiana, 406 U.S. 715, 738 (1972); See also Kesselbrenner v. Anonymous, 33 N.Y.2d 161, 165 (1973) ("To subject a person to a greater deprivation of his personal liberty than necessary to achieve the purpose for which he is being confined is, it is clear, violative of due process"); Carter v. Beckwith, 128 N.Y. 312, 319 (1891) ("[The] exercise of the jurisdiction of the court to deprive a person of his liberty and property on the ground of lunacy, however necessary, is, nevertheless, the exercise of a supreme power, and should be surrounded by all reasonable safeguards to prevent mistake or fraud…").

172. Guardianship proceedings for individuals living with intellectual or developmental disabilities may, under current law, be brought either pursuant to Article 17A or Article 8l.

173. MHL Article 81:

a. limits the appointment of guardianship even if the person is found to be incapacitated;

b. ensures sufficient notice is provided to reasonably inform the alleged incapacitated person of the nature and potential consequences of the proceeding and the right to a hearing and counsel;

c. applies the clear and convincing standard for the appointment of guardianship;

d. provides access to legal representation;

e. mandates an evidentiary hearing be held to allow for the greatest participation of the alleged incapacitated person;

f. mandates periodic reporting on the status of the guardianship;

g. prescribes a mechanism for termination of guardianship;

h. places the burden for the continuation of the guardianship on the party seeking to continue the guardianship;

i. specifically directs that guardianship must be administered in the least restrictive manner after consideration of all other alternatives.

174. In stark contrast, Article 17A

a. relies exclusively on the best interest standard for appointment of guardianship;

b. applies a lesser evidentiary standard (preponderance of the evidence) for the appointment of guardianship;

c. fails to provide notice reasonably certain to inform the allegedly incapacitated person of the nature and consequences of the proceeding;

d. lacks any procedure for the appointment of legal counsel;

e. permits hearings to be waived with the consent of a petitioner;

f. permits the presence of the alleged incapacitated person at the hearing to be waived;

g. places the burden on the person with a disability to modify or terminate the guardianship;

h. specifically directs that all guardianships are plenary without consideration for any other lesser restrictive alternatives.

175. There is no compelling or legitimate governmental interest for applying greater protections for appointing a guardianship over a person with an intellectual or developmental disability in one court proceeding (Article 81) and applying a totally different and lesser standard over a person with an intellectual or developmental disability in another court (Article 17A).

Fourth Claim for Relief – ADA claim under 42 U.S.C. § 12132

176. Plaintiff reasserts and incorporates paragraphs 1 to 175 as though fully set forth herein.

177. Under the Americans with Disabilities Act (42 U.S.C.A. § 12132) ("ADA"), a qualified individual with a disability may not be subject to discrimination for reason of his disability by any state entity or program receiving federal support. 42 U.S.C.A. § 12132.

178. A disability is defined as "a physical or mental impairment that substantially limits one or more major life activities of such individual." 42 U.S.C. § 12102(1)(A).

179. The definition of disability must be construed in favor of broad coverage of individuals under the ADA. 42 U.S.C. § 12102(4)(A).

180. A "qualified individual with a disability" is defined as "an individual with a disability who … meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity." United States v. Georgia, 546 U.S. 151, 153–54 (2006) (quoting 42 U.S.C. § 12131(2)).

181. Individuals with intellectual disabilities and developmental disabilities qualify as having disabilities under New York Law. See SCPA §§ 1750-1750-a

182. The New York Unified Court System is the judicial arm of the New York State Government.

183. Individuals with disabilities who are subjected to an Article 17A proceeding do not have a choice of forum for the guardianship proceeding. The petitioner seeking the guardianship elects the forum.

184. Individuals with intellectual and developmental disabilities are placed under Article 17A guardianships because of their disabilities.

185. Failure to afford qualified individuals with disabilities the procedures and protections afforded to other individuals with disabilities through Article 81 – including consideration of the least restrictive form of intervention in determining the need for a guardian - has a discriminatory effect.

186. Individuals with disabilities must not be subjected to a different guardianship standard which presents greater barriers to their full participation in society or enjoyment of their rights and liberties.

187. In order to avoid a discriminatory outcome, defendants must make reasonable modifications.

188. The defendants recognize the discriminatory impact of the strict application of Article 17A but have not taken steps to reasonably modify the practice of appointing guardianships.

Fifth Claim for Relief –Section 504, 29 U.S.C. § 794

189. Plaintiff reasserts and incorporates paragraphs 1 to 188 as though fully set forth herein.

190. Section 504 of the Rehabilitation Act requires that "[n]o otherwise qualified individual with a disability . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance . . . ." 29 U.S.C. § 794(a).

191. A disability is defined as "a physical or mental impairment that substantially limits one or more major life activities of such individual." 29 U.S.C. § 705(9)(B) *citing* 42 U.S.C. § 12102(1)(A).

192. The definition of disability must be construed in favor of broad coverage of individuals under Section 504. See 42 U.S.C. § 12102(4)(A).

193. Individuals with intellectual disabilities and developmental disabilities qualify as having disabilities under New York Law. SCPA § 1750-1750-a.

194. The term "program and activity means all the operations of a department, agency, special purpose district, or other instrumentality of a State." 29 U.S.C. § 794(b)(1)(A)

195. The New York Unified Court System is the judicial arm of the State of New York.

196. New York State received federal financial assistance to operate programs and activities in New York State.

197. The New York State Unified Court System receives federal assistance in the form of grants which it distributes to programs it administers and is therefore a covered public entity under Section 504. See NY State Unified Court System, Fiscal Year 2016-2017 Budget at https://www.nycourts.gov/admin/financialops/Budgets.shtml.

198. Individuals with disabilities who are subjected to an Article 17A proceeding do not have a choice of forum for the guardianship proceeding. The petitioner seeking the guardianship elects the forum.

199. Individuals with qualifying disabilities are placed under Article 17A guardianships because of their disabilities.

200. Failure to afford qualified individuals with disabilities the procedures and protections afforded to other individuals with disabilities through MHL Article 81 – including consideration of the least restrictive form of intervention in determining the need for a guardian - has a discriminatory effect.

201. Individuals with intellectual and developmental disabilities must not be subjected to a different guardianship standard which presents greater barriers to their full participation in society or enjoyment of their rights and liberties.

202. In order to avoid a discriminatory outcome defendants must make reasonable modifications.

203. The defendants recognize the discriminatory impact of the strict application of Article 17A but have not taken steps to reasonably modify the practice of appointing guardianships.

RELIEF REQUESTED

THEREFORE, Plaintiff respectfully ask that this Court grant the following relief against defendants, including:

1) Entering a declaratory judgment, pursuant to Rule 57 of the Federal Rules of Civil Procedure, stating that

   a. Article 17A violates the United States Constitution;

   b. Article 17A violates the Americans with Disabilities Act; and

   c. Article 17A violates Section 504 of the Rehabilitation Act of 1973.

2) Entering a permanent injunction requiring defendants to

   a. notify all people who are currently subject to guardianship orders pursuant to Article 17A of their right to request modification or termination the guardianship order; and

   b. upon defendants receiving such a request, to promptly hold a proceeding regarding termination or modification of the order, at which the burden of proof by clear and convincing evidence shall be on the party opposing the termination or modification of the order, and which provides substantive and procedural rights to the allegedly

incapacitated person that are no less than the substantive and procedural rights of an allegedly incapacitated person in an MHL Article 81 proceeding.

3) Permanently enjoining defendants from adjudicating incapacity and appointing guardians pursuant to SCPA Article 17A, until defendants ensure that the proceedings provide substantive and procedural rights that do not violate the United States Constitution, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act of 1973, and which are not inferior to the substantive and procedural rights enjoyed by allegedly incapacitated persons in MHL Article 81 proceedings.

4) Awarding reasonable costs and attorneys' fees, and awarding any and all other relief, according to proof, that may be necessary and appropriate.

DATED: September 21, 2016

Albany, New York

Respectfully submitted,

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Report and Recommendations of the Olmstead Cabinet

A Comprehensive Plan for Serving New Yorkers with Disabilities in the Most Integrated Setting

OLMSTEAD
Community Integration for Every New Yorker

Andrew M. Cuomo
Governor

Roger Bearden
Special Counsel for Olmstead

"People with disabilities have the right to receive services and supports in settings that do not segregate them from the community; it is a matter of civil rights."

—Governor Andrew M. Cuomo

REPORT AND RECOMMENDATIONS OF THE OLMSTEAD CABINET

A Comprehensive Plan for Serving People with Disabilities in the Most Integrated Setting

New York State

Andrew M. Cuomo, Governor

October 2013

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Introduction

Under Governor Andrew M. Cuomo, New York is reclaiming its leadership role in serving people with disabilities. In 2011, the Governor directed a landmark redesign of the state's Medicaid program in order to improve care coordination and the delivery of cost-effective, community-based care. The Governor also established the Justice Center for the Protection of People with Special Needs (Justice Center), which provides the strongest protections from abuse and neglect for people with disabilities in the nation.

To further safeguard the rights of people with disabilities, in November 2012, Governor Cuomo issued Executive Order Number 84 to create the Olmstead Development and Implementation Cabinet (Olmstead Cabinet). The Olmstead Cabinet was charged with developing a plan consistent with New York's obligations under the United States Supreme Court decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999) (Olmstead). Olmstead held that the state's services, programs, and activities for people with disabilities must be administered in the most integrated setting appropriate to a person's needs.

To examine New York's compliance with Olmstead, the Olmstead Cabinet employed a broad and inclusive process. The Olmstead Cabinet received public comment through four public forums and through a dedicated page on the Governor's website. The cabinet met with over 160 stakeholder organizations and received over 100 position papers. Hundreds of state agency personnel across a dozen agencies providing services to people with disabilities participated in multiple discussions and provided data regarding New York's service systems for people with disabilities.

The results of the Olmstead Cabinet's work are contained in this report. This report identifies specific actions state agencies responsible for providing services to people with disabilities will take to serve people with disabilities in the most integrated setting. These actions will:

- Assist in transitioning people with disabilities out of segregated settings and into community settings;
- Change the way New York assesses and measures Olmstead performance;
- Enhance the integration of people in their communities; and
- Assure accountability for serving people in the most integrated setting.

Together, the actions described in this report will ensure that New York is a leader in providing services to people with disabilities in the most integrated setting, consistent with their fundamental civil rights.

Report and Recommendations

I. The Olmstead Mandate

The Olmstead decision addressed the rights of two women who had been confined in a Georgia state psychiatric hospital for five and seven years beyond the time at which they had been determined ready for community discharge. The United States Supreme Court held that the failure to provide community placement for these people constituted discrimination under the Americans with Disabilities Act. The court also held that states are required to provide community-based services to people with disabilities when: (a) such services are appropriate; (b) the affected persons do not oppose community-based treatment; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the state and the needs of others who are receiving disability services from the state.[1]

The Olmstead case itself concerned people in a psychiatric hospital. Subsequent cases have addressed developmental centers, board and care homes, and people at-risk of institutional care. Most recently, the Olmstead mandate has been extended to segregated employment services for people with disabilities. Given the breadth and continuing evolution of the Olmstead mandate, in order to develop its specific recommendations, the Olmstead Cabinet sought the views of a broad set of stakeholders regarding the areas in which the cabinet should focus its attention. Through this stakeholder engagement, four areas of focus emerged:

1. The need for strategies to address specific populations in unnecessarily segregated settings, including:
    a. People with intellectual and developmental disabilities in developmental centers, intermediate care facilities (ICFs), and sheltered workshops;
    b. People with serious mental illness in psychiatric centers, nursing homes, adult homes, and sheltered workshops; and
    c. People in nursing homes.
2. The need to increase opportunities for people with disabilities to live integrated lives in the community;
3. The need to develop consistent cross-systems assessments and outcomes measurements regarding how New York meets the needs and choices of people with disabilities in the most integrated setting;
4. The need for strong Olmstead accountability measures.

The following sections of this report discuss each of these areas of focus in turn.

[1] *Olmstead v. L.C.*, 527 U.S. 581. (1999).

II. Transitioning People with Disabilities from Segregated Settings to the Community

In collaboration with state agencies providing services to people with disabilities and a broad set of stakeholders, the Olmstead Cabinet sought to identify specific strategies to assist people with disabilities residing in segregated settings to transition to community-based settings. The specific settings and strategies are described in the sections that follow.

A. People with Intellectual and Developmental Disabilities in Developmental Centers, Intermediate Care Facilities, and Sheltered Workshops

In April 2013, Governor Cuomo announced a comprehensive transformation plan for serving people with intellectual and developmental disabilities in the most integrated setting.[2] The plan addresses the approximately 1,000 people who resided in developmental centers as of April 2013. The Office for People With Developmental Disabilities (OPWDD) closed its West Seneca Developmental Center in May 2011 and the Staten Island Multiple Disabilities Unit in June 2012, with the individuals residing at these facilities moving to community-based residential services. In addition, OPWDD will close the Monroe and Taconic developmental centers by December 2013, and the 155 people residing at those centers will move to community-based residential settings.

The transformation plan includes the closure of four additional developmental centers in the next four years: Oswald D. Heck (by March 2015); Brooklyn (by December 2015); Broome (by March 2016); and Bernard M. Fineson (by March 2017). It is projected that OPWDD will retain capacity for 150 individuals to receive short-term intensive treatment services in the remaining developmental centers. In addition, over the next few months, OPWDD will finalize its timeline for additional community transition opportunities for other people with intellectual and developmental disabilities residing in community-based ICFs and nursing homes.

OPWDD is also changing the nature of its service system by developing consistent, person-centered intake practices through its Front Door initiative, a comprehensive, person-centered needs assessment process with enhanced, person-centered planning, a fuller menu of community-based supports to better meet a person's needs in community-based settings, and quality oversight that examines individual outcomes as well as systems measures.[3]

Under its transformation plan, OPWDD will also be exploring new options for community-based housing and has begun participating in the New York State Money Follows the Person (MFP) demonstration. Within the MFP demonstration, people with intellectual and developmental disabilities will transition from institutional settings (developmental centers, community-based ICFs, and nursing homes) to community-based independent housing, supported housing, or supervised residences of four or fewer unrelated people, as appropriate. With this range of housing options and smaller residential service settings, OPWDD anticipates that the people transitioning from institutional settings will lead more integrated lives.

OPWDD's participation in the MFP demonstration began in April 2013. Over the next four years, OPWDD will assist 875 people with developmental disabilities who currently reside in institutional settings to move to community-based settings. This demonstration will require OPWDD to identify people who wish to move to the community and to work with those people to develop transition plans and identify community-based service options to meet their needs in community settings,

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[2] New York. Office for People With Developmental Disabilities. (April 2013). *Road to Reform: Putting People First*. Retrieved from http://www.opwdd.ny.gov/opwdd_about/commissioners_page/OPWDD_Road_to_Reform_April2013.

[3] Additional information about OPWDD's Front Door imitative is available at http://www.opwdd.ny.gov/welcome-front-door-home.

and to facilitate that transition. OPWDD will utilize peer outreach to identify potential MFP demonstration participants, provide accurate information and referral, and effectively address concerns of participants and family members. Contracted transition coordinators will work closely with OPWDD regional staff to transition MFP demonstration participants to the community through Home and Community-Based Services (HCBS) waiver enrollment.

OPWDD will track all participants' experiences in the MFP demonstration using the Quality of Life Survey to measure the community integration outcomes. This survey will be administered prior to MFP demonstration participants' transition to the community, at 11 months post transition, and at 24 months post transition. This survey measures key integration outcomes for people transitioning from institutional to community-based settings, including living situation, choice and control, access to personal care, respect/dignity, community integration/inclusion, overall life satisfaction, and health status.[4]

OPWDD will also promulgate regulatory amendments to align OPWDD regulations and requirements with the federal Centers for Medicare & Medicaid Services' (CMS) proposed standards for HCBS settings.[5] These requirements, which largely mirror existing OPWDD regulations, will be implemented throughout OPWDD's service delivery system and will further define the characteristics of a community-based setting that must be present wherever HCBS services are delivered. In addition to the regulations, OPWDD will adopt implementation guidelines and integrate these enhanced standards into its oversight activities.

An important goal of the transformation of the service system for people with intellectual and developmental disabilities is implementation of a self-directed approach in which MFP demonstration participants and/or their designated representatives will be given the option of self-directing by employer authority and budget authority or, at the preference of the individual, either employer authority or budget authority. As part of this effort, OPWDD will offer increased education to all stakeholders by providing a standard curriculum on self-direction to at least 1,500 people and their designated representatives per quarter beginning on April 1, 2013. As a result, OPWDD has set a goal of enabling 1,245 new people to self-direct their services by March 31, 2014.

Recognizing the need to build additional community capacity to support people with developmental disabilities and their families in the community, OPWDD is piloting the national Systemic, Therapeutic, Assessment, Respite, and Treatment (START) program model to provide emergency crisis services and limited therapeutic respite services.[6] This program will begin as a pilot in the Finger Lakes and Taconic regions, where OPWDD plans to close its developmental centers in 2013.

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[4] Additional information about the Money Follows the Person Quality of Life Survey can be found at http://apply07.grants.gov/apply/opportunities/instructions/oppCMS-1LI-13-001-cfda93.791-cidCMS-1LI-13-001-013945-instructions.pdf.

[5] State Plan Home and Community Based Services under the Act," Proposed Rulemaking. *Federal Register,* 77:86, (May 3, 2012) p. 26361.

[6] Additional information about the Systemic, Therapeutic, Assessment, Respite, and Treatment program can be found at http://www.centerforstartservices.com/community-resources/newyorkpublic.aspx.

OPWDD is also increasing integrated employment opportunities for people with developmental disabilities. On May 31, 2013, New York provided CMS with a baseline count of the number of enrollees receiving supported employment services and the number of enrollees engaged in competitive employment. As of July 1, 2013, OPWDD no longer permits new admissions to sheltered workshops. By October 1, 2013, New York will increase the number of people with developmental disabilities in competitive employment by no fewer than 250 people. Only integrated, gainful employment at minimum wage or higher will be considered competitive employment. New York submitted a draft plan to CMS for review on October 1, 2013, and will submit a final plan no later than January 1, 2014, on its transformation toward a system that better supports competitive employment for people with developmental disabilities.[7]

B. People with Serious Mental Illness in Psychiatric Centers, Nursing Homes, Adult Homes and Sheltered Workshops

The New York State Office of Mental Health (OMH) is implementing the Olmstead mandate in several ways. First, the development of behavioral health managed care will enhance community integrated health and mental health plans of care. Second, the development of Regional Centers of Excellence (RCE) will reorient OMH's state psychiatric center system to focus on high quality, intensive treatment with shorter lengths of stay and enhanced treatment and support in the community.[8] Third, the implementation of two settlement agreements will assist people in moving from nursing homes and adult homes to integrated community apartments supported by services that focus on rehabilitation, recovery, and community inclusion.

Under Medicaid redesign for managed behavioral health care, New York will create special needs Health and Recovery Plans (HARPs): distinctly qualified, specialized, and integrated managed care programs for people with significant behavioral health needs. Mainstream managed care plans may qualify as HARPs only if they meet rigorous standards or if they partner with a behavioral health organization to meet those standards.[9] HARPs will include plans of care and care coordination that are person centered and will be accountable for both in-plan benefits and non-plan services. HARPs will interface with social service systems and local governmental units to address homelessness, criminal justice, and employment related issues, and with state psychiatric centers and health homes to coordinate care. HARPs will include specialized administration and management appropriate to the populations/services, an enhanced benefit package with specialized medical and social necessity/utilization review approaches for expanded recovery-oriented benefits, integrated health and behavioral health services, additional quality metrics and incentives, enhanced access and network standards, and enhanced care coordination expectations.

To support the extension of outpatient services to people in their homes and communities, OMH will seek federal approval to provide mental health outpatient services outside of facility-based locations. Providing mobile services will increase access and effectiveness of care for people who cannot or will not access facility-based services. More accessible, consistent, and effective treatment is expected to reduce the need for inpatient care, and will instead serve people with psychiatric disabilities in the most integrated setting.

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[7] The workplan is available at: http://www.opwdd.ny.gov/opwdd_services_supports/employment_for_people_with_disabilities/draft-plan-increase-employment-opps.

[8] Additional information about the Regional Centers of Excellence is available at http://www.omh.ny.gov/omhweb/excellence/rce/.

[9] New York. Department of Health. (June 18, 2013). *MRT Behavioral Health Managed Care Update*. (PowerPoint slides). Retrieved from http://www.health.ny.gov/health_care/medicaid/redesign/docs/2013-6-18_mc_policy_planning_mtg.ppt.

Complementing its transformation of community-based services, in July 2013, OMH announced its plan to transform New York's inpatient psychiatric hospitals into regional centers of excellence (RCEs).[10] RCEs will be regionally-based networks of inpatient and community-based services, each with a specialized inpatient hospital program located at its center with geographically dispersed community service "hubs" overseeing state-operated, community-based services throughout the region. The RCE plan reduces the number of state psychiatric centers from 24 to 15, eliminating 655 inpatient beds in favor of community services. Over the next year, OMH will pursue a regional planning process to guide the development of its RCEs. This planning process will include the assessment of existing community capacity within its five state regions and recommendations for the development of additional community capacity to prevent unnecessary hospitalization and to transition people currently residing in psychiatric hospitals back to their communities. These recommendations will be prepared by December 2013.

Coupled with its community capacity evaluation, OMH will focus on transitioning long-stay patients currently residing at psychiatric hospitals back into the community. OMH has steadily reduced its inpatient psychiatric population from 43,803 in 1973 to 3,876 in 2012 by creating appropriate community placements and supports. As of July 1, 2013, the total number of non-forensic patients in New York's state psychiatric centers was 2,980, 1,328 of whom have stayed longer than one year. Over the next two years, OMH has established a goal to reduce this number of long-stay patients by 10 percent by transitioning these people to appropriate community housing and services.[11]

In addition to its inpatient psychiatric reforms, in September 2011, New York settled a federal class action lawsuit, *Joseph S. v. Hogan*, concerning people with serious mental illness discharged or at risk of discharge to nursing homes from state-operated psychiatric centers and psychiatric wards of general hospitals. All remedy class members capable of and willing to live in the community will be provided with, or otherwise obtain, community housing and community supports by November 2015. In July 2012, OMH awarded contracts for 200 units of supported housing in order to increase the housing available for qualified people transitioning out of nursing homes. An initial community transition list of remedy class members was developed in December 2012 and will continue to be revised through November 2014. In addition, New York revised its pre-admission screen and resident review process for people with serious mental illness proposed for admission to nursing homes to further prevent unnecessary admissions to these facilities.[12]

New York has also pursued a comprehensive strategy to provide community housing for people with serious mental illness residing in transitional adult homes.[13] In 2012, New York awarded contracts for 1,050 supported housing opportunities for residents of transitional adult homes. In 2012, the Department of Health (DOH) and OMH finalized regulations regarding residents of

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[10] New York. Office of Mental Health. (July 11, 2013). *OMH Regional Centers of Excellence: Today Begins a New Era in New York's Behavioral Health System.* Retrieved from http://www.omh.ny.gov/omhweb/excellence/rce/docs/rceplan.pdf.

[11] Non-forensic patients are those not on the following statuses: felony defendants found incompetent to stand trial (CPL §730); defendants found not responsible for criminal conduct due to mental disease or defect (CPL §330.20); pre-trial detainees in local correctional facilities in need of inpatient care (CL §508); inmates sentenced to state and local correctional facilities in need of inpatient care (CL §402); civil patients transferred to a forensic facility (14NYCRR §57.2); and people committed to sex offender treatment programs within a secure treatment facility (MHL Art. 10).

[12] *Joseph S. v. Hogan.* No. 06-cv-01042, ECF 232 (E.D.N.Y. Sept. 7, 2011).

[13] Transitional adult homes are defined in regulations as adult homes with a certified capacity of 80 beds or more in which 25 percent or more of the resident population are people with serious mental illness. See 18 NYCRR §487.13 for more information.

transitional adult homes to assist in their movement to more integrated settings. These regulations were based on a 2012 OMH clinical advisory, which found that such homes "are not clinically appropriate settings for the significant number of people with serious mental illness who reside in such settings, nor are they conducive to the rehabilitation or recovery of such people."[14]

In July 2013, New York reached a settlement with the plaintiffs in longstanding litigation concerning 23 adult homes in New York City serving people with serious mental illness. Over the next five years, New York will provide integrated supported housing to at least 2,000 adult home residents along with appropriate community-based services and supports. The agreement also will ensure that adult home residents have the information they need to make an informed choice about where to live. As these adult home residents choose to move to supported housing, they will participate in a person-centered, transition planning process.

Since January 2011, OMH has shifted its reliance on sheltered workshops to integrated, competitive employment for people with psychiatric disabilities who desire to work. As of December 31, 2013, all OMH funding of community-based sheltered workshops will be converted to funding of programs that support integrated and competitive employment. Agencies received technical support through New York State Rehabilitation Association and the Medicaid Infrastructure Grant to develop sound business plans to transition individuals served in sheltered workshops into integrated, competitive employment. Local government units played integral roles in developing and reviewing plans that were submitted to OMH for review and approval, and agencies operating sheltered workshops were able to reinvest this sheltered workshop funding into one of several alternatives, including assisted competitive employment, transitional employment program, affirmative business, and transitional business programs.[15]

C. People in Nursing Homes

New York has pursued a number of policies to support community living for people with disabilities residing in, or at risk of placement in, nursing homes. These include the MFP demonstration, the Nursing Home Transition and Diversion Waiver, the Traumatic Brain Injury Waiver, the Long-Term Home Health Care Plan, and the Care at Home I and II waivers. All of these alternatives provide access to community-based supports for people who meet the criteria for nursing home level of care.

Through its Medicaid redesign initiatives, over the next several years, New York will include all Medicaid-eligible nursing home residents in mandatory managed care. The mandatory "care management for all" initiative is well underway for people receiving Medicaid only, as well as for people who are dually-eligible (Medicaid and Medicare), over the age of 21, and who require at least 120 days of community-based care. New populations and benefits are expected to steadily phase in to mainstream managed care and managed long-term care over the next few years.

Building on the care management for all initiative, reforms in the 2012-2013 budget removed the financial incentives that may have encouraged nursing home placement. Previously, nursing home costs were "carved out" of managed care rates and were instead covered by the state. This policy had the potential to encourage managed care plans to pressure high-cost people served in community-based settings to enter nursing homes. Budget reforms will include the full cost of nursing home care in managed care rates, which is expected to encourage these plans to seek lower cost, community-based services.

[14] L.I. Sederer, MD, memorandum, August 8, 2012, available at http://www.omh.ny.gov/omhweb/advisories/Clinical_Advisory_Adult.pdf.

[15] Definitions of these programs are available at http://www.omh.ny.gov/omhweb/cbr/fy09/section_30.html.

For certain people with significant disabilities, the cost of community-based care will exceed that of nursing home care. For these people, New York is developing financing structures that will permit these people to continue to reside in the community or transition from nursing home to the community, as well as avoid clustering people with significant disabilities in certain plans with preferred benefits. These financing structures will likely include the development of a funding pool to provide supplemental payment to plans serving these people to support their high-cost needs in the community.

To complement these initiatives, DOH is currently exploring mechanisms to enhance existing transition and diversion efforts for people currently residing in nursing homes. DOH will develop and adopt Olmstead performance measures which will be incorporated into its managed care contracts. These measures will evaluate the extent to which plans encourage the transition of people from nursing homes to the community; maintain people in the community; prevent nursing home placement; offer consumer-directed services as the first option for plan enrollees; support the use of assistive technologies; and encourage consumer choice and control.

Additionally, DOH has committed to reduce the long-stay population in nursing homes.[16] As of December 31, 2012, the total number of nursing home residents in New York was 119,987, of which 92,539 have stayed 90 days or more.[17] DOH has set a goal of reducing the long-stay population by 10 percent over the next five years. This target will be coupled with a home and community-based services and housing investment strategy to increase the availability of appropriate community-based housing and services.

[16] Here, long stay is defined as residence in a nursing facility for 90 days or longer, for other than a rehabilitative stay.

[17] Data were derived from the Minimum Data Set 3.0 and include all payment sources. Data include continuing care retirement communities and pediatric facilities, but excludes transitional care Units and four non-Medicaid facilities.

III. Assessment and Outcomes Strategies to Advance Community Integration

In addition to identifying strategies to transition people with disabilities from segregated to community-based settings, the Olmstead Cabinet examined the methods by which the state agencies providing services to people with disabilities understand the needs and choices of the people they serve and how those agencies measure whether those needs and choices are being met in the most integrated setting. The Olmstead Cabinet found inconsistencies in these outcome measures and recommends that state agencies providing services to people with disabilities develop or improve their assessment instruments and processes and Olmstead outcomes measures.

Over the past several years, New York has increasingly standardized its assessments of needs and choice for people with disabilities within its service systems. DOH consolidated eight separate assessment instruments previously used in its home care programs into a single instrument, called the Uniform Assessment System-New York (UAS-NY).[18] OPWDD is developing the Coordinated Assessment System-New York (CAS-NY) for all people served within its service system.[19] Significantly, the CAS-NY shares a common core of clinical items with the UAS-NY, which will permit OPWDD and DOH to assure no-wrong-door access to services and programs administered by these two agencies.

Building upon this initiative, OMH will develop an assessment for its community-based mental health system that shares a common core with both the UAS-NY and CAS-NY. OMH will then explore extending this assessment tool to its inpatient psychiatric hospitals.

Similarly, the State Office for the Aging (SOFA) will revise its Comprehensive Assessment for Aging Network Community Based Long Term Care Services (COMPASS) tool to share a common core with the UAS-NY, CAS-NY, and OMH's revised assessment tool. Currently, while the people and families served by SOFA programs are at high risk of spending down to Medicaid eligibility levels, SOFA's current assessment is not interoperable with the UAS-NY and the Minimum Data Set 3.0, used to assess residents of nursing homes. As a result, opportunities for strategic investment in non-Medicaid services to avoid institutionalization may not be readily identified. The development of consistent, cross-systems core assessments of the service needs and choices of people with disabilities of all ages will address this deficiency. Further, technological interfaces between SOFA and DOH data systems will help facilitate meeting cross-systems needs of people and enhance the ability to follow an individual through different systems and determine their progress in meeting their care plans, goals, and objectives.

The process for conducting assessments will also change. To enhance person-centered planning, New York will implement the Community First Choice Option (CFCO) as an amendment to its Medicaid State Plan. The assessment process will be expected to assess for "community first" service options as the default mechanism, so that every person with a disability is offered services in the most integrated setting and only receives services in a more restrictive setting when necessary. Under CFCO, New York will examine and revise existing assessment processes to ensure that service plans will reflect the services and supports important to the individual, identified through an assessment of functional need and preferences for the delivery of such services and

[18] For more information on the Uniform Assessment System-New York, see http://www.health.ny.gov/health_care/medicaid/redesign/uniform_assessment_system/.

[19] For more information on the Coordinated Assessment System-New York, see http://www.opwdd.ny.gov/people_first_waiver/coordinated_assessment_system/.

supports. This revised assessment process will also seek to minimize conflicts of interest by requiring the assessments be conducted independent of the service delivery system.

Building upon interoperable assessment tools and processes, the agencies providing services to people with disabilities will examine and revise their current outcome measures to incorporate Olmstead measures. To achieve community integration for people with disabilities, New York's service systems must measure whether these services maximize the opportunity for people with disabilities to lead integrated lives. These measures should include whether people with disabilities have control over their own day, whether they control where and how they live, whether they have the opportunity to be employed in non-segregated workplaces for a competitive wage, and whether they have the opportunity to make informed choices about services and supports.

Through design teams and workgroups associated with the People First Waiver, OPWDD explored the best practices for measuring the outcomes that are most important to people with developmental disabilities. After this review, OPWDD selected the Council on Quality and Leadership's Personal Outcome Measures (CQL POMs).[20] The 21 measures of the CQL POMs identify the areas of greatest importance to a person receiving supports and the support areas in which improvements may be needed.[21] OPWDD will incorporate the CQL POMs into the new managed care infrastructure for the developmental disabilities service system.

As part of the implementation of Medicaid managed care, DOH, OMH, OPWDD, and the Office of Alcoholism and Substance Abuse Services (OASAS) are establishing common quality measures across all managed care plan types. Similar to the CQL POMs, these measures will include whether people with disabilities have control over their own day, whether they control where and how they live, whether they have the opportunity to be employed in integrated workplaces for a competitive wage, and whether they have the opportunity to make informed choices about services and supports. These measures will be developed in time for the planned June 2014 implementation of the behavioral health managed care initiative.

In addition, state agencies will enhance the comprehensiveness of their assessment tools. For people with disabilities, true community integration involves the ability to access integrated housing, employment, transportation, and support services. In revising their assessment tools, state agencies will jointly identify relevant items that include these domains and incorporate these items into their assessment tools.

Reforms to New York's assessment of needs and choice and Olmstead outcomes measurement will be sustained by investments made under the federal Balancing Incentive Program (BIP).[22] Participation in the BIP will reinforce New York's ongoing efforts to improve access to home and community based long-term care services for those with physical, behavioral health, and/or

[20] Additional information about the Council on Quality and Leadership's Personal Outcome Measures is available at http://www.opwdd.ny.gov/opwdd_services_supports/people_first_waiver/documents/POMs_fact_Sheet_clean.

[21] In addition to personal outcomes, the CQL POMs measure community integration outcomes, such as whether the person is connected to natural support networks, has intimate relationships and friends, chooses where and with whom they live, chooses where they work, lives in integrated environments, interacts with other members of the community, performs different social roles, chooses services, chooses and realizes personal goals, and participates in the life of the community.

[22] New York received an award letter from CMS on March 15, 2013, to participate in the federal Balancing Incentive Program authorized under the Affordable Care Act. For more information about this program, see http://www.health.ny.gov/health_care/medicaid/redesign/balancing_incentive_program.htm.

intellectual and developmental disabilities throughout the state. Through improved access to information and assistance, people with disabilities will be able to make informed choices regarding services, settings, and related issues. To achieve these goals, New York will implement the three structural changes required under BIP. Specifically, New York will enhance the existing New York Connects network to assure a no wrong door/single point of entry for long-term care services and supports, implement a standardized assessment instrument, and assure conflict-free case management services.[23,24]

[23] New York Connects is currently operational in 54 counties and serves as an information and assistance system for long term care services. Additional information about New York Connects is available at www.nyconnects.ny.gov/.

[24] Conflict-free case management is defined by the Balancing Incentive Program as eligibility determination independent of service provision; case managers and evaluators not related to service recipients; robust monitoring and oversight; accessible grievance process; measurement of consumer satisfaction; and meaningful stakeholder engagement. For more information, see http://www.balancingincentiveprogram.org/resources/what-design-elements-does-conflict-free-case-management-system-include.

IV. Supporting Community Integration for People with Disabilities

The Olmstead mandate addresses not only the movement of people with disabilities from segregated to community-based settings, but also the ability of those people to lead integrated lives. Therefore, the Olmstead Cabinet's review sought to identify how New York can further support the integration of people with disabilities in their communities and worked with state agencies to develop policies that would improve community integration.

A. Housing Services

New Yorkers with disabilities need affordable, accessible housing to lead integrated lives. New York has long been a leader in the development of a continuum of housing options for people with disabilities, which include congregate and scattered-site supportive housing, tenant-based rental assistance that enables people with disabilities to lease housing in integrated developments, and apartments specifically set aside for people with various disabilities in mainstream, multi-family housing developments. New York invests over $900 million annually in supportive housing initiatives, and in the past two years, New York has invested an additional $161 million in supportive housing as part of Medicaid redesign.

The Medicaid Redesign Team Affordable Housing Work Group is a cross-agency body composed of representatives from multiple state agencies administering and/or funding supportive housing programs, including OMH, OPWDD, OASAS, DOH, Homes and Community Renewal (HCR), and the Office of Temporary and Disability Assistance (OTDA).[25] This work group has achieved $161 million in supportive housing investments over the last two years for high-cost Medicaid recipients. The work group will reconvene in October 2013 to consider further collaborations to increase the number of available and affordable housing options and community supports to increase the availability of integrated housing.

HCR facilitates the availability of community-based supportive housing for people with disabilities through early decision, scoring, and financing incentives for multi-family housing projects. Housing projects may be jointly funded by HCR and a state human service agency, such as OPWDD, OMH, or OASAS. In 2013 (as in past years) early decision incentives are available for multi-family, supportive housing projects that set aside a percentage of units for low-income veterans with special needs and people with intellectual and developmental disabilities. Project developers must also show that they have entered into agreements with human service providers to operate and fund community-based support services. HCR also awards developers applying for New York State low-income housing tax credits additional points in its scoring system for projects which reserve a percentage of units for people with mobility and sensory impairments, and for those that give preference in tenant selection for people with special needs. Additional tax credits, tax-exempt bond financing, and funding in excess of usual program limits are also available for multi-family housing projects with units set aside for special needs populations, depending on ownership and financing circumstances. Beginning in its 2013 annual funding round, HCR will examine new project applications to assess whether new developments are consistent with Olmstead principles.[26]

[25] For more information about the Medicaid Redesign Team Affordable Housing Work Group, see http://www.health.ny.gov/health_care/medicaid/redesign/affordable_housing_workgroup.htm.

[26] For more information on the Homes and Community Renewal Annual Funding Round RFP, see http://www.nyshcr.org/Funding/UnifiedFundingMaterials/2013/RFP_MultiFamilyPrograms.pdf.

As part of its monitoring of completed projects, HCR verifies that project units set aside for people with disabilities are occupied by the special needs population intended, as provided for in the developer's regulatory agreement and affirmative marketing plan. In instances where a service provider is unable to provide qualified applicants or has discontinued operations, HCR requires that an acceptable replacement provider be identified and may allow a different special needs population to be targeted.

OTDA engages in a variety of housing initiatives to support the state's implementation of its Olmstead Plan. The agency's Bureau of Housing and Support Services (BHSS) administers both capital and housing programs that are focused on providing supportive housing for homeless people with disabilities and their families in the least restrictive environment possible. OTDA's Homeless Housing and Assistance Program (HHAP), created in 1983, was the first state-funded program in the country to develop supportive housing units for homeless people with disabilities and their families. Among those for whom such housing is provided are homeless people with serious and persistent mental illness, including those with co-occurring substance abuse disorders; people living with HIV/AIDS; people with cognitive impairments such as those caused by traumatic brain injury; and people with other mental and/or physical disabilities. In addition, OTDA's New York State Supportive Housing Program (NYSHHP) provides funding for housing retention services and other supports for formerly homeless people with disabilities who are living in supportive housing programs throughout the state. Many of these supportive housing programs are located in "mixed use" apartment buildings which house people with disabilities along with other community members. Finally, OTDA's Solutions to End Homelessness Program (STEHP) contracts with local not-for-profit agencies to provide eviction prevention services to prevent people at risk of homelessness, including those with disabilities, from losing their housing. STEHP also provides short-term rental assistance and other supports to homeless individuals, including those with disabilities and their families in order to obtain housing available in the general rental market. All of OTDA's housing efforts are aimed at assisting homeless people, including those with disabilities, to obtain and retain housing of their own choosing within the community.

In addition to these programs and incentives, the Olmstead Cabinet examined opportunities for expansion of integrated housing models that will support people with disabilities leaving institutions or at serious risk of institutional care. The Frank Melville Supportive Housing Investment Act of 2010 authorized Section 811 Project Rental Assistance (PRA), specifically designed to support Olmstead implementation efforts by funding developments and subsidizing rental housing with the availability of supportive services for very low income people with disabilities.[27] State-level housing (i.e., HCR) and health and human services agencies (e.g., OPWDD, OMH, DOH) partner to meet the housing and support needs of the target population. The health care agency develops a policy for referrals, tenant selection, and service delivery to ensure that this highly-integrated housing is targeted to a population most in need. Through an interagency partnership, New York will develop and submit an application for PRA when the request for proposals (RFP) is released. Subject to the RFP's guidance, this application will target low income people with disabilities transitioning from institutions or at serious risk of institutional placement.

Additionally, New York has expanded the information available to people with disabilities through the www.NYHousingSearch.gov website. HCR maintains this website as a free service to list and find affordable, accessible housing in New York. To expand the listings of affordable housing, HCR requires that owners and managers of multi-family projects developed since 2006 list all adaptable and adapted apartments, as well all special needs/supportive services apartments. Further, HCR requires developers of new multi-family projects to list all units adapted or set aside for people with

[27] For more information about Section 811 Project Rental Assistance, see http://portal.hud.gov/hudportal/HUD?src=/program_offices/housing/mfh/progdesc/disab811.

disabilities when advertising new units or accepting tenant applications.

B. Employment Services

The continued strengthening of New York's economic development strategies will help to assure an adequate supply and breadth of jobs available to people with disabilities. Certain reforms implemented under Governor Cuomo's Spending and Government Efficiency (SAGE) Commission have aligned workforce development programs more closely with the New York's economic development efforts. The Department of Labor (DOL) will build upon these reforms for people with disabilities by coordinating disability workforce strategies and assuring that these initiatives are aligned with New York's economic development strategies, such as Regional Economic Development Council priorities.[28]

DOL will coordinate with state agencies serving people with disabilities (e.g., OMH, OPWDD, OASAS, State Education Department's Adult Career Continuing Education Services – Vocational Rehabilitation (ACCES-VR), and New York State Commission for the Blind (NYSCB)), to better align DOL's disability workforce strategies with the vocational rehabilitation and employment programs administered by those agencies. DOL will increase coordination of disability workforce initiatives by establishing a stronger linkage between disability resource coordination (DRC) activities at One-Stop Career Centers and ACCES-VR. Specifically, DOL regional business services teams, responsible for coordinating One-Stop Career Center business services with regional business strategies and regional labor market information, will include ACCES-VR services in its coordination activities.[29] Further, DOL will use disability resource coordinators, established under a federal Disability Employment Initiative pilot program, to provide specialized services designed to increase employment opportunities for people with disabilities through skills upgrading (e.g., on-the-job training, obtaining industry-recognized credentials, entrepreneurial training, and customized training) and community partnerships with agencies that support people in employment, life coaching, and asset development.[30]

This increased employment coordination will build upon the comprehensive employment supports coordination and data system called the New York Employment Services System (NYESS).[31] NYESS provides New Yorkers of all abilities with a central point of access to all employment-related services and supports offered by DOL, ACCES-VR, NYSCB, OMH, OPWDD, OASAS, and SOFA. This system connects to the New York State Job Bank, where approximately 90,000 job openings are currently listed each month by employers. Increasing the number of providers and customers in NYESS will allow for comprehensive data analysis of the talent pipeline of people with disabilities. This analysis will include the educational attainment, employment status, and career sectors in which people with disabilities are represented, which will better enable New York to strategically implement effective policy around employment services for people with disabilities.

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[28] For more information about New York's 10 Regional Economic Development Council priorities, see http://regionalcouncils.ny.gov/.

[29] For more information about the Department of Labor regional business services teams, see http://www.labor.ny.gov/workforcenypartners/ta/ta10-12.pdf.

[30] For more information about the federally-funded Disability Employment Initiative in New York, see http://www.labor.ny.gov/workforcenypartners/dpn_dei.shtm.

[31] For more information about the New York Employment Services System, see http://www.nyess.ny.gov/.

DOL and other partner staff will continue to engage Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI) beneficiaries with benefits advisement and work incentive counseling in an effort to increase the assignment of tickets to the state under the Social Security Administration's (SSA) Ticket to Work (TTW) program. For people eligible for the TTW program, DOL, ACCES-VR, OPWDD, OMH, and NYSCB will develop a cross-systems assessment protocol to assess each individual's vocational rehabilitation and employment service needs. This protocol will assure that an individual's ticket assignment options are based on individual needs to achieve competitive employment, consistent with the unique strengths, abilities, interests, and informed choice of the individual. This cooperative approach will provide a broad range of employment and career services options for people with disabilities.

Engaging community employers around the benefits of hiring people with disabilities would also improve the opportunities for competitive, integrated employment. Efforts such as the "Think Beyond the Label" advertising campaign help to raise awareness among employers across the state about the benefits of hiring people with disabilities. New York will market various tax credits and incentives, such as the Workers with Disabilities Tax Credit and the Work Opportunity Tax Credit to encourage community employers to hire people with disabilities.

C. Transportation Services

In addition to New York's housing and employment services, transportation services are also fundamental to community living for people with disabilities. New York has conducted a variety of self-evaluation exercises to review its disability transportation strategies (e.g., assessments conducted by the Department of Transportation, Most Integrated Setting Coordinating Council (MISCC), and New York Makes Work Pay[32,33,34]) in recent years. These reports, and the Olmstead Cabinet's review, show a continued need for coordination of disability transportation services.

A federal executive order was issued in 2004 supporting coordinated transportation planning.[35] A cornerstone of such efforts is the establishment of mobility management, a strategic approach to service coordination and customer service to enhance the ease of use and accessibility of transportation networks. Mobility management meets the unique set of transportation needs in each local area by acting as a functional point of coordination for each community's public and private human services organizations and public transportation providers. Mobility management forms and sustains effective partnerships among transportation providers in a community by providing a single, localized source for coordinating and dispatching the full range of available transportation resources to customers. The partnerships formed by mobility management are meant to increase the available travel services for riders and create resource and service efficiencies for transportation providers.

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[32] For more information about the Department of Transportation review of transportation services, see https://www.dot.ny.gov/programs/adamanagement/ada-management-plan/appendix.

[33] For more information about the Most Integrated Setting Coordinating Council review of transportation services, see http://www.opwdd.ny.gov/node/784.

[34] To access the New York Makes Work Pay report, see http://www.nymakesworkpay.org/docs/Transportation_PWDs_NYS_032010.pdf.

[35] Exec. Order No. 13330. 69 FR 9185-9187. (2004). Retrieved from http://www.gpo.gov/fdsys/pkg/FR-2004-02-26/pdf/04-4451.pdf.

Under Medicaid redesign, New York implemented a transportation management system, through state-managed contracts, to improve coordination and cost effectiveness for non-emergency Medicaid transportation.[36] Non-emergency Medicaid transportation is only available to access medical care covered by Medicaid. Therefore, there remains a need for enhanced coordination of transportation resources to assure the availability of services for people with disabilities who need transportation to work or engage in other non-medical activities.

Prior to Medicaid redesign, a number of local transportation providers had begun to implement mobility management programs for both non-emergency Medicaid and non-medical transportation. New York will review the impacts of Medicaid redesign on these local mobility management efforts. This review will evaluate the cost effectiveness and availability of non-emergency Medicaid and non-medical transportation resources for people with disabilities. Based upon this analysis, New York will consider a pilot program to expand the existing Medicaid transportation management system to non-medical trips.

D. Children's Services

Children with disabilities in residential care and those at risk of placement require strategies capable of specifically addressing their personal, familial, and educational resource needs. New York has long recognized the unique relationships between children and families, the roles of multiple agencies in addressing children's needs, and the need to plan for transitions from childhood to adulthood.

The decision that a student needs out-of-home placement in a residential school must be based on the Committee on Special Education's determination that there is no appropriate alternative available to meet the educational needs of the student. New York adopted Chapter 600 of the Laws of 1994, which was intended to discourage unnecessary out-of-home placements by increasing the connection between families and children at risk of placement with local support services.[37] Recognizing that a single system cannot meet all the needs of children with disabilities and their families, CSE membership includes, with the consent of the parent (or student if age 18 or older), representatives from local social service departments, state agencies (e.g., OMH, OPWDD), and local school districts. CSEs provide families with information about in-home and community support services available as alternatives to out-of-home placement to address the unique needs of the child and family. CSEs also consider post-secondary goals and transition services for older students. In 2011, the State Department of Education strengthened its review of proposed out-of-state educational placements to assure adherence with the law.[38]

The Coordinated Children's Services Initiative (CCSI) is another mechanism for serving children with disabilities in the most integrated setting. This initiative began in the 1990s and is currently operated by the Council on Children and Families. CCSI is an approach to developing individual/family-, county- and state-level mechanisms to identify individual and family needs, coordinate multiple service systems, address barriers to coordinated service delivery, and assure that funding is available to prevent out-of-home placement of children with disabilities.[39]

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[36] For more information about the Medicaid transportation management initiative, see http://www.health.ny.gov/funding/rfp/inactive/1103250338/.

[37] For more information about the changes to New York's Social Services and Education Law as a result of Chapter 600, see http://www.p12.nysed.gov/specialed/publications/policy/chap600.pdf.

[38] For more information about the updated procedures, forms, and policy regarding a school district's responsibilities under Chapter 600 of the Laws of 1994, see http://www.p12.nysed.gov/specialed/publications/outofstateplacementsEIP.htm.

[39] For more information about the Coordinated Children's Services Initiative, see http://ccf.ny.gov/CCSI/index.cfm.

Recent Medicaid redesign initiatives have further sought to coordinate the unique service needs of children with disabilities and their families to prevent out-of-home placements. In 2011, the Medicaid Redesign Team Children's Work Group was created to redesign behavioral health services for children. This work group focused on early identification of trauma and behavioral health needs via primary care, collaborative, multi-system care models of treatment, specialty care treatment capacity (including clinical and wrap-around services), family engagement, cross-systems care coordination, and funding and administrative alignment.

The children's work group determined that the Medicaid Children's Behavioral Health Care system, currently funded through Medicaid fee-for-service, should be transitioned to Medicaid managed care. Under Medicaid managed care, physical health, behavioral health, and community support services will be coordinated through person- and family-centered care plans. Olmstead outcome measures will be incorporated into managed care plans, and will seek to ascertain whether services for children maximize the opportunity for children with disabilities to lead integrated lives. The transition to this reformed children's managed care system is planned for January 2016.

E. Aging Services

In addition to the Medicaid redesign initiatives to assist people with disabilities residing or at risk of placement in nursing homes, the Olmstead Cabinet reviewed non-Medicaid services for older adults that may delay or prevent institutionalization, hospital utilization, and Medicaid spend down. Federal, state, and local funds sustain a variety of non-medical, long-term services and supports targeted at older people at risk of nursing home placement and Medicaid spend-down, with the goal of avoiding higher levels of care and public financing of such care. In particular, the Expanded In-home Services for the Elderly Program provides case management and non-medical, in-home and ancillary services for people who need assistance with activities of daily living and instrumental activities of daily living.[40,41,42] Other services, such as congregate and home delivered meals, transportation, and caregiver services, supported through federal, state, and local funds, also assist older New Yorkers to remain in their homes and communities.

As previously noted, SOFA will revise its COMPASS tool to share a common core with the UAS-NY, CAS-NY, and OMH's revised assessment. This revision will help identify opportunities for strategic investment in non-Medicaid services to avoid institutionalization. Further, technological interfaces between SOFA and DOH data systems will help meet cross-systems needs of people with disabilities and enhance the ability to follow a person through different service systems and determine his/her progress in meeting care plan goals and objectives.

SOFA also administers New York Connects, the state's federally-designated Aging and Disability Resource Center to serve as a no wrong door/single point of entry to long-term supports and services for people of all ages with disabilities.[43] Using BIP funds, New York Connects will be strengthened to provide better information to people with disabilities and older adults about both private and public community-based services and supports available to meet their needs. This resource center will also provide options counseling to assist with decision making. These services

[40] For more information about the Expanded In-home Services for the Elderly Program, see http://www.health.ny.gov/health_care/medicaid/program/longterm/expand.htm.

[41] Self-care activities are activities that a person tends to do every day, including feeding, bathing, toileting, dressing, and grooming.

[42] In addition to activities of daily living, a person must be able to perform instrumental activities in order to live independently, including shopping, transportation, and housekeeping.

[43] For more information about New York Connects, see http://www.nyconnects.ny.gov/nyprovider/consumer/indexNY.do.

are expected to enhance a person's ability to receive the right service at the right time in the right setting for the right cost.

Further, SOFA will strengthen its Long-Term Care Ombudsman Program to assist residents of nursing homes and adult homes to transition to community-based services and supports.[44] Ombudsmen currently help residents understand and exercise their rights in facilities and work to resolve problems between residents and facility staff/administrators. Ombudsmen will be trained to assist nursing home and adult home residents to exercise their rights to community placement and to facilitate linkages to community resources, consistent with proposed federal guidelines regarding long-term care ombudsmen.[45]

F. Criminal Justice

The Olmstead Cabinet examined two criminal justice issues concerning people with disabilities and the Olmstead mandate. First, the cabinet sought to assure that people with disabilities who leave correctional facilities are able to access needed community-based services. Second, the cabinet reviewed current state policies to assure that people with disabilities are not unnecessarily incarcerated for minor offenses that are a result of their disability.

Under Medicaid redesign, New York has enhanced its ability to voluntarily engage people with significant behavioral health needs in services and provide strong follow-up upon discharge from institutional settings. For the limited number of people who do not voluntarily access services, the New York Secure Ammunition and Firearms Enforcement (SAFE) Act strengthened assisted outpatient treatment.[46]

OMH works closely with the Department of Corrections and Community Supervision to implement robust statewide policies for screening people in prisons for mental illness, provide mental health services in prisons, and facilitate reentry from prisons to the community. OMH also offers in-reach services to link prisoners with community-based services and employs pre-release coordinators in prisons throughout the state. These coordinators link mentally ill prisoners with appropriate services in the community and assist, where appropriate, in applying for entitlements such as Medicaid and SSI/SSDI.[47]

County-based services for mentally ill jail inmates are supplemented with state funding through the Medication Grant Program to pay for psychotropic medications for released inmates while their Medicaid application is pending. In addition, OMH provides over $4 million annually to support transition programming in local jails.

The majority of services to divert people with disabilities from the criminal justice system and transition mentally ill inmates back into the community, however, are administered at a local level.

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[44] For more information about the Long-Term Care Ombudsman program, see http://www.ltcombudsman.ny.gov/.

[45] "State Long-Term Care Ombudsman Program, Proposed Rules." *Federal Register*, 78:117. (June 18, 2013) p. 36449-36469. Retrieved from http://www.gpo.gov/fdsys/pkg/FR-2013-06-18/html/2013-14325.htm.

[46] Information about the impact of the New York Secure Ammunition and Firearms Enforcement Act on mental health services can be found at http://www.omh.ny.gov/omhweb/safe_act/.

[47] Recipients of services at OMH forensic facilities are almost always discharged to an OMH civil psychiatric center prior to transitioning back to the community. Residents in OMH secure treatment facilities are transitioned back into the community through the Strict and Intensive Supervision and Treatment program, established by MHL Art. 10.

These local services include law enforcement, courts, jails, and community supervision. Examples of pre-arrest diversion programs that exist across the state are crisis intervention teams, emotionally disturbed people response teams, and mobile crisis teams. In addition, there are currently 28 mental health courts throughout the state, and the Mental Health Connections program shares current mental health court resources with counties that do not have an established mental health court.

A number of recent reforms will further support the diversion of people with disabilities from the criminal justice system and facilitate reentry from the criminal justice system. Notably, OMH has significantly increased the number of supported housing units for parolees with serious mental illness. It also has partnered with the Center for Urban Community Services (CUCS) to develop the Reentry Coordination System in New York City, which operates as a forensic single point of entry for services, including housing, intensive case management, assertive community treatment, and outpatient clinic services. In addition, OMH has collaborated with the New York City Department of Health and Mental Hygiene and with CUCS to establish the Academy for Justice-Informed Practice to cross-train mental health and criminal justice practitioners on best practices for working with justice-involved, mental health service recipients.[48]

The Division of Criminal Justice Services (DCJS) oversees the operation of 19 county reentry task forces and provides $3 million annually through performance-based contracts with localities to support the reentry of people returning from state prisons. DCJS also provides specialized training to police officers to address the needs of people with mental illness.

DCJS was recently awarded a grant from the Bureau of Justice Assistance to provide training and technical assistance to up to 10 localities with high crime rates and high per member per month Medicaid spending to address the needs of people with serious mental illness in the criminal justice system and coordinate with community-based treatment and supports. Using the Sequential Intercept Model, DCJS will work collaboratively with OMH to assist localities in conducting countywide mapping of mental health and criminal justice resources for planning purposes.[49] DCJS and OMH also will provide training and technical assistance to identify local service gaps and develop strategies to address unmet need at each interception point. These strategies will help counties address the needs of people with serious mental illness involved in the criminal justice system and connect them to community-based treatment and supports, which is expected to decrease crime rates and the burden on local jails while improving mental health outcomes for the people served. Initial outcome measures for this initiative will seek to identify probationers screened for mental illness, probationers supervised through the joint probation/mental health case management model, probationers with mental illness successfully completing probation supervision, the number of jail admissions screened for mental illness, and the number of police officers completing crisis intervention training.

G. Legal Reform

To promote the full integration of people with disabilities in the community, the Olmstead Cabinet examined legal and regulatory barriers that impact the ability of people with disabilities to achieve

[48] For more information about the Center for Urban Community Services and the Academy for Justice-Informed Practice, see http://www.cucs.org/training-and-consulting/training/nyc-training-program.

[49] The Sequential Intercept Model, developed by SAMHSA's GAINS Center for Behavioral Health and Justice Transformation, identifies five key points within the criminal justice system where people with serious mental illness can be intercepted and diverted to community-based alternatives: (1) law enforcement, (2) initial detention/initial court hearings, (3) jails/courts, (4) re-entry, and (5) community corrections. For more information, see http://gainscenter.samhsa.gov/pdfs/integrating/GAINS_Sequential_Intercept.pdf.

community integration. The Olmstead Cabinet identified two issues requiring legal reform: access to health-related task assistance in community settings and guardianship laws for people with intellectual and developmental disabilities.

A barrier to community integration for many people with disabilities is their ability to access community-based assistance with health-related tasks, including medication management, medication administration, and other home health treatments. Recognizing these barriers, current law authorizes people with disabilities served by certain programs to receive assistance with these tasks from non-nursing personnel. People receiving home care services under the Consumer Directed Personal Assistance Program (CDPAP) may direct another individual to provide them with health-related task assistance.[50] Additionally, people with intellectual and developmental disabilities residing in OPWDD certified residences can utilized trained and certified direct care staff for medication, tube feedings, and insulin administration, as well as for other health-related tasks under the supervision of a registered professional nurse.[51]

However, for people with disabilities not served by these programs, facility-based care is often the only option for receiving needed assistance with these health-related tasks. For example, while a person with a developmental disability residing in a group home certified by OPWDD may receive assistance with medication administration by an unlicensed direct care staff member, the same person could not receive this level of assistance in an independent apartment. Likewise, people with physical disabilities enrolled in the CDPAP program can receive the assistance of an unlicensed aide in their own homes if they or a designee assumes full responsibility for hiring, training, supervising, terminating the employment of people providing the services, but could not make use of an unlicensed aide if they wish to direct another in the provision of health-related task assistance, but do not wish to assume all responsibilities associated with the CDPAP program. Similar barriers exist for other people with disabilities who need assistance with health-related tasks to live successfully in the community.

In order to fully support community integration for people with disabilities, current restrictions on community-based health-related task assistance require reform. A broader application of the current self-direction exemption of the Nurse Practice Act for CDPAP enrollees should be explored to cover all people with disabilities who are capable of directing others to provide health-related task assistance. For people not capable of directing others to provide this assistance, a broader application of the exemption within the Nurse Practice Act for certified settings, as currently implemented by OPWDD, should be explored to cover all integrated, community-based housing for people with disabilities.

The Olmstead Cabinet also recommends reform to law governing guardianship over people with developmental disabilities. Community integration includes the ability of people with disabilities to make their own choices to the maximum extent possible. Guardianship removes the legal decision-making authority of an individual with a disability and should, consistent with Olmstead, only be imposed if necessary and in the least restrictive manner. New York maintains two separate systems of guardianship for people with disabilities. Article 17A of the Surrogate Court's Procedure Act, adopted in 1969, applies to people with developmental disabilities. Article 81 of Mental Hygiene Law, adopted in 1987, applies to all other people with disabilities.

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[50] For more information about Consumer Directed Personal Assistance Program requirements, see http://www.health.ny.gov/health_care/medicaid/program/longterm/cdpap.htm.

[51] To access the Office for Mental Retardation and Developmental Disabilities and State Education Department's joint Memorandum of Understanding #2003-01 for registered nursing supervision of unlicensed direct care staff in certified residential facilities, see http://www.op.nysed.gov/prof/nurse/nurse-omrddadminmemo2003-1.htm.

Under Article 17A, the basis for appointing a guardian is diagnosis driven and is not based upon the functional capacity of the person with disability. A hearing is not required, but if a hearing is held, Article 17A does not require the presence of the person for whom the guardianship is sought. Additionally, Article 17A does not limit guardianship rights to the individual's specific incapacities, which is inconsistent with the least-restrictive philosophy of Olmstead. Once guardianship is granted, Article 17A instructs the guardian to make decisions based upon the "best interests" of the person with a disability and does not require the guardian to examine the choice and preference of the person with a disability.

In contrast, Article 81 imposes guardianship based upon a functional analysis of a person's disability, requires a hearing, requires the presence of the person over whom guardianship is sought at the hearing, requires guardianship to be tailored to the person's functional incapacities, and requires the guardian to consider the person's choice and preference in making decisions. The Olmstead Cabinet recommends that Article 17A be modernized in light of the Olmstead mandate to mirror the more recent Article 81 with respect to appointment, hearings, functional capacity, and consideration of choice and preference in decision making.

In addition to reforming guardianship law, New York should build upon current OPWDD regulations that recognize certain actively involved family members as surrogates for people who cannot provide their own consent.[52] By extending the authority of these people, OPWDD has minimized those instances in which guardianship is pursued. This outcome could be beneficial to all other people with disabilities to support decision-making activities without pursuing guardianship.

[52] Among other things, actively-involved family members may give informed consent for major medical procedures on behalf of individuals residing in OPWDD facilities who lack the "capacity to understand appropriate disclosures regarding proposed professional medical treatment" (14 NYCRR 633.11(a)(1)(iii)(a) and (b)), may approve service plans (14 NYCRR 681.13), object to OPWDD-related services on behalf of such individuals (14 NYCRR 633.12), may provide informed consent for behavior support plans that include restrictive/intrusive interventions (14 NYCRR 633.16(g)(6)(i)and (iii)), and make end-of-life decisions on behalf of individuals with developmental disabilities. (Surrogate's Court Procedure Act § 1750-b [1] [a]; see also 14 NYCRR 633.10 [a] [7] [iv]).

V. Ensuring Accountability for Community Integration

Although this report provides the foundation for New York's compliance with the Olmstead mandate, effective oversight is required in order to protect the rights of person with disabilities to live in the community on an ongoing basis.

Since 2011, New York has undertaken significant initiatives to ensure the protection of people with disabilities and other special needs. In June 2013, Governor Cuomo established the Justice Center to investigate and prosecute cases of abuse and neglect against people with disabilities and to provide oversight and monitoring of the systems of care serving these people. Governor Cuomo also designated Disability Rights New York as the state's federally-funded Protection and Advocacy and Client Assistance Program to provide independent oversight of these systems. Additionally, New York initiated independent ombudsman functions through Medicaid redesign to assist people with disabilities served in the Medicaid managed care system. Finally, the Governor created the Olmstead Development and Implementation Cabinet and designated a representative of the Governor's Office to direct its activities. Together, these measures strengthen the oversight of providers and service systems and provide access to independent advocacy to protect the rights of people with disabilities to live in the community.

New York's sustained attention to serving people with disabilities in the community requires continued leadership from the Governor's Office. The legislature created the MISCC in 2002 as the statutory body intended to develop New York's Olmstead plan and hold state agencies accountable.[53] As designed, MISCC had a rotating chairmanship among the commissioners of four state agencies. This model has proved challenging because one state agency commissioner does not have the authority to command other state agency commissioners. The creation of the Olmstead Cabinet, with a chair from the Governor's Office, was intended to provide leadership from the Governor's Office in the development of a plan for Olmstead compliance. To sustain this leadership over time and to hold state agencies accountable for Olmstead compliance, a representative of the Governor's Office will continue to provide leadership to the MISCC. MISCC meetings will be a continuing means of public accountability for the state's accomplishment of Olmstead goals.

In addition, the Governor's Office will develop and maintain a dashboard to monitor Olmstead compliance. This dashboard will contain key agency Olmstead initiatives and metrics to measure New York's progress in serving people with disabilities in the most integrated setting. The Governor's Office will also maintain a dedicated website, http://www.governor.ny.gov/olmstead/home. This website will provide relevant information regarding New York's implementation of Olmstead and a mechanism for the public to provide feedback regarding New York's Olmstead Plan.

[53] Additional information about past MISCC Olmstead proceedings is available at http://www.opwdd.ny.gov/opwdd_community_connections/miscc/press_releases_and_important_documents.

Conclusion

This report and recommendations, developed by the Olmstead Cabinet, provide the framework for New York to serve people with disabilities in the most integrated setting appropriate to their needs and desires. Through implementation of these recommendations, New York will:

- Assist in transitioning people with disabilities into the community from developmental centers, ICFs, sheltered workshops, psychiatric centers, adult homes, and nursing homes;
- Reform the assessment of the needs and choices of people with disabilities;
- Adopt new Olmstead outcome measures for people with disabilities;
- Enhance integrated housing, employment, and transportation services available to people with disabilities;
- Improve services to children, seniors, and people with disabilities involved with the criminal justice system;
- Remove legal barriers to community integration; and
- Assure continuing accountability for serving people with disabilities in the most integrated setting.

The effective implementation of these recommendations will safeguard the fundamental civil rights of New Yorkers with disabilities to lead integrated lives.

www.governor.ny.gov/olmsteadplan

Case Law Update 2019

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ELDER LAW UPDATE

Matthew Nolfo & Associates

1

SECURE ACT

- "Setting Every Community Up for Retirement Enhancement (SECURE) Act of 2019"
- Bi-partisan Sponsorship and Support in the House – 417 to 3
- Effective Date: IRA owners that die in 2020 and later
- Government plans where owners die in 2022 and later?
- Special Delay for contracts under collective bargaining agreements?
- Companion Bill Pending in Senate

2

SECURE ACT – STRETCH OUT CHANGES

- "Stretch Out" distributions after death of Owner to beneficiaries significantly altered in favor of 10 year Payout (Senate Bill is 5 years for Accounts over $450,000)
- 10 Year Payout starts to run in the year following the IRA or Plan Owner's Death (Pre or Post RBD)
- No RMDs, but instead just has to be withdrawn by the 10th year
- This applies to IRAs and other qualified plans and Roths

3

SECURE ACT

- Exempt Beneficiaries:

1) Spouses
2) Disabled Individuals
3) "Certain Chronically Ill Individuals" – IRC 7702B
4) Beneficiaries whose age is within 10 years of the Deceased
5) Minors (10 year payout starts to run in the year when the Beneficiary reaches age of majority)
6) Recipients of certain annuitized payments that commenced before the enactment of the Secure Act

4

SECURE ACT

- "Spouse"
- Still allowing for full rollover
- Concern that if surviving spouse lives for a long time, upon death, the 10 year payout will result in more tax being paid
- Consider having some of the Decedent spouse's IRA not rollover and disclaim
- Rate shopping

5

SECURE ACT

- Disabled Individual
- Does not have to be a descendant of the IRA Owner
- Not fully defined – probably the SSA rules
- RMDs will still apply
- Accumulation Trusts will still work
- How will this impact 98 MA/024 for a beneficiary if not held in trust? Along with Federal Bankruptcy cases that say an Inherited IRA is not an exempt asset?

6

SECURE ACT

- "Certain Chronically Ill Individuals" – appears to be those with Cognitive Impairment or who need substantial assistance with ADLs
- Beneficiaries whose Age is within 10 years of the Decedents
- Minors (has to be a child of the Decedent only)
- Age of Majority to start 10 year run. The age in the Bill is 21.

7

SECURE ACT – NEW PLANNING?

- What does this do for planning?
- If you have a non-disabled person who is not a minor, RMDs do not matter, and can do a spendthrift trust, but will have to consider how the trust will be taxed on income
- Conduit Trusts – should be revisited. The consequences could be unintended
- Accumulation trusts will still work for disabled and minor beneficiaries
- Discretionary Spray Trusts for the rest – Children and Grandchildren because IRA distributions do not appear to be subject to the Kiddie Tax

8

SECURE ACT – NEW PLANNING?

- Make payable to CRT if client is charitably inclined – no income tax going in – IRC Section 664
- When comes out to life beneficiary there is income tax due
- Rate Management
- Use Life Insurance to make up the difference or allow for the surviving spouse to do a Roth Conversion

9

SECURE ACT – OTHER CHANGES

- Owners do not have to start taking distributions until the year he or she turns 72 (as opposed to 70 and ½)
- Traditional IRA contributions can be made at any age now
- Care Payments for Medicaid waiver programs – compensation can now be used to fund a retirement account
- 529 Distribution options are expanded
- Most small businesses will now be able to offer a plan
- Part time workers should now be eligible to participate with an employer plan

10

RECENT CASES

11

HOME CARE HOURS

- Andryeyeva v. New York Health Care, Inc. 2019 N.Y. LEXIS 617 (Court of Appeals)
- Issue whether employer must pay its home care aide employees for each hour of a 24 hour shift
- The DOL's interpretation of its Wage Order to require payment for 13 hours of a 24 hour shift is reasonable if the employee is allowed a sleep break for at least 8 hours and actually receives 5 hours of uninterrupted sleep and 3 hours of meal break time
- Because DOL's interpretation of its Wage Order was not irrational or unreasonable, it is upheld and the AD's finding that DOL's interpretation of its own Wage Order was not reasonable is reversed
- Remitted back to the lower courts to see if other class certification is warranted

12

TINSMON CASE -SNT HOME PURCHASE

- Appellate Division, 3rd Department – 2019 NY Slip Op 01471
- Affirmance of Order of the Albany County Surrogate Court to allow Trustees of Self Settled Trust to use trust funds to purchase the residence for Trust beneficiary to be held in her name
- SSI POMS 01120.201(F)(1) allow for this as the house is a "durable item"
- Trustees are not obligated to conserve the Trust assets for the benefit of Medicaid for the payback
- Within the Trustee's discretion to make expenditures for disabled person's benefit after considering impact on the beneficiary's access to government benefits

13

ESTATE OF ELI T., 2018 NYLJ LEXIS 4125 (DECEMBER 2018) 17-A DENIED

- Kings County Surrogate denied 17-A guardianship where respondent with IQ of 64 did not need guardian and that with support of loving family, he could make decisions on his own.
- "The appropriate legal standard is not whether the petitioners can make better decisions than respondent; rather, it is whether or not respondent has the capacity to make decisions." Advance directives could be executed for any authority his parents sought – more targeted than guardianship that takes away all rights of developmentally disabled person (not tailored approach like Article 81 guardianships).
- Good case for discussion on definition of a "developmentally disabled person" under 17-A.

14

MATTER OF ANNA F., 2018 NY SLIP OP 05590 (AUGUST 2018) ARTICLE 17-A GRANTED

- Second Department reversed Brooklyn Surrogate Court's dismissal of a 17-A guardianship application for Petitioner's 51-year old sister, who had a severe intellectual disability for most of, if not all of her life, directing that the case be brought as an Article 81 guardianship. Second Department held that the Petitioner's sister was indeed intellectually disabled within the meaning of SCPA 17-A and deemed that the Petitioner was best suited to care for her sister, appointing her as guardian.

15

MATTER OF DELANEY, NY SLIP OP 02090 (MARCH 2019) POA CREATES SNT

- Agent under durable POA signed by Principal with paranoid schizophrenia commenced proceeding in Rockland Surrogate's Court to create an SNT for individual who was receiving government benefits, including SSDI, to receive the principal's inheritance from his parents that had not yet been paid. SNT was for principal's supplemental care, maintenance, support, and education. Application was denied.
- 2nd Department reversed Rockland Surrogate's decision that the agent under durable POA did not have authority to commence proceeding to create SNT on principal's behalf. POA granted authority for, among other things, "claims and litigation", "estate transactions, and "all other matters", citing GOL 5-1502H; Matter of Perosi v. LiGreci 98 AD3d 230.

16

BRONSTEIN V. CLEMENTS, 2019 NY SLIP OP 01470 (FEBRUARY 2019) STATE LAWS CONFLICT IN GUARDIANSHIP

- Defendant had IP sign 2 POAs in New York using PA form: one gave unrestricted authority to Plaintiff, and second gave restricted authority to Defendant to engage in real estate transactions and to create a trust for the IP. Plaintiff filed for guardianship in PA and was granted same and filed the Guardianship Order in NY pursuant to 83.39. Plaintiff commenced this proceeding to revoke the limited POA given to Defendant.
- Under PA law, the guardian could revoke POAs, but not the same under MHL 81.22(b)(2). Court held that POA fell under preview of GOL.
- Under a choice of law analysis: "the applicable law should be that of the jurisdiction which, because of its relationship or contact with the occurrence or the parties, has the greatest concern with the specific issue raised in the litigation."
- Trial Court held and Third Dept. agreed that POA could be revoked given PA's greater concern in the matter.

17

MATTER OF KRONIK, 2019 NY SLIP OP 30178(U) TRUST REVOKED BY GUARDIANSHIP COURT

- Decedent signed Irrevocable Trust and pour over Will in March 2000. Decedent found to be incapacitated in August 2000. Guardians applied for revocation of trust and after a jury trial it was determined that Decedent lacked capacity to sign Trust and that there was undue influence.
- Court held that the two instruments were part of same transaction. The Will was incidental to the Trust and any claim of its validity was barred.
- MHL 81.29 bars guardianship court from voiding a will; but that decision can indirectly occur with facts as they existed in this case.

18

MATTER OF PROSPECT PARK UNION ASSOC. V. DEJESUS, 2018 NY SLIP OP 09016 FHA AND GUARDIANSHIP

- Landlord/tenant case (Bronx): GAL stipulated to have apartment cleaned by certain date as alternative to eviction of tenants in HUD section 8 housing. Tenant failed to comply with multiple stipulations. APS got involved and temporary guardian was appointed for both tenants and cured the problem.
- Motion to vacate the eviction was denied because cure was not timed and Appellate Term First Department affirmed.
- Appellate Division modified the decision saying that the landlord must make reasonable accommodations under the Fair Housing Act for mentally disabled people and that the case should be remanded to decide whether the existence of a guardianship is sufficient for tenant to fulfill lease obligations and avoid eviction.
- Appointment of Article 81 guardian sufficiently establishes that these tenants are "handicapped" within the meaning of the FHA.

19

MATTER OF TIMPANO (MCGURK), 2018 NY SLIP OP 28298 COMPETING NH AND DSS JUDGMENTS

- NH obtained judgment over NH resident while living but did not yet begin collection on judgment before resident died. County was appointed Administrator of the estate and filed accounting and proposed to pay balance of estate to DSS (amount in estate was less than both NH and DSS's, separately).
- The Court held that the judgment that the NH had was not secured by real property and the NH had not already begun perfecting the lien against the decedent and the lien was not secured. The Court distinguished this case from a case where a DSS was not able to cut in front of NH, but in that case the NH had perfected the judgment by filing a lien against *real property*. The case at hand did not involve real property; thus, the judgment was not perfected and DSS was still a preferred creditor for balance of estate.
- If NH filed a UCC-1, may have led to different result as judgment would have been secured.

20

MATTER OF BREIER V. NY DSS, 2019 NY SLIP OP 00433 SECOND DEPARTMENT (SUFFOLK) NH ACTS PRECLUDE APPEAL OF DENIAL

- Decedent's attorney-in-fact authorized Medicaid coordinator at NH to represent decedent during Medicaid eligibility process. Medicaid coordinator applied for benefits and was denied by County DSS due to failure to submit proper documentation. Coordinator reapplied and denied again. Then coordinator requested a fair hearing but was denied because the request had not been made in a timely manner.
- Petitioner argued that SOL on deadline to apply for fair hearing should have been tolled because the attorney-in-fact was not noticed. Court denied and said that the coordinator was the proper person to notice as they were authorized and recognized representative.

21

MATTER OF SHAMBO 2019 NY SLIP OP 01280 (FEBRUARY 2019): ADMINISTRATOR SURCHARGED

- Third Department upheld surcharge against unfit Administrator
- Court held that Admin. failed to act diligently and prudently in the management of the estate's sole asset, which she could have sold at a reasonable price within a reasonable amount of time
- Medicaid was respondent in this case seeking to be paid their claim against estate for care provided to decedent

22

MATTER OF ALEXANDER B.P., 2018 NY SLIP OP 07644 SECOND DEPARTMENT (NASSAU)

- Where Court found that a guardianship was not brought in bad faith by nursing home, it was an improvident exercise of discretion for the Court to require petitioner to pay the fee of the court appointed guardian.

23

MATTER OR R.T. : JOINT ACCOUNTS BETWEEN SPOUSES; GUARDIANSHIP

- Broome County, May 15, 2019
- Spouse of IP cannot spend income being paid to a joint account in a manner inconsistent with prior spending pattern unless she has 1) the consent of the other joint holder spouse, and 2) doing so is a breach of her duty to conserve such marital funds once the other spouse/joint holder suffers diminished capacity.
- All expenditures made by the well spouse from the joint account that were not consistent with prior spending patterns were recovered by the children of the incapacitated spouse as they were spent on items that only benefitted the well spouse and her own family.

24

MATTER OF A.B.D. : DD PERSON CAN PAY INCOME TO AN ABLE ACCOUNT

- Nassau County Surrogate Court June 13, 2019. 2019 N.Y. Misc. LEXIS 3237
- Guardians for DD Person (who is on SSI and Medicaid) applied to have income from internship paid to an ABLE account
- Because this account will not affect SSI or Medicaid if account is not more than $100,000 and the maximum annual contribution is not exceeded, the transfer to the ABLE account was allowed by the Court

25

BEDNAREK V. INGERSOLL, 2019 NY SLIP OP 50142(U): PARTIES SUBJECT TO GUARDIANSHIP

- Chemung County, February 4, 2019
- Ms. I. was a person entitled to notice under an Article 81 proceeding under MHL 81.07
- Ms. I appeared at the initial hearing, pro se
- Attorney for Ms. I then appeared by filing a notice of appearance and participated on behalf of Ms. I in the guardianship
- Ms. I nor her counsel ever petitioned or cross petitioned in the matter
- Because of her appearance and participation in the hearing, she is a person subject to the jurisdiction of the court and the court had the power to order relief against her related to the guardianship

26

FAIR HEARING 7923571Y: PROMISSORY NOTE UPHELD DESPITE NONCOMPLIANT PAYMENTS

- Genesee County 4/29/19
- Promissory Note that was otherwise DRA compliant
- DSS argued that Note was a countable resource because some of the payments were not made exactly as the Note has set forth
- Intent of the parties to the loan and circumstances surrounding the loan were considered more important than strict adherence
- DSS's claim that Promissory Note was a sham was rejected

27

FH # 7393751Z: MLTC DECISION TO DENY 24 HOUR LIVE IN REVERSED

- NYC 5/23/19
- Increase in service sought and denied
- But MLTC's own UAS put the plan on notice of Appellant's "Mayer III" status
- GIS 97 MA 033 applies and this should require 24 hour care in the absence of formal or informal supports
- The UAS also showed a change in circumstances from a current stroke
- FH successful and 24 hour live in care required
-

28

SECURE ACT

U.S. HOUSE VERSION

THE SETTING EVERY COMMUNITY UP FOR RETIREMENT ENHANCEMENT ACT OF 2019 (THE SECURE ACT)

TITLE I: Expanding and Preserving Retirement Savings

Section 101. Expand Retirement Savings by Increasing the Auto Enrollment Safe Harbor Cap

The legislation increases the cap from 10 to 15 percent of employee pay that required automatic escalation of employee deferrals go no higher than under an automatic enrollment safe harbor plan.

Section 102. Simplification of Safe Harbor 401(k) Rules

The legislation changes the nonelective contribution 401(k) safe harbor to provide greater flexibility, improve employee protection and facilitate plan adoption. The legislation eliminates the safe harbor notice requirement, but maintains the requirement to allow employees to make or change an election at least once per year. The bill also permits amendments to nonelective status at any time before the 30th day before the close of the plan year. Amendments after that time would be allowed if the amendment provides (1) a nonelective contribution of at least four percent of compensation (rather than at least three percent) for all eligible employees for that plan year, and (2) the plan is amended no later than the last day for distributing excess contributions for the plan year, that is, by the close of following plan year.

Sec. 103. Increase Credit Limitation for Small Employer Pension Plan Start-Up Costs

Increasing the credit for plan start-up costs will make it more affordable for small businesses to set up retirement plans. The legislation increases the credit by changing the calculation of the flat dollar amount limit on the credit to the greater of (1) $500 or (2) the lesser of (a) $250 multiplied by the number of nonhighly compensated employees of the eligible employer who are eligible to participate in the plan or (b) $5,000. The credit applies for up to three years.

Section 104. Small Employer Automatic Enrollment Credit

Automatic enrollment is shown to increase employee participation and higher retirement savings. The legislation creates a new tax credit of up to $500 per year to employers to defray startup costs for new section 401(k) plans and SIMPLE IRA plans that include automatic enrollment. The credit is in addition to the plan start-up credit allowed under present law and would be available for three years. The credit would also be available to employers that convert an existing plan to an automatic enrollment design.

Section 105. Treat Certain Taxable Non-Tuition Fellowship and Stipend Payments as Compensation for IRA Purposes

Stipends and non-tuition fellowship payments received by graduate and postdoctoral students are not treated as compensation and cannot be used as the basis for IRA contributions. The legislation removes this obstacle to retirement savings by taking such amounts that are includible in income into account for IRA contribution purposes. The change will enable these students to begin saving for retirement and accumulate tax-favored retirement savings.

Section 106. Repeal of Maximum Age for Traditional IRA Contributions

The legislation repeals the prohibition on contributions to a traditional IRA by an individual who has attained age 70½. As Americans live longer, an increasing number continue employment beyond traditional retirement age.

Section 107. Qualified Employer Plans Prohibited from Making Loans through Credit Cards and Other Similar Arrangements

The legislation prohibits the distribution of plan loans through credit cards or similar arrangements. The change will ensure that plan loans are not used for routine or small purchases, thereby preserving retirement savings.

Section 108. Portability of Lifetime Income Options

The legislation permits qualified defined contribution plans, section 403(b) plans, or governmental section 457(b) plans to make a direct trustee-to-trustee transfer to another employer-sponsored retirement plan or IRA of lifetime income investments or distributions of a lifetime income investment in the form of a qualified plan distribution annuity, if a lifetime income investment is no longer authorized to be held as an investment option under the plan. The change will permit participants to preserve their lifetime income investments and avoid surrender charges and fees.

Section 109. Treatment of Custodial Accounts on Termination of Section 403(b) Plans

Under the provision, not later than six months after the date of enactment, Treasury will issue guidance under which if an employer terminates a 403(b) custodial account, the distribution needed to effectuate the plan termination may be the distribution of an individual custodial account in kind to a participant or beneficiary. The individual custodial account will be maintained on a tax-deferred basis as a 403(b) custodial account until paid out, subject to the 403(b) rules in effect at the time that the individual custodial account is distributed. The Treasury guidance shall be retroactively effective for taxable years beginning after December 31, 2008.

Section 110. Clarification of Retirement Income Account Rules Relating to Church-Controlled Organizations

The legislation clarifies individuals that may be covered by plans maintained by church controlled organizations. Covered individuals include duly ordained, commissioned, or licensed ministers, regardless of the source of compensation; employees of a tax-exempt organization, controlled by or associated with a church or a convention or association of churches; and certain employees after

separation from service with a church, a convention or association of churches, or an organization described above.

Section 111. Allowing Long-term Part-time Workers to Participate in 401(k) Plans

Under current law, employers generally may exclude part-time employees (employees who work less than 1,000 hours per year) when providing a defined contribution plan to their employees. As women are more likely than men to work part-time, these rules can be quite harmful for women in preparing for retirement. Except in the case of collectively bargained plans, the bill will require employers maintaining a 401(k) plan to have a dual eligibility requirement under which an employee must complete either a one year of service requirement (with the 1,000-hour rule) or three consecutive years of service where the employee completes at least 500 hours of service. In the case of employees who are eligible solely by reason of the latter new rule, the employer may elect to exclude such employees from testing under the nondiscrimination and coverage rules, and from the application of the top-heavy rules.

Section 112. Penalty-free Withdrawals from Retirement Plans for Individuals in Case of Birth or Adoption

The legislation provides for penalty-free withdrawals from retirement plans for any "qualified birth or adoption distributions."

Section 113. Increase in Age for Required Beginning Date for Mandatory Distributions

Under current law, participants are generally required to begin taking distributions from their retirement plan at age 70 ½. The policy behind this rule is to ensure that individuals spend their retirement savings during their lifetime and not use their retirement plans for estate planning purposes to transfer wealth to beneficiaries. However, the age 70 ½ was first applied in the retirement plan context in the early 1960s and has never been adjusted to take into account increases in life expectancy. The bill increases the required minimum distribution age from 70 ½ to 72.

Section 114. Community Newspapers Pension Funding Relief

Community newspapers are generally family-owned, non-publicly traded, independent newspapers. This provision provides pension funding relief for community newspaper plan sponsors by increasing the interest rate to calculate those funding obligations to 8%. Additionally, this bill provides for a longer amortization period of 30 years from 7 years. These two changes would reduce the annual amount struggling community newspaper employers would be required to contribute to their pension plan.

Section 115. Treating Excluded Difficulty of Care Payments as Compensation for Determining Retirement Contribution Limitations

Many home healthcare workers do not have a taxable income because their only compensation comes from "difficulty of care" payments exempt from taxation under Code section 131. Because such workers do not have taxable income, they cannot save for retirement in a defined contribution plan or IRA. This provision would allow home healthcare workers to contribute to a plan or IRA by amending Code sections 415(c) and 408(o) to provide that tax exempt difficulty of care payments are treated as compensation for purposes of calculating the contribution limits to defined contribution plans and IRAs.

TITLE II: Administrative Improvements

Section 201. Plans Adopted by Filing Due Date for Year May Be Treated as in Effect as of Close of Year

The legislation permits businesses to treat qualified retirement plans adopted before the due date (including extensions) of the tax return for the taxable year to treat the plan as having been adopted as of the last day of the taxable year. The additional time to establish a plan provides flexibility for employers that are considering adopting a plan and the opportunity for employees to receive contributions for that earlier year and begin to accumulate retirement savings.

Section 202. Combined Annual Reports for Group of Plan

The legislation directs the IRS and DOL to effectuate the filing of a consolidated Form 5500 for similar plans. Plans eligible for consolidated filing must be defined contribution plans, with the same trustee, the same named fiduciary (or named fiduciaries) under ERISA, and the same administrator, using the same plan year, and providing the same investments or investment options to participants and beneficiaries. The change will reduce aggregate administrative costs, making it easier for small employers to sponsor a retirement plan and thus improving retirement savings.

Section 203. Disclosure Regarding Lifetime Income

The legislation requires benefit statements provided to defined contribution plan participants to include a lifetime income disclosure at least once during any 12-month period. The disclosure would illustrate the monthly payments the participant would receive if the total account balance were used to provide lifetime income streams, including a qualified joint and survivor annuity for the participant and the participant's surviving spouse and a single life annuity. The Secretary of Labor is directed to develop a model disclosure. Disclosure in terms of monthly payments will provide useful information to plan participants in correlating the funds in their defined contribution plan to lifetime income. Plan fiduciaries, plan sponsors, or other persons will have no liability under ERISA solely by reason of the provision of lifetime income stream equivalents that are derived in accordance with the assumptions and guidance under the provision and that include the explanations contained in the model disclosure.

Section 204. Fiduciary Safe Harbor for Selection of Lifetime Income Provider

The legislation provides certainty for plan sponsors in the selection of lifetime income providers, a fiduciary act under ERISA. Under the bill, fiduciaries are afforded an optional safe harbor to satisfy the prudence requirement with respect to the selection of insurers for a guaranteed retirement income contract and are protected from liability for any losses that may result to the participant or beneficiary due to an insurer's inability in the future to satisfy its financial obligations under the terms of the contract. Removing ambiguity about the applicable fiduciary standard eliminates a roadblock to offering lifetime income benefit options under a defined contribution plan.

Section 205. Modification of Nondiscrimination Rules to Protect Older, Longer Service Participation

The legislation modifies the nondiscrimination rules with respect to closed plans to permit existing participants to continue to accrue benefits. The modification will protect the benefits for older, longer-service employees as they near retirement.

TITLE III: Other Benefits

Section 301. Benefits for Volunteer Firefighters and Emergency Medical Responders

The legislation reinstates for one year the exclusions for qualified State or local tax benefits and qualified reimbursement payments provided to members of qualified volunteer emergency response organizations and increases the exclusion for qualified reimbursement payments to $50 for each month during which a volunteer performs services.

Section 302. Expansion of Section 529 Plans

The legislation expands 529 education savings accounts to cover costs associated with registered apprenticeships; homeschooling; up to $10,000 of qualified student loan repayments (including those for siblings); and private elementary, secondary, or religious schools.

TITLE IV: Revenue Provisions

Section 401. Modifications to Required Minimum Distribution Rules

The legislation modifies the required minimum distribution rules with respect to defined contribution plan and IRA balances upon the death of the account owner. Under the legislation, distributions to individuals other than the surviving spouse of the employee (or IRA owner), disabled or chronically ill individuals, individuals who are not more than 10 years younger than the employee (or IRA owner), or child of the employee (or IRA owner) who has not reached the age of majority are generally required to be distributed by the end of the tenth calendar year following the year of the employee or IRA owner's death.

Section 402. Increase in Penalty for Failure to File

The legislation increases the failure to file penalty to the lesser of $400 or 100 percent of the amount of the tax due. Increasing the penalties will encourage the filing of timely and accurate returns which, in turn, will improve overall tax administration.

Section 403. Increased Penalties for Failure to File Retirement Plan Returns

The legislation modifies the failure to file penalties for retirement plan returns. The Form 5500 penalty would be modified to $105 per day, not to exceed $50,000. Failure to file a registration statement would incur a penalty of $2 per participant per day, not to exceed $10,000. Failure to file a required notification of change would result in a penalty of $2 per day, not to exceed $5,000 for any failure. Failure to provide a required withholding notice results in a penalty of $100 for each failure, not to exceed $50,000 for all failures during any calendar year. Increasing the penalties will encourage the filing of timely and accurate information returns and statements and the provision of required notices, which, in turn, will improve overall tax administration.

Section 404. Increase Information Sharing to Administer Excise Taxes

The legislation allows the IRS to share returns and return information with the U.S. Customs and Border Protection for purposes of administering and collecting the heavy vehicle use tax.

ANDRYEYEVA HOME CARE HOURS

Copy Citation
Court of Appeals of New York
March 26, 2019, Decided
No. 11, No. 12
Reporter
2019 N.Y. LEXIS 617 * | 2019 NY Slip Op 02258 | 2019 WL 1333030

Lilya Andryeyeva, & c., et al., Respondents, v New York Health Care, Inc., d/b/a New York Home Attendant Agency, et al., Appellants.Adriana Moreno, & c., et al., Respondents, v Future Care Health Services, Inc., et al., Appellants.

Disposition:
For Case No. 11: Order reversed, with costs, matter remitted to Supreme Court, Kings County, for further proceedings in accordance with the opinion herein and certified question answered in the negative. For Case No. 12: Order, insofar as appealed from, reversed, with costs, matter remitted to the Appellate Division, Second Department, for further proceedings in accordance with the opinion herein and certified question answered in the negative.

Core Terms

sleep, wage order, aides, employees, minimum wage, home health care, meal, deference, labor law, breaks, plaintiffs', requirements, residential, regulation, patients, compensable, shifts, class certification, opinion letter, promulgated, interpreting, Occupations, Industries, on call, rule rule rule, uninterrupted, irrational, assigned, services, hours worked

Case Summary

Overview
ISSUE: [1]-The common issue presented in these joint appeals was whether, pursuant to the New York State Department of Labor's (DOL) Miscellaneous Industries and Occupations Minimum Wage Order (Wage Order), an employer must pay its home health care aide employees for each hour of a 24-hour shift; [2]-DOL has interpreted its Wage Order to require payment for at least 13 hours of a 24-hour shift if the employee is allowed a sleep break of at least 8 hours--and actually receives five hours of uninterrupted sleep--and three hours of meal break time. DOL's interpretation of its Wage Order did not conflict with the promulgated language, nor had DOL adopted an irrational or unreasonable construction, and so the Appellate Division erred in rejecting that interpretation.

Outcome
The court reversed the Appellate Division orders and remitted for consideration of alternative grounds for class certification for alleged violations of New York's Labor Law, inclusive of defendants' alleged systematic denial of wages earned and due, unaddressed by the courts below because of their erroneous rejection of DOL's interpretation.

LexisNexis® Headnotes

Administrative Law > Judicial Review > Standards of Review > Rule Interpretation
HN1 Rule Interpretation
The court's review of the New York State Department of Labor's interpretation of its Miscellaneous Industries and Occupations Minimum Wage Order is quite circumscribed. As a general rule, courts must defer to an administrative agency's rational interpretation of its own regulations in its area of expertise. Thus, an agency's construction of its regulations, if not irrational or unreasonable, should be upheld. However, courts are not required to embrace a regulatory construction that conflicts with the plain meaning of the promulgated language. Judicial deference to an agency's interpretation of its rules and regulations is warranted because, having authored the promulgated text and exercised its legislatively delegated authority in interpreting it, the agency is best positioned to accurately describe the intent and construction of its chosen language. More like this Headnote
Shepardize - Narrow by this Headnote (0)

Administrative Law > Judicial Review > Standards of Review > Rule Interpretation
HN2 Rule Interpretation
When an agency adopts a construction which is then followed for "a long period of time," such interpretation is entitled to great weight and may not be ignored. Further, when set forth in official statements, an agency's consistent interpretation reflects an enduring body of informed administrative analysis and provides a reviewing court with the agency's interpretive position, as well as a measure of the enduring quality of the administrative judgment. Indeed, the court has previously given weight to the New York State Department of Labor's (DOL's) opinion letters when deciding whether to defer both to DOL's interpretation of its own regulations as well as the Labor Law. More like this Headnote
Shepardize - Narrow by this Headnote (0)

Administrative Law > Judicial Review > Standards of Review > Rule Interpretation
HN3 Rule Interpretation
Judicial deference to an agency's interpretation of its own regulations is a basic tenet of administrative law. More like this Headnote
Shepardize - Narrow by this Headnote (0)

Administrative Law > Judicial Review > Standards of Review > Deference to Agency Statutory Interpretation
Administrative Law > Judicial Review > Standards of Review > Rule Interpretation
HN4 Deference to Agency Statutory Interpretation
An agency's interpretation is entitled to no deference where the question is one of pure legal interpretation of statutory terms. That rule does not apply to an agency's interpretation of its own

regulations. The court must defer to an administrative agency's rational interpretation of its own regulations. More like this Headnote
Shepardize - Narrow by this Headnote (0)

Business & Corporate Compliance > ... > Wage & Hour Laws > Labor & Employment Law > Wage & Hour Laws
HN5 Wage & Hour Laws
The New York State Department of Labor's (DOL) Miscellaneous Industries and Occupations Minimum Wage Order does not define what it means for an employee to be "required to be available for work at a place prescribed by the employer" (refer to 12 NYCRR 142-2.1(b)). The New York State Department of Labor (DOL) has interpreted the phrase as applied to employees assigned to 24-hour shifts, (including home health care aides), to exclude up to 11 hours for sleep and meal breaks from compensable hours, based on DOL's understanding that these are regularly scheduled substantial periods of assignment-free personal time. Upon the court's review of the Wage Order and DOL's policy statements, the court concludes that DOL's interpretation is not inconsistent with the plain language as promulgated, nor is it an irrational or unreasonable construction of the Wage Order as applied to 24-hour shift workers. More like this Headnote
Shepardize - Narrow by this Headnote (0)

Business & Corporate Compliance > ... > Wage & Hour Laws > Labor & Employment Law > Wage & Hour Laws
HN6 Wage & Hour Laws
The plain text of the New York State Department of Labor's (DOL) Miscellaneous Industries and Occupations Minimum Wage Order requires that an employee be paid the minimum wage for the time when they are "required to be available for work at a place prescribed by the employer" (12 NYCRR 142-2.1(b)). That language requires both presence and an availability during a time scheduled for actual work. More like this Headnote
Shepardize - Narrow by this Headnote (0)

Governments > Legislation > Interpretation
HN7 Interpretation
Two fundamental rules of statutory construction that apply with equal force in the administrative regulatory text are: words must be "harmonized" and read together to avoid surplusage. More like this Headnote
Shepardize - Narrow by this Headnote (0)

Governments > Legislation > Interpretation
HN8 Interpretation
All parts of a statute must be harmonized with each other as well as with the general intent of the whole statute, and effect and meaning must, if possible, be given to the entire statute and every part and word thereof. Meaning must be given to every part and word. More like this Headnote
Shepardize - Narrow by this Headnote (0)

Administrative Law > Judicial Review > Standards of Review > Rule Interpretation
HN9 Rule Interpretation
That an agency's interpretation might not be the most natural reading of the regulation, or that the regulation could be interpreted in another way, does not make the interpretation irrational. More like this Headnote

Shepardize - Narrow by this Headnote (0)

Civil Procedure > Special Proceedings > Class Actions > Certification of Classes
HN10 Certification of Classes
New York's statutory class certification provisions are to be liberally construed. More like this Headnote
Shepardize - Narrow by this Headnote (0)

Civil Procedure > Special Proceedings > Class Actions > Certification of Classes
HN11 Certification of Classes
Claims of uniform systemwide violations are particularly appropriate for class certification. More like this Headnote
Shepardize - Narrow by this Headnote (0)

Civil Procedure > ... > Class Actions > Prerequisites for Class Action > Commonality
HN12 Commonality
The fact that damages may vary by class member does not per se foreclose class certification. As the court has explained, the legislature enacted CPLR 901(a) with a specific allowance for class actions in cases where damages differed among the plaintiffs, stating the amount of damages suffered by each class member typically varies from individual to individual, but that fact will not prevent the suit from going forward as a class action if the important legal or factual issues involving liability are common to the class. A difference in damage awards is an insufficient basis to deny certification as a matter of law where the class may rely on representative evidence of the class-wide violations. More like this Headnote
Shepardize - Narrow by this Headnote (0)

Counsel: [*1] Sari E. Kolatch, for appellants (Case No. 11).

Jason J. Rozger, for respondents (Case No. 11).

Home Care Association of New York State, Inc. et al.; Consumer Directed Personal Assistance Association of New York State, Inc.; Home Care Association of America et al.; Greater New York Hospital Association, et al.; Sanford Heisler Sharp, LLP; Community Development Project, et al.; New York State Association of Health Care Providers, Inc.; New York State Department of Labor; National Center for Law and Economic Justice, amici curiae (Case No. 11).

Aaron C. Schlesinger, for appellants (Case No. 12:).

Michael J. D. Sweeney, for respondents (Case No. 12:).

Sanford Heisler Sharp, LLP; Greater New York Hospital Association, et al.; Community Development Project, et al.; New York State Department of Labor, amici curiae (Case No. 12:).

Judges: Opinion by Judge Rivera. Chief Judge DiFiore and Judges Stein, Wilson and Feinman concur. Judge Garcia dissents and votes to affirm in an opinion in which Judge Fahey concurs.

Opinion by: RIVERA

Opinion

RIVERA, J.

The common issue presented in these joint appeals is whether, pursuant to the New York State Department of Labor's (DOL) Miscellaneous Industries and Occupations Minimum Wage Order [*2] (Wage Order), an employer must pay its home health care aide employees for each hour of a 24-hour shift. DOL has interpreted its Wage Order to require payment for at least 13 hours of a 24-hour shift if the employee is allowed a sleep break of at least 8 hours-and actually receives five hours of uninterrupted sleep-and three hours of meal break time. DOL's interpretation of its Wage Order does not conflict with the promulgated language, nor has DOL adopted an irrational or unreasonable construction, and so the Appellate Division erred in rejecting that interpretation. Therefore, we reverse the Appellate Division orders and remit for consideration of alternative grounds for class certification for alleged violations of New York's Labor Law, inclusive of defendants' alleged systematic denial of wages earned and due, unaddressed by the courts below because of their erroneous rejection of DOL's interpretation.

I.

Statutory and regulatory background

New York's Labor Law requires that all employees be paid a minimum wage for each hour worked (Labor Law § 652). The Legislature passed the Minimum Wage Act (the "Act") in 1937 to ensure that workers "receive wages sufficient to provide adequate maintenance and [*3] to protect their health" (L 1937, ch 276, § 551). In 1971, the Legislature extended the Act to cover home health care aides living outside the employer's home (L 1971, ch 1165, § 1), and in 1978 again amended the Act to require a minimum wage for "each hour worked" (L 1978, ch 747, § 1).

The Act delegates to the Commissioner of Labor1 the authority to set that minimum wage by issuing "wage orders" (L 1937, ch 276, §§ 555-557), which are promulgated as regulations in accordance with the State Administrative Procedure Act (SAPA) and the dictates of the Labor Law (see Labor Law § 659). The Commissioner has exercised this statutory authority periodically by publishing the minimum wage rate for employment in five industries, subclassified by occupation, employer size, and geographic location (12 NYCRR ch II, subch B, F).

Since 1972, home health care aides have come under DOL's Minimum Wage Order Number 11 for Miscellaneous Industries and Occupations (12 NYCRR part 142), which applies to all non-exempt employees who are not subject to a different wage order (i.e., those not in the hospitality industry, the building services industry, or farm workers) (see 12 NYCRR 142-2.14; DOL, Minimum Wage Order for Miscellaneous Industries and Occupations at 1 [effective [*4] Dec. 31, 2016] ["This Part shall apply to all employees, as such term is defined in this Part, except: (a) employees who are covered by minimum wage standards in any other minimum wage order promulgated by the commissioner; and (b) employees of a nonprofitmaking institution which has elected to be exempt from coverage under a minimum wage order, pursuant to subdivision 3 of section 652 of the Minimum Wage Act"]).

The Wage Order states, in relevant part:

"The minimum wage shall be paid for the time an employee is permitted to work, or is required to be available for work at a place prescribed by the employer, and shall include time spent in traveling to the extent that such traveling is part of the duties of the employee. However, a residential employee-one who lives on the premises of the employer-shall not be deemed to be permitted to work or required to be available for work:

(1) during [the employee's] normal sleeping hours solely because [the employee] is required to be on call during such hours; or

(2) at any other time when [the employee] is free to leave the place of employment" (12 NYCRR 142-2.1 [b]).

In March 2010, DOL issued an opinion letter, responding to questions about the application of the Wage Order [*5] to home health care aides, including the calculation of hours worked when assigned to a patient's home, referred to as a "live-in employee." The letter distinguishes between employees who are "on call"-meaning employees who are considered to be working during all hours they are required to remain in a particular work area, including when they are waiting to perform their services-and employees who are "subject to call" such that they are able to leave the work area between assignments and are paid only for work performed.

The letter further acknowledges that a "residential employee," defined in the Wage Order as a person who lives on the premises of the employer, is deemed not to be working during normal sleeping hours solely because they are "on call," or when free to leave the place of employment. The letter goes on to explain that DOL treats all "live-in" employees the same when determining the number of hours worked, regardless of whether they are residential employees. Specifically, the letter states that

"it is the opinion and policy of this Department that live-in employees must be paid not less than for thirteen hours per twenty-four hour period provided that they are afforded [*6] at least eight hours for sleep and actually receive five hours of uninterrupted sleep, and that they are afforded three hours for meals. If an aide does not receive five hours of uninterrupted sleep, the eight-hour sleep period exclusion is not applicable and the employee must be paid for all eight hours. Similarly, if the aide is not actually afforded three work-free hours for meals, the three-hour meal period exclusion is not applicable" (Opinion Letter from Maria L. Colavito, Counsel, DOL, Mar. 11, 2010).

The letter explains that home health care aides assigned to a 24-hour shift at a patient's home are live-in, nonresidential employees, who must be paid for at least 13 hours of work. Under DOL's interpretation of the Wage Order, the remaining 11 hours of the shift are not included in the calculation of compensable hours because this time is allocated for eight hours of sleep and three hours of meal time for the employee. If the home health care aide does not receive a minimum of five hours uninterrupted sleep and work-free meal breaks, the employer must pay for every hour of a 24-hour shift-meaning the employer cannot exclude 11 hours from the compensable hours total-because when [*7] the aide is not provided with actual and substantial duty-free periods for personal use, the employer rather than the employee benefits from the time and the employer must pay for profiting off the employee's labor.

The March 2010 opinion letter, issued prior to the filing of plaintiffs' underlying actions and specifically addressed to the status of home health care aides, is only a recent articulation in a long line of official statements by DOL explaining its general policy towards compensable work for 24-hour shift employees. For decades, DOL has consistently interpreted the Wage Order as applied across occupations to account for substantial periods of employee inactivity during a 24-hour shift when an employee is able to utilize the time for personal matters. As far back as 1969, DOL determined that, in the case of employees "required to be on duty for a 24 hour period," it would consider "up to 8 hours of sleeping time . . . as not being hours worked" within the meaning of the Wage Order, if certain conditions were met (DOL, Mem from George Ostrow to Daniel A. Daly [Oct. 27, 1969]). The exclusion would only apply if there was "express or implied agreement" to exclude time for sleep, [*8] the employer provided "adequate sleeping facilities for an uninterrupted night's sleep," the employee actually received five hours of sleep, and interruptions to perform duties were considered work time (id.).

In 1998, the Commissioner expressly addressed home health care aides, in response to a letter from an employee of a home health care provider and explained that, for "live-in" home health care aides, including those working an on-site 24-hour shift:

"it is the policy of the [DOL] that such persons must be paid for no less than 13 hours of each 24-hour day they are required to remain on call' in the home of the person receiving their

services-provided that they are afforded eight hours for sleep and actually receive five hours of uninterrupted sleep and that they are afforded three hours for meals. If a live-in' home health aide does not receive five hours of uninterrupted sleep the eight hour sleep period exclusion is not applicable, and the home health aide must be paid for all eight hours in question. Similarly, if a live-in' home health aide is not actually afforded three work-free hours for meals, the three-hour meal period exclusion is not applicable" (DOL, Letter from James [*9] J. McGowan [Oct. 27, 1998]).

This interpretation of the Wage Order is similar to the federal government's guidance on the minimum compensable hours for 24-hour shift employees under the Fair Labor and Standards Act (FLSA). According to the United States Department of Labor, when an employee is "required to be on call for 24 hours a day," but has "a normal night's sleep" and "ample time in which to eat . . . meals," it may be "justif[ied to conclude] that the employee is not working at all times during which [the employee] is subject to call in the event of an emergency" (U.S. Dept. of Labor, Interpretative Bulletin No. 13: Hours Worked - Determination of Hours for Which Employees are Entitled to Compensation Under the Fair Labor Standards Act of 1938 [July 1939] at 4). Under current federal regulations, an employer may exclude up to eight hours of sleep time from compensable time for employees who work 24-hour shifts, assuming certain conditions are satisfied (29 CFR 785.22).

II.

Plaintiffs' putative classes based on defendants' alleged New York Labor Law violations

In both appeals, plaintiffs seek certification of a class of home health care aides for alleged violations of the Labor Law based on their [*10] respective employer's failure to pay putative class members a required minimum wage for each hour of a 24-hour shift. Plaintiffs care for some of the most vulnerable members of our society, doing work essential to the survival of their patients. Plaintiffs allege that they are part of a workforce that is predominantly composed of women and recent immigrants, and one that they claim is easily exploited and vulnerable to various forms of wage abuse. Plaintiffs and amici paint a picture of a growing home health care industry where employers reap huge profits from both private and taxpayer funds, while refusing to pay the minimum wage for each hour worked to those who do challenging labor, at all hours of the day and night, often four or five times a week.

Defendants are private home health care companies and their owners who employ plaintiffs and other home health care aides to serve elderly and infirm patients for up to 24 hours at a time. Throughout these litigations, defendants maintained that the applicable law and DOL regulations do not mandate that they pay the equivalent of minimum wage for each hour of a 24-hour shift, relying on DOL's interpretation of its Wage Order.

Andryeyeva [*11] v New York Health Care, Inc.

Plaintiffs Lilya Andryeyeva and Marina Ordus are former employees of New York Home Attendant Agency, an entity formed by defendant New York Health Care (NYHC), a New York State Department of Health licensed home health care agency. They commenced an action individually and sought class certification on behalf of all other home health aides who were employed by NYHC and worked 24-hour shifts. NYHC provides home care services to elderly and disabled individuals in New York City and Nassau County pursuant to contracts with various managed care companies and local health departments. Defendants' home care aides assist patients with a range of tasks, including cooking, feeding, bathing, housework, using the restroom, and changing diapers.

NYHC regularly assigns home care aides to work 24-hour "sleep-in" shifts. During such shifts, a home care aide is required to be present in the patient's home for a full 24-hour period. Plaintiffs allege that defendants violated the Labor Law by failing to pay the required minimum wage, overtime, and "spread of hours" premiums2 to home aides who worked 24-hour shifts. Plaintiffs allege they routinely did not receive five hours [*12] of uninterrupted sleep because their patients required assistance multiple times each night. Plaintiffs also allege that they were never allowed to take meal breaks; indeed, NYHC's orientation manual states expressly: "Patients are never to be left alone!" According to Andryeyeva, the patient for whom she cared most frequently suffered from dementia, "never" slept through the night, and "usually got up two or three times each night to use the bathroom," requiring assistance each time. Plaintiffs further allege they were never told that they should receive five hours of uninterrupted sleep during 24-hour shifts and that defendants failed to record when (or even whether) plaintiffs took sleep and meal breaks. Defendants maintain that home health care aides in their employ are "expected" to receive an eight-hour sleep break and three hours of meal breaks per 24-hour shift.

In support of their motion for class certification, plaintiffs argued that they met each of the statutory requirements of CPLR 901, namely, numerosity, predominance, typicality, adequacy of representation, and superiority. Plaintiffs argued that the proposed class includes 1,063 employees who suffered the same core injury, i.e., [*13] defendants' alleged failure to pay lawful wages for each hour worked during 24-hour shifts. Plaintiffs further asserted that they would fairly and adequately represent the class because they had actively participated in the litigation and selected qualified class counsel, and that class treatment was superior to other methods of adjudication because a single judicial adjudication would be more efficient than numerous individual determinations. Plaintiffs argued that they satisfied the requirements of CPLR 902-the interest of class members in controlling the litigation, the inefficiency of individual actions, the extent of prior litigation in the controversy, the desirability of concentrating the litigation in the forum, and any difficulties that may arise in the management of the class action-for many of the same reasons.

In opposition, defendants asserted that they were not required to pay the minimum wage to home care aides for each hour of a 24-hour shift because the aides were "live-in employees," and under DOL's March 2010 opinion letter, they could be paid less than the minimum wage for up to eight hours of sleep time and three hours of meal time. Therefore, defendants argued, each worker's [*14] claim required an individual examination of the facts and circumstances of their respective employment, rendering the claims unsuitable for class certification.

Unpersuaded, Supreme Court refused to adopt DOL's interpretation and granted plaintiffs' motion to certify a class of home attendants who worked 24-hour shifts during a defined period. The Appellate Division affirmed, concluding that "DOL's interpretation is neither rational nor reasonable, because it conflicts with the plain language of the Wage Order" (Andryeyeva v New York Health Care, Inc., 153 AD3d 1216, 1218, 61 N.Y.S.3d 280 [2d Dept 2017]). The court reasoned that, because plaintiffs were required to be present at the patient's home and to perform services as needed if called upon, they were "available for work," regardless of whether they were afforded sleep and meal breaks. In reaching this conclusion, the court held that the phrase "available for work" includes nighttime hours when the employee was "not called upon to perform services" (id. at 1219). The court relied on the First Department's decision in Tokhtaman v Human Care, LLC (149 AD3d 476, 52 N.Y.S.3d 89 [1st Dept 2017]), in which that court similarly rejected DOL's interpretation of the Wage Order as in conflict with its plain meaning. The Second Department further concluded that plaintiffs adequately established the requirements of [*15] CPLR 901 and that none of the CPLR 902 factors warranted a denial of the certification motion. The Appellate Division granted defendants' motion for leave to appeal pursuant to CPLR 5602 (a).

Moreno v Future Care Health Servs., Inc.

Plaintiffs Adriana Moreno and Leonidas Peguero-Tineo are home health care aides employed by defendants Future Care Health Services, Inc. and Americare Certified Special Services, Inc. As in Andryeyeva, plaintiffs allege that defendants underpaid their employees by failing to pay the minimum wage for each hour of their assigned 24-hour shifts, not paying overtime, and failing to pay "spread of hours" premiums. The Moreno plaintiffs further allege that defendants failed to pay employees adequate wages to attend mandatory "in service" training sessions, reimburse employees for supplies or uniform cleaning, and maintain adequate employment records as required by Labor Law § 195 and 12 NYCRR 142-2.

Plaintiffs moved to certify "a class of current and former home health care workers employed by Defendants." Plaintiffs argued that they satisfied the requirements under CPLR 901 because the proposed class included at least 40 members and presented several common questions, including whether defendants "engaged in a pattern [*16] or practice of not paying all wages due for work performed and overtime" and "whether Defendants have kept true and accurate time records for all hours worked by Plaintiffs and the Class." They further argued that plaintiffs were adequate class representatives and had selected qualified counsel to prosecute the class wage claims. Finally, plaintiffs argued that class treatment was superior to other means of resolving their claims because requiring hundreds of class members to file separate actions alleging the same misconduct against the same defendants was inefficient and would waste judicial resources. Plaintiffs also argued that the requirements of CPLR 902 were satisfied.

Like the Andryeyeva defendants, the Moreno defendants responded in opposition that plaintiffs failed to establish grounds for certification because resolving plaintiffs' claims would require "individualized investigation, proof and determination." Defendants relied, in large part, on the fact that under DOL's interpretation of the Wage Order, plaintiffs' sleep and meal time was non-compensable and defendants were not obligated to pay the minimum wage for this time so long as plaintiffs received at least five hours of uninterrupted [*17] sleep and three hours for meals. With respect to plaintiffs' other claims, defendants asserted that there was no evidence to support plaintiffs' allegations. Defendants further argued that plaintiffs failed to satisfy CPLR 902, in part because the individualized issues presented by the litigation were not appropriate for resolution in a class action. Supreme Court agreed with defendants that certification was unwarranted and denied plaintiffs' motion.

The Appellate Division reversed in an opinion decided the same day as Andryeyeva. The court concluded that the DOL opinion letter "conflicts with the plain meaning of" the Wage Order, and that home health care aides were entitled to be paid the minimum wage for every hour of a 24-hour shift even if they were afforded sleep and meal time because they are not "residential employees" within the meaning of the Wage Order (Moreno v Future Care Health Servs., Inc., 153 AD3d 1254, 1255-1256, 61 N.Y.S.3d 589 [2d Dept 2017]), citing Andryeyeva, 153 AD3d at 1219). The court further concluded that plaintiffs had established the prerequisites for class treatment and certified the proposed class. As in Andryeyeva, the Appellate Division granted defendants' motion for leave to appeal to this Court.

DOL's Emergency Regulation

In direct response to these decisions and the holding in [*18] Tokhtaman, DOL issued an emergency regulation which added the following language to the Wage Order:

"Notwithstanding the above, this subdivision shall not be construed to require that the minimum wage be paid for meal periods and sleep times that are excluded from hours worked under the Fair Labor Standards Act of 1938, as amended, in accordance with sections 785.19 and 785.22 of 29 C.F.R. for a home care aide who works a shift of 24 hours or more" (NY Reg, Oct. 25, 2017 at 6).

In DOL's Notice of Emergency Rulemaking, it announced that the emergency regulation was "needed to preserve the status quo, prevent the collapse of the home care industry, and avoid

institutionalizing patients who could be cared for at home, in the face of recent decisions by the State Appellate Divisions that treat meal periods and sleep time by home care aides who work shifts of 24 hours or more as hours worked for purposes of state (but not federal) minimum wage" (id. at 5). In the accompanying Regulatory Impact Statement (RIS),3 DOL explained that its interpretation had been long-standing, and evolved as legislative expansions covered workers in the home. DOL explained that by the 1970s, the Commissioner interpreted the minimum wage requirement [*19] to exclude sleep and meal periods for these groups of workers, and included this interpretation in formal guidelines, legal opinions, investigators' manuals and the Commissioner's determinations. The RIS further stated that the Commissioner amended the Wage Order in 1986 to provide for overtime calculation in accordance with federal methodology and "grew increasingly to look to, and rely upon federal FLSA regulations interpreting" federal law regarding work hours, meal and sleep periods, "so that hours worked were calculated consistently at the state and federal level for overtime (and other) purposes" (id. at 6).

The emergency regulation expired approximately two months later, on January 2, 2018. To avoid any lapse in coverage, DOL promulgated a series of substantially identical emergency regulations between January and September 2018, as well as a proposed final rule on April 5, 2018 (NY Reg., Apr. 25, 2018 at 43-45). Then, in a separate action by different plaintiffs, Supreme Court invalidated the emergency regulation in September 2018, holding DOL failed to justify an emergency in accordance with the SAPA (see Matter of Chinese Staff and Workers Association v Reardon, 2018 NY Slip Op 32391[U], at *8 [Sup Ct, NY County 2018]).

III.

As defendants' respective challenges to the Appellate Division's approval [*20] of class certification in Andryeyeva and Moreno are analytically indistinguishable, we address these matters jointly. Defendants argue the Appellate Division should have deferred to DOL's rational and reasonable interpretation of the Wage Order, which requires individualized assessment of plaintiffs' minimum wage claims, thus precluding certification of a class. Plaintiffs in both appeals submit the same response namely, that the plain language of the Wage Order requires defendants to pay them minimum wage for every hour of their 24-hour shifts and issues common to their respective classes are defendants' alleged failure to comply with the Wage Order and with regulatory recording keeping requirements.4 Given the decisions below and the arguments as narrowed by defendants, the only issues before us are whether the Appellate Division erroneously disregarded DOL's interpretation of its Wage Order and, if so, whether application of the DOL's interpretation necessarily forecloses class certification. As we discuss, because of the posture of these appeals, we remit so that the courts below may consider unaddressed grounds for class certification.

Standard of Judicial Review

HN1 Our review of DOL's [*21] interpretation of its Wage Order is quite circumscribed. As a general rule, "courts must defer to an administrative agency's rational interpretation of its own regulations in its area of expertise" (Matter of Peckham v Calogero, 12 NY3d 424, 431, 911 N.E.2d 813, 883 N.Y.S.2d 751 [2009]). Thus, an agency's construction of its regulations " if not irrational or unreasonable,' should be upheld" (Samiento v World Yacht Inc., 10 NY3d 70, 79, 883 N.E.2d 990, 854 N.Y.S.2d 83 [2008], quoting Matter of Chesterfield Assoc. v New York State Dept. of Labor, 4 NY3d 597, 604, 830 N.E.2d 287, 797 N.Y.S.2d 389 [2005]). However, "courts are not required to embrace a regulatory construction that conflicts with the plain meaning of the promulgated language" (Visiting Nurse Serv. of New York Home Care v New York State Dept. of Health, 5 NY3d 499, 506, 840 N.E.2d 577, 806 N.Y.S.2d 465 [2005], citing

Matter of 427 W. 51st St. Owners Corp. v. Division of Hous. & Community Renewal, 3 NY3d 337, 342, 819 N.E.2d 1032, 786 N.Y.S.2d 416 [2004]). Judicial deference to an agency's interpretation of its rules and regulations is warranted because, having authored the promulgated text and exercised its legislatively delegated authority in interpreting it, the agency is best positioned to accurately describe the intent and construction of its chosen language (see Peckham, 12 NY3d at 431).

HN2 When an agency adopts a construction which is then followed for "a long period of time," such interpretation "is entitled to great weight and may not be ignored" (Ferraiolo v O'Dwyer, 302 NY 371, 376, 98 N.E.2d 563 [1951]). Further, when set forth in official statements, an agency's consistent interpretation reflects an enduring body of informed administrative analysis (see Samiento, 10 NY3d at 79), and provides a reviewing court with the agency's interpretive position, as well [*22] as a measure of the enduring quality of the administrative judgment. Indeed, we have previously given weight to DOL's opinion letters when deciding whether to defer both to DOL's interpretation of its own regulations as well as the Labor Law (see e.g. Samiento, 10 NY3d at 79-80 [relying on DOL's opinion letters to support upholding DOL's interpretation of Labor Law § 196-d]).

We have no occasion to deviate from our well-settled law in the appeals before us. Thus, if DOL's interpretation of the Wage Order meets our deferential standard, we may not reject it. In making our determination, we must give our foremost consideration to DOL's opinion letters and prior statements because they represent a long-standing articulation of its interpretation of the Wage Order, as applied to nonresidential 24-hour shift employees, including home health care aides. We are also mindful that DOL's fair and studied consideration is grounded in its specialized knowledge and experience of both round-the-clock work assignments and the home health care industry.

There is nothing "novel" (dissenting op at 11) about the standard of review we reiterate today. As revealed by the case law cited above, HN3 judicial deference to an agency's interpretation of its [*23] own regulations is a basic tenet of administrative law. The dissent appears to confuse our discussion of the well-established justifications for deference (e.g., administrative expertise and the fact that an agency is best positioned to explain what it meant by the words it chose) for the standard itself. Further, the dissent relies on case law addressing agency interpretation of statutory-not regulatory-text to bootstrap an inapposite rule and observes that HN4 an agency's interpretation is entitled to no deference "where the question is one of pure legal interpretation of statutory terms'" (dissenting op at 10 [quoting Matter of Toys "R" Us v Silva, 89 N.Y.2d 411, 419, 676 N.E.2d 862, 654 N.Y.S.2d 100 [1996] [concluding that a municipal zoning board's determination revoking a building permit was not inconsistent with local zoning code]). That rule does not apply to an agency's interpretation of its own regulations. As noted above, the Court "must defer to an administrative agency's rational interpretation of its own regulations" (Peckham, 12 NY3d at 431 [emphasis added]; see also Visiting Nurse Serv., 5 NY3d at 506).

DOL's interpretation of the Wage Order

HN5 The Wage Order does not define what it means for an employee to be "required to be available for work at a place prescribed by the employer" (see 12 NYCRR 142-2.1 [b]). DOL has interpreted [*24] the phrase as applied to employees assigned to 24-hour shifts, (including home health care aides), to exclude up to 11 hours for sleep and meal breaks from compensable hours, based on DOL's understanding that these are regularly scheduled substantial periods of assignment-free personal time. DOL, appearing as amicus curiae, argues that we should defer to its construction because it is consistent with the plain text of the Wage Order, and reflects DOL's well-founded concern for the wellbeing of workers on round-the-clock assignment, informed judgment grounded in its specialized knowledge of the home health care industry, and the Commissioner's election to align the state's requirements with the federal

approach. Upon our review of the Wage Order and DOL's policy statements, we conclude that DOL's interpretation is not inconsistent with the plain language as promulgated, nor is it an irrational or unreasonable construction of the Wage Order as applied to 24-hour shift workers. DOL's interpretation is not inconsistent with HN6 the plain text of the Wage Order, which requires that an employee be paid the minimum wage for the time when they are "required to be available for work at a place prescribed [*25] by the employer" (12 NYCRR 142-2.1 [b]). That language requires both presence and an availability during a time scheduled for actual work. Plaintiffs mistakenly argue, and the Appellate Division erroneously concluded, that once a worker is physically present at the designated work site, they are thus able to work if called upon and so are "available for work." That interpretation ignores the entirety of the phrase and renders superfluous the regulation's separate requirement that the employee be both "available for work" and be so available "at a place prescribed by the employer," in violation of HN7 two fundamental rules of statutory construction that apply with equal force in the administrative regulatory text: words must be "harmonize[d]" and read together to avoid surplusage (Matter of Tall Trees Const. Corp. v Zoning Bd. of Appeals of Town of Huntington, 97 N.Y.2d 86, 91, 761 N.E.2d 565, 735 N.Y.S.2d 873 [2001]; Matter of Kamhi v Planning Bd. of Town of Yorktown, 59 NY2d 385, 391, 452 N.E.2d 1193, 465 N.Y.S.2d 865 [1983]; see also FDA v Brown & Williamson Tobacco Corp., 529 U.S. 120, 132-133, 120 S. Ct. 1291, 146 L. Ed. 2d 121 [2000]); cf. McKinney's Cons. Statutes § 98 HN8 ["All parts of a statute must be harmonized with each other as well as with the general intent of the whole statute, and effect and meaning must, if possible, be given to the entire statute and every part and word thereof"]). Put another way, if plaintiffs are correct that the only meaning that may be ascribed to this language is physical presence in the patient's home, then the Wage [*26] Order is internally redundant as it already conveys that with the words "or required to be at a place prescribed by the employer." By contrast, DOL has given meaning to the complete phrase by interpreting "available for work," in the context of a 24-hour shift to exclude the hours when the employee is not working because the employee is on a scheduled sleep and meal break (see Roberts v Tishman Speyer Properties, L.P., 13 NY3d 270, 289, 918 N.E.2d 900, 890 N.Y.S.2d 388 [2009] [meaning must be given to "every part and word"]). Moreover, plaintiff's alternative reading of the Wage Order is beside the point. HN9 "That [DOL's] interpretation might not be the most natural reading of the regulation, or that the regulation could be interpreted in another way, does not make the interpretation irrational" (Elcor Health Servs., Inc. v. Novello, 100 NY2d 273, 280, 794 N.E.2d 14, 763 N.Y.S.2d 232 [2003]).5

When it first adopted the Wage Order in 1960, DOL recognized the difficulty of defining hours worked for employees who are on call around the clock and the hardship imposed at setting a work day at 24 hours (DOL, Report of the Industrial Commissioner Upon the Promulgation of Minimum Wage Order No. 11 for Miscellaneous Industries and Occupations [Sept. 29, 1960] at 6). Nevertheless, the realities of the workplace are such that there are many industries and occupations where employees are assigned to 24-hour shifts. This is not a case where [*27] DOL has vacillated in its position, rendering its interpretation capricious or unmoored from the realities of workplace life. DOL's interpretation of the Wage Order language has been consistent for nearly five decades, during eight gubernatorial administrations and the tenure of 13 Commissioners of Labor, representing the same fair and studied judgment of officials throughout that time. DOL's position has been set forth and explained in its Investigator's Manual, DOL memoranda, and opinion letters, up to its recent March 2010 correspondence. As intended, this articulated position has informed and guided the industries that rely on 24-hour shift workers, including home health care services employers. This consistent interpretation is further support for this Court's deference to the DOL's reading of its own Wage Order (see Barenboim v Starbucks Corp., 21 NY3d 460, 471, 995 N.E.2d 153, 972 N.Y.S.2d 191 [2013]).6

Here, DOL explains that its interpretation is an attempt to apply the Wage Order's requirement that workers be paid for the time that they are "required to be available for work at a place prescribed by the employer" (12 NYCRR 142-2.1 [b]) with the realities of in-home health aides who work 24-hour shifts. According to its brief in this Court, DOL has "concluded that an employee who [*28] enjoys genuine sleep and meal breaks consistent with the strict requirements of DOL's policy-i.e., regularly scheduled, substantially uninterrupted, work-free times to eat and sleep-is not meaningfully available for work' during those breaks, precisely because DOL's criteria are intended to identify breaks that are predictably and largely free from work interruptions." This echoes the position it took in its 2010 opinion letter, where DOL distinguished between employees who are "on call" and "considered to be working during all the hours that they are confined to the workplace including those hours in which they do not actually perform their duties" and those who are "subject to call," which includes "that time in which employees are permitted to leave the work room or workplace between work assignments to engage in personal pursuits and activities" (2010 Opinion Letter at 3). DOL has concluded that "[i]n some cases, employees who are subject to call' may be restricted to a specified area, to be reachable by telephone or otherwise, to report to the work assignments within 15 to 30 minutes, etc. In cases in which an employee is subject to call,' working time starts when they are actually [*29] ordered to a specific assignment or at the time in which they perform work for the employer" (id.). In adopting its interpretation, DOL "sought to protect . . . employees' ability to engage in a significant degree of personal activity during their breaks by imposing strict rules that employers must comply with if they wish to exclude such breaks from compensable time." Moreover, DOL's interpretation of the Wage Order reflects its specialized knowledge of labor law's evolving application to domestic workers and the home health care industry (see International Union of Painters, 32 NY3d at 208-209; Matter of KSLM-Columbus Apts., Inc v New York State Div of Hous. & Community Renewal, 5 NY3d 303, 312, 835 N.E.2d 643, 801 N.Y.S.2d 783 [2005]). It further reflects DOL's expertise in handling labor law violations and its historical efforts to ensure that its policies reflect the realities of the diverse industries and occupations over which it has administrative oversight. With respect to home health care aides, this interpretation of the Wage Order is supported by DOL's experience with the particularities of this occupation, where the needs of some patients allow for regularly scheduled work-free uninterrupted periods to sleep and eat. In other words, DOL has determined that a patient may need an aide on site around-the-clock without requiring adult care services for all 24 hours [*30] of the day. Indeed, defendants maintain that when a patient requires full-time attention and care, two home health care aides are, or ought to be, assigned to separate twelve-hour shifts. DOL's interpretation based on this industry reality is neither irrational nor unreasonable.

DOL's interpretation also reflects the Commissioner's interest in conforming state and federal guidance on the proper calculation of compensable hours. Interpreting the Wage Order to exclude sleep and eating breaks in a 24-hour shift, on the presumption that the employer will in fact structure the work assignment to provide such time for a home health care aide, harmonizes with the federal approach. It is neither unreasonable nor irrational for DOL to interpret its Wage Order in a manner that reduces administrative burdens, such as dual-sovereign reporting and wage payment requirements, and also has the added benefit of avoiding intergovernmental conflict.7

Plaintiffs unpersuasively argue that DOL's interpretation is a misapplication of the residential exception set forth in the Wage Order. Contrary to plaintiffs' suggestion, the Wage Order's treatment of residential employees is not an exception or a particularized [*31] carve-out (which creates nothing more than a general exception) (see e.g. Mullen v. Zoebe, Inc., 86 NY2d 135, 142, 654 N.E.2d 90, 630 N.Y.S.2d 269 [1995]). The Wage Order does not exclude residential employees from coverage, but rather, subjects these workers to a particular interpretation of compensable hours, grounded in DOL's knowledge and experience with this type of work. Nor

do plaintiffs argue that a home health aide working a 24-hour shift who does not live in the employer's residence is a residential employee for purposes of the Wage Order (Matter of Settlement Home Care, Inc. v Industrial Bd. of Appeals of Dept. of Labor, 151 A.D.2d 580, 581, 542 N.Y.S.2d 346 [2d Dept 1989]). Instead, such an employee is covered under the remaining language of the Wage Order, language which DOL applies to an employee assigned to a 24-hour shift. Nothing in the Wage Order language precludes DOL from interpreting the remainder of the provision and, specifically, the "available for work" language, as implementing a similar approach to compensable hours for non-residential home health care employees working 24-hour shifts. Moreover, there is nothing unreasonable or irrational about recognizing the similarities and dissimilarities between residential and nonresidential employees to reach the conclusion that a home health care aide assigned to a 24-hour shift should have significant amounts of regularly scheduled [*32] work-free periods.8

Plaintiffs' argument is essentially a claim that DOL must issue a separate wage order for home health care aides. Although courts must ensure that administrative entities comply with their statutory, regulatory, and SAPA requirements in exercising their legislatively delegated powers, DOL's highly fact-specific, industry-specific interpretation of its own Wage Order is a far cry from the "fixed, general principle to be applied by an administrative agency without regard to other facts and circumstances relevant to the regulatory scheme of the statute it administers" that requires a separate rulemaking under SAPA (Roman Catholic Diocese of Albany v New York State Dept. of Health, 66 N.Y.2d 948, 951, 489 N.E.2d 749, 498 N.Y.S.2d 780 [1985]). Apart from the fact that DOL complied with procedural requirements when it promulgated the Wage Order, and plaintiffs do not argue to the contrary, plaintiffs' interpretation devolves to a requirement that DOL issue individualized wage orders for each of the numerous occupations across a variety of industries for which it has administrative responsibility. Plaintiffs' approach is in contravention of the Act's requirement of periodic publication of Wage Orders, is unworkable in practice and ignores DOL's administrative knowledge of how [*33] best to address the common concerns that arise for 24-hour shift workers.9

Significantly, DOL's interpretation is congruent with the enforcement provisions of the Labor Law, which authorize private and regulatory enforcement actions for wage theft and other minimum wage law violations as a means to hold an employer accountable for abuse and exploitation of its workers (Labor Law § 663 [1]-[2]). DOL has determined that it can avoid exploitation of these employees by interpreting its Wage order to mandate a substantive period for sleep and meals to directly benefit the employee. The employer must pay when the employee is interrupted during these breaks for any time worked and must pay for the entire break when the employee does not receive the requisite hours of sleep and meal breaks. In other words, when the employee is able to take the prescribed eight hours of sleep and three hours of meal breaks, the home health care aide is paid for working the remaining time of the 24-hour shift-13 hours. If, in fact, the aide does not receive the minimum break time because the patient needs assistance, the aide is paid for 24 hours of work time. As DOL confirms, failure to provide a home health care aide with the minimum [*34] sleep and meal times required under DOL's interpretation of the Wage Order is a "hair trigger" that immediately makes the employer liable for paying every hour of the 24-hour shift, not just the actual hours worked. Thus, even if a home health care aide sleeps without interruption for four hours and 59 minutes, but is not able to obtain five full hours of sleep, DOL mandates the employer pay for the entire eight hours allotted for sleep. This is not inconsistent with interpreting the Wage Order's mandate as requiring an employee be paid for when they are intended to be available for work, and there is nothing unreasonable or irrational about interpreting "available for work" in this way. Indeed, under DOL's interpretation of the Wage Order, a home health aide is paid for every hour during which patient care is actually provided.

While we ultimately conclude that the Appellate Division failed to afford adequate deference to DOL's interpretation of the Wage Order, we do not ignore plaintiffs' and amici's claims that a

vulnerable population of workers is being mistreated. Plaintiffs' allegations are disturbing and paint a picture of rampant and unchecked years-long exploitation. Plaintiffs [*35] allege, among other things, that they rarely received required sleep and meal time during 24-hour shifts, were expected and required to attend to patients numerous times each night, and that defendants failed to track actual hours worked or make a serious effort to ensure adequate sleep and meal times, as required by law. In concluding that DOL's interpretation of the Wage Order is rational, we express no opinion on the ultimate merits of plaintiffs' claims. Moreover, to the extent plaintiffs' allegations suggest current enforcement priorities and methods are inadequate, it is for DOL and the Legislature, not this Court, to consider whether the sleep and meal time exemption is a viable methodology to ensure employer compliance with the law and proper wage payment in the case of home health care aides.

IV.

Class Certification

Defendants in both appeals argue that, assuming we defer to DOL's interpretation of the Wage Order, individual issues preclude class certification.10 According to defendants, because each putative class member's claim is fact-specific and turns on whether the health care aide received the requisite number of uninterrupted sleep and meal hours, plaintiffs may not offer [*36] generalized proof on a class-wide basis. While we do not pass on the ultimate merits of plaintiffs' class certification motions, we observe that HN10 New York's statutory class certification provisions are to be liberally construed (City of New York v Maul, 14 NY3d 499, 509, 929 N.E.2d 366, 903 N.Y.S.2d 304 [2010]; Sponsor's Mem at 1, Bill Jacket, L 1975, ch 207 [Article 9 was intended to replace New York's prior "restrictive" class action rules which "fail(ed) to accommodate pressing needs for an effective, flexible and balanced group remedy"]. CPLR article 9 recognizes that certain claims are unlikely to be litigated because the costs of individual cases outweigh the possible damages, thus making those cases unattractive to the private bar and resource-strapped government and nonprofit entities (see Sperry v Crompton Corp., 8 NY3d 204, 213, 863 N.E.2d 1012, 831 N.Y.S.2d 760 [2007] ["class actions are designed in large part to incentivize plaintiffs to sue when the economic benefit would otherwise be too small, particularly when taking into account the court costs and attorneys' fees typically incurred"]; Sponsor's Mem at 1, Bill Jacket, L 1975, ch 207 ["(Article 9) will enable persons similarly aggrieved to enforce existing substantive rights, which presently go without redress solely because of the financial impracticability of financing individual suits"]; 82 NY Jur 2d § 254 ["The statutory criteria [*37] governing the permissibility of class actions should be liberally construed so as to allow for the adjudication of claims that would not be economically litigable except by means of a class action"]).

Plaintiffs allege, and claim there is evidence of, defendants' systemic violations of the Wage Order and Labor Law, such as defendants' failure to adequately compensate home health care aides when they did not receive the minimum time for sleep and meal breaks during their 24-hour shifts, maintain adequate records of, or compensate for, the hours actually worked, and provide appropriate sleep facilities. HN11 Claims of uniform systemwide violations are particularly appropriate for class certification (see e.g. Maul, 14 NY3d at 513-514). Indeed, plaintiffs' allegations suggest a policy or practice of unlawful action of the type our courts have previously found ripe for class treatment (see id. at 513 [affirming certification of a class challenging "a de facto policy followed by (a city agency) of delaying the receipt of services as a result of its practices"]; Labor Law § 661; 12 NYCRR 142-2.6 [a] [4] [requiring employers to maintain records of "the number of hours worked daily and weekly]). DOL maintains that if plaintiffs establish prima facie that [*38] defendants failed to comply with Labor Law and regulatory record keeping requirements that the burden would shift to defendants to establish

they maintained the required work records, serving as another basis for class certification. We do not reach the underlying legal question raised by DOL's argument, but note only that assertion of these types of common questions may be considered by the courts in determining whether class certification is appropriate.

Conversely, HN12 the fact that damages may vary by class member does not per se foreclose class certification. As we have explained, "the legislature enacted CPLR 901 (a) with a specific allowance for class actions in cases where damages differed among the plaintiffs, stating the amount of damages suffered by each class member typically varies from individual to individual, but that fact will not prevent the suit from going forward as a class action if the important legal or factual issues involving liability are common to the class'" (Borden v 400 E. 55th St. Assocs., L.P., 24 N.Y.3d 382, 399, 998 N.Y.S.2d 729, 23 N.E.3d 997 [2014], quoting Mem of State Consumer Protection Bd at 3, Bill Jacket, L 1975, ch 207). A difference in damage awards is an insufficient basis to deny certification as a matter of law where the class may rely on representative evidence of the class-wide violations [*39] (see id.).11

Given the posture of these appeals-where the Appellate Division determined that class certification was appropriate under its erroneous interpretation of the Wage Order-we may not consider unaddressed or alternative grounds proffered for class certification. The courts below are charged with that task in the first instance and therefore we remit for that determination.

V.

For the reasons discussed, the Appellate Division orders should be reversed and the matters remitted to permit the courts below to evaluate the issues in accordance with DOL's interpretation of the Wage Order and to consider alternative bases for class certification. In Andryeyeva, because Supreme Court certified the class upon finding that DOL's interpretation did not apply to plaintiffs, and the Appellate Division affirmed, neither court reached the issue of whether class certification is otherwise warranted. Accordingly, in Andryeyeva, the Appellate Division order should be reversed, with costs, the matter remitted to Supreme Court for further proceedings in accordance with this decision, and the certified question answered in the negative. In Moreno, Supreme Court considered all of plaintiffs' [*40] alternative bases for class certification under DOL's interpretation of the Wage Order and the Appellate Division reversed based on that court's rejection of DOL's interpretation of the Wage Order. Accordingly, in Moreno, the Appellate Division order, insofar as appealed from, should be reversed, with costs, the matter remitted to the Appellate Division for further proceedings in accordance with this decision, and the certified question answered in the negative.

Lilya Andryeyeva v New York Health Care, Inc.
Adriana Moreno v Future Health Servs., Inc.
Nos. 11 & 12

Dissent by: GARCIA

Dissent

GARCIA, J. (dissenting):

Workers are entitled to a minimum wage for each hour worked (Labor Law § 652 [1]). Today, the majority defers to a New York State Department of Labor (DOL) interpretation of a wage order, allowing home health care aides to be paid an hourly rate less than minimum wage. That result is not only unfair, it is completely at odds with the plain text of the wage order. Accordingly, I dissent.

I.
The Minimum Wage Act, first enacted in 1937, was designed to address the financial hardship faced by those receiving "wages insufficient to provide adequate maintenance for themselves and their families" (Labor Law § 650). Payment of insufficient [*41] wages, the legislature noted, "threatens the health and well-being" of our State's workers (id.). In enacting the Minimum Wage Act, the legislature sought to provide relief "as rapidly as practicable without substantially curtailing opportunities for employment or earning power" (id.). Minimum wage standards are vital to accomplishing that goal (id.; see West Coast Hotel Co. v Parrish, 300 U.S. 379, 398-399, 57 S. Ct. 578, 81 L. Ed. 703 [1937] ["minimum wage requirements" prevent "the exploiting of workers at wages so low as to be insufficient to meet the bare cost of living"]). Given these important policy objectives, and the careful balancing critical to setting a minimum wage, the Minimum Wage Act sets forth a detailed procedure for issuing wage orders-one that mandates transparency and the inclusion of various affected stakeholders (see Labor Law §§ 655-659).
As a first step, the Commissioner must convene and appoint a "wage board . . . composed of not more than three representatives of employers, an equal number of representatives of employees, and an equal number of persons selected from the general public" (Labor Law § 655 [1]). The wage board has extensive authority. It has the power to "conduct public hearings," "consult with employers and employees," issue subpoenas for "testimony . . . and books, records, [*42] and other evidence," and "cause depositions" (Labor Law § 655 [3]). The wage board's end goal is, with the approval of a "majority of its members," to "submit to the [C]ommissioner a report, including its recommendations as to minimum wages" in certain occupations (Labor Law § 655 [4]).
The wage board's submission of a report is followed by continued dialogue and consultation. The Commissioner is statutorily obligated to "publish a notice" of the report and to receive "objections to the report and recommendations" (Labor Law § 656). The Commissioner may then "accept . . . the board's report and recommendations"-potentially with modifications-or "reject" them (Labor Law § 657). If the board's report and recommendations are accepted, "[t]he Commissioner . . . thereafter issues a wage order setting a minimum wage in a specific occupation" (National Rest Ass'n v Comm'r of Labor, 141 AD3d 185, 192, 34 N.Y.S.3d 232 [3d Dept 2016]). The statute also contemplates further amendments; after the wage order "has been in effect for six months or more," the same wage board may be "reconvene[d]" by the Commissioner or on a "petition of fifty or more residents . . . in or affected by" the covered occupations (Labor Law § 659 [1]). "[A]ny minimum wage order . . . issued by the [C]ommissioner . . . shall, unless appealed from . . . be final" (Labor Law § 657 [1]).
This exhaustive process complies, [*43] as it must, with the strictures of the State Administrative Procedures Act (SAPA) (see majority op at 3). SAPA was formulated "[a]fter years of study . . . to guarantee that the actions of administrative agencies conform to uniform, sound and equitable standards" (Cortlandt Nursing Home v Axelrod, 66 NY2d 169, 177, 486 N.E.2d 785, 495 N.Y.S.2d 927 [1985]). Among other things, SAPA "outlines uniform administrative procedures that State agencies must follow in their rule making, adjudicatory and licensing processes" (Industrial Liaison Comm of Niagara Falls Area Chamber of Commerce v Williams, 72 NY2d 137, 144, 527 N.E.2d 274, 531 N.Y.S.2d 791 [1988]).
DOL's Minimum Wage Order Number 11 for Miscellaneous Industries and Occupations (the Wage Order) was passed in 1960 in accordance with the procedures required by SAPA and the Minimum Wage Act (see 12 NYCRR 142-2.14; see also Report of the Industrial Commissioner Upon the Promulgation of Minimum Wage Order No. 11 for Miscellaneous Industries and Occupations 1 [Sept 29, 1960]). In relevant part, the Wage Order provides:
"The minimum wage shall be paid for the time an employee is permitted to work, or is required to be available for work at a place prescribed by the employer, and shall include time spent in

traveling to the extent that such traveling is part of the duties of the employee. However, a residential employee-one who lives on the premises of the employer-shall not be deemed [*44] to be permitted to work or required to be available for work:
during [the employee's] normal sleeping hours solely because [they are] required to be on call during such hours; or
at any other time when [the employee] is free to leave the place of employment" (12 NYCRR 142-2.1 [b]).
As relevant here, the Wage Order mandates minimum wage compensation whenever an employee is "available for work at a place prescribed by the employer" (12 NYCRR 142-2.1 [b]). The Wage Order contains only one exception-applicable only to residential employees-permitting employers to deduct certain hours' of pay that would otherwise be compensable.

II.
Plaintiffs are non-residential home health care aides who work 24-hour shifts. During each shift, home health care aides are required to be present in the patient's home for the full 24-hour period (majority op at 9). They assist with a variety of tasks integral to a patient's daily functioning: "cooking, feeding, bathing, housework, using the restroom, and changing diapers" (majority op at 8). According to plaintiffs' allegations, home health care aides routinely do not receive meal breaks or adequate time for uninterrupted sleep, as their patients require assistance throughout the shift. As one employer's [*45] orientation manual states: "Patients are never to be left alone!" Plaintiffs further allege that defendants failed to record when (or even whether) plaintiffs took sleep and meal breaks, making it impossible to reconstruct their actual hours of work.
All agree that the Wage Order applies to plaintiffs in this case, and that plaintiffs do not fall within the Wage Order's "residential employee" exception (see majority op at 24-25). Though home health care aides are nowhere excepted from minimum wage requirements, DOL nonetheless contends that the Wage Order should be interpreted to exclude eleven hours of each plaintiff's work day: eight hours for "sleep time" and three hours for "meal time." Specifically, DOL argues that the phrase "available for work at a place prescribed by the employer" imposes two distinct requirements-"available for work" and "at a place prescribed by the employer"-such that physical presence on the premises is, by itself, inadequate for an employee to be deemed "available for work" (majority op at 19-20). In other words, DOL contends that, for non-residential employees like plaintiffs, the Wage Order should be interpreted to require both "presence and an availability [*46] during a time scheduled for actual work" (majority op at 19). Applying that interpretation, DOL asserts that home health care aides are not technically "available for work" during "sleep time" and "meal time," and therefore they need not be paid for those periods.
DOL (and the majority) may be correct that the Wage Order's "available for work" requirement entails more than physical presence at a place prescribed by the employer (majority op at 19). Unlike mere presence, the notion of availability implies that an employee is "ready, willing, and able to" take on work (Black's Law Dictionary, Available for Work [10th ed 2014]). Thus, an employee might not be "available for work" at a time when, for instance, the employee cannot be reached, or is otherwise guaranteed to remain undisturbed. Plaintiffs, then, must be both present and "available for work"-not merely present-to be entitled to minimum wage compensation.
But DOL (and the majority) cannot be correct that plaintiffs' sleep time may be excluded from their wages. Under the Wage Order's single exception-not applicable to plaintiffs-residential employees' "sleeping hours" are expressly excluded from the time they are considered "available [*47] for work," thereby allowing employers to deduct those hours' of pay. By providing that, for residential employees, sleep hours do not constitute time the employee is

"available for work," the exception signifies that, for all other employees, sleep hours do constitute time they are "available for work"-and, accordingly, must be paid (Walker v Town of Hempstead, 84 NY2d 360, 366-67, 643 N.E.2d 77, 618 N.Y.S.2d 758 [1994] [noting that it is "not . . . necessary" to provide exceptions to a general term if they "fall within the preceding general proscription"]; McKinney's Cons. Law of NY, Book 1, Statutes § 213 [noting that an exception encapsulates items that would "otherwise would fall within (the) scope" of a term]; CJS Statutes § 505 [noting that an exception operates to "remov(e) something . . . which would otherwise be within" the clause to which it applies]). Put differently, because residential employees' sleep hours are specifically excluded from compensable time, it must follow that sleep hours would otherwise constitute time for which the employee must be compensated; if sleep time did not fall within "available for work" time, there would be no need to expressly exclude it. Accordingly, while the "available for work" requirement might demand more than physical presence-for instance, [*48] prompt readiness or accessibility-it cannot exclude "sleeping hours" for non-residential employees.

The majority asserts that the "residential employee" exception does not "exclude" sleeping hours from compensable time, but rather serves only to "clarif[y] that sleeping hours shall not be deemed work hours solely because the employee is required to be on call during such hours" (majority op at 25 n 8 [quotation marks, brackets, and citation omitted]). Whether called an "exception" or a "clarification," the provision's import is the same: In specifying that a residential employee's sleeping hours should not be compensated solely because the employee is on call, the provision signifies that-for all other employees-sleeping hours should be compensated solely because they are on call.

By distinguishing residential from non-residential employees in this way, the Wage Order reflects the policies of dignity and fairness advanced by the Minimum Wage Act. Residential employees, by definition, have living quarters on the premises and are provided regular periods of rest. "In the ordinary course of events," a residential employee "has a normal night's sleep, has ample time in which to eat his meals, [*49] and has a certain amount of time for relaxation and entirely private pursuits," and "the employee may be free to come and go during certain periods" (U.S. Dept. of Labor, Interpretative Bulletin No. 13: Hours Worked - Determination of Hours for Which Employees are Entitled to Compensation Under the Fair Labor Standards Act of 1938 [July 1939] at 3). Recognizing this unique arrangement, the Wage Order permits employers to deduct a residential employee's "sleeping hours," as well as time when the employee is "free to leave the place of employment" (12 NYCRR 142-2.1 [b]).

Those presumptions of ample free time and private pursuits do not apply to non-residential home health care aides, who "do challenging labor, at all hours of the day and night" (majority op at 8; DOL Br at 29 ["To be sure, even during their sleep and meal breaks, employees working twenty-four hour shifts are not truly free from their employment - for example, they are generally not free to leave their employers' premises, and are expected to respond if called back to work"]). Unlike residential employees, who reside in their workplace, home health care aides report for a 24-hour shift, often remaining available from beginning to end. Given the nature [*50] of a home health care aide's work-providing 24-hour patient care without meaningful breaks-the Wage Order sensibly excludes them from the "residential employee" exception and its corresponding compensation deductions. In the context of "sleeping hours," the Wage Order recognizes that home health aides remain on call (i.e., "available for work") even during those hours designated for sleep12.

Under the plain terms of the Wage Order, for non-residential employees like plaintiffs-who remain consistently "available for work," even during sleeping hours-sleep time cannot be deducted from their pay. DOL's contrary reading is expressly belied by the text of the regulation, and therefore warrants no deference (see Visiting Nurse Serv. of New York Home Care v. New York State Dep't of Health, 5 NY3d 499, 506, 840 N.E.2d 577, 806 N.Y.S.2d 465 [2005]; Albano v Bd of Trustees of New York City Fire Dep't, 98 NY2d 548, 553, 780 N.E.2d 159, 750 N.Y.S.2d

558 [2002]; Raritan Dev Corp v Silva, 91 NY2d 98, 100, 689 N.E.2d 1373, 667 N.Y.S.2d 327 [1997]).

III.

Casting aside the plain text of the Wage Order, the majority defers to DOL's incompatible reading. Not only does that holding impose a new and problematic standard for agency deference, it enables DOL to circumvent statutory promulgation procedures in favor of an informal and erratic process replete with inconsistency. Worst of all, DOL's interpretation, now adopted by the majority, will have profound and far-reaching ramifications for a vulnerable and often mistreated workforce. [*51]

A.

Under the guise of deference, the majority adopts a construction of the Wage Order that runs contrary to the regulation's text. Deference is unwarranted, however, where an agency's interpretation is "irrational or unreasonable" (Matter of Howard v Wyman, 28 NY2d 434, 438, 271 N.E.2d 528, 322 N.Y.S.2d 683 [1971]) or, in other words, unsupported by the regulation's plain text (Visiting Nurse Serv, 5 NY3d at 506). While we will defer to "a rational interpretation that [is] not inconsistent with the plain language" (James Square Associates LP v Mullen, 21 NY3d 233, 251, 993 N.E.2d 374, 970 N.Y.S.2d 888 [2013]), we have never elevated deference over clear, unambiguous text.

Rather, as we have repeatedly emphasized, plain language must control over an inconsistent agency interpretation (see Raritan Dev Corp, 91 NY2d at 100 [noting our "long-established rule" that we "decline() to enforce" an agency interpretation that is "contrary to the plain meaning" of the relevant "language"]). We have therefore declined to "embrace a regulatory construction that conflicts with the plain meaning of the promulgated language" (Visiting Nurse Serv, 5 NY3d at 506). Indeed, where "the question is one of pure legal interpretation of statutory terms," we have held that "deference to the [agency] is not required" altogether (Matter of Toys "R" Us v Silva, 89 NY2d 411, 419, 676 N.E.2d 862, 654 N.Y.S.2d 100 [1996]). Because pure interpretation is the "function" of the courts, we have reasoned that there is "little basis to rely on any special competence [*52] or expertise of the administrative agency" (Albano v Board of Trustees of New York City Fire Dep't, 98 N.Y.2d 548, 553, 780 N.E.2d 159, 750 N.Y.S.2d 558 [2002]).

According to the majority, however, deference to DOL is warranted because, "having authored the promulgated text and exercised its legislatively delegated authority in interpreting it, the agency is best positioned to accurately describe the intent and construction of its chosen language" (majority op at 16). That is not, and has never been, a basis for deference at the expense of plain text13. The majority's novel standard elevates DOL's construction over the text of the Wage Order, suggesting that deference is warranted simply because DOL itself promulgated the regulation (majority op at 16-17). Of course, every agency interpreting its own regulation will satisfy the majority's negligible standard, even if the agency's construction is irrational or defied by the regulation's plain language. Such a toothless standard-deferring to an agency's construction of a regulation solely because the agency wrote it-not only distorts our principles of deference, it abandons the Court's role as the proper authority on matters of textual construction.

B.

DOL's atextual construction warrants particularly exacting scrutiny in light of the extensive, collaborative [*53] process by which wage orders must be created. The Minimum Wage Act establishes detailed procedures, involving research, consultation, public hearings, notice, and

input from various stakeholders. The transparency and delicate balancing that typify this process assure "fair and studied consideration" (majority op at 17), and ensure that each wage order furthers the critical policy goals underlying the Minimum Wage Act.

Rather than codify rules through the processes required by statute-mandating public notice, hearings, and comments-DOL opts to promulgate revised wage orders "under the guise of interpreting a regulation" (Christensen v Harris Cty, 529 U.S. 576, 588, 120 S. Ct. 1655, 146 L. Ed. 2d 621 [2000]; see also Talk Am, Inc v Michigan Bell Tel Co, 564 U.S. 50, 69, 131 S. Ct. 2254, 180 L. Ed. 2d 96 [2011] [Scalia, J., concurring] [allowing an agency "to do what it pleases" with an existing regulation "frustrates the notice and predictability purposes of rulemaking, and promotes arbitrary government"]; Axelrod, 66 NY2d at 177 [SAPA was designed to "guarantee that the actions of administrative agencies conform to uniform, sound and equitable standards"]). For instance, in support of its most recent interpretation of the Wage Order, DOL relies heavily on a 2010 opinion letter issued in response to the query of an undisclosed recipient. The opinion letter, signed only by an associate [*54] attorney at DOL, inserts a new exception into the Wage Order for "live-in, non-residential employees," permitting employers to compensate them for only 13 hours of each 24-hour shift (majority op at 5-6). Presumably, that opinion letter was never considered by the members of the wage board. It was never reviewed in consultation with affected employers or employees. And it certainly was never the subject of public notice or comment. Yet DOL contends that its opinion letter constitutes an "official statement" embodying the "general policy towards compensable work for 24-hour shift employees" (majority op at 6), irrespective of its consistency with the Wage Order's text. Such informal and unchecked modifications-through opinion letters, agency manuals, and other documents-enable DOL to circumvent statutory safeguards in favor of "interpretations" carrying the force of a duly promulgated regulation. And by issuing interpretations untethered to the Wage Order's text, DOL undermines the collective outcome of a comprehensive, statutorily-mandated process.

The majority predicts "staggering burdens" if DOL were forced to issue a separate regulation (majority op at 26 n 9). But the federal government's [*55] scheme-which the majority seeks to emulate (majority op at 24)-has done just that. In lieu of ever-changing "interpretations," the federal Department of Labor employs detailed, duly promulgated provisions aimed at implementing clear, codified rules (see 20 FR 9963, 9965 [Dec 24, 1955]). For instance, unlike the Wage Order, the relevant federal provisions expressly carve out exceptions for "employee[s] . . . required to be on duty for 24 hours or more" (20 FR at 9965; see also 29 CFR 785.22). For that category of employees, "the employer and employee may agree to exclude bona fide meal periods and a bona fide regularly scheduled sleeping period of not more than 8 hours from hours worked, provided adequate sleeping facilities are furnished" (20 FR at 9965; see also 29 CFR 785.22). And for "[e]mployees residing on employer's premises," any "reasonable agreement of the parties which takes into consideration all of the pertinent facts will be accepted" (20 FR at 9965; see also 29 CFR 785.23).

If DOL prefers an alternative compensation scheme-so as to dock eleven hours of plaintiffs' pay-it should amend the Wage Order in accordance with statutory procedure. While a "separate regulation" is not required "for every circumstance" (majority op at 26 n 8 [emphasis added]), it is required for those instances [*56] involving dramatic pay cuts that are directly precluded by existing regulations. DOL itself apparently recognizes the importance of the promulgation process in adopting exceptions to minimum wage requirements; DOL saw fit to codify the "residential employee" provision before implementing those pay exclusions. Given the devastating impact of DOL's "interpretation"-imposing substantive changes and substantial pay cuts-compliance with formal promulgation procedures is hardly an unreasonable requirement. Any "burdens" that may result (majority op at 26 n 9) are in place by design: the Minimum Wage Act requires a comprehensive and transparent process in order to ensure a balanced and fair result for our State's employees.

As this case bluntly demonstrates, agency regulations carry the force of law; they "frequently play a more direct role than statutes in defining the public's legal rights and obligations" (John F Manning, Constitutional Structure and Judicial Deference to Agency Interpretations of Agency Rules, 96 Colum L Rev 612, 615 [1996]). DOL's "experience with the particularities of this occupation" might well provide a basis for modifying the existing regulatory regime (majority op at 23). It does not, however, [*57] permit DOL to unilaterally impose an entirely new wage order.

C.

Seeing no issue with DOL's evasion, the majority asserts that deference is further warranted because, "for five decades," DOL has not "vacillated in its position" (majority op at 21). Even if a longstanding, uniform construction could supersede plain text, DOL has not exhibited the consistency or clarity that the majority describes. Rather, DOL has been consistent on one and only one position: nonresidential home health care aides may be paid for fewer hours than their shift requires. The interpretations that DOL has adopted to achieve that result have "vacillated" dramatically.

In a 1972 version of DOL's enforcement manual, investigators were told that, to discount a home health care aide's working hours, a "bona fide, regularly scheduled sleeping period'" must be established, and "[t]he employer and the employee [must] agree to exclude" those hours from "working time" (DOL Br at ADD91). The 1972 manual also stated that, in order to exclude an aide's sleeping period, "[a]dequate sleeping facilities" must be "provided" to the employee (id.). That guidance was relatively short-lived. In a 1988 opinion letter issued by the [*58] Supervisor for the Administrative Services Unit, DOL moved to a "rule of thumb" that fixed "13 hours as the normal standard for working time" for home health care aides (DOL Br at ADD134). A bona fide, regularly scheduled sleeping period was no longer required. An agreement between employer and employee was no longer required. And adequate sleeping facilities were no longer required.

DOL shifted yet again in 1995. That year, DOL Counsel's Office issued an opinion letter explicitly distinguishing between "live-in home health aides" and "non-live-in home health aides" (DOL Br at ADD139-140). For "non-live-in home health aides," the opinion letter established that only "time actually afforded for sleeping and eating" may be excluded from pay. The 13-hour "rule of thumb," however, no longer applied. Three years later, in 1998, the Commissioner issued another opinion letter returning to the 1988 rule (DOL Br at ADD148-149). Four years after that, in 2002, DOL Counsel's Office reverted back to the 1972 scheme, requiring an agreed-upon sleeping period and adequate sleeping facilitates (DOL Br at ADD150). Eventually, in opinion letters sent to various recipients in 2009 and 2010, DOL swung [*59] back to its "rule of thumb" (DOL Br at ADD153-160).

Far from "consistently interpret[ing] the Wage Order" (majority op at 6), DOL has adopted varying and even conflicting interpretations of the very same text. These so-called "minor variations" (majority op at 22 n 6) have very real effects on plaintiffs' lives: they make the difference between adequate sleeping facilities (or not), an agreed-upon schedule (or not), and a livable wage (or not). In light of the profound impact on plaintiffs' daily lives, they are certainly entitled to "quibble[]" (majority op at 21 n 6) over these meaningful departures from their governing wage order.

IV.

As the majority notes, home health aides "care for some of the most vulnerable members of our society, doing work essential to the survival of their patients" (majority op at 7). These employees are "predominantly composed of women and recent immigrants" (majority op at 7),

and comprise a workforce that is "easily exploited and vulnerable to various forms of wage abuse" (majority op at 8). Plaintiffs allegations in this case are "disturbing" to say the least, and "paint a picture of rampant and unchecked years-long exploitation" (majority op at 28). DOL's [*60] interpretation of the Wage Order not only enables this mistreatment of home health care aides, it directly affects their livelihood: with eleven hours of pay deducted from their earnings, home health care aides are paid an hourly rate less than the statewide minimum wage. Rather than hold DOL accountable, the majority defers.

In lieu of relief, the majority instructs plaintiffs to go back and seek class certification-which may ultimately be denied-so they might retroactively recover pay for years-old violations of DOL's sleep and meal rules (majority op at 28-31). It is little consolation to afford plaintiffs merely a chance to win what they have already earned: a day's wages for a day's work.

For Case No. 11: Order reversed, with costs, matter remitted to Supreme Court, Kings County, for further proceedings in accordance with the opinion herein and certified question answered in the negative. Opinion by Judge Rivera. Chief Judge DiFiore and Judges Stein, Wilson and Feinman concur. Judge Garcia dissents and votes to affirm in an opinion in which Judge Fahey concurs.

For Case No. 12: Order, insofar as appealed from, reversed, with costs, matter remitted to the Appellate Division, Second [*61] Department, for further proceedings in accordance with the opinion herein and certified question answered in the negative. Opinion by Judge Rivera. Chief Judge DiFiore and Judges Stein, Wilson and Feinman concur. Judge Garcia dissents and votes to affirm in an opinion in which Judge Fahey concurs.

Decided March 26, 2019

Footnotes

1

The Act initially referred to the "Industrial Commissioner," which remained the title until 1982 when the Legislature renamed the position "Commissioner of Labor" (L 1982, ch 86, §§ 1-2). To avoid confusion, we refer to the individual holding this position as the "Commissioner."

2

Under DOL regulations, employers are required to pay a "spread of hours" premium of "one hour's pay at the basic minimum hourly wage rate" to a covered employee who works a shift of more than 10 hours (12 NYCRR 142-2.4 [a]).

3

The RIS is a statutory requirement. Pursuant to SAPA, except under circumstances not relevant to these appeals, an agency shall "issue a regulatory impact statement for a rule proposed for adoption or a rule adopted on an emergency basis," containing information such as the statutory basis for the proposed rule, "needs and benefits," projected costs of the rule, and a compliance schedule (SAPA § 202-a [2]-[3]).

4

Plaintiffs have not argued that DOL's interpretation of the Wage Order conflicts with New York State's Labor Law and no such question is presented in these appeals.

5

The dissent rejects DOL's interpretation of "available for work," in part, because home health care aides "provid[e] 24-hour patient care without meaningful breaks" (dissenting op at 8; see also dissenting op at 16 [plaintiffs are entitled to "a day's wages for a day's work"]). This conclusion assumes plaintiffs' allegations are true. If defendants complied with DOL's guidance, then plaintiffs should have been paid the minimum wage for every hour worked and received the required sleep and meal breaks. If, as plaintiffs allege and the dissent apparently accepts, plaintiffs worked 24-hour shifts without "meaningful breaks," then, as DOL agrees, plaintiffs would be entitled to compensation for the entire 24-hour period. In fact, it is possible that a home health care aide may be paid for more hours than they actually work

under DOL's interpretation. If an aide receives a modicum of sleep below the five-hour minimum and less than three hours of meal breaks, the employee must be paid for the full 24 hours. There is nothing irrational about this construction of the Wage Order, nor is it inconsistent with the plain language of the regulatory text.

6

The dissent's contention that DOL's interpretation has " vacillated' dramatically" (dissenting op at 14) is unfounded. The substance of DOL's interpretation is that employees who work 24-hour shifts and receive bona fide, uninterrupted sleep and meal breaks are not "working" within the meaning of the Wage Order during those breaks, unless actually called upon to perform tasks. The dissent does not argue-because it cannot-that DOL has departed from this core understanding in any of the publications it has issued over the past 50 years. Instead, the dissent quibbles that DOL stated in 1972 that the exclusion only applies when sleep breaks are "bona fide" and "regularly scheduled" and "[a]dequate sleeping facilities" are "provided," but then explained 16 years later that, as "a rule of thumb," DOL considered 13 hours to be the " normal standard for working time' for home health care aides" (dissenting op at 15). Minor variations in DOL's articulation do not change the fact that DOL has never said that a home health care aide must be paid the minimum wage for every hour of a 24-hour shift in all circumstances. Instead, DOL has consistently maintained that home health care aides are not "available for work" within the meaning of the Wage Order during sleep and meal breaks, but must be compensated if called upon to work.

7

The dissent is mistaken that the Court "seeks to emulate" the federal regulatory scheme (dissenting op at 12). The Court is not emulating or adopting any particular approach. Instead, we have applied our well-established jurisprudence to defer to DOL's interpretation because it is neither irrational nor unreasonable and is not contrary to the regulatory text. However, as explained above, we cannot see how it would be irrational or unreasonable for DOL to track the federal approach with respect to sleep and meal breaks for employees who work 24-hour shifts.

8

The dissent argues that the residential employee provision "expressly exclude[s]" such employees' sleeping hours, and so "it must follow" that sleep time is otherwise compensable under the Wage Order (dissenting op at 6-7). This analysis is fundamentally flawed. Contrary to the dissent's claim, the clause does not "expressly exclude[]" a residential employee's sleeping hours from compensable time. Rather, it clarifies that sleeping hours "shall not be deemed" work hours "solely because [the employee] is required to be on call during such hours" (12 NYCRR 142-2.1 [b] [1] [emphasis added]). The dissent contends that this language indicates that sleep time for all other employees "should be compensated solely because they are on call" (dissenting op at 7). However, the Wage Order's text does not compel that interpretation, and DOL has reasonably determined that home health care aides are not "on call" when asleep and certain conditions are satisfied.

9

The dissent appears to embrace this position, concluding that deference to DOL's interpretation allows the agency to "circumvent statutory safeguards in favor of interpretations'" (dissenting op at 12). The dissent's position is unprecedented and would upset established administrative law doctrine. Issuing interpretative guidance is a critical aspect of an agency's role, allowing regulated entities to understand how the law applies to their unique and varied circumstances. As noted above, the Wage Order was duly promulgated pursuant to SAPA. To require DOL to issue a separate regulation for every circumstance facing every profession is not required under SAPA and would impose staggering burdens on the State's administrative agencies.

10

The Andryeyeva defendants apparently concede that if we adopt plaintiffs' interpretation of the Wage Order, there is no statutory or factual impediment to class certification. The Moreno defendants contend that, regardless of whether the Court adopts DOL's interpretation, plaintiffs failed to offer sufficient evidence to satisfy the numerosity, commonality, or typicality requirements.

11

The Andryeyeva defendants' argument that Andryeyeva's disavowal of liquidated damages was an insufficient waiver on behalf of the class is without merit as she clearly stated she was waiving the liquidated damages claim in order to pursue the matter as a class action (see Borden, 24 NY3d at 394).

12

Whether a home health care aide is in fact called upon to perform services during "sleeping hours" does not determine whether the aide is, in the plain meaning of the term, "available for work."

13

Nor is that approach condoned by Matter of Peckham v Calogero (12 NY3d 424, 911 N.E.2d 813, 883 N.Y.S.2d 751 [2009]), the authority on which the majority relies (majority op at 16).

TINSMON CASE

Matter of Tinsmon (Lasher)

Matter of Tinsmon (Lasher) 2019 NY Slip Op 01471 Decided on February 28, 2019
Appellate Division, Third Department Published by New York State Law Reporting Bureau pursuant to Judiciary Law § 431. This opinion is uncorrected and subject to revision before publication in the Official Reports.

Decided and Entered: February 28, 2019
526747

[*1]Guardianship of JENNIFER LASHER TINSMON.

and

CHRISTOPHER J. LASHER et al., Respondents; ALBANY COUNTY DEPARTMENT OF SOCIAL SERVICES, Appellant.

Calendar Date: January 9, 2019
Before: Egan Jr., J.P., Clark, Mulvey, Devine and Rumsey, JJ.

Daniel Lynch, Albany County Attorney, Albany (Albert F. Dingley of counsel), for appellant.

Wilcenski & Pleat PLLC, Clifton Park (Edward V. Wilcenski of counsel), for respondents.

MEMORANDUM AND ORDER

Devine, J.

Appeal from an order of the Surrogate's Court of Albany County (Pettit, S.), entered February 22, 2018, which granted petitioners' application, in a proceeding pursuant to SCPA 2107, for advice and direction regarding a proposed sale of certain real property.

In 2011, Jennifer Lasher Tinsmon suffered a disabling traumatic brain injury at the age of 42. Petitioners are her parents and, following her injury, were named the guardians of her person and property. They are also the trustees of a first-party supplemental needs

trust that was established in August 2011 and exists "to shelter [Tinsmon's] assets for the dual purpose of securing or maintaining eligibility for state-funded services, and enhancing [her] quality of life with supplemental care paid by [the] trust assets" (Matter of Abraham XX., 11 NY3d 429, 434 [2008]; see 42 USC § 1396p [d] [4]). Tinsmon's home, which is jointly owned by herself and petitioner Helena Lasher, was not placed in trust inasmuch as a residence cannot be counted in determining eligibility for certain means-tested benefits (see 42 USC § 1382b [a] [1]; 20 CFR 416.1212 [a]; 18 NYCRR 360-1.4 [f]; 360-4.7 [a] [1]). Tinsmon qualified for and began receiving such benefits, namely, supplemental security income (hereinafter SSI) and Medicaid benefits.

In September 2017, petitioners commenced this proceeding pursuant to SCPA 2107 to obtain, as is relevant here, approval for their proposal to expend trust funds to purchase Lasher's interest in Tinsmon's home and pay off an encumbering mortgage on it, leaving them with title to the home as Tinsmon's guardians. Over respondent's opposition, Surrogate's Court approved the plan. Respondent now appeals.

We affirm. Petitioners proposed acquiring Lasher's interest in the home on very favorable terms and paying off the mortgage, actions that would leave Tinsmon, through petitioners as her guardians, as the sole owner of an unencumbered residence without impacting her SSI or Medicaid benefits. A guardian ad litem appointed for Tinsmon by Surrogate's Court supported this proposal, which appears to be well within petitioners' "sole and absolute discretion" under the trust agreement to make expenditures for Tinsmon's benefit after considering any impact on her access to government benefits (see EPTL 7-1.12). Respondent objected only to the proposed transfer of title to petitioners as Tinsmon's guardians, arguing that administrative interpretations of the applicable statutes require that petitioners either hold title to the home as trustees or provide security to the trust for its investment into the home. Respondent's interest in this regard may be explained by the fact that the trust assets remaining when Tinsmon dies, regardless of how old she is when that occurs, will be first used to reimburse the entities that provided Medicaid benefits to her during her life (see 42 USC § 1396p [d] [4] [A]; Social Services Law § 366 [2] [b] [2] [iii]; Matter of Abraham XX., 11 NY3d at 436; compare Social Services Law § 369 [2] [restricting the respondent's ability to recover against the assets of a benefits recipient who dies before reaching 55 years of age]).

Respondent does not point to, and our review does not disclose, any statutory authority that would require its desired outcome. Respondent suggests that such a requirement may be found in guidelines, used by the Social Security Administration to process SSI benefit claims, that reflect the agency's expertise in implementing the pertinent statutes and are "entitled to 'substantial deference'" (Lopes v Department of Social Servs., 696 F3d 180, 186 [2d Cir 2012], quoting Bubnis v Apfel, 150 F3d 177, 181 [2d Cir 1998]; see Matter of Jennings v Commissioner, N.Y.S. Dept. of Social Servs., 71 AD3d 98, 109 [2010]). The guidelines contradict respondent's argument, however, providing that when funds from a trust are "used to purchase durable items, e.g., a car or a house, the individual (or the trust) must be shown as the owner of the item in the percentage that the funds represent the [item's] value" (Program Operations Manual System [POMS]

former SI 01120.201 [F] [1] [emphasis added]). Further, petitioners are not obligated to conserve trust assets for respondent's eventual benefit, which would conflict with their mandate to act for Tinsmon's benefit by using "so much (even to the extent of the whole) of the net income and/or principal of th[e] trust" (EPTL 7-1.12 [e] [1] [1]; see e.g. Matter of Shah [Helen Hayes Hosp.], 95 NY2d 148, 163 [2000]). Surrogate's Court was accordingly correct to conclude that petitioners' proposal was permissible and did not err in approving it.

To the extent that the contention is properly before us, the Social Security Administration does not possess a "remainder interest" in the trust that would entitle it to notice of this proceeding (Social Services Law § 366 [b] [2] [v]; see 42 USC § 1396p [d] [4] [A]; SCPA 103 [39]; 2101 [3]). Respondent's remaining arguments have been examined and are lacking in merit.

Egan Jr., J.P., Clark, Mulvey and Rumsey, JJ., concur.

ORDERED that the order is affirmed, with costs.

ESTATE OF ELI T.

17-A APPLICATION DENIED

Elder Law and Special Needs Section

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Dec 16, 2018 11:10 AM

Ira Salzman

In this SCPA Article 17-A case the respondent had an IQ of 64. An application for the appointment of a guardian was denied because the court determined that with the support of his loving family he could make decisions on his own.

Estate of Eli T., 2018 NYLJ LEXIS 4125

Copy Citation

Surrogate's Court of New York, Kings County

December 12, 2018, Decided; December 14, 2018, Published

16-XXX/C

Reporter

2018 NYLJ LEXIS 4125 *

ESTATE OF ELI T., Deceased

Notice:

(ESTATE OF ELI T., Deceased (16-XXX/C), NYLJ, Dec. 14, 2018 at p.43, col.3)

Core Terms

guardianship, disability, appointment, make a decision, decisions, manage, best interest, psychologist, guardian, licensed, individual's

Judges: [*1] Surrogate Torres

Opinion

ESTATE OF ELI T., Deceased (16-XXX/C) Before the court is a guardianship proceeding pursuant to Article 17-A of the Surrogate's Court Procedure Act (Article 17-A) to appoint Sarah T. and Solomon T. (together, the petitioners) as guardians of the person of Eli T. (the respondent or Eli), and for the appointment of Chaim T. as stand-by guardian.

Article 17-A governs guardianship of persons who are diagnosed with an intellectual or developmental disability. SCPA 1750 , SCPA 1750-a . An intellectually disabled person is defined by SCPA 1750 as one who is permanently or indefinitely incapable of managing oneself and/or one's own affairs because of an intellectual disability. The condition must be certified by a licensed physician and a licensed psychologist or by two licensed physicians, one of whom has familiarity with or knowledge of the care and treatment of persons with intellectual disabilities. It must appear to the satisfaction of the court that the best interests of such person will be promoted by the appointment of a guardian. SCPA 1754 (5) . A developmentally disabled person is defined by SCPA 1750-a as one who has an impaired ability to understand and appreciate the nature and consequences of decisions which result in one's incapacity to manage oneself and/or one's [*2] own affairs. The developmental disability must be permanent or indefinite and attributable to cerebral palsy, epilepsy, neurological impairment, autism, traumatic brain injury, or any condition found to be closely related to intellectual disability. The condition must have originated before the age of 22, except for traumatic brain injury which has no age limit. As with SCPA 1750 , the condition must be certified by a licensed physician and a licensed psychologist or by two licensed physicians, one of whom has familiarity with or knowledge of the care and

treatment of persons with developmental disabilities, and the court must determine that it is in such person's best interest that a guardian is appointed. SCPA 1754 (5) . The legal analysis in determining the need for guardianship is functionally the same whether an individual's disability is categorized under section 1750 or 1750-a of SCPA and relies upon the same body of law.

Under Article 17-A, the appointment of guardianship results in the complete removal of the individual's legal right to make decisions over her or his own affairs. "The imposition of an Article 17-A guardianship is plenary, and, under the provisions of the statute, results in the total deprivation of the individual's **[*3]** liberties," Matter of Michael J.N., 58 Misc 3d 1204 (A) (Sur Ct, Erie County 2017). On its face, the plain statutory language of Article 17-A does not grant a court authority or discretion to limit or tailor the scope of guardianship to meet the individual's specific areas of need, unlike guardianships available under Article 81 of the Mental Hygiene Law (Article 81) which expressly provides a tailored approach to meeting the needs of an alleged incapacitated person. Matter of Chaim A.K., 26 Misc 3d 837 (Sur Ct, New York County 2009) ; Matter of D.D., 50 Misc 3d 666 (Sur Ct, Kings County 2015) ; Matter of Michael J.N., supra; Matter of Sean O., NYLJ, Oct. 7, 2016, at 26, col 6 (Sur Ct, Suffolk County). For this reason, an Article 17-A guardianship is the most restrictive type of guardianship available under New York law and should only be granted in the absence of less restrictive alternatives. See Matter of K.L., NYLJ 1202792444598 (Sur Ct, Richmond County 2017); Matter of Michelle M., 52 Misc 3d 1211(A) (Sur Ct Kings County 2016) .

Submitted in support of the petition are two requisite certifications, from Moshe Lazar, M.D., and Alan Blau, Ph.D.1 Dr. Blau, who supervised the administration of the Stanford Binet Intelligence Scales-Fifth Edition and Vineland Adaptive Behavior Scales, confirms the diagnosis of Downs Syndrome and adds, in his certification, that the respondent "functions within the mild range of intellectual disability" with a full scale IQ score of 64 and adaptive **[*4]** behavior composite score of 77. Dr. Lazar's certification, in describing the mental and physical condition of the respondent, simply states, "physical condition normal. Mental retardation. Down's syndrome."

A psychological evaluation from the New York State Hamaspik Association (the evaluation) and a psycho-social summary completed by Neil Weinstein, LMSW, were also submitted. The evaluation reveals that Eli's area of cognitive strength is fluid reasoning, described as "ability to solve verbal and nonverbal problems using inductive or deductive reasoning." His score of 79 in this area is classified as "borderline deficient." The evaluation also shows that Eli's area of relative cognitive weakness is knowledge, described as "acquired accumulated fund of general information acquired at home, school or work." His score of 60 in this area is classified as "mildly deficient." The

evaluation describes Eli as a young man who possesses communication, daily living, and socialization skills ranging from "adequate" in certain areas of adaptive behavior, to "moderately low" in others. In the area of communication, the psychologist found that Eli is capable of describing short and long term goals, [*5] giving directions to and receiving directions from others, and "using irregular plurals correctly." The psychologist further found that "Eli understands sayings that are not meant to be taken word for word. He follows three part instructions. Eli follows instructions in if-then form and follows instructions heard five minutes before." With respect to reading and writing skills, Eli reads on at least a fourth, sometimes a sixth grade level, and he writes reports, papers or essays that are one or more pages long, completes mailing and return addresses on letters and packages, and composes business letters and correspondence at least ten sentences long. The psychologist observed that Eli sometimes self-edits or corrects before submitting his written work. In the area of daily living skills, the evaluation shows that Eli is independent in all aspects of his personal hygiene. He also takes his medicine as directed, cares for minor cuts, and seeks medical help in an emergency. He is able to use the stove, oven and the microwave for heating, baking, or cooking meals. He prepares food using a sharp knife and uses ingredients that require measuring mixing and cooking. Mr. Weinstein described [*6] Eli as "a very sweet, good natured 22 year old young man with the diagnosis of Down Syndrome and mild intellectual disability." According his summary, Eli received centerbased education services, including speech therapy, occupational therapy, and physical therapy during his perschool years, and then was placed in a MIS-4 special education program through the Board of Education. After he graduated, he attended the Jewish Center for Special Education, a high school program for boys with Downs Syndrome, and attended their vocational training program. Having graduated, Eli volunteers at the Boro Park Rehabilitation Center (the Center).

A hearing was held during which oral testimony was given by Eli and the petitioners, who are Eli's parents, and who were represented by counsel. The Court had an opportunity to observe Eli's demeanor, which the Court found to be engaging, inquisitive, observant, informed, and highly conversant.

Eli testified that he volunteers five days a week at the Center, which he explained was a rehabilitation and healthcare center. His responsibility as a patient transporter is to bring patients from their rooms to the rehabilitation rooms, and then transport the patients [*7] back to their rooms in their wheelchairs. He testified he liked his job and when asked why, he responded, "Well, it keep me healthier. It keeps me on my feet." He testified that he tries to get to work at 9 o'clock but "it depends how long prayer takes." His shift ends at 2:30 p.m. Eli uses public transportation

independently. Although he has not yet been travel trained to use the subway, Eli uses buses to travel. In his commute to the Center, Eli rides the public bus for 45 minutes to an hour each way. Three times a week, he works out at a gym after work, traveling independently from the Center to the gym. "I take the B11 from the Center, and then from the gym I take the B68," Eli testified. At the gym, Eli works out on the treadmill, lifts weights, uses the bike, and engages in other aerobic activities. He testified that working out makes him feel better and helps him lose weight so he can avoid diabetes. The petitioners testified that Eli's doctor had informed them that he was a prediabetic candidate. Eli stated, "I've decided to get out of the zone before I get onto it," explaining his plan to start eating healthier and get more exercise.

Currently, Eli receives Supplemental Security [*8] Income (SSI) and his parents assist him in managing his money. Eli testified that most of his money is deposited at Signature Bank but he carries pocket money, given to him by his dad from his own account, from which he makes purchases on his own. Eli testified that he does not get paid for the work he does at the Center, but he would one day like to have a job that pays.

Eli expressed that he would like to get married at some point, and "the money in the bank will buy, I'd pay for the apartment and the mortgage." He does not currently have a girlfriend nor is he dating, which he described as "when you actually meet a girl and you take her out." At one point when the Court asked, "do you see girls in the synagogue?" Eli corrected, "I see ladies."

Eli testified that he enjoys listening to music, reading the Bible, dancing, watching the news as well as shows on YouTube such as "The Three Stooges," "The Dick Van Dyke Show," "I Love Lucy," and "the Honeymooners." When asked why he likes to watch these old shows, Eli explained that he learns lessons from them. From "The Honeymooners," Eli explained that he learned, "don't be a big shot," while from "I Love Lucy," he learned "don't get into [*9] so much trouble," elaborating that "Lucy is like, she's a simple lady who gets into a lot of trouble with her husband." He also opined that he would not like to have a marriage exactly like Lucy's; rather he would like his marriage to be "hopefully calm." When asked if he found the show to be calm, he responded, "No, no. Plenty of yelling , shouting, hitting...[t]hat's when you begin to fall apart...[t]hat's when you ruin a marriage." Eli also follows the news, noting that there are "interesting politics" with respect to the (then) upcoming presidential election. Eli testified he is registered to vote and planned to vote in the November presidential election. When asked who was running, he said "Hillary Clinton and some crazy guy that's Trump." He also observed "Well, it looks like Hillary is going to win the White House. That's what the polls are saying."

Eli resides with his parents, the petitioners, and is the youngest of 11 adult children. Eli testified

that his responsibilities at home include taking out the garbage and helping clean the house. He does not usually assist his mother, who does most of the cooking, in the kitchen but he testified he can cook light things like eggs [*10] and a sandwich, and in the past he has helped bake.

Eli testified that he believes he needs help with issues like medical choices. Aside from expressing concern over how knowing much medicine to take, Eli articulated no other type of medical situations for which he needed a guardian. He testified that he does not regularly take medicine, but during the previous summer he recalled having to take a "Z pack" for his sore throat. He appears to be generally healthy.

Eli's mother testified that they would like to help Eli make wise decisions including medical and financial decisions. She testified that Eli can't do math problems, but she thinks he could learn how to manage a checking account. Eli's father testified that Eli's SSI checks are directly deposited into a joint checking account held in Eli's and his father's names. Eli's father further testified that he then writes out a check from that joint account to himself, deposits it into his personal account, and then he uses the funds for Eli's benefit. Often Eli's expenses exceed what he receives in SSI, and his parents make up the difference. Eli's father testified that there hasn't been anything that Eli has wanted that they did not [*11] provide for, which Eli confirmed. Eli's father expressed that they want to be included in Eli's medical care and to be able to discuss medical issues with Eli's doctors, although both parents testified that Eli has never objected to their presence and participation during his doctor's visits. Eli's father also testified that it would be must easier to talk with the SSI program. When asked to articulate any other reasons the petitioners seek guardianship, Eli's mother testified "I don't see the down side to it." The petitioners affirmed that they never looked into obtaining a healthcare proxy or becoming a payee for Eli's SSI funds. The sole area of contention between the petitioners and Eli, as presented, was with respect to the petitioners' concern about Eli's weight. Eli's mother testified that they have to monitor what Eli eats, and that she prepares Eli's breakfast and dinner in order to manage his food intake. "If we did not watch the pantry and minimize the amount of nosh in the house, things would get out of control," Eli's mother testified.

Aside from a disagreement between Eli and the petitioners over whether Eli administered medication independently or was assisted by Eli's [*12] mother, and an erroneous recollection of the duration of the "Z pack" medicine, there were no specific examples proffered of how Eli has made any medical decisions that have adversely affected his well-being. The petitioners, who make medical appointments for Eli, are always present and authorized by Eli to speak with his physicians. With his consent, Eli's finances are already managed by the petitioners in a joint bank

account, and to the extent that Eli desires that his parents communicate more directly with the Social Security Administration regarding his SSI, he may choose to designate the petitioners as his payee, a far less restrictive alternative to guardianship. With respect to Eli's weight, it has not been shown how the petitioner's desire to help Eli maintain a healthy weight, a goal which Eli evidently shares, will be aided by the imposition of an Article 17-A guardianship.

There is no doubt that the petitioners are deeply devoted to Eli and are motivated by what they believe is in his best interest. While one's natural instinct to protect one's loved one may be assuaged by the appointment of a guardian, it is not, however, in the best interest of a person who can make decisions [*13] aided by the support of those he trusts, to have his ability to make decisions wholly removed by appointing a Article 17-A guardian, no matter how well-intentioned the guardians. The appropriate legal standard is not whether the petitioners can make better decisions than Eli; rather, it is whether or not Eli has the capacity to make decisions. The record presented is devoid of evidence regarding Eli's inability to make decisions with the support he currently has; indeed, no actual harm resulting from Eli's decision-making, preventable by the appointment of guardianship, has been demonstrated or even alleged.

Upon the record presented, the credible evidence demonstrates that Eli is an adult who has cognitive limitations but also has capacity to make decisions affecting the management of his affairs with the sufficient and reliable support of his loving family. Where, as here, the individual has strong support from family members and/or supportive services with whom he already consults in managing his affairs and making decisions, imposing a plenary guardianship is not in the individual's "best interest." Matter of Dameris, supra at 579. To allow Eli to retain the legal right to make [*14] personal decisions about his own affairs, while providing him with any necessary assistance to make or communicate those decisions in a supported decision-making framework, is ultimately in his best interest.

To the extent that Eli may desire additional support, evidence of which has not been presented, alternatives to guardianship, such as a durable power of attorney, advance directives, health care proxies, and representative payee arrangements, can provide targeted assistance without wholly supplanting Eli's right to make decisions in every aspect of his affairs.

Accordingly, the petition is denied and dismissed.

Dated: December 5, 2018

Brooklyn, New York

Footnotes

- 1

  These certifications are generally boilerplate forms where the affirmant physician or psychologist checks off pre-printed conclusions relating to the decision-making capabilities of an intellectually or developmentally disabled individual. These forms are dismally wanting in details and useful information regarding the functional capacity of the respondent.

MATTER OF DELANEY

POA CAN CREATE SELF SETTLED SNT

Matter of Anna F., 2018 N.Y. App. Div. LEXIS 5541

Copy Citation

Supreme Court of New York, Appellate Division, Second Department

August 1, 2018, Decided

2017-07686

Reporter

2018 N.Y. App. Div. LEXIS 5541 * | 2018 NY Slip Op 05590 **

[**1] In the Matter of Anna F. (Anonymous). Faina Laut, petitioner-appellant. (File No. 1908/16)

Notice:

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Core Terms

disability, guardian, manage, intellectually, guardianship, appointed, evaluated, incapable, primary care physician, licensed psychologist, mentally retarded, best interest, court-authorized, indefinitely, affirmation, apartment, permanent, appeals, decree, lived, remit

Counsel: [*1] The Family Center, Brooklyn, NY (Lauren Elizabeth Groetch of counsel), for petitioner-appellant.

Judges: MARK C. DILLON, J.P., SHERI S. ROMAN, SYLVIA O. HINDS-RADIX, VALERIE BRATHWAITE NELSON, JJ. DILLON, J.P., ROMAN, HINDS-RADIX and BRATHWAITE NELSON,

JJ., concur.

Opinion

DECISION & ORDER

In a guardianship proceeding pursuant to Surrogate's Court Procedure Act article 17-A, the petitioner appeals from an order of the Surrogates Court, Kings County (Margarita Lopez Torres, S.), dated February 16, 2017. The order, after a hearing, denied the petition and dismissed the proceeding.

ORDERED that the order is reversed, on the law and the facts, without costs or disbursements, the petition for guardianship pursuant to Surrogate's Court Procedure Act article 17-A is granted, and the matter is remitted to the Surrogate's Court, Kings County, for the entry of an appropriate decree naming the petitioner to serve as guardian of Anna F.

The petitioner commenced this proceeding in August 2015, pursuant to Surrogate's Court Procedure Act article 17-A, seeking to be appointed guardian of her sister, Anna F. A hearing was held on the petition, at which the petitioner established that Anna, then 51 years old, had suffered severe intellectual disability most, if not all, of her life. Anna's primary care physician certified that Anna suffers from "cerebral [*2] palsy with profound mental retardation,"[1] and is in need of 24-hour supervision, as she is not capable of feeding herself or moving about on her own. A psychological evaluation by the YAI-National Institute for People with Disabilities confirmed that Anna was "largely nonverbal" and "non-ambulatory" and that she was so cognitively limited that her intelligence could not be successfully evaluated employing traditional IQ tests. Utilizing the Bayley Scales of Infant and Toddler Development, the evaluator assessed Anna of having attained a developmental age equivalent of 4 months, 10 days.

At the hearing, the petitioner testified that her parents had cared for Anna her entire life, until 2014, when both parents died. Since that time, Anna had remained in the apartment she had lived in with her parents, and home attendants were assisting her 24 hours a day. The petitioner further testified that although she had been able to manage some of Anna's affairs, she was limited without court-authorized guardianship, and had experienced difficulty in renewing the lease for the apartment where Anna lived and in maintaining Anna's Supplemental Nutritional Assistance Program benefits. In support [*3] of the petition, the petitioner submitted the affirmation of Anna's primary care physician and the affidavit of a licensed psychologist who also evaluated Anna, in [**2] which each independently concluded that Anna was incapable of managing herself and her affairs by reason of

her disability, which was permanent in nature or likely to continue indefinitely. In the order appealed from, the Surrogate's Court denied the petition and dismissed the proceeding, concluding, without discussion, that a proceeding under Mental Hygiene Law article 81 would be more appropriate. The petitioner appeals.

Pursuant to article 17-A of the Surrogate's Court Procedure Act, "the court is authorized to appoint a guardian of the person [who is intellectually disabled] . . . if such appointment . . . is in the best interest of the person who is intellectually disabled." Under the statutory scheme, a person is intellectually disabled if that person has been certified by, among other possibilities, one licensed physician and one licensed psychologist "as being incapable to manage him or herself and/or his or her affairs by reason of intellectual disability and that such condition is permanent in nature or likely to continue indefinitely" (SCPA 1750[1]).

Here, the record establishes that Anna is intellectually **[*4]** disabled within the meaning of Surrogate's Court Procedure Act article 17-A. Further, the record also establishes that it would be in Anna's best interest to have the petitioner appointed as her guardian. The record shows that Anna is incapable of providing for her most basic needs and that in the absence of court-authorized guardianship, the petitioner, Anna's only sibling, is unable to adequately manage Anna's affairs. Nothing in the record suggests that the petitioner is unqualified to act as Anna's guardian. To the contrary, despite the legal limitations she has encountered, the petitioner has been managing Anna's affairs and providing for Anna since their parents' deaths. Accordingly, the Surrogate's Court should have granted the petition (*see* *Matter of Mark C.H.*, 28 Misc 3d 765, 776 [Sur Ct, NY County]; *cf.* *Matter of Michelle M.*, 52 Misc 3d 1211[A] [Sur Ct, Kings County]; *Matter of Chaim A. K.*, 26 Misc 3d 837, 843 [Sur Ct, NY County]). We grant the petition and remit the matter to the Surrogate's Court, Kings County, for the entry of an appropriate decree naming the petitioner to serve as Anna's guardian (*see* SCPA 1754[5]).

DILLON, J.P., ROMAN, HINDS-RADIX and BRATHWAITE NELSON, JJ., concur.

Footnotes

- 1

  The physician's affirmation certifying Anna's diagnosis was dated March 17, 2015, which was prior to the July 21, 2016, amendments to article 17-A of the Surrogate's Court Procedure Act replacing "mental retardation" with "intellectual disability" (*see* L 2016, ch 198).

MATTER OF DELANEY

POA CAN CREATE SNT

Matter of Delaney, 2019 N.Y. App. Div. LEXIS 2095

Copy Citation

Supreme Court of New York, Appellate Division, Second Department

March 20, 2019, Decided

2017-11662

Reporter

2019 N.Y. App. Div. LEXIS 2095 * | 2019 NY Slip Op 02090 **

[**1] In the Matter of Thomas J. Ernest Delaney. Dean Pacchiana, appellant. (File No. 758/16)

Notice:

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Core Terms

supplemental, power of attorney, guardian ad litem, attorney-in-fact, commence, amended order, incapacity, funds, further proceedings, disabled person, short form, act act act, designated, disability, disbursed, appeals, remit, law law law, acknowledgment, schizophrenia, consequences, transactions, eligibility, competence, comprehend, conveyance, jeopardize, prescribed, provisions, appointed

Counsel: [*1] Mackey, Butts & Wise, LLP, Poughkeepsie, NY (Kyle A. Steller of counsel), for appellant.

Patrick J. Carle , New City, NY, guardian ad litem for Thomas J. Ernest Delaney.

Judges: RUTH C. BALKIN , J.P., CHERYL E. CHAMBERS , SHERI S. ROMAN , SYLVIA O. HINDS-RADIX , JJ. BALKIN , J.P., CHAMBERS , ROMAN and HINDS-RADIX , JJ., concur.

Opinion

DECISION & ORDER

In a proceeding to create a supplemental needs trust, the petitioner appeals from an amended order of the Surrogate's Court, Rockland County (Rolf Thorsen, S.), dated September 6, 2017. The amended order denied the petition to create a supplemental needs trust on behalf of an allegedly disabled person, Thomas J. Ernest Delaney, on the ground that the petitioner, as attorney-in-fact for the allegedly disabled person, lacked authority to commence the proceeding.

ORDERED that the amended order is reversed, on the law, without costs or disbursements, and the matter is remitted to the Surrogate's Court, Rockland County, for further proceedings consistent herewith.

On December 9, 2015, Thomas J. Ernest Delaney executed a statutory short form power of attorney designating Dean Pacchiana as his attorney-in-fact, and granting him authority, as his agent, to handle, among other **[*2]** things, "claims and litigation," "estate transactions," and "all other matters" on his behalf. On or about November 1, 2016, Pacchiana, acting as Delaney's agent under the power of attorney, commenced this proceeding in the Surrogate's Court seeking an order creating and funding a supplemental needs trust in order to provide for Delaney's "supplemental care, maintenance, support and education." The petition alleged that Delaney was disabled, had been diagnosed with paranoid schizophrenia, and received Social Security disability benefits. The petition further alleged that both of Delaney's parents were deceased, that the trust funds would consist of funds that Delaney had inherited from his mother, which had not yet been disbursed, and that the trust, when established, would enable Delaney to "maintain his medical insurance under the Medicaid Program."

The Surrogate's Court appointed a guardian ad litem to represent Delaney, and the guardian ad litem prepared a report dated March 31, 2017. In the report, the guardian ad litem found that the proposed supplemental needs trust "would not jeopardize [Delaney]'s [Medicaid] eligibility" and complied with the relevant provisions of Social Services Law § 366 . However, **[*3]** the guardian ad

litem asserted that Pacchiana, as Delaney's attorney-in-fact, was not permitted to commence a proceeding to create a supplemental needs trust on Delaney's behalf, and, further, that Pacchiana was not properly designated Delaney's attorney-in-fact. In the order appealed from, the Surrogate's Court denied the petition "for the reasons set forth in the Report of the Guardian Ad Litem." Pacchiana [**2] appeals.

To be valid, a statutory short form power of attorney must "[b]e signed and dated by a principal with capacity, with the signature of the principal duly acknowledged in the manner prescribed for the acknowledgment of a conveyance of real property" (General Obligations Law § 5-1501B[1][b] ; *see* *Matter of Batlas*, 144 AD3d 791, 791-792) . "Capacity" is defined as the "ability to comprehend the nature and consequences of the act of executing and granting, revoking, amending or modifying a power of attorney, any provision in a power of attorney, or the authority of any person to act as agent under a power of attorney" (General Obligations Law § 5-1501[2][c]). "A party's competence to enter into a transaction is presumed, even if the party suffers from a condition affecting cognitive function, and the party asserting incapacity bears the burden of proof'" (*Pruden v Bruce*, 129 AD3d 506, 507 , quoting *Er-Loom Realty, LLC v Prelosh Realty, LLC*, 77 AD3d 546, 548 ; *see* *Buckley v Ritchie Knop, Inc.*, 40 AD3d 794, 795) . "The incapacity must **[*4]** be shown to exist at the time the pertinent document was executed" (*Lynch v Carlozzi*, 129 AD3d 1240, 1241). Such incapacity was not shown here (*see* *Pruden v Bruce*, 129 AD3d 506, 507).

Pacchiana, as Delaney's attorney-in-fact, had the authority to commence a proceeding in the Surrogate's Court for the creation of a supplemental trust in Delaney's behalf (*see* General Obligations Law § 5-1502H; *Matter of Perosi v LiGreci*, 98 AD3d 230, 238; *Matter of Community Hosp. at Glen Cove v D'Elia*, 79 AD2d 1025; *Matter of Lando*, 11 Misc 3d 866, 867 [Sur Ct, Rockland County]). Accordingly, the court should not have denied the petition on the ground that Pacchiana lacked the authority to commence the proceeding, and we remit the matter for further proceedings on the petition.

BALKIN, J.P., CHAMBERS, ROMAN and HINDS-RADIX, JJ., concur.

BRONSTEIN

STATE LAW CONFLICT

Bronstein v Clements, 2019 N.Y. App. Div. LEXIS 1447

Copy Citation

Supreme Court of New York, Appellate Division, Third Department

February 28, 2019, Decided; February 28, 2019, Entered

526669

Reporter

2019 N.Y. App. Div. LEXIS 1447 * | 2019 NY Slip Op 01470 ** | 2019 WL 960164

[**1] ANITA L. BRONSTEIN, as Guardian of the Person and Property of SEYMOUR B. BRONSTEIN SR., Respondent, v MAHLON T. CLEMENTS, Appellant.

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Core Terms

power of attorney, limited power, law law law, appointing, powers, revoke, act act act, guardian, transactions, revocation, principles, unavailing, prohibits, mortgage, purposes, listing, loyalty, lease

Case Summary

Overview

HOLDINGS: [1]-The trial court properly granted a guardian's motion for summary judgment action seeking, among other things, a revocation of a Pennsylvania limited power of attorney (POA) given to a friend by the ward because Pennsylvania had the greater concern with the dispute at issue where the POA did not fall within the ambit of General Obligations Law § 5-1501C(1) or (9) -the POA, on its face, did not indicate that it was created primarily for business or commercial purposes and the record did not reflect that buying and selling real property was the ward's primary business-and Mental Hygiene Law § 81.22(b)(2) prohibited the guardian from unilaterally revoking the POA.

Outcome

Order affirmed.

LexisNexis® Headnotes

- Civil Procedure > Preliminary Considerations > Federal & State Interrelationships > Choice of Law

HN1 **Federal & State Interrelationships, Choice of Law**

The first step in any case presenting a potential choice of law issue is to determine whether there is an actual conflict between the laws of the jurisdictions involved. More like this Headnote

Shepardize - Narrow by this Headnote

- Estate, Gift & Trust Law > Estate Planning > Powers of Attorney

HN2 **Estate Planning, Powers of Attorney**

General Obligations Law § 5-1501 generally governs powers of attorney. More like this Headnote

Shepardize - Narrow by this Headnote

- Estate, Gift & Trust Law > Estate Planning > Powers of Attorney > Construction & Interpretation

HN3 **Powers of Attorney, Construction & Interpretation**

General Obligations Law § 5-1501C(1) and (9) exclude from § 5-1501 , respectively, "a power of attorney given primarily for a business or commercial purpose" and "a power given to a licensed real estate broker to take action in connection with a listing of real property, mortgage loan, lease, or management agreement," among others. More like this Headnote

Shepardize - Narrow by this Headnote

- Civil Procedure > ... > Federal & State Interrelationships > Choice of Law > Significant Relationships

HN4 **Choice of Law, Significant Relationships**

Under established conflict of laws principles, the applicable law should be that of the jurisdiction which, because of its relationship or contact with the occurrence or the parties, has the greatest concern with the specific issue raised in the litigation. More like this Headnote

Shepardize - Narrow by this Headnote

Counsel: **[*1]** The Clements Firm, Glens Falls (Thomas G. Clements of counsel), for appellant.

Barclay Damon LLP , Syracuse (Michael J. Balestra of counsel), for respondent.

Judges: Before: Garry , P.J., Egan Jr. , Aarons , Rumsey and Pritzker , JJ. Garry , P.J., Egan Jr. , Rumsey and Pritzker , JJ., concur.

Opinion by: Aarons

Opinion

MEMORANDUM AND ORDER

Aarons , J.

Appeal from an order of the Supreme Court (Farley, J.), entered July 17, 2017 in St. Lawrence County, which granted plaintiff's motion for summary judgment.

Defendant and Seymour B. Bronstein Sr., a physician who resided in Pennsylvania, are personal acquaintances who also had some real estate matters with each other. In 2013, Bronstein took a bus to visit defendant in New York. Due to Bronstein's declining mental health, Bronstein missed his bus stop and lost his briefcase, causing defendant to have to pick him up. Defendant thereafter assisted Bronstein in preparing two powers of attorney. One power of attorney granted unrestricted authority to plaintiff. The other power of attorney was a limited power of attorney appointing defendant as Bronstein's agent and granted him two powers - "[t]o create a trust for [Bronstein's] benefit" and "[t]o engage in real property transactions **[*2]** in New York State" on Bronstein's behalf. Defendant used a Pennsylvania form for both powers of attorney, and Bronstein executed them in New York.

After Bronstein's health continued to decline, plaintiff, based upon the general power of attorney to act on Bronstein's behalf, sent a purported revocation of defendant's limited power of attorney. Notwithstanding the foregoing, defendant continued to engage in real estate transactions on Bronstein's behalf. In January 2016, plaintiff advised defendant that Bronstein suffered from dementia and that defendant's power of attorney had been revoked. Plaintiff subsequently commenced a proceeding in Pennsylvania for plenary guardianship of Bronstein. In May 2016, an order was issued in this Pennsylvania proceeding appointing plaintiff as Bronstein's guardian. Plaintiff then filed a certified copy of the Pennsylvania order in the St. Lawrence County Clerk's office, as well as a revocation of defendant's power of attorney. Plaintiff thereafter commenced this action seeking, among other things, a revocation of the limited power of attorney given to

defendant by Bronstein. Following joinder of issue, plaintiff moved for, among other things, summary [*3] judgment seeking a declaration that defendant's limited power of attorney was revoked. Supreme Court, among other things, granted plaintiff's motion. Defendant appeals. We affirm.

HN1 "The first step in any case presenting a potential choice of law issue is to determine whether there is an actual conflict between the laws of the jurisdictions involved" (*Allstate Ins. Co. v. Stolarz*, 81 NY2d 219, 223, 613 N.E.2d 936, 597 N.Y.S.2d 904 [1993]). Under the Pennsylvania statute in effect at the relevant time, plaintiff could revoke any prior powers of attorney made by Bronstein once she was appointed as his guardian (*see* 20 Pa Code § 5604 [c] [former (1)]). Meanwhile, under New York law, a guardian may not "revoke an appointment . . . made by the incapacitated person pursuant to [General Obligations Law §§ 5-1501, 5-1601 and 5-1602]" (Mental Hygiene Law § 81.22 [b] [2]). As such, whether a conflict between New York and Pennsylvania law exists turns on whether the limited power of attorney given to defendant was made, as relevant here, pursuant to General Obligations Law § 5-1501. If so, then a conflict exists; if not, there is no conflict.

HN2 General Obligations Law § 5-1501 generally governs powers of attorney. Plaintiff relies on ***HN3*** General Obligations Law § 5-1501C (1) and (9), which excludes from General Obligations Law § 5-1501, respectively, "a power of attorney given primarily for a business or commercial purpose" and "a power given to a licensed real estate broker [*4] to take action in connection with a listing of real property, mortgage loan, lease or management agreement," among others. To that end, plaintiff maintains that because the limited power of attorney issued to defendant falls into either of these two categories, it does not constitute an appointment made pursuant to General Obligations Law § 5-1501. We disagree. Such document, on its face, does not indicate that it was created primarily for business or commercial purposes. Nor does the record reflect that buying and selling real property was Bronstein's primary business. Indeed, defendant averred in his affidavit that Bronstein owned a house in the Town of Oswegatchie in St. Lawrence County and that he would spend time there. Furthermore, the two powers given to defendant in the limited power of attorney - creating a trust for Bronstein's benefit or to engage in real estate transactions on his behalf in New York - are not powers that are solely reserved for business or commercial purposes. The record also does not indicate that these two powers were given to defendant so that he could take action in connection with a listing of real property, mortgage loan, lease or management agreement. As such, because the limited [*5] power of attorney does not fall within the ambit of General Obligations Law § 5-1501C (1) or (9), it is not excluded from General Obligations Law §

5-1501 . More to the point, because it is not excluded from General Obligations Law § 5-1501 , New York law prohibits plaintiff from unilaterally revoking it (*see* Mental Hygiene Law § 81.22 [b] [2]). Accordingly, a conflict between Pennsylvania law and New York law exists.1

HN4 "Under established conflict of laws principles, the applicable law should be that of 'the jurisdiction which, because of its relationship or contact with the occurrence or the parties, has the greatest concern with the specific issue raised in the litigation'" (*Matter of Doe*, 14 NY3d 100, 109, 923 N.E.2d 1129, 896 N.Y.S.2d 741 [2010] , quoting *Babcock v Jackson*, 12 NY2d 473, 481, 191 N.E.2d 279, 240 N.Y.S.2d 743 [1963]) . Defendant, as Bronstein's agent, "must act in the utmost good faith and undivided loyalty toward [Bronstein], and must act in accordance with the highest principles of morality, fidelity, loyalty and fair dealing" (*Semmler v Naples*, 166 AD2d 751, 752, 563 N.Y.S.2d 116 [1990] [internal quotation marks and citation omitted], *appeal dismissed* 77 NY2d 936, 572 N.E.2d 48, 569 N.Y.S.2d 607 [1991]) . The record discloses that Bronstein was a resident of Pennsylvania, defendant does not dispute that a Pennsylvania form was used to create both powers of attorney, defendant referred to the limited power of attorney as a "Pennsylvania Durable Power of Attorney" and the limited power of attorney noted that the powers granted to defendant were "explained more fully **[*6]** in Pa. C.S. Chapter 56." In view of the foregoing and [**2] taking into account that defendant was required to act for the benefit of Bronstein, we find that Pennsylvania has the greater concern with the dispute at issue and, therefore, Supreme Court correctly granted plaintiff's motion. Defendant's remaining arguments have been examined and are unavailing.

Garry, P.J., Egan Jr., Rumsey and Pritzker, JJ., concur.

ORDERED that the order is affirmed, with costs.

Footnotes

- 1

  Although plaintiff, once she registered the Pennsylvania order appointing her as Bronstein's guardian, could "exercise in [New York] all powers authorized in the order of appointment," she could only do so to the extent such powers were not "prohibited by the laws of [New York]" (Mental Hygiene Law § 83.39 [a]). In view of our determination that Mental Hygiene Law § 81.22 (b) (2) prohibits plaintiff from revoking any prior powers of attorney given by Bronstein, plaintiff's reliance on Mental Hygiene Law § 83.39 (a) is unavailing.

KRONIK

TRUST REVOKED IN GUARDIANSHIP CASE

Matter of Kronik, 2019 N.Y. Misc. LEXIS 328

Copy Citation

Surrogate's Court of New York, New York County

January 28, 2019, Decided

2009-2812.1

Reporter

2019 N.Y. Misc. LEXIS 328 * | 2019 NY Slip Op 30178(U) **

[**1] Probate Proceeding, Estate of JOSEPH KRONIK, Deceased.

Notice:

THIS OPINION IS UNCORRECTED AND WILL NOT BE PUBLISHED IN THE PRINTED OFFICIAL REPORTS.

Core Terms

decedent, purported, probate, undue influence, invalid, irrevocable trust, propounded, revocation, res judicata, the will, revoked, doctrine doctrine doctrine, testamentary, collateral, estoppel, privity, movant, admitting, Invoking, guardian, litigate, testator, exerted, wishes, law law law, counter-judgment, conclusively, requirements, transactions, dispositive

Judges: [*1] Rita M. Mella , SURROGATE.

Opinion by: Rita M. Mella

Opinion

DECISION

Marek Rozen, petitioner in a proceeding to probate a June 24, 1976 instrument in the estate of Joseph Kronik, has moved for summary determination of his petition - including dismissal of objections filed on June 8, 2010 by distributees Leib Kuzniec and Helena Kronik Bartash - and the issuance of a decree admitting the June 24, 1976 instrument to probate (*see* CPLR 3212).1

Decedent died on March 13, 2009, at age 85, leaving a $2.5 million estate, survived by no one more closely related than first cousins. Marek Rozen, the brother of decedent's predeceased wife, filed a petition on July 31, 2009, and an amended petition on January 14, 2010, for probate of the June 24, 1976 instrument and the issuance to him of letters of administration c.t.a. The propounded instrument contains a single dispositive provision: The estate is bequeathed to [**2] decedent's spouse, but if she does not survive the decedent, then to the decedent's brother, Isaak Kronik, and to Marek Rozen, "jointly in equal shares as their joint property."

The probate petition includes a request, "That the instrument purporting to be the Decedent's Last Will and Testament, dated March 22, 2000[,] be **[*2]** denied probate and declared invalid." Under the March 22, 2000 purported will, the entire estate is left to the trustee of the "Joseph Kronik Trust Dated March 22, 2000."

In an August 15, 2000 bench decision, the Nassau County Supreme Court - in determining a petition that had been filed by decedent's wife on May 26, 2000 - found decedent to be incapacitated, as defined in Mental Hygiene Law § 81.02 , and appointed Mr. Rozen (rather than decedent's wife) guardian of decedent's person and property and authorized Mr. Rozen as such guardian, "to apply for revocation of the [March 22, 2000 Joseph Kronik irrevocable] trust" (*see Matter of Rozen*, NYLJ, Aug. 6, 2002, at 23, col 1 [Sup Ct, Nassau County]). Thereafter, Mr. Rozen, as such guardian, sought - and obtained - from the Nassau County Supreme Court, after a jury trial, a determination that the "Joseph Kronik Irrevocable Trust Dated March 22, 2000" was invalid. The court invalidated the trust on two bases. First, the court determined that decedent had lacked capacity to enter into a trust agreement on March 22, 2000. In addition, the court adjudicated the March 22, 2000 trust instrument to be the product of undue influence exercised by one Lucy Lam.2

The objections **[*3]** to probate of the June 24, 1976 instrument read: "[S]aid Will [**3] was revoked by the Will dated March 22, 2000[,] and said Will does not meet the statutory requirements."3

Invoking EPTL 3-4.1 , objectants allege, in essence, that the language in the introduction of the March 22, 2000 purported will, revoking "any and all of my prior Wills and Codicils," effectively revoked the June 24, 1976 instrument. If objectants are correct, the single disposition contained in

the March 22, 2000 purported will having been rendered ineffectual by the invalidation of the March 22, 2000 trust agreement, decedent died intestate.

In the instant motion, Rozen seeks dismissal of the objections, filed on June 8, 2010, to the probate of the June 24, 1976 instrument, "on the grounds that Objectants are precluded as a matter of law from arguing that the Instrument dated March 22, 2000 purporting to be the Last Will and Testament of Joseph Kronik is a valid instrument." Specifically, movant invokes the doctrines of collateral estoppel "and/or" *res judicata* and argues that, because one objectant, Lieb Kuzniec, was a party to the proceeding whereby the March 22, 2000 trust agreement was invalidated, and because the other objectant, **[*4]** Helena Kronik Bartash, being a distributee of decedent's estate, was in privity with decedent, both are precluded from arguing that: (1) decedent had capacity to execute the March 22, 2000 instrument purporting to be a will - including its provision revoking all prior testamentary instruments - and (2) the execution of such instrument was free of undue influence.

Collateral estoppel, a doctrine "intended to reduce litigation and conserve the resources of the court and litigants," precludes parties from relitigating issues that have been previously decided against them in a prior proceeding in which they had a fair opportunity to litigate the [**4] point (*Kaufman v Eli Lilly & Co.*, 65 NY2d 449, 455, 482 N.E.2d 63, 492 N.Y.S.2d 584 [1985]). It is well established that "[t]he doctrine applies if the issue in the second action is identical to an issue which was raised, necessarily decided and material in the first action, and the plaintiff had a full and fair opportunity to litigate the issue in the earlier action" (*Parker v Blauvelt Volunteer Fire Co.*, 93 NY2d 343, 349, 712 N.E.2d 647, 690 N.Y.S.2d 478 [1999]).

Res judicata, or claim preclusion, is a broader doctrine of which collateral estoppel is a component (*Gramatan Home Investors Corp. v Lopez*, 46 NY2d 481, 485, 386 N.E.2d 1328, 414 N.Y.S.2d 308 [1979]). It bars successive litigation based upon the same transaction or series of transactions when "(i) there is a judgment on the merits rendered by a court of competent **[*5]** jurisdiction, and (ii) the party against whom the doctrine is invoked was a party to the previous action, or in privity with a party who was" (*Matter of Spitzer v Applied Card Systems, Inc.*, 11 NY3d 105, 122, 894 N.E.2d 1, 863 N.Y.S.2d 615 [2008]). Claims arising out of the same series of transactions are barred under *res judicata* "even if based upon different theories or if seeking a different remedy" (*Parker*, 93 NY2d at 347, quoting *O'Brien v City of Syracuse*, 54 NY2d 353, 357, 429 N.E.2d 1158, 445 N.Y.S.2d 687 [1981]).

When a party establishes that a claim is barred by collateral estoppel or *res judicata*, summary judgment may be properly granted in favor of such party (*Ryan v New York Telephone Co.*, 62 NY2d 494, 467 N.E.2d 487, 478 N.Y.S.2d 823 [1984]; *Luscher v Arrua*, 21 AD3d 1005, 801 N.Y.S.2d 379 [2d Dept 2005]).

DISCUSSION

In rendering its advisory opinion that the creation of the March 22, 2000 irrevocable trust was the product of undue influence, the jury applied the same standard that is used to evaluate whether a will is the result of influence exerted by another and not a reflection of a testator's intent ("To be 'undue', the influence exerted must amount to mental coercion that led the testator [**5] to carry out the wishes of another, instead of [his, her] own wishes, because the testator was unable to refuse or too weak to resist" [PJI 7:55]). Agreeing with the jury, the Nassau County Supreme Court determined conclusively in its January 6, 2003 counter-judgment: "[T]he execution of the Trust on March 22, 2000 by Joseph Kronik was **[*6]** procured by the undue influence of Lucy Lam and, accordingly, the Trust is declared invalid." The question now presented is: Are objectants therefore precluded from arguing that the revocation clause in the March 22, 2000 purported will was executed by a decedent free of restraint, specifically, free of the undue influence exercised by Lucy Lam?

The March 22, 2000 purported will and irrevocable trust were integral parts of a single estate plan, one orchestrated by Lucy Lam. The two instruments were also the product of the same transaction, and the purported will was merely incidental to the trust. Although a finding of undue influence does not necessarily invalidate an entire testamentary instrument (*see* *Riggs v Palmer*, 115 NY 506, 512, 22 N.E. 188 [1889] [a particular portion of a will may be excluded from probate if induced by undue influence or the party in whose favor it is]; *Matter of von Knapitsch*, 296 AD2d 144, 148, 746 N.Y.S.2d 694 [1st Dept 2002] [partial probate may be granted and portions of will that do not benefit party who exerted undue influence may be admitted to probate]), here the revocation clause of the March 22, 2000 purported will served the interests of the undue influencer: it - along with the sole dispositive provision of the purported will - ensured that any asset owned **[*7]** by decedent at his death, and subject to administration, would be disposed of in accordance with the terms of the March 22, 2000 irrevocable trust. Therefore, the issue of the invalidity of the revocation clause of the March 22, 2000 purported will was "necessarily decided and material" in the Nassau County Supreme Court proceeding (*Parker*, 93 NY2d at 349). Further, the claim that [**6] the transaction that resulted in the creation of the March 22, 2000 irrevocable trust was procured by Ms. Lam's undue influence was conclusively decided by that court. Accordingly, any claim by objectants that the purported will and its revocation clause, which were an integral part of that same transaction, are a reflection of decedent's wishes and not the product of any restraint is barred by *res judicata* (*id.* at 347).

Objectants' arguments concerning lack of privity are easily addressed. Leib Kuzniec was a party to the proceeding to invalidate the March 22, 2000 irrevocable trust and actively litigated it, and Helena Kronik Bartash, as decedent's distributee is in privity with him. Both are bound by the determination on that proceeding (*Matter of Werger*, 64 Misc 2d 1094, 1097, 315 N.Y.S.2d 943 [Sur Ct, N.Y. County 1970] ; *Matter of Baker*, 189 Misc 159, 160-161, 69 N.Y.S.2d 626 [Sur Ct, Bronx County 1947]) .

The Public Administrator, a statutory party in this probate proceeding (*see* SCPA 1123 [2] [i] [2]), agrees with this **[*8]** court's conclusion concerning the preclusive effect of the Nassau County Supreme Court determination and does not oppose the petition for probate.

Despite being requested on movant's papers, the relief of admitting the June 24, 1976 instrument to probate may not be granted on the application before the court. Movant argues that objectants "do not challenge the validity of the [June 24, 1976] in any respect." The objections filed in this case, however, cite to EPTL 3-2.1 and allege, as previously stated, that the propounded instrument "does not meet the statutory requirements." To be sure, by the instant decision, this court is dismissing those objections to probate which allege that the propounded instrument was revoked by the purported March 22, 2000 will. The other objections remain and, if movant desires to seek summary determination of the validity of the propounded instrument, it is still incumbent upon him, as proponent, to make a prima facie showing that, on June 24, 1976, [**7] decedent had testamentary capacity, duly executed the propounded instrument, and was free of undue influence or any other restraint.

CONCLUSION

Marek Rozen having established that objectants are precluded, as a matter **[*9]** of law, from claiming that the March 22, 2000 purported will effected a revocation of the propounded instrument, and objectants having failed to raise a material issue of fact, his motion is granted. In light of this determination, the court need not address the question of whether objectants are precluded from arguing that decedent lacked testamentary capacity when he executed the March 22, 2000 purported will. To the extent the motion sought a decree admitting the June 24, 1976 instrument to probate, it is denied without prejudice.

This decision constitutes the order of the court.

Clerk to notify.

Dated: January 28, 2019

/s/ Rita M. Mella

SURROGATE

DEJESUS

GUARDIANSHIP AND FHA

Matter of Prospect Union Assoc. v DeJesus, 2018 N.Y. App. Div. LEXIS 8962

Copy Citation

Supreme Court of New York, Appellate Division, First Department

December 27, 2018, Decided; December 27, 2018, Entered

7585, 570838/16, 46932/15

Reporter

2018 N.Y. App. Div. LEXIS 8962 * | 2018 NY Slip Op 09016 **

[**1] In re Prospect Union Associates, Petitioner-Respondent, v Bienvenida DeJesus, et al., Respondents-Appellants.

Notice:

THE LEXIS PAGINATION OF THIS DOCUMENT IS SUBJECT TO CHANGE PENDING RELEASE OF THE FINAL PUBLISHED VERSION.

THIS OPINION IS UNCORRECTED AND SUBJECT TO REVISION BEFORE PUBLICATION IN THE OFFICIAL REPORTS.

Core Terms

tenants, apartment, eviction, guardian, Housing, extermination, permanent, landlord, appointment, stipulations, handicapped, reasonable accommodation, temporary, services, inspect, vacate

Counsel: **[*1]** Bronx Legal Services, Bronx (Sara E. Smith of counsel), for appellants.

Heiberger & Associates, P.C., New York (Lawrence C. McCourt of counsel), for respondent.

Judges: Sweeny, J.P., Manzanet-Daniels, Gische, Gesmer, Singh, JJ.

Opinion

Order, Appellate Term, First Department, entered June 6, 2017, which affirmed an order of the Civil Court, Bronx County (Arlene H. Hahn , J.), dated April 18, 2016, which denied respondents tenants' motion to vacate three stipulations of settlement in the summary holdover proceeding, and an order of the same court and Judge, dated October 31, 2016, which denied respondents' motion to vacate the final judgment of possession and for a permanent stay of the warrant of eviction, unanimously modified, in the exercise of discretion, to grant respondents' motion to vacate the final judgment of possession and for a permanent stay of the warrant of eviction to the extent of granting a temporary stay of the warrant of eviction and remanding the matter to the Civil Court for a hearing on whether to permanently stay the eviction.

Tenants, a married couple, have resided in this HUD regulated, Section 8 subsidized, multifamily housing project since 1998. The wife, Mrs. DeJesus, age 54, claimed **[*2]** before the motion court that she suffers from a cognitive impairment and that her husband, Mr. DeJesus, age 73, has mobility limitations. He uses a cane, crutches, or a wheelchair. As discussed further below, in April 2016, a temporary Mental Hygiene Law article 81 guardian was appointed for both tenants upon a prima facie showing that they both were incapacitated and unable to provide for their personal needs and manage their property and financial affairs.

In June 2015, petitioner landlord served tenants with a notice of termination alleging that they had failed to maintain their apartment in a safe and sanitary condition. The conditions included bedbugs, keeping the apartment in a Collyer-like, cluttered condition posing a fire hazard, and failing to prepare the apartment for extermination. In September 2015, a guardian ad litem (GAL) was appointed for them by Housing Court (CPLR 1201), after this summary holdover proceeding was commenced. The GAL signed three stipulations on tenants' behalf.

In the first stipulation, dated October 22, 2015, the GAL acknowledged that extermination could not take place without proper preparation of the apartment, and agreed to effectuate the completion and return of certain forms so the **[*3]** landlord could inspect and have the apartment exterminated. When that did not occur, the GAL entered into a second stipulation, dated December 9, 2015, which afforded tenants more time to comply with the terms of the first stipulation. In the second stipulation, the GAL consented to entry of a final judgment of possession, but with execution of the warrant of eviction stayed until December 31, 2015 so that tenants would have another opportunity to prepare their apartment for extermination. When, once again, that did not occur, the GAL negotiated a third stipulation (dated January 6, 2016), with a further stay of eviction so that the apartment could be inspected and exterminated on January 11, 2016. Tenants failed to comply with that stipulation as

well. With eviction imminent, tenants obtained legal counsel, who moved to vacate the stipulations on the basis that the GAL had exceeded her authority and tenants had not consented to the stipulations. Housing Court denied the motion and, in its April 18, 2016 order of denial, directed that the New York City Human Resources Administration's (HRA) Adult Protective Services (APS), be notified.

APS commenced an article 81 proceeding on tenants' **[*4]** behalf in Supreme Court, Bronx [**2] County. By order dated April 26, 2016, the court appointed Self Help Community Services, Inc. as tenants' temporary guardian1 under article 81 of the Mental Hygiene Law and ordered that the guardian immediately arrange for a "heavy duty cleaning [and] extermination" of tenants' apartment. The court also ordered a stay of eviction so that the cleaning could be effectuated. HRA exterminated the apartment on June 9 and, in a follow-up inspection report dated June 17, the HRA exterminator reported that he had found no evidence of live bedbugs or roaches. Satisfied with this progress, Supreme Court extended the temporary article 81 guardianship, and granted tenants a further stay of eviction until August 12, 2016.

In Housing Court, before the stay expired, tenants moved to dismiss the judgment of possession and warrant of eviction on the basis that the article 81 guardian had cured the conditions and was in the process of applying for certain benefits and services that would permanently resolve the problem of access and the condition alleged. Landlord opposed the motion, claiming that its agent had inspected the apartment and found that it was still cluttered, but could not inspect for live vermin **[*5]** because the tenant asked him to leave. Housing Court denied tenants' motion in its entirety (Order October 31, 2016), stating that even if tenants had finally cured most of the conditions alleged in the termination notice, the cure was untimely. The court stated that tenants were not entitled to any postjudgment relief because their non-cooperation throughout the proceedings had "severely prejudiced" the landlord. Appellate Term affirmed both the April 8 and October 31, 2016 orders.

We affirm Appellate Term's decision with respect to Housing Court's April 18, 2016 order, denying tenants' motion to vacate the stipulations that the GAL signed on their behalf. A GAL "is not a decision-making position; it is an appointment of assistance. The GAL provides invaluable service to the ward, such as applying for public assistance or arranging clean-ups" (*1234 Broadway LLC v Feng Chai Lin*, 25 Misc 3d 476, 495, 883 N.Y.S.2d 864 [Civ Ct, NY County 2009]) . As opposed to a guardian under article 81 of the Mental Hygiene Law , the GAL is required to appear and "adequately assert and protect the rights" of his or her ward (*New York Life Ins. Co. v V.K.*, 184 Misc 2d 727, 729, 711 N.Y.S.2d 90 [Civ Ct, NY County 1999]) . The record, viewed as a whole, shows that the GAL attempted to help her wards protect their rights during the proceeding by obtaining

extensions of time for them to comply with landlord's demand for access to their **[*6]** apartment. There is no evidence that she forced a settlement or that tenants would have fared any better by going to trial. Tenants failed to meet their burden of showing that the GAL either inadvisedly entered into those stipulations or failed to look out for their best interests.

We modify, however, because we disagree with Housing Court's determination that tenants are not entitled a permanent stay of eviction because the conditions in the apartment were not timely cured or they are ongoing. Aside from blanket statements by the landlord and the court about the likelihood of an ongoing "exodus" of bedbugs into neighboring apartments, there are no affidavits by neighbors or statements by any other individuals with personal knowledge of those facts. The determination that tenants are incapable of keeping the apartment in a safe and clean condition going forward is a serious determination that was made without the benefit of a hearing and without a proper evaluation of whether the article 81 guardian's management of their personal (and property) affairs will now make a difference in their ability to stay in their home without harming others.

Under the Fair Housing Act (FHA), as amended, **[*7]** it is unlawful to discriminate in housing practices on the basis of a "handicap" (42 USC § 3604[f][2][A]). Handicap is very broadly defined, and a person is considered handicapped and thereby protected under the FHA if he or she:

1. Has a physical or mental impairment that substantially limits one or more major life activities, or
2. Has a record of such impairment, or
3. Is regarded as having such an impairment.

No specific diagnosis is necessary for a person to be "handicapped" and protected under the statute. In fact, the determination may even be based upon the observations of a lay person (*Douglas v Kriegsfeld Corp.*, 884 A2d 1109, 1131 [DC 2005]). The appointment of an article 81 guardian for tenants sufficiently establishes that these tenants are "handicapped" within the meaning of the FHA, leading us to consider whether they are entitled to a reasonable accommodation. What is "reasonable" varies from case to case, because it is necessarily fact-specific (*see Shapiro v Cadman Towers Inc.*, 844 FSupp 116 [EDNY 1994] [bladder disorder necessitated moving tenant to the top of the waiting list for an indoor parking spot], *affd* 51 F3d 328 [2d Cir 1995]). The overarching guiding factor, however, is that a landlord is obligated to provide a tenant with a reasonable accommodation if necessary for the tenant to keep his or her apartment. The " refusal **[*8]** to make reasonable accommodations in rules, policies, practices, or services, when such accommodations may be necessary to afford [the handicapped individual] equal opportunity to use and enjoy a dwelling'" is a discriminatory practice (*see e.g. Shapiro* 51 F3d at 333, quoting 42 USC § 3604[f][3][B]). A landlord does not have to provide a reasonable accommodation if it puts other tenants at risk, but should consider whether such risks can be minimized (*see Sinisgallo v Town of Islip Hous. Auth.*, 865 F

Supp 2d 307 [ED NY 2012] [a reasonable accommodation might be imposition of a probationary period after tenant with bipolar disorder attacked a neighbor]).

The circumstances before us warrant a hearing on whether tenants are entitled to a permanent stay of eviction as an accommodation. More narrowly, the issue is whether, with the involvement of the article 81 guardian and its management of their affairs, tenants can fulfill their lease obligations and avoid eviction. Housing Court failed to consider whether with ongoing supportive services and suitable monitoring tenants can continue to live an orderly existence in the apartment without harming or affecting their neighbors (*RCG-UA Glenwood, LLC v Young*, 9 Misc 3d 25, 801 N.Y.S.2d 481 [App Term, 2d Dept 2005] [tenant offered evidence of his improved behavior after enrollment in a treatment program]). We remand for a hearing to determine **[*9]** whether the accommodations proposed by the guardian are reasonable, whether they will curtail the risk of the nuisance recurring, and whether there should be a permanent stay of eviction (*see Strata Realty Corp. v Pena*, AD3d , 86 N.Y.S.3d 74, 2018 NY Slip Op 07350 [1st Dept 2018]).

THIS CONSTITUTES THE DECISION AND ORDER OF THE SUPREME COURT, APPELLATE DIVISION, FIRST DEPARTMENT.

ENTERED: DECEMBER 27, 2018

Footnotes

- 1

  Although this appointment was intended to be temporary, tenants' attorney informed this Court at oral argument that it is now a permanent appointment.

TIMPANO

COMPETING JUDGMENTS

Matter of Timpano (McGurk), 2018 N.Y. Misc. LEXIS 4140

Copy Citation

Surrogate's Court of New York, Oneida County

September 25, 2018, Decided

2011-907/B

Reporter

2018 N.Y. Misc. LEXIS 4140 * | 2018 NY Slip Op 28298 **

[**1] In the Matter of the Accounting of Joseph J. Timpano as the Administrator of the Estate of Jean McGurk, Deceased.

Notice:

THE LEXIS PAGINATION OF THIS DOCUMENT IS SUBJECT TO CHANGE PENDING RELEASE OF THE FINAL PUBLISHED VERSION.

THIS OPINION IS UNCORRECTED AND SUBJECT TO REVISION BEFORE PUBLICATION IN THE OFFICIAL REPORTS.

Core Terms

Decedent, nursing home, real property, funds, personal property, summary judgment, docketed, services

Counsel: **[*1]** For the Petitioner: Alison Steates, Esq.

For the Objectant/Movant: Michael D. Callan, Esq.

For the Cross-Movant: John A. Herbowy, Esq.

Judges: Hon. Louis P. Gigliotti, Surrogate.

Opinion by: Louis P. Gigliotti

Opinion

Louis P. Gigliotti, S.

Decedent Jean McGurk died intestate on October 25, 2011. At the time of her death, Decedent resided in a nursing home and was a recipient of Medicaid assistance. Voluntary administration proceedings were commenced in 2012 for the purpose of liquidating assets to pay the funeral home expenses. Joseph Timpano, Oneida County Comptroller, subsequently was appointed Administrator of her Estate on July 31, 2012. Having concluded his work, Mr. Timpano filed a petition for judicial settlement of account. He reports having received a total of $14,329.80 in assets and income, with a net balance of $10,247.30 after payment of attorney's fees, costs and commissions. Mr. Timpano proposes to pay this amount to the Oneida County Department of Social Services, hereinafter referred to as "DSS," in partial satisfaction of the Medicaid lien.

In February 2012, prior to Mr. Timpano's appointment, St. Joseph's Pastoral Care, Inc., which operated the nursing home where Decedent lived and will hereinafter [*2] be referred to as the "Nursing Home," filed a claim against the estate for $99,530.50 for unpaid nursing home services. The Nursing Home then filed another notice of claim in September 2014 in the amount of $107,626.84. After Mr. Timpano filed his accounting, the Nursing Home filed an objection to the account and moved for summary judgment on the ground that its claim against decedent has priority over the Medicaid lien.1 DSS cross-moved for summary judgment. Oral argument was [**2] heard May 15, 2018, following which this Court reserved decision.

Factual Background

Decedent entered the Nursing Home in April 2009. Afterward, her son Timothy wrote checks to himself from her bank account in excess of $26,000.00. He was subsequently prosecuted. The principal received by the estate consists of the court-ordered restitution payments collected from

Timothy. Even though he still owes money in this regard, Timothy left the area in 2016. The Administrator has been unable to locate him, despite diligent efforts to do so.

Meanwhile, on April 11, 2011, DSS issued its determination that Decedent qualified for Medicaid coverage retroactively to September 1, 2010. On October 19, 2010, the Nursing Home commenced **[*3]** a collections action against Decedent and Timothy. On October 11, 2011, Supreme Court issued an order awarding judgment to the Nursing Home to cover services, attorney's fees and costs. Although Decedent and her son defaulted in appearing in the action, Timothy did appear at the damages inquest but presented no evidence. The record before this Court does not indicate that a *guardian ad litem* was appointed to appear on Decedent's behalf. Judgment on default was entered on October 24, 2011 in the amount of $99,530.50.

Decedent died the day after the default judgment was entered. The Nursing Home served Timothy with a notice of entry on November 1, 2011. On March 13, 2014, the Oneida County Sheriff received the Nursing Home's income execution relative to Timothy. On November 14, 2014, Supreme Court issued a conditional order requiring Timothy to make biweekly installments toward the total judgment owed.

The Court must now consider the priority of the judgment obtained by the Nursing Home relative to the Medicaid lien asserted by DSS.

Legal Analysis

The Nursing Home concedes that pursuant to statute, DSS is a preferred creditor. (*See* Social Services Law § 104(1) ["In all claims of the public welfare official made under **[*4]** this section the public welfare official shall be a preferred creditor."]). The Nursing Home argues however, that its judgment lien nevertheless takes priority because it was docketed prior to the effective date of the Medicaid lien, which according to federal and state laws cited by the Nursing Home, is the date of death.

The Nursing Home's argument relies in part on two cases. The first is *Matter of Pierce*, 106 AD2d 892 [4th Dept 1984], *lv. denied*, 64 NY2d 609 [1985]. In this memorandum decision, the Fourth Department concluded that a hospital with docketed judgments against the decedent held a "prior specific lien" superior to a Medicaid lien. The Nursing Home suggests this general principal applies here, as it too has a docketed judgment against Decedent. As DSS points out however, the appellate decision must be read in conjunction with the underlying Surrogate's Court opinion, *Matter of Pierce*, 122 Misc 2d 908 [Sur Ct, Onondaga County 1984], to gain a complete

understanding of the factual circumstances in which this legal principle was applied.

The decedent in *Pierce* died owning real and personal property. Prior to decedent's death, the hospital obtained and filed two judgments. Decedent also received Medicaid assistance. As part of the estate proceedings, the hospital claimed that it was a preferred creditor [*5] relative to the real estate and an unsecured creditor relative to the personal property. The Surrogate interpreted the CPLR to mean that once the judgments were docketed, the hospital's liens attached immediately to the real property. Since these docketed liens preceded the Medicaid lien, and since the value of the hospital's liens exceeded the value of the real property, the Surrogate held that the value of the *real property* was to be credited entirely toward the hospital debt.

The distinction drawn between real property and personal property is important in the case at hand, since Decedent in the instant matter died without owning real property. With only personal property available to satisfy estate debts, and employing the rationale of both the Surrogate's Court and the hospital in *Pierce*, the Nursing Home is nothing more than an unsecured creditor. The Medicaid lien would be given priority regardless of the date on which the Nursing Home's judgment was entered.

The Nursing Home tries to avoid this outcome by citing to *Matter of Pizzirusso*, NYLJ, Nov. 17, 2005 at 32, col 3 [Sur Ct, Westchester County 2005]. Aware of the holding in *Pierce*, the Surrogate in *Pizzirusso* determined that [*6] DSS held a priority lien not only because the decedent died owning no real property, but also because the respondent judgment creditor had taken no action during the decedent's lifetime to perfect his lien upon the decedent's personal property by utilizing such tools as are found in CPLR article 52. The Nursing Home argues that unlike the general creditor in *Pizzirusso*, it did take such steps by filing an income execution and obtaining a conditional order in Supreme Court for payments toward the amount owed. The flaw in this logic however, is that these steps were taken against Decedent's son Timothy and not Decedent herself. The fact that Decedent died the day after entry of the default judgment and before collection efforts could be initiated against her does not permit the Court to presume the Nursing Home would have taken such steps. Furthermore, simply because Timothy stole Decedent's money does not mean the collection efforts undertaken against Timothy should be viewed as having been executed against Decedent personally. The Nursing Home still has the option of enforcing its judgment against Timothy. The practical barriers to doing so will not permit the Nursing Home to leapfrog the priority [*7] Medicaid lien relative to settling Decedent's estate. In the alternative, the Nursing Home reasons that because DSS knew about the stolen funds at the time Medicaid assistance was approved, and because those funds were taken at a time when

Decedent was a private pay resident, the restitution payments now held by the estate should be applied toward the Nursing Home lien because "[DSS] would have categorized said monies as uncompensated transfers or excess resources, and [DSS] would have ordered the uncompensated transfers or excess resources to be paid directly to the [Nursing Home] prior to Medicaid becoming effective." (Affidavit of Elizabeth Kearns in support of summary judgment, sworn to March 7, 2018, ¶ 25). The Court finds this logic unavailing. First of all, the monies taken by Timothy were not uncompensated transfers made by Decedent, but rather funds taken without Decedent's permission as evidenced by Timothy's criminal conviction. Second, even if the Nursing Home were correct that DSS did not take the stolen funds into consideration when approving Decedent's Medicaid application, the Court is unaware of authority granted to DSS to [**3] "order" uncompensated transfer funds (presuming [*8] such funds can be recovered) be paid to a creditor. Third, as DSS points out, Medicaid coverage began prior to the Nursing Home obtaining its judgment. Prior to the entry of such judgment, the validity of the Nursing Home's claim against Decedent was not yet determined.

At oral argument, the Nursing Home added that once Decedent became Medicaid eligible, she was obligated to make NAMI payments to the Nursing Home to supplement her Medicaid assistance. The judgment lien however, is for services provided when Decedent was a private pay resident. Whatever monies Decedent may have owed after she became Medicaid eligible have not been reduced to judgment.

In sum, both caselaw and the specific facts of this particular proceeding support a finding that Mr. Timpano's account correctly allocates the payment of assets to DSS. As such, it is hereby

ORDERED that the motion for summary judgment brought by the Nursing Home is DENIED; and it is further

ORDERED that the cross-motion for summary judgment brought by DSS is GRANTED; and it is further

ORDERED that the objections to the petition for judicial settlement of account brought by the Nursing Home are DISMISSED; and it is further

ORDERED that counsel [*9] for Mr. Timpano is to submit a proposed decree in accordance with this Decision and Order.

Dated: September 25, 2018

Hon. Louis P. Gigliotti, Surrogate

Footnotes

- 1

The Nursing Home's moving papers consist of an affidavit signed by an individual who describes herself as an "Authorized Representative" (as opposed to an officer or member of the Board). When asked at oral argument what legal grounds supported this Authorized Representative submitting such an affidavit, counsel indicated she is a Board member and received Board authorization. The Court will accept this explanation at face value, even though the Court has no independent verification such as a copy of the resolution or a copy of the corporate by-laws. The Court does however, recommend that legal arguments not be included in a layperson's affidavit, as was done here.

BREIER

NURSING HOME EMPLOYEE AMD FAIR HEARINGS

Matter of Breier v New York State Dept. of Social Servs., 2019 N.Y. App. Div. LEXIS 491

Copy Citation

Supreme Court of New York, Appellate Division, Second Department

January 23, 2019, Decided

2016-00656

Reporter

2019 N.Y. App. Div. LEXIS 491 * | 2019 NY Slip Op 00433 ** | 2019 WL 288154

[**1] In the Matter of Arthur D. Breier, deceased, by Marc J. Breier, administrator of the estate of Arthur D. Breier, petitioner, v New York State Department of Social Services, et al., respondents. (Index No. 156/15)

Notice:

THE LEXIS PAGINATION OF THIS DOCUMENT IS SUBJECT TO CHANGE PENDING RELEASE OF THE FINAL PUBLISHED VERSION.

THIS OPINION IS UNCORRECTED AND SUBJECT TO REVISION BEFORE PUBLICATION IN THE OFFICIAL REPORTS.

Core Terms

decedent's, fair hearing, attorney-in-fact, applications, benefits, notices, review a determination, statute of limitations, medical assistance, proper party, tolled

Counsel: [*1] Marc J. Breier, petitioner, Pro se, Old Bethpage, NY.

Letitia James, Attorney General, New York, NY (Andrew W. Amend and David Lawrence III of counsel), for respondents New York State Department of Social Services and New York State Department of Health.

Dennis M. Brown, County Attorney, Hauppauge, NY (L. Adriana Lopez and Dana Kobos of counsel), for respondent Suffolk County Department of Social Services.

Judges: WILLIAM F. MASTRO, J.P., REINALDO E. RIVERA, COLLEEN D. DUFFY, VALERIE BRATHWAITE NELSON, JJ. MASTRO, J.P., RIVERA, DUFFY and BRATHWAITE NELSON, JJ., concur.

Opinion

DECISION, ORDER & JUDGMENT

Proceeding pursuant to CPLR article 78 to review a determination of the Commissioner of the New York State Department of Health dated September 5, 2014. The determination, after a hearing, denied, as untimely, the petitioner's request for a fair hearing to review two separate determinations of the Suffolk County Department of Social Services, dated July 13, 2013, and December 5, 2013, respectively, denying the decedent's applications for medical assistance benefits.

ORDERED that the proceeding is dismissed insofar as asserted against the Suffolk County Department of Social Services; and it is further,

ADJUDGED that the determination [*2] is confirmed, the petition is otherwise denied, and the proceeding is otherwise dismissed on the merits, without costs or disbursements.

In 2013, the decedent was admitted to long-term care at the Franklin Center for Rehabilitation & Nursing (hereinafter Franklin). The decedent's attorney-in-fact authorized Mayda Cruz, a Medicaid coordinator employed by Franklin, to represent the decedent during the Medicaid eligibility process. On June 18, 2013, Cruz filed, on behalf of the decedent, an application for medical assistance benefits, which was denied by the Suffolk County Department of Social Services

(hereinafter the DSS) on July 13, 2013, due to the failure to submit proper documentation. Cruz refiled on September 11, 2013, and on December 5, 2013, DSS denied that application on the same ground. On February 24, 2014, Cruz requested a fair hearing regarding the denials dated July 13, 2013, and December 5, 2013. In a determination dated September 5, 2014, made after a fair hearing, the Commissioner of the New York State Department of Health (hereinafter the DOH) denied the request for a fair hearing regarding those denials because the request had not been made in a timely manner. The [*3] petitioner, the administrator of the decedent's estate, then commenced this CPLR article 78 [**2] proceeding, contending that the applicable statute of limitations should have been tolled because the notices denying the applications were not sent to the decedent's attorney-in-fact. The proceeding was then transferred to this Court pursuant to CPLR 7804(g) .

The determination by the DOH that, since the request for a fair hearing was made more than 60 days after the DSS denied the applications, the DOH was without jurisdiction to review the determinations, is supported by substantial evidence (*see* Social Services Law § 22[4][a]; 18 NYCRR 358-3.5[b][1]; *Matter of Notman v New York State Dept. of Health*, 162 AD3d 1704, 1705, 80 N.Y.S.3d 763 ; *Matter of Fieldston Lodge Nursing Home v DeBuono*, 261 AD2d 543, 543-544, 690 N.Y.S.2d 606 ; *Glengariff Health Care Ctr. v Glass*, 231 AD2d 717, 718, 647 N.Y.S.2d 998) .

Contrary to the petitioner's contention, the statute of limitations was not tolled on the ground that the denial notices were not sent to the decedent's attorney-in-fact. Cruz, who had applied for Medicaid benefits on behalf of the decedent as his recognized representative, was the proper party to receive the notices of denial (*see* Social Services Law § 22[12]; 18 NYCRR 358-3.1[a]; *Matter of Fieldston Lodge Nursing Home v DeBuono*, 261 AD2d at 544).

Additionally, since the determination of the DOH is final and binding on the DSS, and the DSS must comply with it (*see* 18 NYCRR 358-6.1[b]), the DSS is not a proper party to this proceeding and the proceeding should be dismissed insofar as asserted against it (*see Matter of Weiss v Suffolk County Dept. of Social Servs.*, 121 AD3d 703, 706, 993 N.Y.S.2d 368 ; *Matter of Loiacono v Demarzo*, 72 AD3d 969, 898 N.Y.S.2d 513).

MASTRO , J.P., RIVERA, [*4] DUFFY and BRATHWAITE NELSON, JJ., concur.

ESTATE OF SHAMBO

ADMINISTRATOR SURCHARGED

Matter of Shambo, 2019 N.Y. App. Div. LEXIS 1310

Copy Citation

Supreme Court of New York, Appellate Division, Third Department

February 21, 2019, Decided; February 21, 2019, Entered

526709

Reporter

2019 N.Y. App. Div. LEXIS 1310 * | 2019 NY Slip Op 01280 **

[**1] In the Matter of the Estate of PENNY LEE SHAMBO, Deceased. MELISSA THOMPSON, as Administrator of the Estate of PENNY LEE SHAMBO, Appellant; SARATOGA COUNTY DEPARTMENT OF SOCIAL SERVICES, Respondent. (Proceeding No. 1.);In the Matter of the Estate of PENNY LEE SHAMBO, Deceased. ROWLANDS & LeBROU, PLLC, Appellant; SARATOGA COUNTY DEPARTMENT OF SOCIAL SERVICES, Respondent. (Proceeding No. 2.)

Notice:

Core Terms

expenses, decedent, decedent's estate, real property, sell property, reimbursement, fiduciary, surcharge, mortgage, summary judgment, estate's assets, accounting, administrator's letter, counsel fees, outstanding, funeral, parties, removal, circumstances, documentation, improvidence, dissipation, diligence, benefits, modified, prudent, reside, unpaid, facie, law law law

Counsel: [*1] Rowlands & LeBrou, PLLC, Latham (Nicholas J. Orecki of counsel), for appellants.

Stephen M. Dorsey, County Attorney, Ballston Spa (Hugh G. Burke of counsel), for respondent.

Judges: Before: Lynch, J.P., Clark, Mulvey, Devine and Aarons, JJ. Lynch, J.P., Mulvey, Devine and Aarons, JJ., concur.

Opinion by: Clark

Opinion

MEMORANDUM AND ORDER

Clark, J.

Appeal from an order of the Surrogate's Court of Saratoga County (Kupferman, S.), entered July 20, 2017, which, among other things, in proceeding No. 1 pursuant to SCPA article 22, partially granted respondent's motion for summary judgment on its objections to petitioner's accounting.

This appeal arises out of the administration of the estate of Penny Lee Shambo (hereinafter decedent), who died intestate on September 26, 2009 as a resident of Saratoga County. However, for purposes of this appeal, we must rewind to November 24, 2007, when decedent's spouse, William J. Shambo Jr. (hereinafter Shambo), passed intestate. At the time of his passing, Shambo resided in a home, located in the Town of Rotterdam, Schenectady County, that he owned with decedent and which had an outstanding mortgage of $49,603.70.

In May 2008, Schenectady County Surrogate's Court granted petitioner Melissa Thompson, [*2] the daughter of Shambo and decedent, limited letters of administration in Shambo's estate. Two months later, Thompson obtained an appraisal of the real property owned by Shambo and decedent, which was given an "as is" value of $125,000. Thompson thereafter sought and, by a March 2009 order, received judicial authority to establish a special needs trust for the benefit of decedent, who had been receiving Medicaid benefits since June 2004. Thompson also received judicial authority to sell the property to herself, her husband, her half sister (who is the daughter of Shambo, but not decedent) and her half sister's husband at the discounted price of $117,500 "in order to have a quick closing and to expedite the funding of" the special needs trust. The March 2009 order further directed that the proceeds from the sale of the real property be used to fund the special needs trust

after reimbursing Thompson for certain expenses - in particular, property expenses totaling $11,634.33, estate administration expenses totaling $12,368.91 and the payment of counsel fees in the amount of $7,0551 . Thompson was ultimately reimbursed, from Shambo's estate, for the $12,368.91 spent on administration expenses, [*3] but her reimbursement for the $11,634.33 spent on the property, as well as the counsel fee award, was dependent on the sale of the real property to herself and her three relatives. That sale never occurred.

Roughly seven months after entry of the March 2009 order authorizing the sale of the property, decedent died. Perplexingly, and without explanation in the record, Thompson did not seek clarification or modification of the March 2009 order and she did not petition Surrogate's Court for letters of administration in decedent's estate until November 2012, more than three years after decedent's death. All the while, Thompson continued to pay various expenses relating to the real property, which included sporadic payments toward the outstanding mortgage.

In December 2012, after the Saratoga County Surrogate's Court granted Thompson letters of administration in decedent's estate, respondent filed a claim against decedent's estate for reimbursement of $466,625.59 - the amount of Medicaid benefits that decedent had received from June 1, 2004 through her death on September 26, 2009 - plus interest. Respondent thereafter sought to compel an accounting in decedent's estate. In response, Thompson [*4] filed a petition for judicial settlement of the account (proceeding No. 1), along with a formal accounting, which listed unpaid administration expenses totaling $84,289.26. These [**2] administration expenses included the unpaid amounts due under the March 2009 order, additional counsel fees incurred to settle and close out the administration of Shambo's estate, a $6,000 commission to Thompson and the reimbursement of court and funeral expenses in decedent's estate, as well as costs relating to the real property from November 2008 through July 2013. Respondent filed formal objections to the accounting, alleging that Thompson failed to sell the property within a reasonable amount of time and seeking, among other things, an order imposing surcharges on Thompson.

Thereafter, by a November 2013 order issued upon consent of the parties, Thompson was authorized and directed to list the property for $115,000 and sell it for a minimum of $110,000 and to place the sale proceeds in escrow pending a determination as to whether respondent's Medicaid claim had priority over the existing mortgage on the property2 . About a week later, Wells Fargo Bank, N.A., the mortgage holder, commenced an action in Schenectady [*5] County to foreclose on the property. The foreclosure action was later transferred to Surrogate's Court and consolidated with the administration of decedent's estate.

In April 2015, over five years after decedent's death and more than 16 months after Thompson was authorized to list and sell the property, Surrogate's Court granted, upon the parties' stipulation,

Thompson's request to sell the property to her husband for $110,000 and directed that the sale close within 30 days. The property was ultimately sold to Thompson's husband and, in July 2015, $110,064.35 was deposited with the Saratoga County Treasurer. One year later, Surrogate's Court issued a decree establishing $74,475.28 as the verified mortgage claim of Wells Fargo.

In September 2016, petitioner Rowlands & LeBrou, PLLC - counsel to Thompson as the administrator of decedent's estate - commenced proceeding No. 2 to fix and determine counsel fees (*see* SCPA 2110), which were alleged in the amount of $32,661.32. Following an examination of Thompson pursuant to SCPA 2211 , respondent moved for summary judgment on its objections. Surrogate's Court partially granted respondent's motion for summary judgment and, based on what it found to be Thompson's **[*6]** improvident management of decedent's estate and dereliction of duty, removed Thompson as the administrator of the estate, denied her a commission for her role as administrator and declined to reimburse her for the unpaid administration expenses listed in her account, except for reasonable funeral expenses and the outstanding amounts due under the March 2009 order. The court further found that decedent's real property reasonably should have been sold by July 1, 2013 for $117,500 and, so as to place respondent in the position that it would have been in had such a sale occurred at that time, imposed a $14,174.74 surcharge upon Thompson. Finally, Surrogate's Court denied the payment of counsel fees to Rowlands & LeBrou out of decedent's estate, finding that the value of the legal representation provided to the estate did not justify payment of the $32,661.32 fee. Petitioners appeal.3

Respondent's objections to the accounting were largely premised upon Thompson's failure to promptly sell the real property, thereby resulting in the prolonged and unnecessary payment of the property's carrying charges and a corresponding diminution of estate assets that could be used to satisfy respondent's **[*7]** outstanding Medicaid claim. Thus, Surrogate's Court properly identified the dispositive question raised by respondent's objections to be whether Thompson "acted as a diligent and prudent fiduciary." "'[A] fiduciary owes a duty of undivided and undiluted loyalty to those whose interests the fiduciary is to protect'" and, when "acting on behalf of an estate[,] is required to employ such diligence and prudence to the care and management of the estate assets and affairs as would prudent persons of discretion and intelligence in their own like affairs" (*Matter of Billmyer*, 142 AD3d 1000, 1001 [2016] , quoting *Birnbaum v Birnbaum*, 73 NY2d 461, 466 [1989] ; *see Matter of Donner*, 82 NY2d 574, 584 [1993] ; *Matter of Carbone*, 101 AD3d 866, 868 [2012]) .

We agree with Surrogate's Court that respondent came forward with prima facie evidence demonstrating Thompson's mismanagement of decedent's estate and overall dereliction of duty and that petitioners, who were required to lay bare their proof in opposition to respondent's motion (*see Wasson v Bond*, 80 AD3d 1114, 1115 [2011] ; *Johnson v Title N., Inc.*, 31 AD3d 1071, 1072 [2006]) ,

failed to raise a triable question of fact precluding summary judgment on that issue. The legitimacy of respondent's objections to Thompson's unreasonable delay in selling the real property, resulting in an ongoing dissipation of the estate's assets, was readily apparent from the accounting, as well as the irrefutable timeline of events [*8] (*see* *Matter of Carbone*, 101 AD3d at 869).

As Surrogate's Court correctly noted, it did not have jurisdiction over Thompson's conduct prior to the issuance of letters of administration in decedent's estate (*see generally* SCPA 203). Nevertheless, Thompson's failure to comply with the March 2009 order authorizing the expedited sale of the property to her and her three relatives, as well as the unexplained three-year delay in applying for letters of administration in decedent's estate, are relevant to the underlying question of whether Thompson's delay in selling the property was unreasonable. Because decedent was not residing at the property at the time of Shambo's death and did not thereafter return to the property to reside, Thompson had access to and possession of the property for an extended period of time prior to the issuance of the letters of administration in November 2012. Thus, she was uniquely positioned to ensure an expeditious sale, so as to preserve the value of the estate's asset, once she did receive the letters of administration. Nevertheless, the property was not sold to her husband until July 2015, more than 18 months after Surrogate's Court had authorized Thompson to sell the property for at least $110,000. [*9] The evidence demonstrated that, during this 18-month period, the mortgage encumbrance increased by roughly $30,000.

Thompson's broad and conclusory testimony that she was unable to sell the property due to its poor condition was insufficient to defeat respondent's prima facie showing that she had unreasonably delayed in liquidating the estate's sole asset. Thompson did not, in opposition to respondent's motion for summary judgment, provide any documentation to substantiate her claim [**3] that she had unsuccessfully attempted to sell the house or otherwise demonstrate that she had taken any meaningful steps to sell the property for a reasonable price within a reasonable amount of time. She provided no listing for the house, no documentation of any offers received and rejected or any evidence to establish when and for how long the property was listed for sale. Under these circumstances, Surrogate's Court properly determined, as a matter of law, that respondent was entitled to summary judgment on its objection to the unreasonable length of time it took Thompson to sell the property (*see* *Matter of Billmyer*, 142 AD3d at 1002 ; *Matter of Carbone*, 101 AD3d at 869).

Thompson also challenges her removal as the administrator of the estate. SCPA 711 (2) permits the removal of a fiduciary [*10] where he or she is shown to be unfit for the execution of the office by reason of having wasted or improvidently managed the assets of an estate. Similarly, SCPA 711 (8) permits removal "[w]here [the fiduciary] does not possess the qualifications required of a fiduciary by reason of . . . improvidence . . . or who is otherwise unfit for the execution of the office." As

discussed above, Thompson's delay and dilatory conduct in selling the real property caused a dissipation of the assets that would have been available to respondent absent such delay. Accordingly, we discern no abuse of discretion in the determination of Surrogate's Court to remove Thompson as the administrator of the estate under SCPA 711 (2) and (8) (*cf.* *Matter of Witherill*, 37 AD3d 879, 881 [2007]) 4 . For the same reasons, we find no abuse of discretion in the determination of Surrogate's Court to deny Thompson statutory commissions (*see* *Matter of Witherill*, 37 AD3d at 881 ; *Matter of Quattrocchi*, 293 AD2d 481, 481 [2002] ; *Matter of Kelly*, 147 AD2d 564, 564 [1989] , *appeal dismissed* 78 NY2d 904 [1991]) .

Further, we discern no abuse of discretion in the determination of Surrogate's Court to deny Thompson reimbursement for all property expenses listed in the account, except for those amounts specifically directed in the March 2009 order entered during the administration of Shambo's estate. Initially, upon a review of the account and **[*11]** the supporting documentation, as well as the testimony given by Thompson at her SCPA 2211 examination, we agree with Surrogate's Court that the account was "woefully inadequate," as Thompson failed - in response to respondent's prima facie showing that the account was inaccurate - to substantiate many of the alleged property expenses. Moreover, Thompson's ongoing but sporadic payment of property expenses during her lengthy delay in selling the property caused a wasteful dissipation of estate assets, while simultaneously benefiting the property that her husband ultimately obtained. Under all of the circumstances, we find no basis upon which to disturb the denial of reimbursement to Thompson for the property expenses alleged in the account. However, we agree with Thompson that she should have been reimbursed for a $1,725 funeral expense that appears to have been overlooked by Surrogate's Court, as well as $625 in court fees (*see* SCPA 103 [22] ; 1811 [1]; *Matter of Jewett*, 145 AD3d 1114, 1119-1120 [2016]) . Thus, as more fully set forth below, we modify the determination of Surrogate's Court by adjusting the surcharge imposed upon Thompson accordingly.

Turning to the issue of surcharges, a surcharge is warranted where the objectant demonstrates that the fiduciary **[*12]** "acted negligently, and with an absence of diligence and prudence which an ordinary [person] would exercise in his [or her] own affairs" (*Matter of Lovell*, 23 AD3d 386, 387 [2005] ; *accord* *Matter of Billmyer*, 142 AD3d at 1002 ; *see Matter of* *[**4]* *Donner*, 82 NY2d at 585). Here, given Thompson's failure to act diligently and prudently in the management of the estate's sole asset, we find no abuse of discretion in the determination of Surrogate's Court to impose a surcharge upon Thompson in an amount aimed at placing respondent in the position that it would have been in had Thompson fulfilled her fiduciary duty and sold the real property at a reasonable price, within a reasonable amount of time (*see* *Matter of Donner*, 82 NY2d at 585-586 ; *Matter of Jewett*, 145 AD3d at 1123-1124 ; *Matter of Braasch*, 140 AD3d 1341, 1342 [2016]) . To that end, we

agree with Surrogate's Court that, under the unique circumstances of this case, July 1, 2013 - more than seven months after Thompson received letters of administration - was a reasonable date by which the real property should have been sold (*see generally* *Matter of Janes*, 90 NY2d 41, 54 [1997] ; *Matter of Donner*, 82 NY2d at 584-585). However, we disagree with Surrogate's Court as to the reasonable price at which the property should have been sold by this date. Because the parties consented to the November 2013 and May 2015 orders authorizing a sale of the property for $110,000, we find that $110,000, rather than $117,500, constituted a reasonable **[*13]** price at which the property should have been sold by July 1, 2013. In view of our determination regarding the reasonable sale price in July 2013, as well as our finding that Thompson should have been reimbursed for an additional funeral expense and certain court fees, the surcharge imposed upon Thompson must be reduced from $14,174.74 to $4,324.74.

Finally, given the minimal, if any, benefit to the estate derived from the years of legal representation provided by Rowlands & LeBrou, and their excessive request, Surrogate's Court did not abuse its discretion when it denied the payment of counsel fees from the estate (*see generally* *Matter of Rodken*, 2 AD3d 1008, 1009 [2003]). To the extent that we have not expressly addressed any of petitioners' arguments, they have been examined and found to be without merit.

Lynch, J.P., Mulvey, Devine and Aarons, JJ., concur.

ORDERED that the order is modified, on the law, without costs, by reducing the surcharge imposed upon petitioner Melissa Thompson from $14,174.74 to $4,324.74, and, as so modified, affirmed.

Footnotes

- 1

  No appeal was taken from the March 2009 order.

- 2

  This Court ultimately resolved the question of priority and determined that the mortgage holder, Wells Fargo Bank, N.A., had priority creditor status (*Matter of Shambo*, 138 AD3d 1215 [2016]). Contrary to petitioners' contention, this priority dispute in no way prevented Thompson from listing and selling the property.

- 3

  Although a notice of appeal was filed only on behalf of Thompson, the issues raised in the "Brief of the Appellant" concern both petitioners and the CPLR 5531 statement filed with the Court classifies both Thompson and Rowlands & LeBrou as appellants. Accordingly, a notice of appeal should have also been filed on behalf of Rowlands & LeBrou. As the parties do not raise this issue and, in the absence of an allegation of prejudice, we will disregard the error and treat the appeal as having been also taken by Rowlands & LeBrou (*see* *Matter of Curcio v Sherwood 370 Mgt. LLC*, 147 AD3d 1186, 1187 n 1 [2017]).

- 4

  In light of our determination, we need not address whether Thompson's removal as administrator was warranted under SCPA 711 (3).

ALEXANDER B.P.

GUARDIANSHIP FEE AWARD

Matter of Alexander B.P. (Hafner), 2018 N.Y. App. Div. LEXIS 6678

Copy Citation

Supreme Court of New York, Appellate Division, Second Department

October 10, 2018, Decided

2016-11267

Reporter

2018 N.Y. App. Div. LEXIS 6678 * | 2018 NY Slip Op 06744 **

[**1] In the Matter of Alexander B.P. (Anonymous), respondent. Long Island Jewish Valley Stream Hospital, etc., petitioner-appellant; Bruce Robert Hafner, etc., nonparty-respondent. (Index No. 31965/16)

Notice:

THE LEXIS PAGINATION OF THIS DOCUMENT IS SUBJECT TO CHANGE PENDING RELEASE OF THE FINAL PUBLISHED VERSION.

THIS OPINION IS UNCORRECTED AND SUBJECT TO REVISION BEFORE PUBLICATION IN THE OFFICIAL REPORTS.

Core Terms

guardian, compensate, directing, evaluator, seal, incapacitated, substituting, funds, exercise of discretion, property management, entry of the order, render a service, personal needs, good cause, total sum, not-for-profit, proceedings, frivolous, relieving, modified, suitable, appeals, parties, remit

Counsel: [*1] La Salle, La Salle & Dwyer, P.C., Sea Cliff, NY (Lori A. La Salle of counsel), for petitioner-appellant.

Bruce Robert Hafner, Lynbrook, NY, nonparty-respondent, Pro se.

Judges: WILLIAM F. MASTRO, J.P., SANDRA L. SGROI, JOSEPH J. MALTESE, VALERIE BRATHWAITE NELSON, JJ. MASTRO, J.P., SGROI, MALTESE and BRATHWAITE NELSON, JJ., concur.

Opinion

DECISION & ORDER

In a proceeding pursuant to Mental Hygiene Law article 81, the petitioner appeals from an order and judgment (one paper) of the Supreme Court, Nassau County (Daniel R. Palmieri, J.), dated September 4, 2016. The order and judgment, insofar as appealed from, directed the petitioner to compensate the guardian in the sum of $500 per month and to pay the fee of $250 to the court evaluator, and sealed the record of the proceedings.

ORDERED that order and judgment is modified, on the facts and in the exercise of discretion, by deleting the provision thereof directing the petitioner to compensate the guardian in the sum of $500 per month, and substituting therefor a provision directing that the total sum of $3,000 shall be paid from the funds of Alexander B. P. to Bruce Robert Hafner, Esq., the guardian, for his services rendered on behalf of Alexander B. P. to date; as so modified, the [*2] order and judgment is affirmed insofar as appealed from, without costs or disbursements; and it is further,

ORDERED that the matter is remitted to the Supreme Court, Nassau County, for the entry of an order relieving Bruce Robert Hafner, Esq., as guardian, and substituting in his stead a suitable not-for-profit guardian for Alexander B. P.

The petitioner, Long Island Jewish Valley Stream Hospital, by Catherine Hottendorf, in her capacity as its Executive Director, filed a petition pursuant to Mental Hygiene Law article 81 alleging that then patient, Alexander B. P., was in need of a guardian in order to provide for his personal needs and property management. After a hearing, the Supreme Court, in an order and

judgment dated September 4, 2016, granted the petition and appointed an independent guardian, Bruce Robert Hafner, Esq., to manage Alexander B. P.'s person and property. Additionally, the court directed the petitioner to compensate the guardian in the sum of $500 per month and to pay the fee of $250 to the court evaluator, and sealed the record of the proceedings. The petitioner appeals.

Pursuant to Mental Hygiene Law § 81.28(a), the court shall establish a plan for the reasonable compensation of a guardian. The only requirement is that **[*3]** the court "must take into account the specific authority of the guardian or guardians to provide for the personal needs and/or [**2] property management for the incapacitated person, and the services provided to the incapacitated person by such guardian" (*see* *Matter of Goldstein v Zabel*, 146 AD3d 624, 629, 45 N.Y.S.3d 432). Thus, the Legislature did not specifically provide that the guardian's compensation must come from any particular source.

The Legislature provided that the court may direct the petitioner to compensate a court evaluator and/or legal counsel in a guardianship proceeding only when the petition is *denied or dismissed*, or the alleged incapacitated person dies before a determination is made in the proceeding (*see* Mental Hygiene Law §§ 81.09[f]; 81.10[f]; *Matter of Buttiglieri [Ferrel J.B.]*, 158 A.D.3d 1166, 70 N.Y.S.3d 639). "[T]he Legislature was clearly cautioning those who would bring a frivolous petition, or one motivated by avarice, that they might very well have to bear the financial burden of the proceeding" (*Matter of Lyles*, 250 AD2d 488, 489, 673 N.Y.S.2d 122). In contrast, the issue of the source of compensation for a guardian only arises when a petition is granted and thus is not frivolous. Therefore, although Mental Hygiene Law § 81.28(a) does not explicitly prohibit a court from directing a petitioner to compensate a guardian, given that the petitioner was successful and there was no evidence that the **[*4]** proceeding was commenced in bad faith, the Supreme Court's directive that the petitioner compensate the guardian constituted an improvident exercise of discretion (*see generally* *Matter of Lyles*, 250 AD2d 488, 673 N.Y.S.2d 122). Rather, the guardian must be compensated from the funds of Alexander B. P.

However, we agree with the Supreme Court's determination directing the petitioner to pay the court evaluator's fee. "By stipulation, the parties may shape the facts to be determined at trial and thus circumscribe the relevant issues for the court to the exclusion of disputed matters that otherwise would be available to the parties" (*Deitsch Textiles v New York Prop. Ins. Underwriting Assn.*, 62 N.Y.2d 999, 1002, 468 N.E.2d 669, 479 N.Y.S.2d 487; *see* *Dental Health Assoc. v Zangeneh*, 80 AD3d 724, 724, 915 N.Y.S.2d 311). Here, the petitioner entered into a stipulation providing that it would pay the court evaluator's fee.

Finally, we agree with the Supreme Court's determination granting the guardian's application to seal the record pursuant to Mental Hygiene Law § 81.14(b) (*see* *Matter of Linda E. [Justin B.]*, 55 Misc. 3d 700, 49 N.Y.S.3d 272 [Sup Ct, Tompkins County]). Although the court should have entered the order upon a "written finding of good cause [to seal the record], which shall specify the grounds thereof" (Mental Hygiene Law § 81.14[b]), there was good cause to seal the record in light of Alexander B. P.'s privacy interests and the nature of the incapacity involved.

Accordingly, the guardian should be paid the total sum of $3,000 **[*5]** from the funds of Alexander B. P. for his services rendered on behalf of Alexander B. P. to date. We remit the matter to the Supreme Court, Nassau County, for the entry of an order relieving Bruce Robert Hafner as guardian and substituting a suitable not-for-profit guardian for Alexander B. P.

MASTRO, J.P., SGROI, MALTESE and BRATHWAITE NELSON, JJ., concur.

MATTER OF R.T.

JOINT ACCOUNTS/GUARDIANSHIP/SPOUSAL DUTY

Matter of R.T. (D.C.), 2019 N.Y. Misc. LEXIS 2480

Supreme Court of New York, Broome County

May 15, 2019, Decided

EFCA2018001606

Reporter
2019 N.Y. Misc. LEXIS 2480 * | 2019 NY Slip Op 29147 **

[**1] In the Matter of the Application of R.T., Petitioner, Pursuant to Article 81 of the Mental Hygiene Law For the Appointment of a Guardian of the Person and Property of D.C., Jr., An Incapacitated Person.

Notice:
THE LEXIS PAGINATION OF THIS DOCUMENT IS SUBJECT TO CHANGE PENDING RELEASE OF THE FINAL PUBLISHED VERSION.

THIS OPINION IS UNCORRECTED AND SUBJECT TO REVISION BEFORE PUBLICATION IN THE PRINTED OFFICIAL REPORTS.

Core Terms

withdrawals, parties, Co-Guardians, funds, appointment, spouse, resources, issues, monthly, joint tenancy, incapacitated, reimbursement, marriage, joint account, court finds, requesting, expenses, marital, married, memory, transactions, Guardian, execute, refund, days, cross-petition, proceedings, transferred, settlement, bathroom

Counsel: [*1] Richard N. Aswad, Esq., Attorney for Petitioner, Aswad & Ingraham, LLP, Binghamton, NY.

A. Laura Bevacqua, Esq., Attorney for Alleged Incapacitated Person (AIP), Binghamton, NY.

Kristen K. Luce, Esq., Keegan J. Coughlin, Esq., Attorneys for Cross-Petitioners,

oughlin & Gerhart, LLP, Binghamton, NY.

Judges: David H. Guy, J.

Opinion by: David H. Guy

Opinion

PROCEDURAL HISTORY
This proceeding was commenced on June 14, 2018 by a petition filed by R. T. (hereinafter referred to as Petitioner), requesting to be appointed Guardian of the Person and Property of her husband, D. C., Jr. (hereinafter referred to as AIP), pursuant to Article 81 of Mental Hygiene Law. The Court signed an Order to Show Cause on June 19, 2018, appointing Philip J. Artz, Esq. as Court Evaluator. On July 5, 2018, AIP's son, DCIII, and AIP's daughter, [**2] AB (collectively "Cross-Petitioners") filed a cross-petition requesting their appointment as co-guardians of the person and property of AIP. By Order dated July 10, 2018, the Court appointed Mental Hygiene Legal Service (3rd Dept.), A. Laura Bevacqua, Esq., of counsel, as counsel to represent AIP, in this matter. The matter was first before the Court on August 21, 2018. Appearing were Petitioner; Richard Aswad, Esq., counsel for Petitioner; [*2] Philip J. Artz, Esq., Court Evaluator; Cross-Petitioners, DCIII and AB; Kristen K. Luce, Esq. and Keegan Coughlin, Esq., counsel for Cross-Petitioners; Mental Hygiene Legal Service (3rd Dept.), A. Laura Bevacqua, Esq., of counsel, for AIP; AIP was also present, with one of the aides who assisted with his care at Petitioner's home. After testifying about his analysis of the situation and recommendations, the letter and reports of Mr. Artz were admitted into evidence.
The parties agreed that they could work together in AIP's best interests on matters affecting his personal needs. The Court made a finding, based on the testimony and reports of Mr. Artz, that AIP has limitations that impact his ability to address his personal and financial needs, and that if arrangements were not either currently in place, or could not be put in place, to address those limitations, he would be at risk of harm and a guardian would have to be considered, and likely appointed. The matter was adjourned to give the parties the opportunity to exchange information and work cooperatively to address AIP's personal and financial needs.

The matter was again before the Court on November 13, 2018. The same parties appeared, [*3] with the exception of AIP, by then residing in Brookdale West, an adult care facility in Vestal, New York. Mr. Artz, the Court Evaluator, did appear, but was excused from this and further proceedings. The day before this appearance, Petitioner filed an Amended Petition, with supporting memorandum of law, requesting authority to utilize AIP's income for her own support. The amended petition requested authority inconsistent with Petitioner's previously requested authority to serve as Guardian of the Property of AIP Following substantial conferencing among the Court, counsel and the parties, Petitioner withdrew the portion of her original petition requesting she be appointed as Guardian of the Property of AIP, and consented to the appointment of the Cross-Petitioners as property Co-Guardians. DCIII and AB both testified, and the Court found them appropriate Co-Guardians of the Property of their father.

The parties negotiated a possible resolution with respect to property issues which would provide for some monthly support of Petitioner from AIP's income. A hearing date was scheduled, with interim settlement conferences to attempt resolution of this matter per the tentative agreement. With [*4] a substantial insurance reimbursement payment to AIP anticipated after December 1, 2018, the Court directed that no withdrawals be made from AIP's account after that date, so that the proper allocation of that refund payment could be made.

The appointment of Cross-Petitioners as Co-Guardians of the Property of AIP was confirmed by Order of the Court dated December 20, 2018.

On December 26, 2018, Cross-Petitioners filed an amended cross-petition seeking a monetary judgment against Petitioner, alleging theft of the AIP's income. The matter was again before the Court on January 17, 2019. The parties agreed to a settlement of most of the open issues, as detailed and memorialized in the Court's January 23, 2019 Amended Order and Judgment. This broad settlement left open only the property claims asserted by Cross-Petitioners against Petitioner in paragraph ten of their amended cross-petition. These remaining property claims were tried before the Court on January 17, 2019 and February 15, 2019. Petitioner, Cross-Petitioners and counsel for AIP all submitted post-hearing written summations.

FINDINGS OF FACT

AIP and Petitioner met and began a romantic relationship in 2008. AIP moved into Petitioner [*5] 's home in the spring of 2011. He put a substantial amount of his own resources into renovating and improving her home. In recognition of AIP's financial contribution to these improvements, Petitioner granted him ownership rights in her home, which was accomplished by the execution of two

deeds. AIP and Petitioner now own the property as tenants in common, with each reserving a life estate.

AIP and Petitioner were each married and divorced twice before their marriage to each other. From the time their romantic relationship began in 2008 until AIP's health would not allow it to continue, they enjoyed an active lifestyle, socializing, traveling, and participating in the events of their respective children and grandchildren. Petitioner attended the Covert family's events. Their home was well maintained. AIP and Petitioner were well dressed and groomed and utilized their respective income in a generally collective way to enjoy life.

AIP's income consists of a lifetime annuity, paying about $4,000 a month, monthly social security of more than $1,200 and a required minimum distribution from an IRA of approximately $270 per month, totaling over $5,500 per month in recent years. AIP's income [*6] was, until this Article 81 proceeding, deposited into a Visions Federal Credit Union (Visions) account.

Petitioner's income consists of Social Security retirement and a required minimum distribution payment from an IRA, totaling between $1,600 and $1,700 per month. Petitioner's income flows to an individual account she maintains at Horizons Federal Credit Union (Horizons). In addition to the Horizons account, Petitioner owns at least one investment account and, until 2017, she owned other real estate.

Petitioner and AIP clearly developed a habit of using all of their combined monthly income to enjoy life, family and each other. AIP's two prior failed marriages impacted him and played a role in his decision to convert a substantial amount of his savings into the lifetime annuity which is the biggest portion of his monthly income. His children were aware of this, and his determination to use his money as he saw fit during his lifetime.

Beginning by at least 2014, AIP was exhibiting memory issues. He received a dementia diagnosis in that year, of which both Petitioner and his children were aware. On March 5, 2014, AIP made Petitioner a joint owner of his Visions account.

Over time, AIP's [*7] memory issues progressed. If he had not already been doing it before, he developed a routine of going to Visions every month and withdrawing all his income in cash. At the same time, Petitioner's control over AIP's finances increased. There were incidents where AIP lost some of the cash he withdrew. This was a concern to both Petitioner and AIP's children.

AIP's family became increasingly concerned about his dementia progression. Petitioner attended training at local nursing homes to assist her in providing the best care possible for AIP. Petitioner and AIP's children held family meetings outside AIP's presence to discuss his memory issues, in both February and

December of 2016. The family discussed potential nursing home placement and in-home health care for AIP.
In August of 2016, Petitioner and AIP met with Jamie Lindsey, Esq., of Levene Gouldin & Thompson about AIP executing a new Power of Attorney naming Petitioner as agent. Attorney Lindsey concluded at that meeting that AIP lacked capacity to execute a Power of Attorney. Later in 2016, Petitioner took AIP to James Mack, Esq. who had represented both [**3] parties before, including in the preparation of the deeds to Petitioner 's house, [*8] to execute a new Power of Attorney. Attorney Mack also indicated that while AIP only needed a "moment of clarity" to execute a Power of Attorney, he did not possess the requisite clarity at the time of that meeting. No Power of Attorney was executed by AIP.
Early in 2017 modifications were made to a bathroom in the couple's house to enhance access and safety. This work was financed through a loan taken out by Petitioner alone.
In March or April of 2017, DCIII was added to AIP's Visions account. DCIII utilized this authority to begin to monitor his father's financial affairs. DCIII took AIP to Visions to make his monthly withdrawals in this time period. Due to concern with AIP's driving, Petitioner also sometimes took him to Visions to make the withdrawals. At some point, apparently in 2017, AIP no longer went to Visions to make the withdrawals; Petitioner started doing that on his behalf. The withdrawn funds were all deposited into Petitioner's individual Horizons checking account, from which she took care of all the couple's bills.
From early on in their romantic relationship, AIP asked Petitioner to marry him on multiple occasions. These requests began before AIP moved into Petitioner's [*9] house and continued throughout their relationship. Petitioner declined multiple proposals, having become, in her own words, "disillusioned" about the institution of marriage, due to her own failed marriages. AIP's children were aware of his multiple proposals, but similarly cautioned him about marrying again, due to his own marital history.
Petitioner traveled from Binghamton to Las Vegas, to visit with family, on June 7, 2017. AIP's children arranged to stay with him in his home, as they and Petitioner believed AIP could not be left home by himself.
On June 28, 2017, AIP left his home to run an errand and became lost. He was ultimately found driving in Minerva, New York, almost four hours north of his home. He was retrieved and brought home safely by DCIII. Within days of this incident, DCIII, with the knowledge and agreement of Petitioner, spoke to his father and took away his car keys, to prevent him from being able to drive. Two days later, AIP called DCIII back to his house to discuss driving privileges. DCIII did not relent, and at the end of the conversation, AIP confided in DCIII that he and Petitioner had obtained a marriage license and were planning to be married

imminently. [*10] This news was not favorably received by DCIII, who confronted Petitioner and, ultimately, their minister, about AIP's capacity to enter a marriage. On July 5, 2017, AIP and Petitioner were married, with no members of AIP's family present.

The marriage led to a cooling of the relationship between Petitioner and AIP's children. Within days of the wedding, DCIII received a letter dated July 3, 2017, from Visions advising that he had been removed from AIP's account.

Petitioner continued to manage AIP's and her own funds independently from July of 2017 forward. She retained counsel to commence this Article 81 proceeding in February of 2018. In April of 2018 Petitioner facilitated the transfer of AIP's Volkswagen to herself.

AIP's continuing deterioration necessitated the hiring of an in-home health care aide in January of 2018. An aide remained in place to assist in the home until September of 2018, when AIP was transferred to Brookdale West, a memory care facility in Vestal, New York. AIP moved to Vestal Park, a skilled nursing facility, in early December of 2018, where he remains a resident.

AIP is the owner of a long-term care insurance policy issued by GE Capital Life [**4] Insurance Company [*11] of New York. The policy was issued January 18, 2000 and covers services ranging from home care to institutionalized skilled nursing. AIP is past his elimination period, so the policy is currently paying or reimbursing all or a portion of his Vestal Park care costs. The understanding of the parties is that this is a New York "Partnership Plan," meaning that upon the expiration of benefits payable by the policy, AIP will automatically qualify for **Medicaid** coverage, without any asset spend-down requirement.

LAW AND ANALYSIS

Per the parties' settlement, the only issues left for Court determination are those set forth in paragraph ten (10) of the Cross-Petitioners' Amended Petition filed on December 26, 2018. Cross-Petitioners seek a judgment on behalf of AIP against Petitioner in an amount exceeding $124,000. They allege AIP lacked capacity to manage his own affairs as of January 1, 2017, and the requested amount represents his gross income received in 2017 and 2018, reduced by Cross-Petitioners' calculation of AIP's half share of the expenses of the parties' joint household.

Cross-Petitioners argue that the evidence allows the Court to establish a date by which AIP was incapacitated, after [*12] which they request the Court apply the provisions of Mental Hygiene Law §81.29(d). That section allows the Court to "modify, amend, or revoke any previously executed contract, conveyance, or disposition, *made by the incapacitated person* prior to the appointment of the

guardian if the court finds that the previously executed transaction was made while the person was incapacitated." MHL §81.29(d). (emphasis added). Assuming incapacity, AIP would be without the ability to consent to Petitioner's use of his funds via their joint account. The explicit language of this provision allows the Court to reverse transactions made by *the incapacitated person* but is silent as to reversing transactions made by a spouse or joint bank account holder. Therefore, the Court finds that the provisions of Mental Hygiene Law §81.29(d) are not directly applicable for providing the relief requested by the Cross-Petitioners.

Cross-Petitioners ask the Court to find the joint tenancy in regard to the joint Visions account was terminated in 2017 when Petitioner began taking all of the money from the joint account. *Mullen v Linnane*, 268 AD2d 313, 314 (1st Dept 2000). Cross-Petitioners argue that once Petitioner took control of AIP's joint account, her withdrawal of all the funds in that account terminated the joint tenancy and rendered [*13] Petitioner subject to a claim for recovery of one-half of the amount in the account. *Id; In re Mullen*, 268 AD2d 313 (1st Dept 2000). Cross-Petitioners correctly state the legal impact of Petitioner's excess withdrawals. However, the analysis does not end there; in any claim for a recovery of excess withdrawals, the withdrawing tenant may avoid surcharge by proving, by clear and convincing evidence, that the withdrawals were for the other tenant's benefit or with his consent. *Matter of Giacalone*, 143 AD2d 749 (2d Dept 1988); *Matter of Byrnes*, 85 AD2d 601 (2d Dept 1981).

The testimony at the hearing established that all of AIP's needs were being met while he was under the care of Petitioner. That continues at Vestal Park, where he now resides. Atypically, he is also the owner of a long-term care policy, the terms of which not only provide for his current care, but also ensure his ultimate qualification for **Medicaid**, if necessary, without impacting his assets.

While it is not clear from the record before the Court how Petitioner and AIP handled the mechanics of bill paying and expense management, it is clear that their total income was used for individual and collective needs and desires, including their home, clothing, travel and entertainment. As Petitioner testified, she and AIP did not plan for accumulation but spent [*14] all their income. She stated that AIP "likes things nice and was very generous." DCIII similarly testified that his father "spent his money."

As AIP's memory issues became more serious, he began to "cash out" the joint Visions account into which his monthly income flowed, giving the cash to Petitioner to use in taking care of their bills. DCIII accompanied his father to the bank twice for these withdrawals, so the family was all aware of the new protocol: Petitioner handling the couple's bills and finances. Over time, the process further evolved to where Petitioner was handling the joint account withdrawals herself,

then transferring the funds into her individual Horizons account, from which they were expended.

The consent of the joint tenant need not be express but can be implied. *Kleinberg v Heller*, 38 NY2d 836 (1976). Factors to determine implied consent include the nature, duration and closeness of the relationship between the joint tenants; the presence or absence of a habit of freely commingling their funds; testamentary dispositions for the excess withdrawer; prior generosity toward the excess withdrawer; the pattern, purpose and amounts of the withdrawals; the age and physical condition of the joint tenant when the [*15] excess withdrawals were made; the source of the funds in the joint account; and the tenant's knowledge of the withdrawals. *Id.* at 843-844; *In re Miller*, 1996 NYLJ LEXIS 7940, *1 (Sur Ct, Nassau County 1996).

Here, the joint tenancy in the Visions account was created six years after the parties' relationship began, but three years before they were married. AIP was clearly generous to Petitioner and himself when he had capacity, and actively participated in their pattern of freely spending. The parties elected to own the marital residence as tenants in common, with reciprocal life uses, rather than as joint tenants. AIP made no provision for Petitioner in his will, though he did make her the beneficiary of one of his retirement accounts.

In addition to the examination as to whether Petitioner had AIP's implied consent, as a joint account holder, to use all the income in the account, there is a related question: does a spouse have a duty to use marital funds solely for the financial support of an incapacitated spouse prior to the commencement of an Article 81 proceeding? This appears to be a question of first impression and would impose on a spouse a fiduciary duty to conserve all marital funds once the other spouse suffers diminished capacity. Cross-Petitioners are [*16] essentially asking the Court to find there is an additional responsibility on a spouse to preserve jointly held funds when the other spouse is suffering from diminishing capacity. Historically, at common law, a husband had a duty to support his wife and provide for her necessary expenses, including food, shelter, and medical care, while a wife had a reciprocal duty to provide domestic services for the well-being of her family. *Medical Business Assoc. v Steiner*, 183 AD2d 86, 90 (2d Dept 1992). This "doctrine of necessaries" was utilized to impose liability on the husband to third parties who provided essential goods and services to his wife and children. *Id.* The Appellate Division affirmed the essential principals of the doctrine and also held it applies equally to both spouses, under the New York Constitution's Equal Protection Clause. *Id* at 91 (citing *Garlock v Garlock*, 279 NY 337 [1939]). New York courts have also found that spouses have a fiduciary duty to each other in the context of executing separation agreements, which can be

set aside upon a finding of fraud, duress, or mistake. *Manes v Manes*, [**5] 277 AD2d 359, 361 (2d Dept 2000).

The Court finds that AIP's continued intellectual deterioration ultimately rendered the lifestyle and spending habits of AIP and Petitioner impossible to maintain. As AIP continued to suffer the impacts of dementia, [*17] Petitioner knew or should have known that she had a duty, as a spouse, to not spend AIP's income in a manner inconsistent with his established pattern of support for her, him, and them.

Reviewing these factors, the Court finds that certain transactions by Petitioner, starting as of January 1, 2017, and continuing through 2018, were in breach of her duty to act consistently with their previous expenditure pattern; AIP by then lacked the capacity to affirmatively consent to her use of his income; and some expenditures were not made with AIP's implied consent.

Therefore, the following transactions must be reversed:

1. Real Property Owned Solely by Petitioner

• In 2017, when all of AIP's income was being transferred from the joint Visions account to Petitioner's Horizons account, and his share of household and care expenses did not exceed or even approach the amount of his monthly income, Petitioner made multiple payments of bills relating to her own real estate, other than the joint marital residence. These totaled $6,969. Sale proceeds on both parcels were received by Petitioner in 2017, far in excess in this amount, and not placed in her Horizons account. Petitioner is directed to repay [*18] $6,969 to AIP via payment to his Property Co-Guardians.

2. Payments to or for Stephen

• Petitioner paid $445 in identifiable dental expenses for her son, Stephen. Other payments are alleged to have been made by her for Stephen's benefit, but cannot be proven by the evidence before the Court. In 2018, Petitioner made gifts to Stephen in the total amount of $3,840. The total of these transactions, $4,285, is reimbursable to AIP, via payment by Petitioner to AIP's Property Co-Guardians.

3. AIP's Volkswagen

• In April of 2018, Petitioner effectuated a transfer of AIP's Volkswagen to herself. Although older and of modest value, its transfer to Petitioner without any indication of her need for it, or use of it, given her clear understanding of her husband's incapacity at that time, must be reversed. Rather than directing the retransfer of the vehicle, the Court directs Petitioner to pay AIP, through his Property Co-Guardians, the sum of $1,700, the lower end of the documented range of value, and modestly below the testified value of the vehicle.

4. Petitioner's Legal Fees

• Petitioner paid $4,812.50 to her counsel in this matter between February 8, 2018 and October 17, 2018, from her Horizon's [*19] account, so arguably from the income of AIP then being transferred to that account. It is in the Court's discretion to set the fees to be paid to petitioner's counsel from the assets of the Alleged Incapacitated Person, when a petition is granted, or as the Court otherwise deems appropriate. MHL §81.16(f). Petitioner's petition was not granted, and from the perspective of the Court she misunderstood that a primary purpose of an Article 81 petition is the preservation and use of an incapacitated person's resources for that person's benefit, as her amended petition sought monthly financial support from AIP This case is not one where the Court deems it appropriate for the petitioner's fees to be paid from AIP's resources.
• After September 17, 2018, when AIP was admitted to Brookdale, his multi-care costs [**6] clearly exceeded his income. Thus, any payments made by Petitioner from the Horizons account after that date, even though all of AIP's income was flowing into it, were in fact not coming from AIP's income. For that reason, the $1,000 payment to her counsel on October 17, 2018, will not be reversed. Petitioner is directed to reimburse $3,800 to AIP through payment to his Property Co-Guardians.
5. Care [*20] Expense Reimbursements
• In late November of 2018, during the pendency of the proceedings, AIP received a reimbursement payment from Genworth, in the amount of $10,649.50, as well as a refund from Brookdale Senior Living, where he had been previously residing, in the amount of $1,471.14. Despite the direct discussion of the potential refund at a Court proceeding earlier in November of 2018, and the Court's Order dated November 13, 2018 expressly prohibiting withdrawals from the joint Visions account, Petitioner withdrew those sums for her own benefit. She is strictly correct the Court's Order set a date of December 1, 2018 to "freeze the account," but she is held to understand that date was used because there was no expectation the refunds would come before December 1, 2018. Petitioner clearly had a sense she should not have withdrawn these funds; she ultimately disclosed that she retained them in cash, in her home. These refunds of expenses made, or deemed to be made, from AIP's income, totaling $12,120.64, are to be returned to AIP, through his Property Co-Guardians.
6. Bathroom Remodel Loan
• Cross-Petitioners also seek to hold Petitioner fully liable for a loan taken out to remodel [*21] a bathroom in the marital residence. This loan financed an improvement to an asset owned jointly by Petitioner and AIP. It is not disputed that the modification of the bathroom was done to assist AIP. The Court finds that payments made on the loan by Petitioner through November 30, 2018, from whatever source, are appropriate and consistent with Petitioner and AIP's joint

ownership of the home and spending pattern in support of each other. The payment of that loan from December 1, 2018 until it is paid off will remain the equal responsibility (50% each) of AIP and Petitioner. The parties' counsel are directed to facilitate a mechanism for ensuring equal payment by their respective clients until the loan is paid.

LEGAL FEES

Counsel for Cross-Petitioners submitted an affirmation requesting that the Court set their fees, to be paid from the assets of AIP. The Court has the discretion in an Article 81 proceeding to award legal fees for a successful petitioner, payable from the AIP's resources. MHL §81.16(f). Here, Cross-Petitioners successfully petitioned for their appointment as Co-Guardians of the Property, and Co-Guardians of the Person with Petitioner.

The total compensation payable to counsel from [*22] Cross-Petitioners is based on their retainer agreement, which is a binding contract between Cross-Petitioners and their attorneys. The Court's only responsibility is to set the reasonable and appropriate portion of that fee payable from AIP's resources. *Matter of Ruth S. (Sharon S.)*, 125 AD3d 978, 980 (2d Dept 2015).

This was a complicated and contentious matter. There were five days of Court proceedings, substantial discovery, and negotiations. But for the efforts of counsel and the parties to settle the bulk of the disputed issues, the proceedings could easily have been [**7] substantially longer and more expensive.

At the same time, the Court needs to be mindful that preservation of AIP's resources, from which Cross-Petitioners now seek payment, was the very basis for their Amended Cross-Petition. Whatever portion of their fees are now deemed payable from AIP's current resources, the balance will be reimbursed to them through their inheritance from his estate.

The Court finds that the sum of $10,000 of the fees payable to counsel for Cross-Petitioners is appropriately payable currently from AIP's resources.

Therefore, it is hereby

ORDERED, that AIP is entitled to recovery from Petitioner in the amount of $27,175. Judgment against Petitioner in that amount [*23] may be entered by AIP, through his Co-Guardians of the Property, against Petitioner, unless payment, or an acceptable arrangement, is made within 30 days of the date of this Order; and it is further

ORDERED, that the sum of $10,000 of legal fees incurred by Cross-Petitioners may be currently paid by the Co-Guardians of the Property of AIP from guardianship resources.

This Decision constitutes the Order of the Court.

Date: May 15, 2019
Hon. David H. Guy
Acting Justice Supreme Court 6JD

Footnotes

- A copy of the policy was admitted as Cross-Petitioners' Exhibit 1. Apparently, through name change or acquisition, the issuing entity is now known as Genworth. All the parties refer to this as the "Genworth" policy.

Matter of R.T. (D.C.), 2019 N.Y. Misc. LEXIS 2480, 2019 NY Slip Op 29147

MATTER OF A.B.D.

INCOME PAYMENT TO ABLE ACCOUNT

In this Article 17-A case the developmentally disabled person was participating in a paid internship through OPWDD. So as not to jeopardize the individuals SSI and Medicaid benefits the court authorized the transfer of the earnings to an ABLE account.

Matter of A.B.D. (L.J.A.), 2019 N.Y. Misc. LEXIS 3237

Surrogate's Court of New York, Nassau County

June 13, 2019, Decided

2016-388351/A

Reporter
2019 N.Y. Misc. LEXIS 3237 * | 2019 NY Slip Op 29182 **

[**1] In the Matter of the Petition of A.B.D. and K.A.A, as Co-Guardians of L.J.A., A Developmentally Disabled Person Pursuant to SCPA 17-A for Leave to Further Lift Restraints, Transfer Assets.

Notice:
THE LEXIS PAGINATION OF THIS DOCUMENT IS SUBJECT TO CHANGE PENDING RELEASE OF THE FINAL PUBLISHED VERSION.

THIS OPINION IS UNCORRECTED AND SUBJECT TO REVISION BEFORE PUBLICATION IN THE OFFICIAL REPORTS.

Core Terms

disability, individuals, expenses, developmental disability, beneficiary, annual, savings account, entitlement, internship, jeopardize, earnings, families, services, deposit, funding, lifted, saving, blind

Counsel: [*1] Andrew Cohen, Esq., Garden City, New York.

Judges: HON. MARGARET C. REILLY, Judge of the Surrogate's Court.

Opinion by: MARGARET C. REILLY

Opinion

Margaret C. Reilly, J.
The following papers were considered in the preparation of this decision:
Before the court is a petition by A.B.D. and K.A.A.(petitioners), to establish a 529A account, commonly referred to as an ABLE account, for their daughter, L.J.A., a developmentally disabled adult. The petitioners are the co-guardians of L.J.A.'s person and property. The petition also seeks an order lifting the restraints on their letters of guardianship and authorization to deposit L.J.A.'s income from a paid internship into the 529A account.
Internal Revenue Code 529A (26 USC 529A) allows for the establishment of tax advantaged savings accounts for individuals with disabilities and their families pursuant to programs "established and maintained by a State, or agency or instrumentality thereof" (26 USC 529A [b][1]). New York enacted the New York Able Act, also called "New York achieving a better

life experience (NY ABLE) savings account act" effective April 1, 2016 (**Mental Hygiene** Law 84.01). The legislative intent is "to encourage and assist individuals and families in saving private funds for the purpose of supporting individuals with developmental disabilities [*2] to maintain health, independence and quality of life; and to provide secure funding for disability related expenses on behalf of designated beneficiaries with intellectual or developmental disabilities that will supplement, but not supplant, benefits provided through existing sources" (L. 2015, ch. 576, § 2). The account may be established for an individual who is blind or "has a medically determinable physical or **mental** impairment, which results in marked and severe functional limitations" and such "blindness or disability occurred before the date on which the individual attained the age 26" (26 USC 529A [e][2][A][i][I] and [II]). The account may be used to pay for qualified disability expenses which include "education, housing, transportation, employment training and support, assistive technology and personal support services, health, prevention and wellness, financial management and administrative services, legal fees, expenses for oversight and monitoring, funeral and burial expenses" (26 USC 529A [e][5]). The aggregate amount that may be contributed to the account annually cannot exceed the annual gift tax [**2] exclusion (26 USC 529A [b][2][B][I]) plus, in the case of a contribution by the beneficiary, the lesser of the compensation included in the beneficiary's [*3] gross income for the taxable year or an amount equal to the poverty line for a one-person household (26 USC 529A [b][2][B][ii][I] and [II]). The account must be subject to repayment to the State upon the death of the beneficiary of all amounts in the account remaining, "not in excess of the amount equal to the total medical assistance paid" (26 USC 529A [f]). The account will not jeopardize the individual's entitlement to SSI or Medicaid as long as the account does not exceed $100,000.00 and the maximum annual contribution is not

exceeded (New York State Office of the State Comptroller, www.osc.state.ny.us/savings/able [last accessed May 15, 2019]).

The petitioners allege that L.J.A. is participating in a paid internship through the Office for Persons with Developmental Disabilities (OPWDD). Through this program, L.J.A. will hopefully transition into future paid employment. According to the petitioners, L.J.A.'s present and possible future earnings will jeopardize her entitlement to government benefits if her earnings are not deposited into the 529A account. The petition is therefore **GRANTED** and the restraints are lifted so that the petitioners can establish the account. A copy of the account should be filed with the court. [*4]

This constitutes the decision and order of the Court.

Dated: June 13, 2019
Mineola, New York
HON. MARGARET C. REILLY
Judge of the Surrogate's Court

Matter of A.B.D. (L.J.A.), 2019 N.Y. Misc. LEXIS 3237, 2019 NY Slip Op 29182

MATTER OF BEDNAREK

DEFINES PERSONS SUBJECT TO GUARDIANSHIP

Matter of Bednarek v Ingersoll, 2019 N.Y. Misc. LEXIS 411

Copy Citation

Supreme Court of New York, Chemung County

February 4, 2019, Decided

2018-2295

Reporter

2019 N.Y. Misc. LEXIS 411 * | 2019 NY Slip Op 50142(U) **

[**1] In the Matter of the Petition of Suzanne Bednarek, Petitioner, against Elizabeth Ingersoll, Power of Attorney, Respondent.

Notice:

THIS OPINION IS UNCORRECTED AND WILL NOT BE PUBLISHED IN THE PRINTED OFFICIAL REPORTS.

Core Terms

legal fees, reimburse, joint account, notice, guardianship, transactions, funds, motion to dismiss, portions, accounting, parties, vacate, participating, appointment, non-party, withdrawn, guardian, caption, days, law law law, misapprehended, procedurally, proceedings, re-argument, Appearance, attorney's, injunctive, questioned, modified, carries

Counsel: **[*1]** Douglas J. Mahr , Esq., of Scolaro Fetter Grizanti & McGough , attorneys for Petitioner.

Denice A. Hamm, Esq., of Hamm & Roe, LLP , attorneys for Respondent.

Robert L. Halpin , Esq., attorney for Elizabeth K.

Judges: Hon. David H. Guy , Acting Supreme Court Justice.

Opinion by: David H. Guy

Opinion

David H. Guy , J.

This proceeding is a petition filed by Suzanne Bednarek, seeking an accounting by Elizabeth Ingersoll, as agent under a power of attorney (POA) for their mother, Elizabeth K. The petition also seeks the revocation of the power of attorney from Elizabeth K to Elizabeth Ingersoll, and enforcement of certain provisions of the June 15, 2018 Decision and Order of this Court in a related matter: Ms. Bednarek's petition for the appointment of an Article 81 guardian for Elizabeth K.

The parties entered into a Stipulation setting forth the timing of Ms. Ingersoll's delivery of her POA accounting. The timing of the accounting has been modified by subsequent stipulations entered into by the parties.

On or about December 26, 2018, Ms. Ingersoll filed a motion requesting an Order striking portions of the Court's June 15, 2018 Decision in the related guardianship matter.1 The [**2] Court set a return date on the motion of January 28, [*2] 2019, on submission. The motion is supported by an affidavit dated December 20, 2018 of Denice Hamm, Esq., counsel for Ms. Ingersoll. Ms. Bednarek submitted papers in opposition to the motion on January 15, 2019, including an affirmation from her counsel, Douglas J. Mahr , Esq. and a memorandum of law. Ms. Hamm filed a reply on January 28, 2019.

This motion seeks to vacate certain portions of the Court's June 15, 2018 Decision and Order in the related guardianship matter. Arguably, the motion is procedurally defective for that reason and could be dismissed. The Court will instead address the substance of the motion.

Even if this motion is considered as having been filed in the related guardianship action, it is procedurally defective and would be dismissed as a motion for reconsideration or re-argument. A motion for re-argument must be identified specifically as such, be based upon matters of fact or law allegedly overlooked or misapprehended by the Court and shall be made within 30 days of service of the order. CPLR 2221(d) . A motion to reargue shall also be identified specifically as such, shall be based upon new facts not offered in the prior motion that would change the prior determination, and [*3] contain reasonable justification for a failure to present such facts. CPLR 2221(e)(3) . This motion satisfies none of the statutory requirements for either a motion to renew or reargue.

In her reply to the response to this motion, Ms. Ingersoll clarifies an alternative basis for the granting of her motion: it should be treated as a motion to vacate under CPLR 5015(a)(4) . Ms. Ingersoll argues that since she was "a person on notice" of the guardianship proceeding, rather than a "party," the Court lacked jurisdiction to order her to reimburse funds to her mother. Ms. Ingersoll misapprehends both her own status in the Article 81 proceeding and the Court's jurisdiction and authority in that proceeding.

Ms. Ingersoll was a person entitled to notice of the Article 81 proceeding pursuant to MHL §81.07(g)(1) . Ms. Ingersoll appeared at the initial hearing date on June 6, 2017, without counsel. On August 10, 2017, Denice Hamm, Esq., filed a Notice of Appearance on behalf of Ms. Ingersoll and appeared and participated at all future proceedings in the Article 81 over the next ten months. Ms. Ingersoll submitted her own motion for summary judgment in the Article 81, which was handled in parallel with Mrs. K's motion for dismissal. Ms. Ingersoll's **[*4]** motion papers included a copy of the check register for the joint account from which the disputed checks for payment/reimbursement of Ms. Ingersoll's legal fees were drawn. Ms. Ingersoll appeared, through counsel, at the oral argument on the motions to dismiss on May 30, 2018, where the issue of Ms. Ingersoll's use of the joint account funds for her own legal expenses, though ancillary to the motion to dismiss the Article 81 proceeding, was raised.

Ms. Ingersoll never formally filed a cross-petition to be appointed as guardian for her mother. At the same time, Mrs. K's pleadings included a nomination of Ms. Ingersoll as guardian, should the Court have found an appointment necessary. The Court finds that Ms. Ingeroll's formal appearance through counsel and her active participation in the guardianship proceedings renders her subject to the Court's jurisdiction in the Article 81 proceeding, despite her not being named as petitioner or respondent in that proceeding. *See, e.g., In the Matter of Luisa P.*, 153 AD3d 1262, 1263, 61 N.Y.S.3d 125 (2d Dept 2017) (court affirmed issuance of injunctive relief against non-party individual); *In the Matter of Barbara Hultay v Mei Wu S.*, 140 AD3d 502, 35 N.Y.S.3d 9 (1st Dept 2016) (court had jurisdiction to grant injunctive relief against non-party individual).

The Court's exercise of its jurisdiction over Ms. Ingersoll in the Article 81 includes **[*5]** its ability to make a determination on the amount and source of payment legal fees pursuant to [**3] MHL §81.10(f) . The determination made by the Court in its decision on the motion to dismiss the Article 81 proceeding was that the participating parties pay their own legal fees, and that petitioner and Mrs. K split the expense of the Court Evaluator.

The Court's determination that it had proper jurisdiction over Ms. Ingersoll in the Article 81 proceeding warrants the dismissal of the currently pending motion as a motion for vacatur under CPLR 5015(a)(4) . However, that does not conclude the analysis. Ms. Ingersoll is correct that the

Court's direction that she reimburse funds to the joint account to the extent that her fees were paid from it goes beyond the Court's appropriate determination that the participating parties be responsible for their own legal fees. The issue of Ms. Ingersoll's authority to pay or reimburse her legal fees as a gift from her mother is a distinct issue and was not before the Court on the May 30, 2018 motions to dismiss the Article 81 proceeding. *See, e.g., Matter of Dandridge*, 120 AD3d 1411, 993 N.Y.S.2d 125 (2d Dept 2014) (while clear evidence of incapacity warranted Supreme Court's annulment of marriage, formal application for such relief was not made and non-party spouse was entitled **[*6]** to notice and opportunity to be heard; matter remanded for hearing).

The currently pending action, in which this motion is brought, is for an accounting by Ms. Ingersoll as agent for her mother; a determination as to the propriety of transactions she undertook as agent; and a determination of the continued viability of the power of attorney as an effective resource for Mrs. K. In the context of this proceeding, Ms. Bednarek will have the opportunity to challenge Ms. Ingersoll's authority to make any and all agent transactions, including those which paid or reimbursed Ms. Ingersoll's legal fees in the Article 81 proceeding. Ms. Ingersoll will similarly have the ability to establish her authority with respect to questioned transactions.2

Ms. Ingersoll's motion to vacate those portions of the Court's June 15, 2018 Decision and Order in the related guardianship proceeding, which directed Ms. Ingersoll to reimburse Mrs. K's joint account for any funds withdrawn by Ms. Ingersoll to pay her own attorney's fees, is granted. The validity of those transactions will be determined by the Court in this proceeding.

Therefore, based on the foregoing, it is hereby

ORDERED, that the motion of Elizabeth **[*7]** Ingersoll is GRANTED, and the following portions of the Court's June 15, 2018 Decision and Order shall be stricken:

The following line from Page 14, second full paragraph: "Ms. Ingersoll is directed to reimburse the joint account for any such funds withdrawn by her, within thirty (30) days of the date of this Order, and provide evidence to petitioner's counsel, and the Court, that she has done so."

Third "ORDERED" paragraph on page 16: "**ORDERED**, that Elizabeth Ingersoll is directed to reimburse the joint account she shares with Elizabeth K for any funds withdrawn by her to pay her own attorney's fees to Denice Hamm, Esq., within thirty (30) days of this Order, and to provide evidence of such repayment to all counsel, and the [**4] Court; and it is further"

This Decision constitutes the Order of the Court.

Date: February 4, 2019

Hon. David H. Guy

Acting Supreme Court Justice

Footnotes

- 1

  The notice prepared and filed with this motion carries the caption of the related Article 81 proceeding. The affidavit in support of the motion carries the caption of the 2018 power of attorney proceeding and recites that it is in opposition to that petition and in support of the motion to vacate portions of the Court's June 15, 2018 Order. The Court modified the filed notice of motion when the return date was set. The Index Number was corrected on the notice of motion to correspond to the action in which the action was brought; the language of the caption was not changed.

- 2

  Ms. Bednarek's current petition before the Court does not reference the legal fee payments as questioned transactions, presumably because the Court addressed them in its earlier decision in the Article 81 proceeding. Instead, Ms. Bednarek moves to enforce that portion of the earlier Order. The Court recognizes that the petition's allegations that question the transactions undertaken by Ingersoll as Mrs. K's agent implicitly call into question the payment of Ingersoll's legal fees from the joint account and will be part of this case.

FAIR HEARING 7923571Y

PROMISSORY NOTE UPHELD DESPITE NONCOMPLIANT PAYMENTS

STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: March 7, 2019
CASE #: MA61411
AGENCY: Genesee
FH #: 7923571Y

In the Matter of the Appeal of

[redacted]

from a determination by the Genesee County Department of Social Services

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR (hereinafter Regulations), a fair hearing was held on March 29, 2019, in Albany, before Sara Duncan, Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

Nicholas Proukou, Esq. (via video)

For the Social Services Agency

Denise Vereeckem, Fair Hearing Representative; (via video)
Tina Kasperek-Assistant County Attorney (via video)

ISSUE

Was the Agency's determination to deny the Appellant's application for Medicaid on the grounds of excess resources correct?

Was the Agency's determination that the Appellant is not eligible for nursing facility services for a period of 11 months or May 2019 correct?

Was the Agency's determination that the Appellant was eligible for nursing facility services with a partial penalty for the month of May 2019 correct?

FINDINGS OF FACT

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. On December 28, 2017, an application for Medicaid was made by or on behalf of the Appellant. The Appellant is 98 years of age, and has been receiving nursing facility services in a local nursing facility since September 2017.

2. By notice dated January 8, 2019 the Agency determined to deny the Appellant's application on the grounds of excess resources in the amount of $118,088.65. By a separate notice dated January 8, 2019 the Agency determined that the Appellant was not eligible under Medicaid for nursing facility services because the Appellant transferred assets valued at $118,153.61 for less than fair market value.

3. The Agency determined to impose a penalty period of 11 months beginning June 1, 2018 through April 30, 3019 during which the Appellant may not receive Medicaid coverage for the cost of nursing facility services by dividing $118,153.61 the uncompensated value of transferred assets, by $10,078.00 the applicable regional rate. The Agency then determined that there was an additional $7,295.61 that the Appellant would have to contribute toward her cost of nursing facility services for the month of May 2019.

4. On March 7, 2019, the Appellant requested this fair hearing.

APPLICABLE LAW

Sections 360-4.1 and 360-4.8(b) of 18 NYCRR (herein referred to as "the Regulations") provide that all income and resources actually or potentially available to a Medicaid applicant or recipient must be evaluated, but only such income and/or resources as are found to be available may be considered in determining eligibility for Medicaid. A Medicaid applicant or recipient whose available non-exempt resources exceed the resource standards will be ineligible for Medicaid coverage until he or she incurs medical expenses equal to or greater than the excess resources.

Under Section 360-4.4 of the Regulations, "Resources" are defined to include any liquid or easily liquidated resources in the control of an applicant or recipient, or anyone acting on his or behalf, such as a conservator, representative, or committee. Certain resources of a Medicaid-qualifying trust, as described in Section 360-4.5 of the Regulations, may also be counted in evaluating Medicaid eligibility.

Section 366.5(d) of the Social Services Law and Section 360-4.4(c)(2) of the Regulations govern Transfers of Assets made by an applicant or recipient or his or her spouse) on or after August 11, 1993. Section 366.5(e) governs transfers made on or after February 8, 2006.

Generally, in determining the Medicaid eligibility of a person receiving nursing facility services, either as an in-patient in a nursing facility (including an intermediate care facility for the mentally retarded), as an in-patient in a medical facility at a level of care such as is provided in a nursing facility, or as a recipient of care, services, or supplies at home pursuant to a waiver under section 1915(c) of the federal Social Security Act ("waivered services"), any transfer of assets for less than fair market value made by the person or his or her spouse within or after the "look-back period" will render the person ineligible for nursing facility services.

For applications filed on or after August 1, 2006, for Medical Assistance coverage of nursing facility services, the "look-back period" is the period immediately preceding the date that an institutionalized individual is both institutionalized and has applied for Medical Assistance. Beginning February 1, 2009 the look back period will increase from 36 months to 37 months and each month thereafter it will increase by one month until February 1, 2011 when a 60 month look-back period will be in place for all types of transfers of assets. 06 OMM/ADM-5. The uncompensated value of an asset is the fair market value of such asset at the time of transfer less any outstanding loans, mortgages, or other encumbrances on the asset, minus the amount of the compensation received in exchange for the asset. Social Services Law 366.5(e).

Sections 366.5(d) and (e) of the Social Services Law provide that an individual will not be ineligible for Medicaid as a result of a transfer of assets if:

(a) the asset transferred was other than a homestead and was a disregarded or exempt asset under Section 360-4.4(d), 360-4.6, and/or 360-4.7 of the Regulations; or

(b) the asset transferred was a home, and title to the home was transferred to:

(1) the individual's spouse; or

(2) the individual's child, who is blind, disabled, or under the age of 21; or

(3) the individual's sibling, who has an equity interest in the home and was residing in the home for a period of at least one year immediately before the date the person became an institutionalized individual, or

(4) the individual's child, who was residing in the home for a period of at least two years immediately before the date the person became an institutionalized individual, and who provided care to the person which permitted her or him to continue residing at home rather than enter into an institution or facility; or

(c) the asset was transferred:

(i) to the individual's spouse or to another for the sole benefit of the spouse; or

(ii) from the individual's spouse to another for the sole benefit of the spouse; or

(iii) to the individual's child who is blind or disabled, or to a trust established solely for the benefit of such child; or

(iv) to a trust established solely for the benefit of a disabled person under 65 years of age.

(d) a satisfactory showing is made that:

(i) the individual or his or her spouse intended to dispose of the asset either at fair market value, or for other valuable consideration; or

(ii) the asset was transferred exclusively for a purpose other than to qualify for Medicaid; or

(iii) all assets transferred for less than fair market value have been returned to the individual.

The purchase of a promissory note, loan, or mortgage on or after February 8, 2006 shall be treated as the disposal of an asset for less than fair market value unless such note, loan, or mortgage meets the following criteria:

- **has a repayment term that is actuarially sound;**
- **provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and**
- **prohibits the cancellation of the balance upon the death of the applicant/recipient.**

Social Services Law 366.5(e), 06 OMM/ADM-5

DISCUSSION

The Appellant is in a nursing home. Her attorney Nicholas Proukou appeared at the hearing on the Appellant's behalf. Attorney Proukou waived the Appellant's right to personally participate in the hearing.

The Assistant County Attorney (ACA) explained that on August 24, 2017 the Appellant withdrew $201,000.00 from her Key Bank account. She transferred $120,000.00 to her son [redacted] and the remaining $81,000.00 was given to [redacted] who signed a Promissory Note whereby he promised to pay the $81,000.00 back to the Appellant with interest commencing September 1, 2017. The ACA contends that because the Promissory Note was not paid back according to the provisions of the Promissory Note, the note is invalid. The Agency determined the Promissory Note was void and therefore the $81,000.00 was an uncompensated transfer. The ACA explained that because the monies were paid back with interest ($82,846.39) the Agency subtracted that amount from the $201,000.00 leaving the total uncompensated transfer amount to be $118,153.61.

The ACA explained that the Agency also determined that the money that was repaid was a resource which rendered the Appellant resource ineligible for Medicaid from the date of application, December 28, 2017, until May 31, 2018 at which time the penalty period for the uncompensated transfers would begin. The ACA explained that after the Agency determined the Promissory Note was not valid, the Agency relied on 06 OMM/ADM-5 page 18, to determine that once the $81,000.00 was paid back to the Appellant it must be treated as though the $81,000.00 was never transferred and thus must be considered a resource as of the date of the application which rendered the Appellant resource ineligible until June 1, 2018. The ACA stated that the penalty period for the uncompensated transfer of $118,153.61 runs from June 1, 2018 through April 30, 2019.

The Agency submitted into evidence an evidentiary packet which contained, among other documents, a copy of the January 8, 2019 notice denying the Appellant's Medicaid application on the grounds of excess resources, a copy of the January 8, 2019 determination that the Appellant is not eligible for nursing facility services for a period of 11 months or until May 2019 and a copy of the Promissory Note.

In response Attorney Proukou argued that the Promissory Note was not invalid and that the Agency erred when it considered the loan proceeds as a resource of the Appellant because the loan was a bona fide loan pursuant to 18 NYCRR Section 352.22. Attorney Proukou stated that the terms of the Promissory Note complies with Social Services Law 366.5 (e), 06 OMM/ADM-6 and the Medicaid Reference Guide. The repayment term is actuarially sound, provides for payments to be made in equal amounts during the term of the loan with no deferral, and no balloon payments and it prohibits the cancellation of the balance upon the death of the Appellant. Attorney Proukou stated that because the Promissory Note is valid, the $81,000.00 is not a resource and the resources the Appellant did have were below the Medicaid eligibility resource threshold as of September 1, 2017, Therefore, the penalty period for the uncompensated transfers should begin on September 1, 2017 not on June 1, 2018 as the Agency contends.

Attorney Proukou referred to Fair Hearing #6248084Y (July 2, 2013) as an analogous case. In that case, on December 30, 2010 the Appellant gave $119,647.00 to her daughter to whom she entered into a ten-month Promissory Note in the amount of $140,715.00, with an interest rate of 3.5% per annum resulting in a monthly repayment of principal and interest of $14,298.22 commencing January 31, 2011. The Promissory Note provided for payments to be

made in equal amounts during the term of the loan with no deferral, no acceleration and no balloon payments. In that case the local Agency argued that the Promissory Note was invalid and therefore treated the entire amount as a resource and denied the Appellant's Medicaid application on the grounds of excess resources. The Commissioner ruled that the Agency erred in including the proceeds of the Promissory Note as an available resource. The decision states:

> *It is noted that under the authority cited above, the validity of the promissory note is determined by its terms and provisions. In this case, the promissory note was paid in full within the ten-month period set forth in the note itself. The fact that the person responsible for making the payments may have paid more or less than the amount due on the required due date during five of the required ten payment periods does not result in the note being invalid or not in compliance with the terms of 06-OMM/ADM-05.*

In response, the ACA stated that FH#7588152H is on point with the instant case. In that case, the Appellant gave his daughter $64,000.00. The daughter executed a Promissory Note to pay the Appellant $64,000.00 with interest at the rate of 2% per annum in 6 monthly installments of $10,728.98 per month on the first day of each month beginning October 1, 2016 through March 1, 2017. The Promissory Note provided for a repayment term of six months, with no deferral, no acceleration, and no balloon payments. The Promissory Note also prohibited the cancellations of any balance of unpaid principal and interest upon the death of the lender and such unpaid amounts due at the death of the lender shall be payable to the lender's estate. The Agency determined that the Promissory Note was invalid on the grounds that the daughter never intended to perform the promises at the time the note was made, and in fact, did not perform. It was undisputed that that none of the required payments under the terms of the note were made, and that as of the date of the Agency's determination as well as the date of the hearing, the entire principal balance plus interest remained outstanding. The Agency argued that the Promissory Note was a sham transaction not only because none of the payments promised were made, but moreover because the Appellant's daughter, as maker of the note, never had any intention of performing the promises to begin with. Therefore, the Agency concluded that based upon this promissory fraud, the Promissory Note in question was invalid and cannot constitute good and valuable consideration for any part of the assets transferred in this case. It was undisputed that the Appellant's daughter did not intend to make any payments on the Promissory Note until the house gifted by the Appellant was sold. In that case, the Commissioner affirmed the Agency's determination to include the $64,000.00 in the uncompensated transfers. The decision states:

> *The otherwise unrefuted evidence on the record supports a finding that at all relevant times, the maker had no genuine intention of honoring the payment terms of the promissory note...the Agency's determination that the Promissory Note was essentially a sham transaction, created solely to justify uncompensated transfers in the broadest sense, was reasonable and amply supported by the evidence on the record.*

Based on the record the Agency's determination that the Promissory Note was invalid and therefore the $81,000.00 must be considered a resource cannot be sustained. A review of the Promissory Note shows that its terms comply with 06 OMM/ADM-5. The Agency's reliance on FH#7588152H is not on point with the instant case. In the instant case, the Appellant's son

[redacted] repaid the loan in full to the Appellant by June 2018. The terms of the Promissory Note were that [redacted] would pay 10 equal monthly installments (from September 1, 2017 through June 2018) of $8,192.13 which represents combined principal and interest payments commencing September 2017 and continuing on the first day of each succeeding months until paid in full in accordance with the amortization schedule which was attached to the note. The following payments were made:

Month	Payment	Date Paid
September 2017	$8,192.13	10/3/2017
October 2017	$8,192.13	10/3/2017
November 2017	$8,192.13	11/22/2017
December 2017	$8,192.13	11/22/2017
January 2018	$8,223.45	02/1/2018
February 2018	$8,223.45	02/1/2018
March 2018	$8,192.13	03/6/2018
April 2018	$8,192.13	3/27/2018
May 2018	$8,192.13	5/23/2018
June 2018	$7,270.83	6/20/2018

A review of the payments show that although the payments were not made in a manner that strictly complied with the terms of the Promissory Note the payments were made on a regular basis and were completed within the 10-month period set forth in the note itself. It is also noted that there was no balloon payment made. It is found that the Promissory Note is valid.

In the case the Agency cited the local Agency argued that the loan and Promissory Note was a sham transaction, created solely to justify uncompensated transfers. The Commissioner found that was a reasonable and persuasive argument based on the specific facts in that case. In the instant case the Assistant County Attorney failed to pursue on cross-examination any line of questioning regarding the intent of the parties to the loan and the circumstances surrounding the loan, instead throughout the hearing the Agency focused solely on the argument that because the payments were not made strictly within the provisions of the Promissory Note, that the note was not valid.

Based on this record, for the reasons set forth above, it is found that the Promissory Note was valid and therefore the Agency erred in considering the $81,000.00 a resource.

DECISION (AND ORDER)

The Agency's determination to deny the Appellant's application for Medicaid on the grounds of excess resources was not correct and is reversed.

The Agency's determination that the Appellant is not eligible for nursing facility services for a period of 11 months or May 2019 is not correct and is reversed.

The Agency is directed to begin the penalty period on September 1, 2017 based on the uncompensated transfers of $118,153.61.

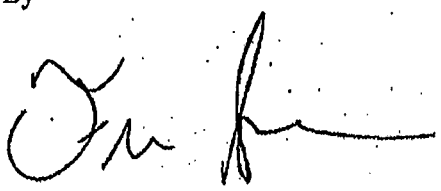
Should the Agency need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is requested, the Appellant must provide it to the Agency promptly to facilitate such compliance.

As required by 18 NYCRR 358-6.4, the Agency must comply immediately with the directives set forth above.

DATED: Albany, New York
04/29/2019

NEW YORK STATE OFFICE OF
TEMPORARY AND DISABILITY ASSISTANCE

By



Commissioner's Designee

FAIR HEARING 7393751Z

DENIAL OF 24 HOUR LIVE IN CARE REVERSED

OAH-4482/20 (Rev. 6/10)

From: **New York State Office of Temporary and Disability Assistance**
P.O. Box 1930
Albany, NY 12201 - 1930

TRANSMITTAL OF FAIR HEARING DECISION TO REPRESENTATIVE

Fair Hearing #: **7933751Z**
Hearing Date: **05/16/19**
Decision Date: **05/23/19**
Case #: **00022875275E**
Category/Subcategory: **MA/HOLD**

Agency: **New York City MAP**
Appellant: **CHAYA SHAIN**
1428 41ST STREET 1FL
BROOKLYN, NY 11218

****
*** ***
*** ENCLOSED IS THE DECISION RENDERED ***
*** ON BEHALF OF THE ABOVE APPELLANT ***
*** FOR WHOM YOU SERVED AS REPRESENTATIVE ***
*** ***
****

TO: **KORSINSKY KLEIN, LLP**
MICHAEL KORSINSKY
2926 AVENUE L
BROOKLYN, NY 11210

If the decision is in favor of the Appellant, the local social service department is required to comply with the decision forthwith (as quickly as possible), and is required to notify the Appellant of its compliance. The Appellant has been advised to notify the State Office of Temporary and Disability Assistance if the Agency fails to comply with the decision within 10 days after receipt of the decision. Our address and phone number are:

New York State Office of Temporary and Disability Assistance
Office of Administrative Hearings
Compliance Unit
P. O. Box 1930
Albany NY 12201 - 1930

1-800-342-3334

If the Appellant did not win the hearing, the Appellant may bring a lawsuit in accordance with Article 78 of the Civil Practice Law and Rules against the State agency whose name appears at the top left of the decision. If the Appellant wishes to bring a lawsuit and does not know how, the Appellant should contact the legal resources available to him/her (e.g. - County Bar Association, Legal Aid, Legal Services, etc.). The Appellant must start a lawsuit within 4 months after the date of decision.

A copy of this decision has been mailed to the Appellant.

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STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: March 27, 2019
CASE #: 00022875275E
CENTER #: MAP, SHP
FH #: 7933751Z

In the Matter of the Appeal of Chaya Shain from a determination by HealthFirst - Senior Health Partners	:	**DECISION AFTER FAIR HEARING**

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on May 16, 2019, in New York City, before Allyson Sackey, Supervising Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

Tracy Connors, Medicaid Specialist, Korsinsky & Klein, LLP

For the Managed Long Term Care Plan (HealthFirst - Senior Health Partners)

Megan Lasnini, Fair Hearing Representative

ISSUE

Was the determination of the Appellant's Managed Long Term Care Plan, HealthFirst - Senior Health Partners, not to authorize the Appellant for Live-in 24 hour personal care services correct?

FINDINGS OF FACT

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. The Appellant, age 80, who resides with her 84 year old husband, is in receipt of authorization for Medical Assistance, and is enrolled in a Medicaid managed long term care plan operated by HealthFirst - Senior Health Partners (SHP).

2. The Appellant has been in receipt of personal care services in the amount of 49 hours

per week, under a task based plan of care.

3. On January 16, 2019, SHP completed a Uniform Assessment System – Assessment (Comprehensive) Report of the Appellant.

6. On January 16, 2019, SHP completed a UAS Aide Task Service Plan for the Appellant, which determined Appellant required 49.01weekly hours of personal care services.

7. A request for an increase in personal care services was made on the Appellant's behalf.

8. By Initial Adverse Determination dated February 21, 2019, SHP denied the Appellant's request on the grounds it was not medically necessary.

9. The Appellant appealed the February 21, 2019 determination.

10. By Final Adverse Determination dated March 22, 2019, SHP upheld its initial determination.

11. This fair hearing was requested on March 27, 2019.

APPLICABLE LAW

Regulations at 18 NYCRR 358-3.7(a) provide that an appellant has the right to examine the contents of the case record at the fair hearing. At the fair hearing, the agency is required to provide complete copies of its documentary evidence to the hearing officer. In addition, such documents must be provided to the appellant and appellant's authorized representative where such documents were not provided otherwise to the appellant or appellant's authorized representative in accordance with 18 NYCRR 358-3.7. 18 NYCRR 358-4.3(a). In addition, a representative of the agency must appear at the hearing along with the case record and a written summary of the case and be prepared to present evidence in support of its determination. 18 NYCRR 358-4.3(b).

Social Services Law §365-a(2) provides that "Medical assistance" shall mean payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies, as authorized in this title or the regulations of the department, which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with this title and the regulations of the department.

Social Services Law §365-a(2)(k) provides that such care, services and supplies shall include care and services furnished by an entity offering a comprehensive health services plan, including an entity that has received a certificate of authority pursuant to sections forty-four

hundred three, forty-four hundred three-a or forty-four hundred eight-a of the public health law (as added by chapter six hundred thirty-nine of the laws of nineteen hundred ninety-six) or a health maintenance organization authorized under article forty-three of the insurance law, to eligible individuals residing in the geographic area served by such entity, when such services are furnished in accordance with an agreement approved by the department which meets the requirements of federal law and regulations.

Part 438 of 42 Code of Federal Regulations (CFR) pertains to provision of Medicaid medical care, services and supplies through Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs) and Primary Care Case Managers (PCCMs), and the requirements for contracts for services so provided.

Section 438.210 of 42 CFR Subpart D provides, in pertinent part:

(a) Coverage - Each contract with an MCO, PIHP, or PAHP must do the following:

(1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.

(2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in Sec. 440.230.

(3) Provide that the MCO, PIHP, or PAHP--

(i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

(ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary;

(iii) May place appropriate limits on a service

(A) On the basis of criteria applied under the State plan, such as medical necessity; or

(B) For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in paragraph (a)(3)(i) of this section; and

(4) Specify what constitutes "medically necessary services"' in a manner that:

(i) Is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and

(ii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services related to the following:

(A) The prevention, diagnosis, and treatment of health impairments.

(B) The ability to achieve age-appropriate growth and development.

(C) The ability to attain, maintain, or regain functional capacity.

(b) Authorization of services. For the processing of requests for initial and continuing authorizations of services, each contract must require:

(1) That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.

(2) That the MCO, PIHP, or PAHP:

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and

(ii) Consult with the requesting provider when appropriate.

(3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease....

Section 438.236 of 42 CFR Subpart D provides, in pertinent part:

(a) Basic rule: The State must ensure, through its contracts, that each MCO and, when applicable, each PIHP and PAHP meets the requirements of this section.

(b) Adoption of practice guidelines. Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements:

(1) Are based on valid and reliable clinical evidence or a consensus of

health care professionals in the particular field.

(2) Consider the needs of the MCO's, PIHP's, or PAHP's enrollees.

(3) Are adopted in consultation with contracting health care professionals.

(4) Are reviewed and updated periodically as appropriate.

(c) Dissemination of guidelines. Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

(d) Application of guidelines. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

Section 438.400 of 42 CFR Subpart F provides in part:

(a) Statutory basis. This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act.

(1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

(2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(b) Definitions. As used in this subpart, the following terms have the indicated meanings:

In the case of an MCO or PIHP-"Action" means--

(1) The denial or limited authorization of a requested service, including the type or level of service;

(2) The reduction, suspension, or termination of a previously authorized service;

(3) The denial, in whole or in part, of payment for a service...

42 CFR 438.402 provides, in part, that:

(a)The grievance and appeal system. Each MCO, PIHP, and PAHP must have a grievance and appeal system in place for enrollees. Non-emergency medical transportation PAHPs, as defined in § 438.9, are not subject to this subpart F.

(b)Level of appeals. Each MCO, PIHP, and PAHP may have only one level of appeal for enrollees.

(c)Filing requirements -

(1)Authority to file.

(i) An enrollee may file a grievance and request an appeal with the MCO, PIHP, or PAHP. An enrollee may request a State fair hearing after receiving notice under § 438.408 that the adverse benefit determination is upheld.

(A)Deemed exhaustion of appeals processes. In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in § 438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.

42 CFR 438.408 provides, in part, that:

(f)Requirements for State fair hearings -

(1)Availability. An enrollee may request a State fair hearing only after receiving notice that the MCO, PIHP, or PAIIP is upholding the adverse benefit determination.

(i)Deemed exhaustion of appeals processes. In the case of an MCO, PIHP, or PAIIP that fails to adhere to the notice and timing requirements in § 438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.

Section 4403-f of the Public Health Law pertains to Managed Long Term Care Plans.

Article 49 of the Public Health Law pertains to Utilization Review and External Appeal.

Section 505.14(a)(1) of the Regulations defines "Personal Care Services" to mean assistance

with nutritional and environmental support functions and personal care functions, as specified in clauses (5)(i)(a) and (5)(ii)(a) of this subdivision. Such services must be essential to the maintenance of the patient's health and safety in his or her own home, as determined by the social services district in accordance with this section; ordered by the attending physician; based on an assessment of the patient's needs and of the appropriateness and cost-effectiveness of services specified in subparagraph (b)(3)(iv) of this section; provided by a qualified person in accordance with a plan of care; and supervised by a registered professional nurse.

Section 505.14(a) of the Regulations provides:

(2) Continuous personal care services means the provision of uninterrupted care, by more than one personal care aide, for more than 16 hours in a calendar day for a patient who, because of the patient's medical condition, needs assistance during such calendar day with toileting, walking, transferring, turning and positioning, or feeding and needs assistance with such frequency that a live-in 24-hour personal care aide would be unlikely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.

(3) Personal care services, as defined in this section, can be provided only if the services are medically necessary and the social services district reasonably expects that the patient's health and safety in the home can be maintained by the provision of such services, as determined in accordance with this section.

(4) Live-in 24-hour personal care services means the provision of care by one personal care aide for a patient who, because of the patient's medical condition, needs assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding and whose need for assistance is sufficiently infrequent that a live-in 24-hour personal care aide would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep.

(5) Personal care services shall include the following two levels of care, and be provided in accordance with the following standards:
(i) Level I shall be limited to the performance of nutritional and environmental support functions.
(a) Nutritional and environmental support functions include assistance with the following:
(1) making and changing beds;
(2) dusting and vacuuming the rooms which the patient uses;
(3) light cleaning of the kitchen, bedroom and bathroom;
(4) dishwashing;
(5) listing needed supplies;
(6) shopping for the patient if no other arrangements are possible;
(7) patient's laundering, including necessary ironing and mending;
(8) payment of bills and other essential errands; and
(9) preparing meals, including simple modified diets.

(b) The authorization for Level I services shall not exceed eight hours per week.
(ii) Level II shall include the performance of nutritional and environmental support functions specified in clause (i)(a) of this paragraph and personal care functions.
(a) Personal care functions include assistance with the following:
(1) bathing of the patient in the bed, the tub or in the shower;
(2) dressing;
(3) grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;
(4) toileting; this may include assisting the patient on and off the bedpan, commode or toilet;
(5) walking, beyond that provided by durable medical equipment, within the home and outside the home;
(6) transferring from bed to chair or wheelchair;
(7) turning and positioning;
(8) preparing of meals in accordance with modified diets, including low sugar, low fat, low salt and low residue diets;
(9) feeding;
(10) administration of medication by the patient, including prompting the patient as to time, identifying the medication for the patient, bringing the medication and any necessary supplies or equipment to the patient, opening the container for the patient, positioning the patient for medication and administration, disposing of used supplies and materials and storing the medication properly;
(11) providing routine skin care;
(12) using medical supplies and equipment such as walkers and wheelchairs; and
(13) changing of simple dressings.

GIS 12 MA/026 entitled "Availability of 24-Hour Split-Shift Personal Care Services" provides, in part, the intent of 18 NYCRR 505.14 is to allow the identification of situations in which a person's needs can be met by a live-in aide and still allow the aide to have an uninterrupted five hours for sleeping.

GIS 12 MA/026 provides as follows concerning the availability of 24 hour, split-shift personal care services in connection with the case of Strouchler v. Shah:

It is the Department's policy that 24-hour split-shift care should be authorized only when a person's nighttime needs cannot be met by a live-in aide or through either or both of the following: (1)adaptive or specialized equipment or supplies including, but not limited to, bedside commodes, urinals, walkers, wheelchairs, and insulin pens, when the social services district determines that such equipment or supplies can be provided safely and cost-effectively; and (2) voluntary assistance available from informal caregivers or formal services provided by an entity or agency.

1. With regard to adaptive or specialized equipment (the "efficiencies"), the nursing

assessment shall include a professional evaluation whether such adaptive or specialized equipment or supplies can meet the recipient's need for assistance and whether such equipment or supplies can be provided safely and cost-effectively when compared to the provision of aide services. Such adaptive or specialized equipment or supplies include, but are not limited to, bedside commodes, adult diapers, urinals, walkers and wheelchairs.

General Information System message GIS 97 MA 033 notified local districts as follows:

> The purpose of this GIS is to provide further instructions regarding the Mayer v. Wing court case, which applies to social services districts' reductions or discontinuations of personal care services. [Mayer v. Wing, 922 F. Supp. 902 (S.D.N.Y., 1996)]. The Mayer case is now final, and the Department is issuing these additional instructions to comply with the court's final order in this case.
>
> Districts were first advised of the Mayer case in May, 1996. (Please refer to GIS 96 MA/019, issued May 28, 1996.) As described in that GIS message, the Mayer case prohibits social services districts from using task-based assessment plans ("TBA plans") to reduce the hours of any personal care services recipient whom the district has determined needs 24 hour care, including continuous 24 hour services ("split-shift"), 24 hour live-in services ("live-in") or the equivalent provided by informal or formal supports. This GIS message identifies the policies and procedures districts must follow in order to comply with this particular provision of the Mayer case.
>
> This particular provision of the Mayer case applies only when the district has first determined that the MA recipient is medically eligible for split-shift or live-in services. To determine whether the recipient is medically eligible for split-shift services or live-in services, the district must continue to follow existing Department regulations and policies. As is currently required, the district must assure that the nursing and social assessments fully document and support the determination that the recipient is, or is not, medically eligible for split shift or live-in services.
>
> When the district has determined that the MA recipient is medically eligible for split-shift or live-in services, it must next determine the availability of informal supports such as family members or friends and formal supports such as Protective Services for Adults, a certified home health agency or another agency or entity. This requirement is no different from current practice. And, as under current practice, the district must assure that the nursing and social assessments fully document and support its determination that the recipient does, or does not, have informal or formal supports that are willing and able to provide hours of care.
>
> Remember that the contribution of family members or friends is voluntary and cannot be coerced or required in any manner whatsoever. A district may choose to implement so-called "statements of understanding" to reflect a family member's or friend's voluntary agreement to provide hours of care to a recipient whom the district has determined is medically eligible for split shift or live-in services. (See 95 LCM-76, section III, issued July 18, 1995, for a description of statements of understanding.)

Once the district has determined that the recipient is medically eligible for split-shift or live-in services and determined whether the recipient has informal or formal supports that are willing and able to provide hours of care, the district can assure that it is complying with the Mayer case by following the appropriate guidelines set forth below:

1.Recipient is medically eligible for split-shift services but has no informal or formal supports:

The district should authorize 24 hour split shift services for this recipient if the recipient otherwise meets the fiscal assessment requirements. The district must not use a TBA plan to reduce this recipient's personal care services.

2. Recipient is medically eligible for split-shift services and has informal or formal supports:

The district should authorize services in an amount that is less than 24 hour split-shift services if the recipient otherwise meets the fiscal assessment requirements. The amount that is authorized, when combined with the amount that informal or formal supports are willing and able to provide, would equal 24 hours. The district must not use a TBA plan to reduce this recipient's services because the recipient is receiving the "equivalent" of split-shift services: part of the services are funded by the MA program and part of the services are provided by the informal or formal supports.

3. Recipient is medically eligible for live-in services but has no informal or formal supports:

The district should authorize 24 hour live-in services for this recipient if the recipient otherwise meets the fiscal assessment requirements. The district must not use a TBA plan to reduce this recipient's personal care services.

4. Recipient is medically eligible for live-in services and has formal or informal supports:

The district should authorize services in an amount that is less than 24 hour live-in services if the recipient otherwise meets the fiscal assessment requirements. The amount that is authorized, when combined with the amount that the informal or formal supports are willing and able to provide, would equal 24 hours. The district must not use a TBA plan to reduce this recipient's services because the recipient is receiving the "equivalent" of live-in services: part of the services are funded by the MA program and part of the services are provided by the informal or formal supports.

General Information Service message GIS 97 MA 033 includes a reminder that the contribution of family members or friends (to the care of a Personal Care Services recipient) is voluntary and cannot be coerced or required in any manner whatsoever.

In Rodriguez v. City of New York, 197 F. 3rd 611 (Federal Court of Appeals, 2nd Circuit 1999), cert. denied 531 U.S. 864, the Plaintiffs were Personal Care Services recipients who alleged that they would be in receipt of inadequate service not meeting legal requirements,

without the provision of safety monitoring as an independent task in their Personal Care Services authorizations. The district court had ruled in favor of the Plaintiffs, but the Court of Appeals held that the Agency is not required to provide safety monitoring as an independent Personal Care Services task in evaluating the needs of applicants for and recipients of Personal Care Services. Local Agencies were advised of this decision in GIS message 99/MA/036.

GIS 03 MA/03 was released to clarify and elaborate on the assessment of Personal Care Services pursuant to the Court's ruling in Rodriguez v. Novello and in accordance with existing Department regulations and policies. In relevant portion, this GIS Message states:

> Social services districts should authorize assistance with recognized, medically necessary personal care services tasks. As previously advised, social services districts are **NOT** required to allot time for safety monitoring as a separate task as part of the total personal care services hours authorized (see GIS 99 MA/013, GIS 99 MA/036). However, districts are reminded that a clear and legitimate distinction exists between "safety monitoring" as a non-required independent stand-alone function while no Level II personal care services task is being provided, and the appropriate monitoring of the patient while providing assistance with the performance of a Level II personal care services task, such as transferring, toileting, or walking, to assure the task is being safely completed.

18 NYCRR 358-5.9(a) provides:

At a fair hearing concerning the denial of an application for or the adequacy of public assistance, medical assistance, HEAP, SNAP benefits or services; or an exemption from work activity requirements the appellant must establish that the agency's denial of assistance or benefits or such an exemption was not correct or that the appellant is eligible for a greater amount of assistance or benefits

DISCUSSION

The record establishes that the Appellant is in receipt of authorization for Medical Assistance, and is enrolled in a Medicaid managed long term care plan operated by HealthFirst - Senior Health Partners (SHP). The record further establishes that by Final Adverse determination dated March 22, 2019, SHP upheld its initial February 21, 2019 determination not to authorize an increase in Appellant's personal care services from 49 hours per week.

SHP produced a UAS Aide Task Service Plan for the Appellant, which determined Appellant required 49.01weekly hours of personal care service. However, SHP's own January 16, 2019 Uniform Assessment System Report (UAS) put the plan on notice of Appellant's status as a "Mayer III" patient, such that evaluation of the Appellant's personal care services needs under a task based plan of care was prohibited. Pursuant to General Information System message GIS 97 MA 033, the Appellant should be provided with a personal care services authorization in an amount which, "when combined with the amount that the informal or formal supports are willing and able to provide, would equal 24 hours."

The regulations require that at a fair hearing concerning the denial of an application for or the adequacy of Medical Assistance, the Appellant must establish that the denial of assistance or benefits was not correct or that the Appellant is eligible for a greater amount of assistance or benefits. In this case, the Appellant's representative has done so.

According to testimony and documentation produced by Appellant's representative, the Appellant suffered a stroke in May 2017, and a second stroke in September 2018 resulted in paralysis of the left side of her body. The Appellant has since regained limited mobility in her left leg and has no mobility in her left arm or hand. Appellant's representative stated Appellant receives services from 2:00 p.m. to 9:00 p.m., seven days per week, and Appellant's family has been paying to have an aide with the Appellant for the other 17 hours of the day.

The January 16, 2019 Uniform Assessment System Report (UAS) indicates the Appellant has a primary diagnosis stroke/CVA, with resulting hemiplegia and hemiparesis affecting her left side, insomnia, and urinary incontinence, among other diagnoses. In the UAS, the nurse assessor indicated, "Declined" to the inquiries: "Change in decision making as compared to 90 days ago (or since last assessment)" and "Change in ADL status as compared to 90 days ago, or since last assessment if less than 90 days ago". The UAS indicates Appellant requires "Extensive" assistance with walking, locomotion, and "transfer toilet", while requiring "Maximal" assistance with toilet use.

The credible evidence in the record reflects the Appellant is in need of both daytime and nighttime ambulating and toileting assistance, and thus in need of 24 hour care as a "Mayer III" patient. It is noted that the January 16, 2019 UAS indicated the Appellant had a urinary tract infection at the time of the assessment. Not only does the weight of the evidence fail to support the determination not to increase the Appellant's hours, the Appellant has established eligibility for a greater amount of assistance.

SHP is reminded that GIS 97 MA 033 also advises that the contribution of family members to the care of a Personal Care Services applicant or recipient is voluntary and cannot be coerced or required in any manner whatsoever.

DECISION AND ORDER

The determination of the Appellant's Managed Long Term Care Plan, HealthFirst - Senior Health Partners, not to authorize the Appellant for Live-in 24 hour personal care services was not correct and is reversed. SHP is directed to:

1. Authorize the Appellant for Live-in 24 hour personal care services.

2. Update its records to indicate that the Appellant is a "Mayer III" patient, entitled to 24 hour personal care services in the absence of formal or informal supports.

3. Notify the Appellant in writing upon compliance with this Decision.

Should SHP need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is required, the Appellant must provide it to SHP promptly to facilitate such compliance.

As required by Section 358-6.4 of the Regulations, SHP must comply immediately with the directives set forth above.

DATED: Albany, New York
05/23/2019

NEW YORK STATE
DEPARTMENT OF HEALTH

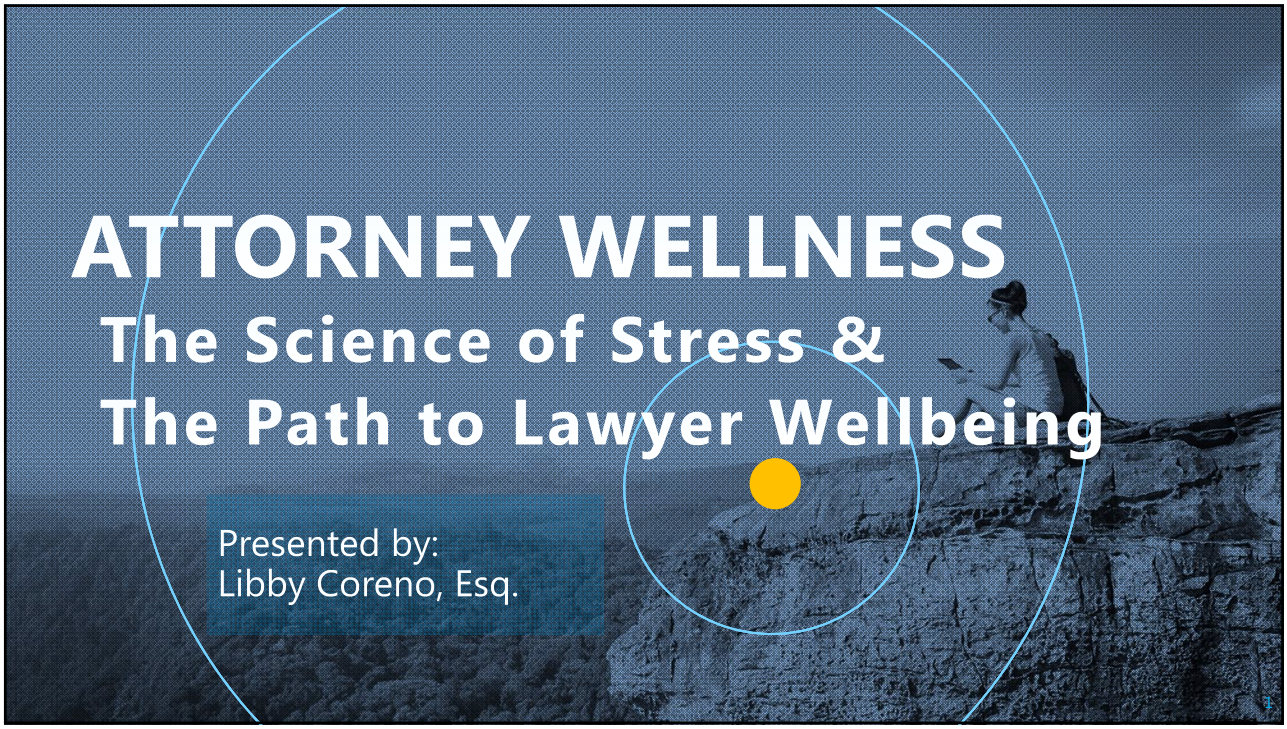
By

Allyson Sackey

Commissioner's Designee

Attorney Wellness: The Science of Stress and the Road to Well-Being

M. Elizabeth Coreno, Esq.
The Law Offices of M. Elizabeth Coreno, Esq., P.C., Saratoga Spring, NY



"To be a good lawyer, one has to be a healthy lawyer. Sadly, our profession is falling short when it comes to wellbeing . . . Studies reveal that too many lawyers and law students experience chronic stress and high rates of depression and substance abuse."

"The current state of lawyers' health cannot support a profession dedicated to client service and dependent on the public trust."

—ABA National Task Force on Lawyer Well-Being
August 14, 2017

The Lawyer Personality?

Are there propensities in those drawn to the legal profession?

Detail Oriented
The ability to pay close attention facts and data thoroughly and consistently to bring about a desired outcome.

Perfectionism
The need to set and meet exceedingly high standards both in self and in others.

"Type A"
Competitiveness, urgency, impatience, achievement-oriented, high stress environments

3

From Law School to Practice . . .

Does the role of lawyer naturally affect well-being?

Anticipatory Anxiety
- Being trained to worry
- High negative arousal
- Negative perception of the future
- Pessimistic

"What Makes Lawyers Happy"
Larry Kreiger, Esq.'s study of lawyers in areas of well-being focused on the loss of the intrinsic value system (autonomy, relatedness, competence) and replacing it with extrinsic (money, power, presige)

4

Culture of a Profession

What is reflected in the professional culture of the law?

High Burn Out Rate
Record high levels of stress with requirements for revenue, management, client relationship and case outcome.

Negative Coping & Isolation
Little collegial support in managing the problems, trauma and stresses that are inherent in the profession.

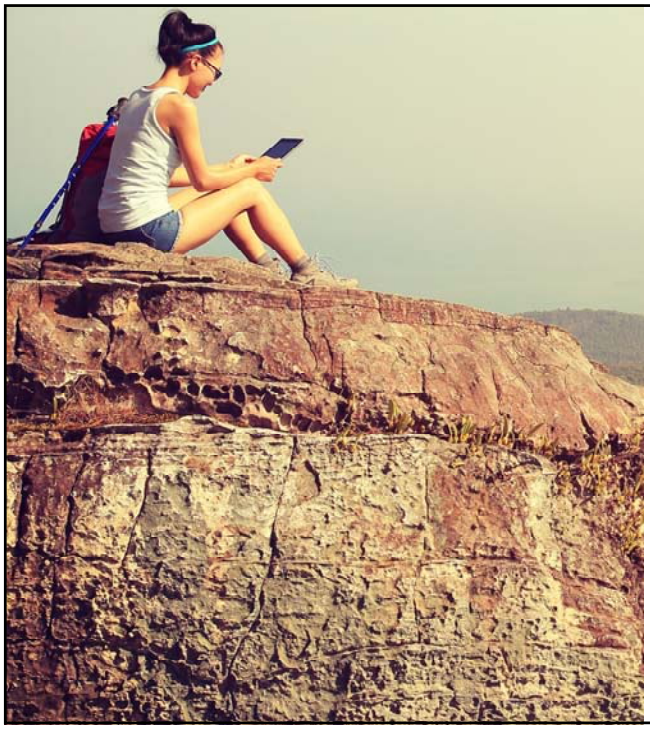
Mental Health Impacts
Highest rates of anxiety, depression, substance abuse of any profession.

5

CHANGE

ABA NATIONAL TASK FORCE RECOMMENDATIONS FOR CHANGE| 5 THEMES

1. Identify stakeholders and the role each of us can play in reducing toxicity
2. Eliminate stigma associated with getting help
3. Emphasize well-being as an "indispensable" part of our duties
4. Educate the profession on issues affecting well-being
5. Take incremental steps to change how law is practiced and regulated



1

Mindfulness & Stress Reduction

S.T.O.P.

Stop | Take a Breath | Observe | Proceed

7

2

Understand and Address any Negative Cultural Messages

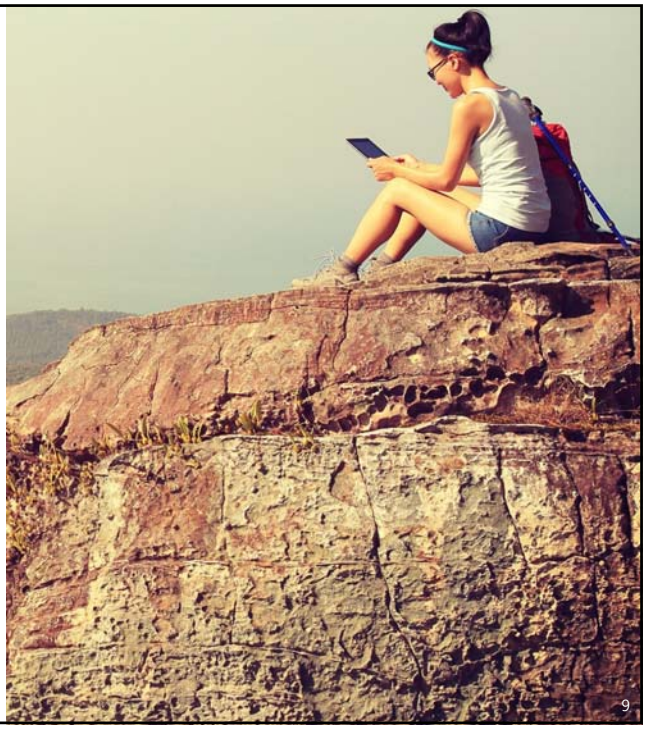
ENGAGE

3

Proactivity in Destigmatizing Help-Seeking Behavior

SUPPORT

"Lawyers are a help-rejecting population."
Alan Levin



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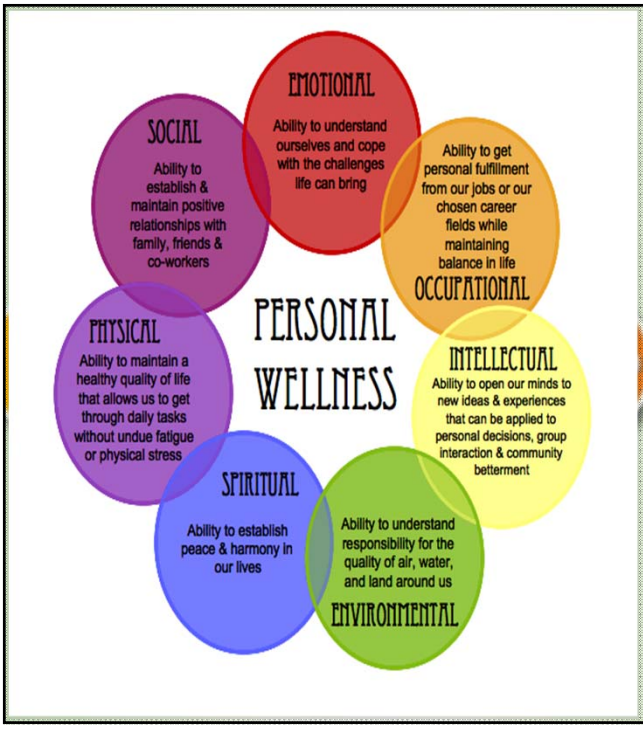

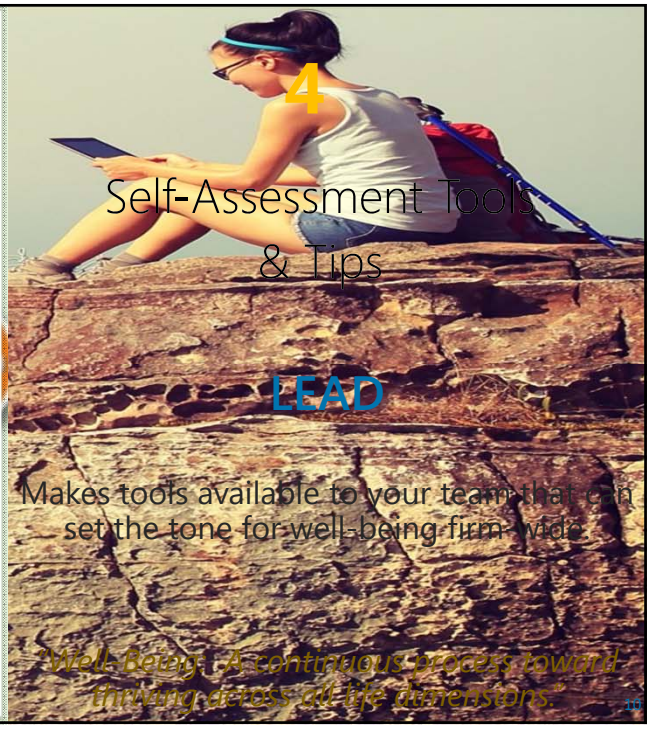

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August 14, 2017

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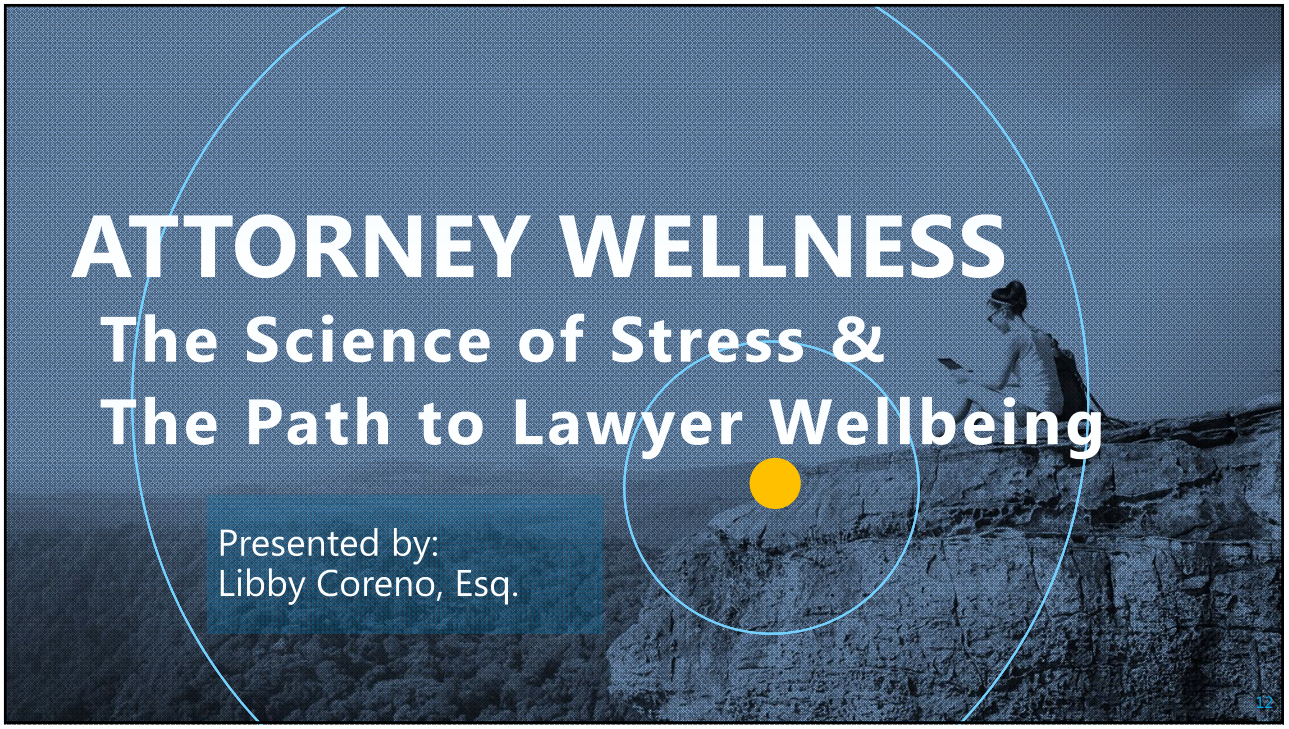

Never Alone: Addiction, Recovery and Community

By Libby Coreno

Let me just say - I love lawyers. I love the passion, intelligence, tenacity, brilliance, skepticism, integrity, and verbosity (I could, of course, go on). It has been a tremendous privilege and pleasure for me to travel across New York in the last five years presenting lawyer training programs on mindfulness, meditation, empowerment, leadership and women's issues. Yet nothing has left such a lasting impression on me as my opportunities to present mindfulness and other techniques to lawyers in recovery - a community within our community. To be among lawyers who have faced addiction and made the choice to live clean and sober is to bear witness to that wondrous combination of humility, strength, wisdom, acceptance, compassion, and not a little bit of laughter.

For me, being in the rooms with lawyers in recovery is like coming home - hearing phrases like "one day at a time" and the serenity prayer (with its emphasis on strength, discernment and acceptance) is like being at my mom's kitchen table. My childhood home was filled with these messages and the library shelves were lined with books on recovery, empowerment, and wellness.

It was not until my early teens when I learned that the meeting my dad got up for each Saturday morning was the weekly gathering of a 12-step group and was a cornerstone of his sobriety;[1] that the inspirational books were part of his recovery process; that when his phone rang, and he mouthed to my mom, "I have to take this," it was someone in real trouble on the other end.

It was not until my college years that I understood the power of addiction and the power of the fellowship that caused my dad to take phone calls day or night.

And it was not until my years as a young lawyer that I saw addiction take root in my friends, peers and colleagues. Whenever I have the opportunity to sit with a fellowship of recovering lawyers, it is always inspiring, uplifting, transformational - and beautifully familiar.

Yet even with my heightened sensitivity to the perils of addiction, I was enormously affected early in my career by the impact of alcohol on a colleague before we were even 30. I remember viscerally being a young attorney with all the pressures, deadlines, and expectations that entry into the profession carries. I found solace in my fellow young lawyers as we would commiserate in a form of negative bonding around the daily management of the toils of practice on the bottom rung. Sometimes that bonding was gathering after work or on the weekends with drinks but it was never anything over which I was particularly concerned. We each seemed to be appropriate, understood limits, and acted accordingly.

It was not until much later that I realized the reason I was not concerned - my friend's alcoholism had taken root away from the small group gatherings and was happening at home. Every single sign was present that he was struggling - decreased personal self-care, forgetfulness, timeliness, and questionable judgment. I knew he was a brilliant, dedicated young attorney but I felt voiceless and powerless to say the one thing that needed to be said - "I see you struggling and I want to help." It seems so incredibly simple to me now and I often wonder if things would have been different if I had found my courage to be the friend and colleague he deserved.

After my early experience, I decided that I would make every effort I could to help lawyers find ways to support and care for one another in the path to personal and professional wellbeing. I began to get involved with the New York State Lawyer Assistance Program and advocate strongly for an increased focus on overall attorney well-being - addiction, stress management, and mental health. As I began to learn all I could about how addiction and mental health issues uniquely affect lawyers, it became increasingly clear that education about the pressures of practice, the impacts on the individual, and maladaptive coping mechanisms was woefully lacking.

Author and lawyer Lisa F. Smith noted the following when discussing her life in recovery in her memoir *Girl Walks Out of a Bar:*

> *Twenty-five years ago when I started practicing law [I was never] educated about . . . the risk that lawyers run of becoming alcoholics, and what you can do about it [and] that there is confidential help out there . . . It was news to me years later, when I found out there were lawyers assistance programs at the state bar level, at the national bar level, and at the city bar level, [made up] of lawyers who are there to help other lawyers who are in trouble. That should be something that lawyers learn about the same time they're learning where the library is and how to overnight a package to a client . . . One thing that is lacking . . . is a session on the fact that lawyers frequently run into mental health issues, depression, anxiety and then frequently this leads to substance abuse. Alcohol being far and away the number one.*[2]

More recently, I have seen a shift toward greater awareness. I recall vividly the moment two years ago when I congratulated a recent law school graduate on her admission day at the Appellate Division. With a concerned and lowered voice, she asked, "I am excited, but I looked through the packet I was given, and it's full of helplines for depression, addiction, and suicide. Is there something I wasn't told?" While it may be the first she was hearing of the higher rates of substance abuse and mental health conditions, the data has been around for some time.

Recently, a Hazelton Betty Ford study found that (1) 20.6 percent of lawyers screened positive for alcohol-dependent drinking (higher among men and younger attorneys); (2) 28 percent of lawyers suffer from depression (higher among men); (3) 19 percent of lawyers struggle with anxiety (higher among women); and (4) 23 percent of lawyers experience significant stress.[3]

At the NYSBA Annual Meeting in January, my co-presenter, Kerry Murray O'Hara, PysD and I laid out our premise that lawyers are predisposed to higher than average rates of addiction and other mental health issues as a result of "a perfect storm" of "certain traits which cause stress and burnout, then are trained into anticipatory anxiety (professional worriers) which is known to be suboptimal psychology, and then are potentially stigmatized and perceived as weak when the burden becomes too much.

Rather than seek professional help, many lawyers withdraw from peers, friends and family, or engage in 'maladaptive coping behaviors' such as self-medicating with alcohol and other substances. In essence, the contributing factors to a lawyer's unhappiness coupled with the resistance to seek help may lead to the higher than average levels of problem drinking and substance abuse according to the most recent research."[4]

In fact, the American Bar Association's 2017 Report of the National Task Force on Lawyer Wellbeing included the list of reasons why lawyers are so help-averse, including: "(1) failure to recognize symptoms; (2) not knowing how to identify or access appropriate treatment or believing it to be a hassle to do so; (3) a culture's negative attitude about such conditions; (4) fear of adverse reactions by others whose opinions are important; (5) feeling ashamed; (6) viewing help-seeking as a sign of weakness, having a strong preference for self-reliance, and/or having a tendency toward perfectionism; (7) fear of career repercussions; (8) concerns about confidentiality; (9) uncertainty about the quality of organizationally-provided therapists or otherwise doubting that treatment will be effective; and (10) lack of time in busy schedules."[5]

As awareness grows and efforts are made to shift a help-resistant profession,[6] the time I spend with lawyers in recovery is incredibly refreshing, fulfilling and inspires me with such hope. Each and every lawyer I have met through Lawyer Assistance Programs, Lawyers Helping Lawyers or as Chair of the Saratoga County Bar Association's Lawyer Assistance Committee has taken the profound and courageous step in asking for help. Many will bravely tell their stories of the moment when they knew their lives had become unmanageable due to alcohol or drugs. They also will tell me about how they received help and about being welcomed into a community of fellowship from those who had walked the path to sobriety before them.

One lawyer shared with me that he was a senior litigation partner at a prestigious law firm but was terrified of the courtroom. He drank larger and larger amounts of alcohol to help him cope with the levels of anxiety that he experienced whenever he was prepping for or in trial. As he continued to rely on alcohol more and more, other areas of his life began to unravel - his health, his marriage, his relationship with his children, and his work. One Monday morning, he awoke to find that he had passed out reviewing deposition transcripts and forgot to set his alarm. He was foggy and disheveled and late for court. He began to feel pains in his chest as his mind raced to figure out how we was going to explain his tardiness, his appearance and his ill health to the judge and his client. On the way to the courthouse, he decided that he could not live another day as he had for the last several years. He contacted another lawyer he knew was in recovery and asked him what to do. His colleague drove to his home that evening and brought him to his first Alcoholics Anonymous meeting. He has been sober since that day and he tells me of how his life has shifted in unbelievable ways - as a happier self and professional.

Another lawyer shared with me that his journey of recovery had taught him to not take things personally and that has enabled to him to experience incidents in the courtroom in a completely different way. He said, "Prior to recovery, I was the maddest person in the courtroom and every ruling that didn't go my way was because the judge had it out for me. I was short-tempered and a bit of a hothead. I would drink after court to blow off the stress of the day, only to wake up the next day more tired and irritable. After entering into recovery, I learned that I didn't have to take everything so personally. I could go easier on myself."

Still another lawyer shared with me the impact on him from a colleague's recent suicide. For the better part of two years, he had looked in on a lawyer he knew had been struggling with mental health and addiction issues. He had repeatedly facilitated and participated in interventions on her behalf with local health care professionals, her family, and others when things looked bleak. She had stabilized many times and he had great hopes for her continued success. He knew from his own family experience that each day was a challenge for his friend but that she continued to practice law and give tremendously to her community. And yet, the day came when he had to share with the legal community the news of her suicide. He remarked to me, "We don't do enough for each other. We all think we are the only one. We need to be good to each other and see that we all struggle and have challenges."

A few years ago, I had a dream come true when my dad and I co-presented "Mindfulness and the 12 Steps" at a weekend retreat for lawyers in recovery. It was easy for me to see that this "community within the legal community" is one of mutual respect, love and tolerance. Anyone who asks for help receives it - no judgment, no questions asked. I remarked to the group that they exemplify the key principles that create a sense of community, belonging and well-being - a template for a profession in need.

While I understand that recovery comes in many forms and that 12-step programs are but one path, I offer these stories as part of my personal journey and the journeys of those who have courageously shared their stories with me for this article.

As the Chair of the newly formed Attorney Wellbeing Committee for the NYSBA, it is my singular hope that we continue to support access to resources and assistance to lawyers struggling with addiction and mental health challenges in any form. We can also apply the core principles of community, belonging and well-being to the entire profession - taking lawyers from striving to thriving.

With those words in mind, I will offer one of my favorite quotes from the Persian poet, Rumi: "*There is a community of the spirit . . . open your hands if you want to be held*." If any of this writing speaks to you, please know that there is a community of the spirit with open hands stretched out to help. You are never, ever alone.

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1. For those who wonder about my father's anonymity in recovery, he has reviewed this article and given me permission to share the story. I am proud to say that he is Barry Levine, founder and Board President for the Capital District Recovery Center (CDRC) on Colvin Avenue in Albany which opened this year and has the mission "to provide a safe and accessible space for people seeking recovery from addictions by offering a one-stop location for 12-step recovery meetings, recovery supports, and programs for self-improvement, and spiritual growth." He has shared his recovery journey as part of the process to found and open CDRC – a journey which is fast approaching three decades. I am honored to serve as volunteer legal counsel to the Board of CDRC. ↵
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4. Coreno, Libby and O'Hara, Kerry, Attorney Wellness: The Science of Stress and the Road to Well-Being, NYSBA Journal, October 2018, Vol. 90, No. 8. (internal citations and quotation marks omitted). ↵
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6. Ciobanu, Terrell, Out of the Darkness: Overcoming Depression Among Lawyers, American Bar Association, GP Solo, March/April 2015, noting a 2004 study of lawyers recovering from mental illness determined that the two greatest factors in failing to seek treatment was the belief that "they could handle it on their own" and that discovery of treatment would stigmatizing to their reputation. ↵

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Attorney Wellness:

THE SCIENCE OF STRESS AND THE ROAD TO WELL-BEING

By Libby Coreno and Kerry Murray O'Hara

"To be a good lawyer, one has to be a healthy lawyer. Sadly, our profession is falling short when it comes to wellbeing . . . the current state of lawyers' health cannot support a profession dedicated to client service and dependent on the public trust." ABA National Task Force on Lawyer Well-Being (August 14, 2017)

"We know what we are, but know not what we may be." Shakespeare provides us a beautiful reminder in Hamlet that we are masters of our own fate. While we may be facing trying or difficult times today, it does not mean it will remain the same forever. It is a reminder that we must embrace uncertainty and live life with an open mind as to what is possible. And so it is with the status of health and well-being among the legal profession and lawyers generally - we know what we are in the current state of assessment, but know not what we may yet become.

The news concerning the statistics of the impact of the profession on the mental, emotional and physical well-being of lawyers is becoming more and more studied (and grim) - and yet solutions can feel elusive. From addiction to depression to suicide, it can feel hopeless to try to determine exactly what drives the sobering statistics among lawyer mental health and well-being. Fortunately, in the last several years enormous strides have been made in the quantitative study of lawyer well-being and happiness, thus pointing us toward the beginning of who we may yet become if we can approach the uncertainty of change with courage and an open mind.

In 2017, the American Bar Association released its report from the National Task Force on Lawyer Well-Being, which outlined recommendations in eight areas for our profession to assist in transforming the practice of law to one that is more focused on the health and well-being of its practitioners.[1] The Report was released on the heels of two other recent and significant quantitative studies of lawyer well-being: Lawrence Kreiger and Kenneth Sheldon's What Makes Lawyers Happy: A Data-Driven Prescription to Redefine Professional Success,George Washington Law Review, 2015, and the ABA/Hazelton Betty Ford Foundation's study in the Journal of Addiction Medicine on substance abuse and mental health issues among attorneys (2016). Yet, the correlation between attorney well-being and the demands of practice are not new. In fact, Johns Hopkins University released a study in 1990 which found that lawyers were nearly four times as likely as the general population to suffer from depression, anxiety, social isolation, and other forms of psychological distress.[2]

Sadly, in the decades between the Johns Hopkins University study on depression and the most recent findings, the health and well-being of lawyers has not improved. The Hazelton Betty Ford study found: (1) 20.6 percent of lawyers screened positive for alcohol-dependent drinking (higher among men and younger attorneys); (2) 28 percent of lawyers suffer from depression (higher among men); (3) 19 percent of lawyers struggle with anxiety (higher among women); and (4) 23 percent of lawyers experience significant stress.[3] In this article, we will look at some of the causes of higher levels of mental health struggles and substance abuse issues in the legal profession and, more important, some of the recommended changes and techniques that can be implemented in lives of lawyers to help them go from striving to thriving.

THE LAWYER 'PERSONALITY'

In 2006, Res Gestae published an article by Stephen Terrell which contained the observation that "what makes for a good lawyer may make for an unhappy human being."[4] The psychological underpinnings for the potential disruption to healthy emotional functioning can be drawn from aspects of the lawyer "personality" such as perfectionism, "Type A" attributes, and anticipatory anxiety (or pessimism). When healthy emotional functioning is disrupted, it is not uncommon to suffer from psychological and emotional distress that can often lead to substance use/abuse, burnout, relationship deterioration, and physical health impairment. "Mental health disorders can profoundly affect attorneys' daily functioning. Irritability, feelings of inadequacy, difficulty concentrating, a sense of worry and impending danger, sleep disturbances, heart palpitations, sweating, fatigue and muscle tension are all side effects of depression and anxiety."[5]

Perfectionism is a pattern of belief where nothing is ever good enough.[6] Law school, law firms, judges and clients reinforce the notion that lawyers must be free from mistakes in order to be effective at their job.[7] At every turn, there is the need to set and meet exceedingly high standards in one's self and in others. Holding the responsibility for the outcome of someone's life can be overwhelming, so all aspects need to be executed without flaws. In order to look at cases "effectively" and maintain a dispassionate detachment to achieve a "perfect" result, lawyers receive early training to be emotionally withdrawn - a trait that can help with professional effectiveness but have disastrous consequences personally.[8] Significantly related to perfectionism is the lawyer trait of being detail-oriented - the ability to pay high-level attention to facts and data, consistently over time, to bring about the desired outcome. Paying attention over long periods of time at such a high level can lead to feelings of competitiveness, urgency, impatience, stress, or Type "A" attributes.[9] Added together, the attributes that are highly prized in lawyers are also known to lead to mental health disturbances.[10]

As one lawyer reflected, "We have the perfect storm of both personality traits and career circumstances which are generally known to cause depression. Most lawyers are Type-A people who put way too much pressure on themselves. In our profession we are always being attacked, literally, from opposing counsel and other players in litigation. Other than professional boxing, I can't think of any other profession where the job requires constant fighting."[11]

Perhaps the most notable of all lawyer traits is that of "anticipatory anxiety," or being trained to worry. Psychologist Tyger Latham notes that lawyers are "[p]aid worriers . . . [and] expected to predict the future, to anticipate threats and guard against anything that could arise. So they learn to see problems everywhere, even when they don't exist. And they start to perceive threats as life or death matters."[12] James A. Fassold, a lawyer in Phoenix, opined that "[Lawyers] constantly ask the question 'what's the worst that could happen?' As a result, lawyers are on a permanent 'fight or flight' mode, constantly on guard. They have nothing to sell but their time and advice. They're not cranking out widgets. They can't make more time."[13]

The training toward worry leads to high negative arousal states, a negative perception of the future, and pessimism. In fact, in the Johns Hopkins study from 1990, the legal profession was the only one where pessimism outperformed optimism.[14] In the normal clinical setting, a trained psychotherapist would begin treatment with a patient to train them away from anticipatory anxiety; rather than toward it. Such worry is a hallmark of suboptimal psychology in a human being and yet is a cornerstone of lawyer training.

A CULTURE IN RESISTANCE

In its current state, the legal profession finds itself facing myriad issues above and beyond a mental health or substance abuse crisis. Lawyers also contend with a changing landscape that includes increased "social alienation, work addiction, sleep deprivation, job dissatisfaction, a 'diversity crisis,' complaints of work-life conflict, incivility, narrowing values in which profit predominates, and negative public perception."[15] And yet, with all that is confronting the industry, the ABA's National Task Force on Attorney Well-Being noted in its 2017 Report a culture with deep barriers and resistance to discussing the problems in practicing law, seeking out help and services, and working as a community to establish best practices for the well-being of its membership.[16] Perhaps most notable of all is that lawyers address these demonstrably high levels of unhappiness and dissatisfaction with "a sense of acceptance rather than outrage."[17]

A 2004 study of lawyers recovering from mental illness determined that the two greatest factors in failing to seek treatment was the belief that "they could handle it on their own" and that discovery of treatment would stigmatize their reputation.[18] The National Task Force on Lawyer Well-Being released its research that included an expansive list of reasons why lawyers are so help-averse, including: "(1) failure to recognize symptoms; (2) not knowing how to identify or access appropriate treatment or believing it to be a hassle to do so; (3) a culture's negative attitude about such conditions; (4) fear of adverse reactions by others whose opinions are important; (5) feeling ashamed; (6) viewing help-seeking as a sign of weakness, having a strong preference for self-reliance, and/or having a tendency toward perfectionism; (7) fear of career repercussions; (8) concerns about confidentiality; (9) uncertainty about the quality of organizationally-provided therapists or otherwise doubting that treatment will be effective; and (10) lack of time in busy schedules."[19] Moreover, some state applications for the bar admission require disclosure by a lawyer if he or she has received treatment for any type of mental illness.[20]

Attorney and author Jeena Cho observed that "Lawyers are risk averse. We don't want to be the first to try anything new because we love stare decisis. Not only is there a resistance to trying a different way of practicing law to reduce these issues lawyers struggle with, it appears that there is a deep level of denial. It's the lawyers at the other law firms who are struggling with depression, problematic drinking or substance abuse. When an attorney is exposed as struggling with these serious mental health issues, it's treated as an isolated incident, that the problem is unique to him or her - not as a systemic issue."[21]

As a result, a perfect storm can be observed where lawyers are predisposed to certain traits that cause stress and burnout, are then trained into anticipatory anxiety (professional worriers), which is known to be suboptimal psychology, and then are potentially stigmatized and perceived as weak when the burden becomes too much. Rather than seek professional help, many lawyers "withdraw from peers, friends and family, or engage in 'maladaptive coping behaviors' such as self-medicating with alcohol and other substances."[22] In essence, the contributing factors to a lawyer's unhappiness coupled with the resistance to seek help may lead to the higher than average levels of problem drinking and substance abuse, according to the most recent research.

CHANGE IS IN THE AIR

In 2015, Larry Kreiger and Kennon Sheldon published What Makes Lawyers Happy? A Data-Driven Prescription to Redefine Professional Success in the George Washington Law Review, which laid out the results of surveys taken from more than 6,200 lawyers throughout the country in every aspect of the profession.[23] For the first time, Kreiger and Sheldon provide lawyers with the statistical proof that the extrinsic values that drive the definition of "success" (power, prestige, money, highly prized achievements) do not bear "any relationship to the well-being of [lawyers]."[24] In fact, the authors found a direct correlation between well-being and intrinsic values such as autonomy, integrity, close relationships, and meaningful and purposeful work - which, when experienced, lead to higher levels of productivity, lower turnover, and overall workplace satisfaction.[25] The conclusions drawn from the data should make a change-resistant profession take notice of the importance of well-being, if not solely for the health of their colleagues writ large, but also because the estimated costs of attorney turnover among large firms is $25 million per year.[26]

Beyond the data and profitability implications, the ABA's National Task Force on Attorney Well-Being estimated in its 2017 Report that "40 to 70 percent of disciplinary proceedings and malpractice claims against lawyers involved substance abuse or depression, and often both."[27] The New York State Rules of Professional Conduct ("Rules") contain multiple references to the responsibility and duty of lawyers charged with the public and client trust. Rule 1.1 requires that a lawyer provide "competent representation" and Rule 1.3 prohibits the neglect of the client matter. In these two examples, it is self-evident that the lawyer must have the capacity to be both competent and attentive - two skills that are substantially affected when the lawyer's health and well-being is suboptimal. From a clinical perspective, the Report illustrated that suffering from depression directly impacts executive functioning that is necessary for memory, attention, and problem-solving, while nearly 80 percent of alcohol abusers suffer mild to severe cognitive impairment.[28]

In addition to the workplace satisfaction, profitability, risk management, and ethical implications, lawyers are a cohort whose ecosystem is impacted by the health and well-being of one another from courtrooms to board rooms. In short, focusing on the well-being of the profession as a collective and individually is simply the right thing to do.

FROM STRIVING TO THRIVING: THE ROAD TO WELL-BEING

While the definition of well-being may vary from person to person, clinical practitioners generalize health and wellness across eight distinct areas of life: social, physical, spiritual, emotional, occupational, financial, environmental, and intellectual.[29] The "Eight Dimensions of Wellness" have been roundly accepted as the integrative approach to assessing and addressing overall well-being - including by the U.S Department of Health and Human Services (Substance Abuse and Mental Health Services Administration).[30] In the Report, the ABA's National Task Force described well-being for lawyers as:

> *A continuous process whereby lawyers seek to thrive in each of the following areas: emotional health, occupational health, creative and intellectual endeavors, sense of spirituality or greater purpose in life, physical health, and social connections with others. Lawyer well-being is part of a lawyer's ethical duty of competence. It includes lawyers' ability to make healthy, positive work/life choices to assure not only a quality of life within their families and communities, but also to help them make responsible decisions for their clients.*[31]

The recommendations from the National Task Force are sweeping - from law schools to Lawyer Assistance Programs to law firm and even malpractice careers.[32] In summary, the Report encourages our profession to (1) identify stakeholders and the role each one can play in reducing toxicity; (2) work to eliminate the stigma associated with asking for and receiving help; (3) emphasize well-being as an "indispensable" part of a lawyer's duties; (4) educate the profession on issues affecting well-being; and (5) take steps to change how law is practiced and regulated with well-being in mind.

In light of the Report's recommendations, and as a direct result of the growing empirical data concerning the state of lawyer well-being, New York has become the sixth state in the nation to form a committee for Attorney Well-Being, which operates as a subcommittee to the Law Practice Management Committee of the New York State Bar Association. The purpose of the Attorney Well-Being subcommittee is to identify areas of support and to offer assistance to members who seek to implement ways of thriving professionally and personally, and partnering with other NYSBA Committees to bring awareness, programming, and leadership to the issues that both affect well-being and build resiliency.

As part of the NYSBA Annual Meeting in 2018, the authors of this article presented four steps that can be undertaken by firms and legal employers now to assist in facilitating well-being in the workplace. First, we encourage legal employers, law schools, and bar associations to invest in or make available mindfulness or stress reduction programs to law students and lawyers, as well as actively support the time commitment required for the course work. Beyond mindfulness, there are cognitive and dialectical behavioral techniques that can also be utilized to help build resiliency, distress tolerance, and emotional regulation. Programs that build leadership skills, increase competency, listening and empowerment are all part of the Eight Dimensions of Wellness and can have a profound effect on overall well-being. Second, we encourage lawyers, especially lawyers with influence and experience, to engage with leadership within the profession to assist in destigmatizing help-seeking for lawyers. It is the intent of the Attorney Well-Being subcommittee to provide online resources to members to facilitate ways to normalize and encourage wellness as a primary factor in the competency of lawyers. Third, we recommend developing best practices in organizations with lawyers (law schools, law firms, government, and bar associations) for addressing and reducing negative cultural messages that perpetuate the "lawyer personality" of pessimism and perfectionism. Programs are being developed that will specifically address the need for lawyers to develop the skills necessary to "turn on" their training to anticipate problems, but also to be able to turn it off so that life is not simply a series of worst-case scenarios. Finally, we invite all members of the NYSBA to review the self-evaluations and lifestyle management resources that are available at the Attorney Well-Being subcommittee's webpage. The availability of technology, apps, and education is wide - stretching across multiple areas of life from substance consumption to tech addiction to financial mindfulness.

CONCLUSION

As Shakespeare's Ophelia pondered philosophically in Hamlet, lawyers now know who they are in terms of well-being, but there is so much possibility in who we may yet become. From productivity and profitability to ethical concerns and the public trust, to the duty we owe to one another, there has never been more evidence or a greater mandate to work toward normalizing well-being in the legal profession. For a slow-to-change profession, the drumbeat continues its rhythm and only grows in volume. It will require courage and open minds to embrace the direction toward the improvement of the lives of lawyers and those who love them.

"The time is now to use your experience, status, and leadership to construct a profession built on greater well-being, increased competence, and greater public trust." The Report of the National Task Force on Attorney Well-Being, 2017.

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13. Roth Port, supra note 11, at p. 7. ↲
14. Gordon, supra note 5. ↲
15. The Path to Lawyer Well-Being, supra note 1, at p. 7. ↲
16. Id. at p. 13. ↲
17. Gordon, supra note 5. ↲
18. Ciobanu, supra note 2. ↲
19. The Path to Lawyer Well-Being, supra note 1, at p. 13. ↲
20. Ciobanu, supra note 2. ↲
21. Cho, Jeena, Study Indicates Lawyers Struggling with Substance Use and Other Mental Health Issues, Forbes.com, July 30, 2016 ↲
22. Gordon, supra note 5. ↲
23. Lawrence S. Kreiger and Kennon M. Sheldon, What Makes Lawyers Happy? A Data-Driven Prescription to Redefine Professional Success, 83 Geo. Wash. L. Rev. 554 (2015). ↲
24. Id. ↲
25. Id. at 623–24. ↲
26. The Path to Lawyer Well-Being, supra note 1, at p. 8. ↲
27. Id. ↲
28. Id. at 9. ↲
29. Swarbrick, M. (2006), A wellness approach, Psychiatric Rehabilitation Journal, 29 (4) 311- 3314. A self-test on well-being is available on the Attorney Wellbeing subcommittee page at NYSBA.org. ↲
30. https://store.samhsa.gov/shin/content//SMA16-4953/SMA16-4953.pdf. ↲
31. The Path to Lawyer Well-Being, supra note 1, at p. 9. ↲
32. Id. ↲

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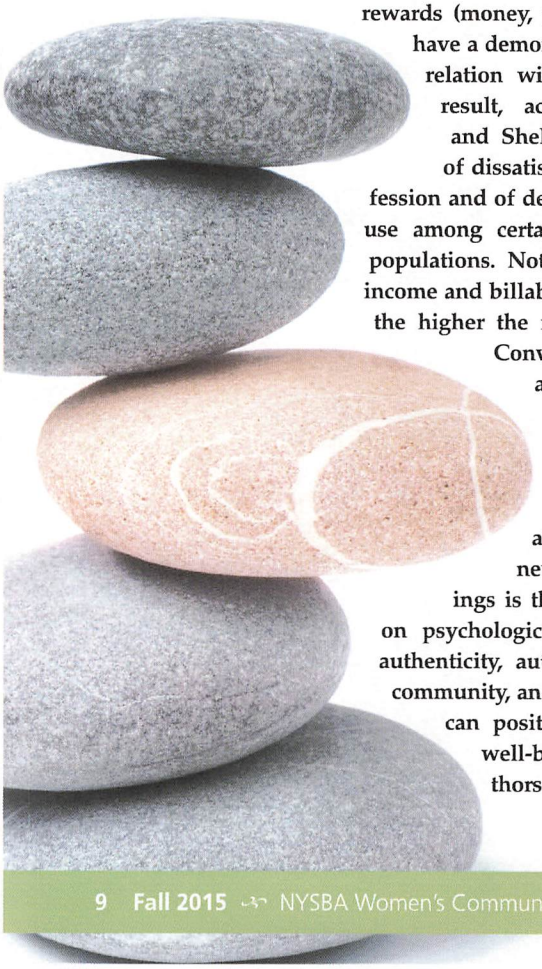
What Makes Lawyers Happy

by Libby Coreno, Esq.

Earlier this year, I congratulated a recent law school graduate on her admission day at the Appellate Division. She smiled, lowered her voice, looked concerned, and said, "I am excited, but I looked through the packet I was given, and it's full of helplines for depression, addiction, and suicide. Is there something I wasn't told?"

Her question immediately bought to mind the recent work of Lawrence S. Krieger, Esq. and Kennon M. Sheldon, "What Makes Lawyers Happy? Transcending the Anecdotes with Data from 6200 Lawyers," which will be published this year by the *George Washington University Law Review*. The authors provide statistical data that supports their conclusion that the extrinsic value system taught in law school, and extended into the legal profession, has an inverse relationship with the level of lawyer happiness. "[T]he psychological factors seen to erode during law school are the very factors most important for the well-being of lawyers," Krieger and Sheldon write. So my answer to my newest colleague was, "Yes. There may be some things you weren't told."

Krieger and Sheldon's work now quantifies what we have intuitively suspected for quite some time: Law schools and the legal profession have the potential to break down attorneys' intrinsic value system in favor of placing predominant value on external rewards (money, power, prestige) that have a demonstrable negative correlation with well-being. The result, according to Krieger and Sheldon, is higher rates of dissatisfaction with the profession and of depression and alcohol use among certain segments of our populations. Notably, the higher the income and billable hour requirement, the higher the rates of alcohol use. Conversely, public service attorneys generally enjoy higher rates of well-being (second only to judges) and lower rates of alcohol use. The good news from their findings is that placing emphasis on psychological values, including authenticity, autonomy, competence, community, and self-understanding, can positively affect attorney well-being. In fact, the authors claim that focusing on these intrinsic values can increase productivity, employee retention, and an overall positive image of the profession itself.



> *"The good news from their findings is that placing emphasis on psychological values, including authenticity, autonomy, competence, community, and self-understanding, can positively affect attorney well-being."*

In my work with attorneys, especially women attorneys, I have long focused on the importance of developing and listening to one's internal compass which provides moorings in the oftentimes choppy seas of law practice life. I encourage attorneys to ask themselves, "What are the intrinsic values unique to me? How can I rely on those values to make decisions in alignment with my own integrity and authenticity?" My invitation to each and every attorney is to begin a path of deep reflection on your personal values and then on finding ways of living and working congruently with those values. This path requires courage, a healthy relationship with consequences, understanding, self-compassion, and, most of all, patience. Recently, one of my mentoring clients had to engage in the difficult process of evaluating a job change from the private sector to the corporate world. She asked, "What if the reason I'm leaving private practice is because I just can't hack it anymore?" My questions to her were: What if "hacking" it isn't bringing you joy anymore? What if joy was an acceptable criterion for evaluating what you value? Is it possible to let go of others' extrinsic values in order to find well-being for you?

Attorneys have the power to create value systems within themselves and within their workplaces that emphasize the discovery of personal purpose, greater collaboration and autonomy—and, as Krieger and Sheldon point out, perhaps become more productive and profitable in the process.

Libby Coreno, Esq. has been in private practice for over 11 years and is a Director at Carter, Conboy. P.C. in its Saratoga Springs office. Her practice centers on real estate development, zoning and planning, and real property, municipal and commercial litigation.

Libby is also the founder of The Silent Partner, a consulting and mentoring firm for lawyers and professionals seeking to learn ways to live, practice, and make transitions mindfully, authentically and creatively. A health crisis in 2008 brought Libby to several prominent spiritual teachers, which blossomed into her own study of Buddhist psychology and mindfulness that has been a cornerstone of her life ever since. She works one-on-one with clients, as well as in facilitating changes in group dynamics within law firms and not-for-profit organizations.

WELLNESS

FOR BERGEN COUNTY

Wellness connects all aspects of health!

body
Visiting a healthcare provider regularly • Exercising and eating healthy • Avoiding cigarettes and substance abuse
Getting the appropriate amount of sleep • Making time for relaxation

emotions
Being aware of feelings • Coping with stress • Building resilience and healthy decision making • Expressing feelings through support systems

knowledge
Being open to expanding intellect and skills • Embracing ideas and creativity

environment
Occupying safe, healthy and stimulating environments that support well-being • Fostering a community that is inclusive of all people and appreciates diversity

work
Gaining personal enjoyment and enrichment through work (paid or unpaid, volunteering or school)

finances
Having satisfaction with current and future financial situations

beliefs
Exploring greater purpose and meaning in life • Being excited about opportunities the future holds

connection
Developing satisfying and supportive relationships with friends, family and community members • Participating in social and recreational activities

CHP *For more information contact Marla Klein at mklein@co.bergen.nj.us*

ZEN SAND

It's a relaxing game of logic that is easy to play but hard to master. Place the bamboo stalks to guide the sand into the vases. Relaxing sounds are played in a zen – like atmosphere. Great for a distraction technique or just for fun. Enjoy all 64 challenging levels.

Breathe2Relax

Stress management tool which provides detailed information on the effects of stress on the body and it includes instruction on practice exercises to help users learn the stress management skill called diaphragmatic breathing. App can be used for anger management, anxiety management and mood stabilization instructions.

Tibetan Bowls

Tibetan Bowls is a fantastic soundboard that allows user to create spiritual sounds by tapping the individual bowls. Can be used as a meditation support or trance induction and prayer.

Don't Get Agro

Game designed to help focus users attention away from negative feelings and simultaneously teaching user how to regulate their emotions and clam themselves down.

Moodtrack

App designed to help you track your moods on the fly. Track as often or as little as you want and look back at your moods over weeks, months or years to learn about yourself and what causes your mood swings and live better.

Safety Plan

App Designed to help user customize their own safety plan. User can track warning signs, places for distraction, coping strategies, supports to call and so on. App also contains an easy to use list of emergency resources that's just a tap away.

DBT Quiz

A Simple quiz that anyone interested in DBT can do and learn from. From beginners to experienced DBT users this app is sure to offer user new knowledge in a fun, interactive way. Each level has a, series of questions based on certain categories. Select the correct answer more times than not and you advance to the next level instantly.

DBT Diary Card App

App contains diary log for each day with 28 skills with a description of each as well. It also contains examples of each skill. Includes a record keeping system that tracks the highest number of days the user has logged in a row as well as your current streak. Very similar to our diary cards.

MoodTools

If user is feeling sad, anxious or depressed, *MoodTools* is designed to help combat depression and alleviate your negative moods while aiding you on your road to recovery. Contains, Thought Diary, Safety Plan, Activity Suggestions and many other tools.

"Breethe"

De-Stress & Sleep better in only 10 minutes with your own personal mindfulness coach. Breethe is the easiest way to meditate. User can learn simple mindfulness and meditation techniques that can help promote happiness, calming and peace of mind into their life.

Aquarium HD

App turns your IPad into a beautiful aquarium. User can change tanks, fish and different audio choices. Very calming and relaxing.

Tec Tec

At its heart TEC TEC is a fast past matching game that takes 1-2 minutes to play. The App is a game version of a powerful psychological technique called *evaluative conditioning*. By continually pairing certain words and images, this technique can change associations with certain objects and concepts. Over time the user can change how they feel about certain things which in turn may change their behaviors. Recent randomized controlled trials published in the Journal Of Consulting and Clinical Psychology found that this method reduced self injurious behaviors.

The Safety Plan

This app is designed for users that are in need of assistance for domestic abuse or bullying. User can link to hundreds of the worlds best free interactive online therapy resources through a navigator section. Offers resources for help with physchologicalabuse, physical abuse, cybers stalking, family violence and more.

Zen Coloring App

Zen out and relax in an immersive coloring experience with hundreds of designs and colors. Turn on peaceful ambient soundtracks like rainy day or mountain stream or ocean waves. Very calming and relaxing.

Pranayama

Pranayama is a breathing meditation app that teaches "Conscious Breathing". Health through breathing, it's a simple and intuitive guide to deep breathing that features a progressive course based on the principles of yoga to help the user find balance and stress relief. The potential health benefits have been shown to help with Migraines, high blood pressure, depression, COPD, Asthma as well as improving overall stamina and fitness.

DBT DIARY CARD APP

This is yet another Diary Card app that brings together every DBT skill you've ever heard of and more into one app. It's a quick reference guide to available skills that can fit in your pocket instead of a book or a binder. It's a virtual therapist and emotion coach with 911 Skills that are a tap away.

DBT 4 Module App

Mindfulness, Distress Tolerance, Emotion Regulation, Interpersonal Effectiveness apps are all included in this bundle. Each app module comes with a complete set of tools to not only learn the individual skill but also to help you practice them, grow from them and make it easier to incorporate them. Each app has a description of what each module does for us as individuals.

Accupressure Heal Yourself App

This app is easy to use with illustrated instructions on how to make point massage. It contains over 90 points combinations that can be used for different situations from migraine headaches to help with sleeping issues. Accupressure is the ancient healing art that uses the fingers to stimulate the body's natural self curative abilities. When these points are pressed, they release muscular tension and promote the circulation of blood and the body's life force to aid healing. This app is not a substitute for medical advice.

Elevate

This app is a brain training program designed to improve focus, speaking abilities, processing speed, memory, math skills and more. Each user is provided with a personalized training program that adjusts over time to maximize results. Contains over 40 games to help improve critical cognitive skills. The more the user trains with Elevate the more they imrove.

UnBlock Me

This app is a simple puzzle game designed to help promote problem solving skills as well as being a great and challenging distraction technique.

Breathe Deep

This app is a paced breathing app that is customizable with audio cues to instruct user when to breathe in and out as well as "Holding Periods" between inhales and exhales. It gives the user immediate feedback via the audio cues and encourages you to keep using deep breathing as a skill.

Word Search Pro

App is a word search game that promotes problem solving skills as well as improving your vocabulary and spelling. User tries to identify hidden words and then swipes up, down, left, right or diagonally to mark them. This app is for distraction as well as being fun and challenging .

Koi Pond & Fish Pond

Koi Pond and Fish Pond are interactive apps that allows the user to build and maintain a Koi Fish pond as well as just relax and watch a ready made pond full of fish. Koi Pond promotes responsibility and the importance of maintaining a schedule. The user feeds the fish and cleans the pond as well as decorates it while Fish Pond lets you relax and admire the fish. Beautiful, serene, calming and relaxing, these apps offer a fun way to learn how to care for a virtual pet or just enjoy the beautiful fish. Great for relaxing or as a distraction technique.

Mindfulness Exercises App

This app contains helpful information for Basic Mindfulness Exercises that can enhance your life. It includes 5 easy mindfulness exercises for anxiety attack relief. As well as the top 5 Mindfulness exercise games and a Cognitive Behavior Mind Exercise for help with insomnia.

The Sober App

This app one of the top selling apps in the APP Store. It counts your clean and sober days as well as the money you have saved by staying sober. It also offers *daily motivational messages* and notifications that remind you to read them. *It includes a process to help you avoid relapsing* :If the user is craving, they Just type in one word to the included search engine to describe how you are feeling and it will lead you to an answer to deal with those feelings thus improving your chances for not relapsing.

Mind Body Breathing

This app offers a simple and effective way to practice better breathing. It helps the user easily integrate the breathing exercises into their daily routine. Different modes will assist the user in any situation to change your emotional state or to just calm down. Continued use of this app has been shown to help user achieve greater emotional balance, to let go of negative thoughts, improve sleep quality and experience an overall general well being.

Anxiety Relief, Depression, Self Esteem, Sleep Well Hypnosis App

This app contains 30 minute audio sessions read by a certified hypnotherapist. Anxiety Relief, Depression, Self Esteem and Sleep Well session are all included. Peaceful background music and nature sounds are played to help the user relax. This app offers possible relief to all modules included.

Good Blocks

Good Blocks is a gamified training application designed to help improve the users self esteem, body image, social anxiety and overall mood. Good Blocks quickly trains the users mind to reject negative thinking and adopt more adaptive, flexible thinking. This app has been shown to help change the way the user thinks about themselves as well as how they view the world around them. This app along with all others of its kind do not replace professional help.

Calm

The Calm app is the number 1 app for mindfulness and meditation to bring more clarity, joy and peace to your daily life. It includes guided meditations, sleep stories, breathing programs and relaxing music that have been shown to help with anxiety, managing stress, relationships, breaking habits, focus and concentration as well as sleep issues.

Relax Melodies

Take back control of your sleep with Relax Melodies. This app lets the user literally design their own meditation specifically designed by them and exactly to their individual liking. Over 52 sounds are included as well as brainwave frequencies to help user reach specific states of sleep. Create different mixes each time or choose and save the mixes you enjoy.

Take A Break

Enjoy Deep Relaxation, Stress Relief and the benefits of meditation with Take A Break. Relax easily and quickly with a voice guided instructor. User can choose from 2 relaxing audios: "Work Break Relaxation" and "Stress Relief Meditation". User chooses whether to listen with or without music or nature sounds.

Yoga Quotes

This is a simple app for yoga enthusiasts that enjoy inspirational quotes. User can change background images and choose when the positive uplifting quotes will be delivered.

Insight Timer

This app has been shown to assist user with lowering their anxiety and stress as well as achieving higher levels of self love and compassion and can help with sleeping issues too. It also Includes deeply peaceful bells with polyphonic overlay, ambient background sounds, 8 different activities, guided meditations and more.

Guided Mind

Relax and get guided through meditations on a variety of topic dealing with stresses and challenges of day to day life. This app features easy effective step by step voice guided meditations of short or long durations. It also included instrumental tracks and a loop function for continuous play. The meditation topics included are affirmations, anxiety, attention, awareness, body image, and motivation among many others. Great for beginners or advanced meditators.

ADDITIONAL RESOURCES

http://www.lawyerswithdepression.com/articles/a-lawyers-guide-to-dealing-with-burnout-does-burnout-mean-i-should-leave-my-job-or-the-law-altogether/

http://www.abajournal.com/magazine/article/how_lawyers_can_avoid_burnout_and_debilitating_anxiety

Inter-Generational Family Representation Case Study in Ethics

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NEW YORK STATE BAR ASSOCIAION

ELDER LAW AND SPECIAL NEEDS SECTION

Ethics Committee CLE Materials

Summer Meeting 2019

CASE STUDY: THE BRADY FAMILY

THE FAMILY

JIM BRADY: Age 85; Family patriarch married to SANDRA for 30 years. JIM was previously married to MICHELLE and they have one child together -CLAUDIA BRADY

SANDRA: Age 65; JIM'S current wife in good health. They have one child, WALTER BRADY

MICHELLE: Age 83; 1st wife of JIM, and mother of CLAUDIA

CLAUDIA: Age 54; has had a number of behavioral issues over the years including paranoia and bipolar disorder and has been hospitalized for those conditions, most recently about six months ago. She has two children, PETER and MEGAN

PETER BRADY: Age 30

MEGAN BRADY: Age 18- has recently graduated from high school and intends to go to college. She has had some developmental delays and issues since birth.

WALTER BRADY: 28, married with three children. His relationship with his wife has become strained over the past couple of years because of his gambling habits.

THE FACTS

JIM has always been friendly with his first wife, MICHELLE. They divorced about 30 years ago and you represented JIM in an uncontested divorce at that time. You have remained friendly with both MICHELLE and CLAUDIA. JIM is the sole owner of a trucking business in New York City and his son, WALTER, has worked for JIM for seven years. While CLAUDIA has a good relationship with her stepmother, SANDRA, she has always been a little suspicious of her and sometimes thinks she is out to get the family money and cut her out of the estate.

About 20 years ago, JIM and SANDRA consulted with you about drafting estate planning documents and they signed "mirror image" Wills which provide that upon the survivor's death the property would be split equally with the share for WALTER being held in a "Minor's Trust" until age 25 and the share for CLAUDIA to be held in an Escher type Trust. The Will directed that MICHELLE act trustee and WALTER as the successor trustee of the trust for CLAUDIA. At that time they disregarded your advice and chose not to sign a Power of Attorney or Health Care Proxy.

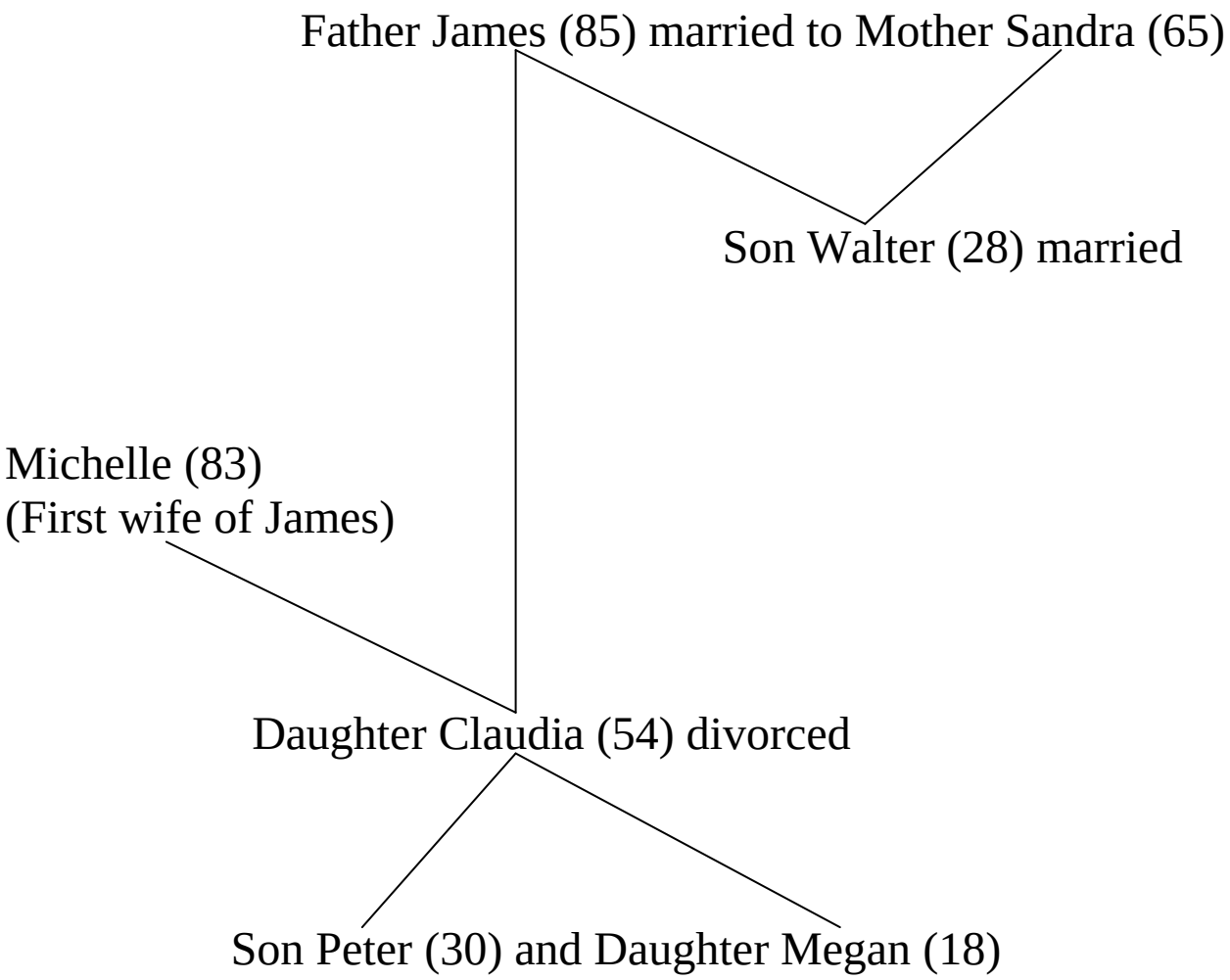
When MEGAN (CLAUDIA's daughter) was 12, she was injured in an automobile accident and received a settlement of $100,000.00 which remains on deposit in a joint bank account with CLAUDIA and a bank officer as signatories. Now that MEGAN is 18 years old, CLAUDIA wants to have MEGAN apply for public benefits but has been told that the settlement funds will interfere with some of MEGAN'S benefits. CLAUDIA only recently told MEGAN about the settlement.

About 5 years ago, prior to surgery, JIM asked you to prepare a Power of Attorney for him designating his son, WALTER, as his agent with no Statutory Gift Rider. As far as you are aware, CLAUDIA has never been informed of the provisions of JIM and CLAUDIA's Wills and does not know about the executed Power of Attorney.

CLAUDIA comes to see you about some options for MEGAN's funds but does not bring MEGAN to the meeting. At the meeting you inform CLAUDIA that a first party special needs trust is the best option. After you tell her how it works, she agrees with you but also tells you that MEGAN is anxious to get the funds and to manage them herself. In passing, she also mentions that she has concerns about her father's (JIM BRADY) mental state. She is also concerned that SANDRA and WALTER have recently been limiting her meetings with her father; although she does have a weekly meeting scheduled with JIM for next week and would like to bring him to see you for a "chat." She is especially concerned about WALTER since he is having marital difficulties and incurring significant gambling debts. About midway through the conversation you realize that CLAUDIA is speaking very rapidly and somewhat incoherently, and you are concerned about her mental state which is heightened when she asks you to draw a will for her leaving $100,000 to the treatment center she currently visits with the entire balance to PETER because leaving money to MEGAN is unnecessary and might cause problems with obtaining benefits in the future and PETER will always take care of MEGAN.

You promise to call CLAUDIA back, but after she leaves your office you ask yourself if you should you meet with JIM and CLAUDIA together. If you do, you question what you can discuss with both of them, or whether you should meet with each of them separately, and what you can share between them.

BRADY FAMILY



NEW YORK STATE BAR ASSOCIAION
ELDER LAW AND SPECIAL NEEDS SECTION
Ethics Committee CLE Materials
Summer Meeting 2019

WHO IS THE CLIENT?

a. Jim Brady?

b. Claudia?

c. Peter?

d. Megan?

e. Some or all of the above?

Because our clients often have diminished capacity or changing capacity and because they are often accompanied or "represented" by others, i.e., an adult child, there are certain ethical challenges often confronting the elder law attorney.

INFORMED CONSENT

New York Rules of Professional Conduct, Rule 1.0(j)

"Informed consent" *denotes the agreement by a person to a proposed course of conduct after the lawyer has communicated information adequate for the person to make an informed decision, and after the lawyer has adequately explained to the person the material risks of the proposed course of conduct and reasonably available alternatives.*

What if the client does not fully understand the explanation or does not have the desire to understand it or prefers to shift the responsibility to the non-client? Informed consent is required for many of the Rules.

DUE DILIGENCE

New York Rules of Professional Conduct, Rule 1.3

Diligence

(a) *A lawyer shall act with reasonable diligence and promptness in representing a client.*

(b) *A lawyer shall not neglect a legal matter entrusted to the lawyer.*

(c) *A lawyer shall not intentionally fail to carry out a contract of employment entered into with a client for professional services, but the lawyer may withdraw as permitted under these Rules.*

The standard of "reasonable diligence and promptness" is, of course, dictated by the circumstances. With elderly clients, time is often even more critical than for younger clients. An elderly client going in for surgery who wants a change to his estate plan, a client with rapidly diminishing capacity who needs to execute a power of attorney, etc., probably take priority over younger clients, despite what your younger client may think. The elder law attorney must prioritize appropriately. Prioritizing inappropriately may amount to neglect and unethical conduct. If you take on the representation of an elderly client, be prepared for late night frantic phone calls from family members, and be ready to assist as needed. Clients who are starting to

have diminished capacity especially may want work done as soon as possible- be sensitive to their concerns, and try to be very clear on the timetable to get the work accomplished.

Maintaining confidentiality is of course essential and required by the Code of Ethics. Confidential information consists of information gained during or relating to the representation of a client, whatever its source, that is (a) protected by the attorney-client privilege, (b) likely to be embarrassing or detrimental to the client if disclosed, or (c) information that the client has requested be kept confidential (Rule 1.6(a)(3)).

If a client cannot give informed consent to a course of action or plan, the disclosure of confidential information is permitted if it will advance the best interests of the client and is reasonable under the circumstances or customary in the professional community or the attorney reasonably believes it is necessary to prevent reasonably certain death or substantial bodily harm. It is prudent for the lawyer to meet with the client to assess whether the client can give informed consent; the lawyer should not rely on the agent's assertions.

CONFIDENTIALTY OF INFORMATION

RULE 1.6.

Confidentiality of Information

(a) *A lawyer shall not knowingly reveal confidential information, as defined in this Rule, or use such information to the disadvantage of a client or for the advantage of the lawyer or a third person, unless:*

(1) the client gives informed consent, as defined in Rule1.0(j);

(2) the disclosure is impliedly authorized to advance the best interests of the client and is either reasonable under the circumstances or customary in the professional community; or

(3) the disclosure is permitted by paragraph (b).

"Confidential information" consists of information gained during or relating to the representation of a client, whatever its source, that is (a) protected by the attorney-client privilege, (b) likely to be embarrassing or detrimental to the client if disclosed, or (c) information that the client has requested be kept confidential.

"Confidential information" does not ordinarily include (i) a lawyer's legal knowledge or legal research or (ii) information that is generally known in the local community or in the trade, field or profession to which the information relates.

***b)** A lawyer may reveal or use confidential information to the extent that the lawyer reasonably believes necessary:*

(1) to prevent reasonably certain death or substantial bodily harm;

(2) to prevent the client from committing a crime;

(3) to withdraw a written or oral opinion or representation previously given by the lawyer and reasonably believed by the lawyer still to be relied upon by a third person, where the lawyer has discovered that the opinion or representation was based on materially inaccurate information or is being used to further a crime or fraud;

(4) to secure legal advice about compliance with these Rules or other law by the lawyer, another lawyer associated with the lawyer's firm or the law firm;

(5) (i) to defend the lawyer or the lawyer's employees and associates against an accusation of wrongful conduct; or

(ii) to establish or collect a fee; or

(6) when permitted or required under these Rules or to comply with other law or court order.

(c) *A lawyer shall make reasonable efforts to prevent the inadvertent or unauthorized disclosure or use of, or unauthorized access to, information protected*

by Rules 1.6, 1.9(c), or 1.18(b).

When a client's capacity to make adequately considered decisions in connection with the representation is diminished, the lawyer shall, as far as reasonably possible, maintain a "conventional relationship" with the client (Rule 1.14(a)). Query: what does that mean?

How does a lawyer determine capacity? Capacity to understand- exactly what? Does the setting matter? Does the time of day matter? Should you have a witness present? Should you record your conversation with the client?

DIMINISHED CAPACITY

New York Rules of Professional Conduct, Rule 1.14

Client With Diminished Capacity

(*a*) *When a client's capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental impairment or for some other reason, the lawyer shall, as far as reasonably possible, maintain a conventional relationship with the client.*

(b) *When the lawyer reasonably believes that the client has diminished capacity, is at risk of substantial physical, financial or other harm unless action is taken and cannot adequately act in the client's own interest, the lawyer may take reasonably necessary protective action, including consulting with individuals or*

entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian ad litem, conservator or guardian. Information relating to the representation of a client with diminished capacity is protected by Rule 1.6. When taking protective action pursuant to paragraph (b), the lawyer is impliedly authorized under Rule 1.6(a) to reveal information about the client, but only to the extent reasonably necessary to protect the client's interests.

When the lawyer reasonably believes that the client has diminished capacity, is at risk of substantial physical, financial or other harm unless action is taken and cannot adequately act in the client's own interests, the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian ad litem, conservator or guardian (Rule 1.14(b)). When taking protective action, the lawyer is impliedly authorized under Rule 1.6(a) to reveal information about the client, but only to the extent reasonably necessary to protect the client's interests (Rule 1.14(c).

Nt. Guidance beyond the Code of Ethics can be found in the *"Assessment of Older Adults with Diminished Capacity. A Handbook for Lawyers"* published by the American Psychological Association (" APA") in collaboration with the ABA:

https://www.apa.org/pi/aging/resources/guides/diminished-capacity.pdf

RULE 1.7.

Conflict of Interest: Current Clients

(a) *Except as provided in paragraph (b), a lawyer shall not represent a client if a reasonable lawyer would conclude that either:*

(1) the representation will involve the lawyer in representing differing interest; or

(2) there is a significant risk that the lawyer's professional judgment on behalf of a client will be adversely affected by the lawyer's own financial, business, property or other personal interests.

(b) *Notwithstanding the existence of a concurrent conflict of interest under paragraph (a), a lawyer may represent a client if:*

(1) the lawyer reasonably believes that the lawyer will be able to provide competent and diligent representation to each affected client;

(2) the representation is not prohibited by law;

(3) the representation does not involve the assertion of a claim by one client against another client represented by the lawyer in the same litigation or other proceeding before a tribunal; and

(4) each affected client gives informed consent, confirmed in writing.

RULE 1.9.

Duties to Former Clients

(a) *A lawyer who has formerly represented a client in a matter shall not thereafter represent another person in the same or a substantially related matter in which that person's interests are materially adverse to the interests of the former client unless the former client gives informed consent, confirmed in writing.*

(b) *Unless the former client gives informed consent, confirmed in writing, a lawyer shall not knowingly represent a person in the same or a substantially related matter in which a firm with which the lawyer formerly was associated had previously represented a client:*

(1) whose interests are materially adverse to that person;

and

(2) about whom the lawyer had acquired information protected by Rules 1.6 or paragraph (c) of this Rule that is material to the matter.

(c) *A lawyer who has formerly represented a client in a matter or whose present or former firm has formerly represented a client in a matter shall not thereafter:*

(1) use confidential information of the former client protected by Rule 1.6 to the disadvantage of the former client, except as these Rules would permit or require with respect to a current client or when the information has become generally known; or

(2) reveal confidential information of the former client protected by Rule 1.6 except as these Rules would permit or require with respect to a current client.

BIOGRAPHIES

MARY ANN D. ALLEN, ESQ.
Biography

Mary Ann D. Allen, Esq. became the executive director and chief executive officer of Wildwood Programs, Inc. on January 1, 2002. She is a 1978 graduate of St. Lawrence University, where she received a B.A. in Government and English Literature, *magna cum laude*. She is a member of Phi Beta Kappa, and a 1981 *cum laude* graduate of Albany Law School. Prior to her work with Wildwood, she was a civil litigation attorney in private practice for approximately twenty years.

In her current position, Ms. Allen leads a non-profit human services organization with over 750 employees and an annual budget of approximately $40 million. Wildwood annually provides a broad range of community-based supports and services in the Capital District region of upstate New York to over 3,000 children, adults and families who live with complex learning disabilities, autism and other developmental disabilities.

CORA A. ALSANTE, ESQ.
Biography

Cora A. Alsante is the Leader of the Elder Law & Special Needs Practice and a partner in the Tax and Trusts & Estates Practices of Hancock Estabrook, LLP, Syracuse, NY. She is also a member of the Firm's Executive Committee. Ms. Alsante focuses her practice on estate planning, trusts, planning for the elderly and disabled, and estate and trust administration. She represents individuals and numerous assisted living and skilled nursing facilities.

Ms. Alsante frequently lectures for organizations such as the New York State Bar Association, Onondaga County Bar Association, Special Needs Alliance and Alzheimer's Association on topics including guardianships, supplemental needs trusts, estate planning, planning for the elderly and disabled, and estate and trust administration.

Ms. Alsante was instrumental in creating and establishing the Loretto Foundation Community Trust, a pooled supplemental needs trust, which benefits many seniors and disabled individuals in the community.

Ms. Alsante was named one of the "Top 25 Female Upstate New York Super Lawyers" for 2011 and 2013 and was selected as a *Best Lawyers in America* "Lawyer of the Year" in the area of "Litigation - Trusts and Estates", in Syracuse, NY, for 2015, 2017 and 2019.

M. ELIZABETH CORENO, ESQ.
Biography

Libby Coreno is general counsel to Bonacio Construction, Inc., a real estate development and construction company in Saratoga Springs, New York. She also is the owner of The Law Offices of M. Elizabeth Coreno, Esq. PC where she provides consulting and legal services to clients seeking to select, develop, and finance real estate development projects. Libby prides herself on authenticity; her directness and honesty establishes an immediate bond of trust with clients. She brings an attitude of creative problem solving to land development challenges either in city hall or in court and she has the tenacity to see things through in the most complex, pressured regulatory scenarios. Her collaborative style pairs the art of persuasion with political poise and she assists her clients in achieving the approvals they need to keep real estate projects on track. The relationships she builds on this foundation increase in value to her clients over time. With years of development, construction, and real estate industry experience, Libby works alongside clients to craft persuasive messages, coupled with astute legal analysis, that demonstrate to decision makers and the public the positive impact of her clients' project. She seamlessly manages relationships among professionals, the press, and governing entities over any real estate development issue. From site selection to the approval process to public/private financing, Libby is well suited to provide comprehensive counsel for the entirety of a project's life-cycle and far beyond it. Libby also brings a personal passion to her daily engagements that changes conversations. In addition to her legal work, she is the founder of The Silent Partner™, a one-of-a-kind consultancy service that helps legal and business professionals learn ways to live, practice, and make life transitions mindfully, authentically, and creatively.

Libby is a 2003 *cum laude* graduate of Albany Law School and earned her undergraduate degree from the University of Kentucky. She is the 2016 recipient of the Saratoga County Women of Influence Award, past president of the Saratoga County Bar Association, and the NYSBA Attorney Wellbeing subcommittee Chair.

KATHRYN E. JERIAN
Biography

Kate Jerian is Deputy Executive Director and General Counsel for The Arc New York located in Latham, New York. She practices law in the areas of disability, guardianship, and non-profit corporations. Prior to her work at The Arc New York, Ms. Jerian worked for a number of years litigating toxic tort matters on behalf of injured children. She has worked extensively in the area of advising The Arc New York and its Chapters on a variety of legal matters involving 17-A guardianships, including counseling on a regular basis regarding the application of the law to matters of end-of-life decision-making for individuals with developmental disabilities, as well as other general matters. She is a member of the New York State Bar Association.

Ms. Jerian earned her J.D. in 2007 from Albany Law School, *magna cum laude*, and her B.A., *summa cum laude,* in 2000 from the University at Albany. She was the 2006 recipient of the Judge Bernard S. Meyer Scholarship. She is admitted to practice in all New York State Courts and the United States District Court for the Northern District of New York.

HONORABLE PETER J. KELLY
Biography

Surrogate Kelly is a graduate of Iona College and St. John's University School of Law where he received his Juris Doctor degree in 1983.

Prior to his election to the bench, Surrogate Kelly was employed in the New York City Criminal and Civil Courts as a Law Assistant Trial Part, in the Queens Supreme Court as Principal Law Clerk, and, ultimately, as the Principal Law Clerk for Queens Surrogate Hon. Robert L. Nahman.

He was elected as a Judge of the New York City Civil Court in 1998 and as a Justice of the New York State Supreme Court in 2002. Thereafter he was elected as Surrogate of Queens County and has served in that capacity since January of 2011.

In addition to his regular duties, Surrogate Kelly has served as an instructor for court clerks and has frequently lectured at various bar associations and organizations including the Queens County Bar Association, the Nassau County Bar Association, the New York State Bar Association, the New York State Trial Lawyers Association, the New York State Surrogate's Association, and the New York State Judicial Institute.

Surrogate Kelly is a member of the Surrogate's Court Advisory Committee to the Chief Administrative Judge, and serves as Chair of the Executive Committee of the New York State Surrogate's Association. He is also a member of the Trust and Estates section of the New York State Bar association, the Queens County Bar Association, the Queens County Women's Bar Association, and the Queens Catholic Lawyer's Guild, serving as Judicial Moderator since 2009. He is also a former member of the Board of Directors of the New York City Supreme Court Justices' Association and the New York City Civil Court Judges Association.

Surrogate Kelly is admitted to the New York State Bar as well as the United States District Court for the Southern District and the United States Supreme Court.

ELLYN S. KRAVITZ, ESQ.
Biography

Ellyn S. Kravitz is a partner at Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara, Wolf & Carone, LLP. She concentrates her practice in elder law, special needs planning, estate planning, estate administration, guardianship, and veterans' benefits. Ellyn is an authority on issues affecting adults and children with disabilities, and our senior population.

Ellyn holds the designation of a Certified Elder Law Attorney (CELA), awarded by the National Elder Law Foundation as accredited by the American Bar Association. Ellyn is also accredited by the U.S. Department of Veterans Affairs to present and prosecute claims for veterans' benefits.

Ellyn has been designated a Super Lawyer by the Thomson-Reuters Company since 2009, a distinction earned by only 5% of the attorneys in the New York Metro area. She was also included in the list of Top Women Attorneys in the New York Metro Area since 2012 in the New York Times Magazine. Further, she was selected by her peers for inclusion in the past six editions of The Best Lawyers in America® in the practice area of elder law.

Ellyn is an active member of the New York State Bar Association where she is an active member of both the Elder Law and Special Needs Section and Trusts and Estate Sections. She is member of the Executive Committee of the Elder Law Section and serves as the current Co-Vice Chair of the Guardianship Committee. Ellyn is also a member of the Executive Committee of the Trusts and Estates section and is a Co-Vice Chair of its Elderly and Disabled Committee.

Ellyn is a member of the National Academy of Elder Law Attorneys (NAELA) and the New York State Chapter of NAELA where she is a board member. She was a former member of the Board of the Estate Planning Council of New York City, Inc.

She is a frequent presenter to both consumer and professional groups and has provided input to state and national programs addressing legal, financial and other related matters involving persons with disabilities and our senior population.

Ellyn received her Juris Doctor degree from the New England School of Law and her LL.M. in estate planning from the University of Miami. She received her undergraduate degree from the University of Michigan.

HOWARD S. KROOKS, ESQ.
Biography

Howard S. Krooks, a partner of Elder Law Associates PA with offices throughout Southeast Florida, is admitted to practice law in New York (1990) and Florida (2004). Mr. Krooks is Of Counsel to Amoruso & Amoruso, LLP, in Rye Brook, New York. Mr. Krooks splits his time between New York and Florida, where his professional practice is devoted to elder law and trusts and estates matters, including representing seniors and persons with special needs and their families in connection with asset preservation planning, supplemental needs trusts, Medicaid, Medicare, planning for disability, guardianship, wills, trusts and health care planning with advance directives.

Mr. Krooks is certified as an Elder Law Attorney by the National Elder Law Foundation and is a past president of the National Academy of Elder Law Attorneys (NAELA) from 2013 to 2014, the past president of the New York chapter of NAELA and serves on the Executive Council of the Florida Bar Elder Law Section as the NAELA Liaison. He currently serves on the Steering Committee for the 2019 NAELA Summit, on the Board of Trustees of the NAELA Foundation, as co-chair of the NAELA State Chapters Committee and as co-chair of the 2020 NAELA Annual Meeting. He is a past chair of the Elder Law Section of the New York State Bar Association from 2004-2005, and serves on the Executive Committee as past chair. He also is the current treasurer of the Florida Bar Elder Law Section. He has been consistently selected as a Florida Super Lawyer and a New York Super Lawyer, named a Top 25 Westchester County Attorney, has a 10.0 (Excellent) rating from AVVO and is AV Preeminent® rated by Martindale-Hubbell, a testament to the fact that Mr. Krooks' peers rank him at the highest level of professional excellence.

Mr. Krooks received the 2006 Outstanding Achievement Award from the NY Chapter of NAELA for serving as Co-Chair of a Special Committee on Medicaid Legislation formed by the NYSBA Elder Law Section to oppose NY Governor George Pataki's budget bills containing numerous restrictive Medicaid eligibility provisions that, if enacted, would severely impact the frail elderly and disabled populations. He was also recognized for serving as co-chair of the NYSBA Elder Law Section Compact Working Group, which received national attention for developing alternative methods of financing long-term care. Additionally, Mr. Krooks served as chair of a Special Committee created by the NYSBA Elder Law Section to address the Statewide Commission on Fiduciary Appointments formed by Chief Justice Judith Kaye.

Mr. Krooks co-authored the chapter, "Creative Advocacy in Guardianship Settings: Medicaid and Estate Planning Including Transfer of Assets, Supplemental Needs Trusts and Protection of Disabled Family Members" included in Guardianship Practice in New York State, and the chapter "Long-Term Care Insurance in New York" included in Estate Planning and Will Drafting in New York, both published by the NYSBA. He is

widely published on many elder law topics. Mr. Krooks is a founding principal of ElderCounsel LLC, the premier elder law and special needs planning document drafting solution for attorneys.

As a frequent lecturer, Mr. Krooks has addressed many organizations including Barron's, NAELA, Stetson Special Needs Conference, ALI-ABA, WealthCounsel, ElderCounsel, the National Guardianship Association, the Florida Bar Association, the Academy of Florida Elder Law Attorneys, the NYSBA, the Alaska Bar Association, the Michigan Bar Association, the North Carolina Bar Association, the Pennsylvania Bar Association, the Utah Bar Association, the Washington Bar Association, the Texas Chapter of NAELA, the Association of the Bar of the City of New York, UJA Federation, the Brooklyn Bar Association, the Nassau County Bar Association, the Richmond County Bar Association, the Suffolk County Bar Association, the Westchester County Bar Association, the Hudson Valley Estate Planning Council, Berkeley College, the United Federation of Teachers and the New York State United Teachers, among others. Mr. Krooks has been quoted in *The Wall Street Journal*, *The New York Times*, *Kiplinger's*, *USA Today*, *The New York Post*, *Newsday*, *The Journal News* and the *Boca Raton News*. He has appeared on PBS, the CBS Early Morning Show and elder law-focused local cable television programs.

HONORABLE RICHARD KUPFERMAN
Biography

Richard Kupferman was elected Surrogate, Saratoga County in 2011 and was appointed Acting Supreme Court Justice in 2014.

From 1988 to 2010, he was an Assistant County Attorney for Saratoga County.

He was counsel to the New York State Senate Committee for Children and Families from 2000 to 2010.

He also operated a general private practice from 1988 to 2011.

Additionally, he served as an attorney for several municipalities, including, the towns of Galway, Edinburg, Northumberland, and the Village of Ballston Spa.

Richard Kupferman earned his bachelor's degree from SUNY Albany and his juris doctor from Albany Law School in 1987.

RON M. LANDSMAN, ESQ.
Biography

Ron M. Landsman is the principal attorney of the Landsman Law Group, with offices in Rockville, Maryland, and a satellite office in Frederick, Maryland. He practices elder law, special needs planning, estate and trusts, and guardianship.

Ron is the co-founder, past president, and long-time board member of First Maryland Disability Trust, Inc., the leading Maryland-based pooled special needs trust. He also drafted and is a former board member and now counsel for the Wesley Vinner Memorial Trust, operated by Shared Horizons, Inc., the leading D.C.-based pooled special needs trust. He received Shared Horizons' Humanitarian Award in 2016.

He is a member of the Special Needs Alliance (SNA) and chairman of its amicus committee. SNA is an invitation-only, national network of attorneys dedicated to the practice of special needs trusts and public benefits law.

He is a founding member, former long-time board member, and Fellow of the National Academy of Elder Law Attorneys; he is also chairman of its litigation committee. He served on the editorial board of the NAELA JOURNAL and received its John S. Regan Writing Award for *When Worlds Collide* in 2015. He received the NABLA Maryland-D.C. Chapter Member of the Year Award in 2010 and Outstanding Achievement Award in 2005.

He has written on special needs trust and Medicaid issues, and regularly presents training programs for lawyers, for the D.C. and Maryland Bars and the Stetson University annual trust program, and is presenting an independent three-day training program for lawyers, *Medicaid Mastery,* in fall, 2019. He has represented NABLA or the SNA as amicus in the First, Third, Fourth. Sixth, Eighth and Tenth Circuits, U.S. Courts of Appeal, and in the supreme courts of Maryland, Massachusetts, Michigan, Iowa, and Montana.

His hobbies are Abraham Lincoln and decidedly amateur woodworking.

CHRISTOPHER R. LYONS, ESQ.
Biography

Chris is the Executive Director of AIM Services, Inc., a large nonprofit Agency based in Saratoga Springs NY that supports individuals with Developmental disabilities and traumatic brain injury. Chris previously served as AIM's Senior Director and Counsel, a position he occupied for five years. Prior thereto, Mr. Lyons was a seasoned trial attorney for more than 25 years, having successfully litigated cases in jurisdictions throughout the U.S., with a breadth of experience which includes a concentration in the human services arena.

Just before coming to AIM, Mr. Lyons was a principal in the established law firm of Towne Ryan & Partners, P.C. His experience includes service with the General Counsel of New York State's former Office of Mental Retardation/Developmental Disabilities and as National Counsel for CNA Insurance's Human Services Program.

As a result of his extensive litigation background in Human Services, Chris has been asked to give numerous key note speeches, presentations and training seminars across the country to various human services organizations, associations and governmental agencies, focusing on recognizing and implementing unique defense strategies for supporting independence for individuals with disabilities and reducing claims against service providers. Mr. Lyons has authored several articles on an individual's Right to Risk, provider liability and the applicable standards of care in the Human Services industry.

JUNE MACCLELLAND
Biography

June MacClelland has served as the Senior Director and Chief Compliance Officer at AIM Services since January 1, 2018. June decided to retire from the Executive Director position at AIM Services, Inc. that she held since November 2008. June is still very actively supporting AIM Service, Inc. and works directly with their Executive Director, Christopher Lyons, Esq.

AIM Services, Inc. is a not-for-profit agency dedicated to supporting the “power of potential” in people of diverse abilities. Through community based services, advocacy, and education, dedicated professionals focus on supporting people in achieving their personal goals, while promoting a sense of self-confidence and independence.

June served on the Board of Directors for AIM Services, Inc. for approximately 10 years and held the position of President for several years. June has a personal passion for the provision of services for individuals with developmental challenges and traumatic brain injured persons. June has adopted two children with Down’s syndrome, one of whom is also on the Autism Spectrum and lives in a group home in Gloversville.

June has a lengthy history in health care. She worked for Glens Falls Hospital for 33 years in a number of progressive positions. When she left the hospital to join AIM, she was the Operations Manager for Adirondack Medical Services overseeing 15 physician practices and more than 250 employees, Budget, Quality Assurance, Joint Commission Preparedness, etc. Prior to that position June spent 7 years as the Compliance Manager, responsible for all internal audits and investigations. June was the Data Quality Coordinator from 1992 – 2001 overseeing all hospital databases, Inpatient, Outpatient and physician coding practices and all NYS and CMS regulatory reporting. Prior to these management positions, she was a direct care provider, working on the nursing units with patients.

June graduated from Warrensburg High School in 1975. She attended Albany Medical College of Nursing 1976 – 1978 and transferred to the American Health Information Management Association (AHIMA) in 1978 where she earned her diploma in Health Information Management. June received her National Certification as a Registered Health Information Technician and credentials as a Certified Coding

Specialist; credentials which she still maintains. June also received 140 credit hours in Health Care Administration and Leadership through the Glens Falls Hospital School of Leadership. June earned her Associates in Science from Excelsior College in Albany, NY.

June has a love of music, theater and travel, especially Disney and thoroughly enjoys her daughter, her pets, family and friends.

RICHARD A. MARCHESE, JR., ESQ.
Biography

Richard A. Marchese is a partner of Woods Oviatt Gilman LLP in Rochester, New York. He is co-chair of the firm's Elder Law and Health Care Practice Group responsible for handling all elder law and health care issues. He concentrates his practice in the areas of long term care and Estate planning, Social Security, Medicare and Medicaid eligibility, long term disability, estate recovery matters, asset protection, issues of spousal support, and the use of trusts in Medicaid planning. Mr. Marchese also provides counsel to health care providers in matters of compliance with federal and state regulations, defense of government audits and investigations, voluntary self-disclosures, corporate compliance and professional licensure issues.

Prior to joining the firm, Mr. Marchese served for over fifteen years as counsel to the Monroe County, N.Y. Department of Human Services, advising the Chronic Care, Home Care and Adult Protective units at that agency. He was a co- director of the Monroe County Provider Fund, Waste and Abuse Demonstration Project, and he now represents Medicaid providers in matters of compliance with government regulations and defense against government audits.

He received his JD from New York Law School and his BA from the State University of New York at Albany.

Mr. Marchese is a member of the Monroe County and New York State Bar Associations and is president-elect of the New York Chapter of the National Academy of Elder Law Attorneys, Inc. (NYNAELA). He is also a member of the Executive Committee of the Elder Law Section of the New York State Bar Association and a member of the Estate Planning Council of Rochester. Mr. Marchese is a frequent lecturer before both the New York State and Monroe County Bar Associations.

ROBERT P. MASCALI, ESQ.
Biography

Robert Mascali is senior consultant with the Center for Special Needs Trust Administration, Inc. which is a national nonprofit organization that administers special needs trusts and Medicare Set Aside Arrangements throughout the United States. In addition, Mr. Mascali is “of counsel” with the Bourget Law Group in Falmouth, Massachusetts and with the firm of Pierro, Conner and Associates, LLC with offices in Manhattan and in Latham, New York. In his private law practice he concentrates in the areas of Special Needs Planning for persons with disabilities and their families and care givers, Long-Term Care Planning, and Estate Planning and is admitted to practice in both Massachusetts and New York. He previously served as Counsel to NYSARC Trust Services and was Deputy Counsel and Managing Attorney at NYS OMRDD (Now OPWDD). Mr. Mascali is a member of the New York State Bar Association and its Elder Law and Special Needs Section and serves on the Executive Committee. He is also a member of Massachusetts NAELA and NY NAELA and is the Past President of the New York Chapter of NAELA.

HONORABLE ACEA M. MOSEY
Biography

Judge Mosey is a lifelong resident of Western New York. She graduated from Amherst High School in 1985. She earned a Bachelors in Business Administration degree from Canisius College in 1992 and then went on to the Thomas M. Cooley School of Law in Lansing, Michigan. She graduated with her Juris Doctorate in 1994 and was admitted to the New York State Bar in March 1995.

Having practiced as a private attorney in Surrogate's Court for over twenty years, including 14 years as Erie County Public Administrator under former Surrogate Judge Barbara Howe, Judge Mosey was elected as New York State Surrogate Judge for the County of Erie in November of 2017.

Judge Mosey was a founding partner with the firm Mosey Associates LLP, formerly known as Mosey Persico LLP, located at 625 Delaware Avenue in Buffalo, New York. She previously served as a Commissioner at the Erie County Water Authority from May 2000 to May 2006, being the first woman to serve as a Commissioner as well as a Chair at this Authority. She gained a vast amount of business experience from her employment with a family-owned, Great Lakes Bureau, Inc. for over twelve years, along with being the trustee of her family's trust which runs and operates, or is involved in, over 20 local companies and businesses.

Judge Mosey resides in Buffalo, New York. She is a lifelong member of St. John Maron Church. She is a member of the New York State Bar Association, the Bar Association of Erie County, and the Western New York Women's Bar Association.

Judge Mosey has been a proud member of her community, previously serving on several boards including the Greater Buffalo Savings Bank, Canisius College Board of Trustees, The Buffalo Zoo Board as well as the Children's Hospital Foundation.

MATTHEW J. NOLFO, ESQ.
Biography

Matthew J. Nolfo is the principal of the Matthew J. Nolfo & Associates. Matt specializes in the areas of Estate Planning and Elder Law. He practices in New York and New Jersey. Matt has served as co-chair for the Legislation Committee of the NYS Bar Association's Elder Law and Special Needs Committee and is the Chair Elect of the Section. Matt is a Past Chair of the Committee on the Problems of the Aging at the Association of the Bar of the City of New York. Matt has chaired and lectured at various symposiums on Estate Planning and Elder Law issues at the Association of the Bar of the City of New York, the New York State Bar Association, the New York County Lawyer's Association, the Jewish Lawyer's Guild, the Metropolitan Women's Bar Association, the Columbian Lawyer's Association, the Suffolk County Bar Association, the National Kidney Foundation, the Archdiocese of New York The Practicing Law Institute, as well as various other civic and community organizations. Mr. Nolfo also served as an adjunct professor at New York University's School of Continuing Education and Professional Studies where he taught courses in Estate Planning and Asset Protection Planning.

PAUL M. RYTHER, ESQ.
Biography

Paul Ryther's solo practice in East Bloomfield, New York, focuses on elder law, planning for individuals with disabilities, trusts and estate planning and administration, and representation of Social Security benefits claimants. A graduate of Cornell University (BA 1971) and Case Western Reserve University (JD 1974), he began his career advocating for Medicaid and welfare recipients and quickly became one of the relatively few lawyers representing claimants for disability benefits under the new SSI program. After leaving employment with legal services organizations in 1986 and beginning to take up estate planning and administration matters, he found his experience aptly suited to the burgeoning field of elder law. Paul has lectured at various continuing legal education seminars, addressing issues in the fields of Medicare, Medicaid, supplemental needs trusts, guardianship and disability benefits advocacy. He is a member of the Elder Law section and of the Trusts and Estates section of the New York State Bar Association of NYSBA. His pro bono activities include assistance statewide to legal services advocates in disability benefits and Medicaid advocacy. Among other community activities, Paul has volunteered since 1997 at his local public broadcasting affiliate, where he currently is a member of the Volunteer Leadership Council.

HONORABLE BRANDON R. SALL
Biography

Surrogate Sall graduated from the University of Miami in 1982, and thereafter from the Benjamin N. Cardozo School of Law in 1985. From October 2014 until he became Surrogate in June 2015, Judge Sall was formerly the managing member of the White Plains law firm of Sall, Geist, Schwarz & Jellinek, PLLC. Prior to that, Judge Sall was a partner in Sall & Geist from 2012 to 2014. Prior to the formation of Sall and Geist in January 2012, Judge Sall was a partner in Schuman & Sall from 1992 to 2002 and of counsel to the Yonkers law firm of Rabin, Panero and Schuman from November 1988 to July 1992. Additionally, until June 2015 Judge Sall was a partner in the White Plains law firm, Gellert & Rodner, which specialized in tax certiorari matters.

Judge Sall specialized in trusts and estates and real estate law and had a significant transactional and litigation practice. In 2002, Judge Sall became general counsel to the Westchester County Public Administrator and served until June 2015

In May of 2015, Judge Sall was appointed as Surrogate of Westchester County by the Hon. Andrew M. Cuomo, Governor of the State of New York and was elected as Surrogate of Westchester County in November 2015.

Judge Sall is a member of the New York State Bar Association and the Westchester County Bar Association as well as the Trusts and Estates sections of the New York State Bar Association and Westchester County Bar Association.

JOANNE SEMINARA, ESQ.
Biography

Joanne Seminara has been an attorney licensed to practice law in New York and New Jersey for over 3 decades. Joanne is a member of the elder law firm of Grimaldi & Yeung LLP with offices located at 9201 Fourth Avenue in Bay Ridge, Brooklyn and 546 Fifth Avenue, New York, New York.

Joanne practices in the areas of elder law, estate and trust planning, including estate tax and Medicaid planning, and special needs planning. An attorney known for her thoroughness, tenacity and compassion, Joanne's legal experience includes other practice areas, including residential and commercial real estate, corporate law, employment law and land use and zoning matters.

Passionate public speaking, organizing and community service has been and remains an important part of Joanne's life. She regularly speaks at community education seminars on estate, trust and tax matters. In 2015, together with Judith Grimaldi, Esq., Joanne authored her first book entitled: *Five @ Fifty-Five; Five Essential Legal Documents You Need by Age 55*, as part of a public education campaign that highlights the critical importance of having 5 legal documents in place by mid-life. Her various television appearances include the 6 PM News on Fox 5 New York, Brooklyn Savvy, NY1, Good Day New York and WPIX Channel 11 News.

Joanne Seminara has received numerous awards and recognitions, among them: 2017 Bay Ridge Third Avenue Merchant's Civic Award, named Outstanding Woman in Business and Community Leadership by NIA Community Services Network, 2017; 2016 Power Women in Business Award from Home Reporter & Spectator News; 2016 Community Service and Law Award from the Brooklyn Real Estate Board; 2014 Winner of New York City Council Women's Community Service Award; 2012 Winner of Top Women in Business Award from Home Reporter & Spectator News;, 30th Anniversary Service Award from the Union Center for Women, Service Award from the Golden Flame Society of St. Rosalia-Regina Pacis Church, and Community Service Award from the Guild for Exceptional Children, Inc.

Joanne is a member of several bar associations including the NYS Bar Association (NYSBA) acting as Ethics Committee Co-Chair and vice-Chair of the Publications Committee for NYSBA's Elder Law and Special Needs Section.

A member of Community Board 10 for over 2 decades, Joanne served as Chair of the Board from 2010 to 2013. A volunteer member of community organizations for many years, Joanne is past President and member of her local chapter of Business Networking International and the elected Democratic State Committeewoman and Executive Committee member of the Brooklyn Democratic Party.

A life-long Bay Ridge, Brooklyn resident, Joanne enjoys traveling, reading and spending time with her grandchildren.

NEAL A. WINSTON, ESQ.
Biography

Neal A. Winston is the principal of Winston Law Group, LLC, a law firm specializing in special needs counseling, estate and disability planning, probate, guardianships and conservatorships, and estate and trust administration. He serves as professional Trustee for special needs trusts. Practicing public benefits law for over 40 years, in 1975, Mr. Winston wrote the first edition of the Social Security Manual for the Community Worker. A nationally recognized expert on Special Needs Trusts and needs-based public benefit programs, he is frequently requested to lecture and train other attorneys and professionals that work in this field. An active client-oriented attorney, he has represented hundreds of claimants before state and federal courts and agencies. He has also been named a Super Lawyer in Boston Magazine since 2006 and is AV Preeminent rated by his peers for Martindale-Hubbell.

Mr. Winston is past president of the Special Needs Alliance (SNA), a national, nonprofit organization composed of attorneys who advise and represent individuals and their families to create and administer Special Needs Trusts. He is a member of the National Academy of Elder Law Attorneys (NAELA) and has been certified as an Elder Law Attorney by the National Elder Law Foundation. He is past president of the Massachusetts Chapter of NAELA, and serves on the public policy committee of both the state and national organizations. He is also a member of the National Organization of Social Security Claimants' Representatives and the American Bar Association Social Security Committee.

Mr. Winston is a member of the Massachusetts Academy of Trial Attorneys and the American Association of Justice. Additionally, he is active in legislative and public policy issues affecting disabled and elder citizens on a state and federal level, and is currently representing the SNA on the advocacy group that meets with the Social Security Administration to review Supplemental Security Income special needs trust policy. He currently serves on the Massachusetts Joint Bar Committee for Judicial Nominations.

He is a graduate of Utica College of Syracuse University and received his Juris Doctor degree at Suffolk University Law School. He is also a founder and president of the Belmont Land Trust.

EDWARD V. WILCENSKI, ESQ.
Biography

Edward V. Wilcenski, Esq., is a co-owner and co-manager of the law firm of Wilcenski & Pleat PLLC, with offices in Clifton Park and Queensbury, New York. He practices in the areas of Elder Law, Special Needs Planning, and Trust and Estate Planning.

Ed is a Trustee of the NYSARC Pooled Trust, and serves as a Trustee of the Wildwood Programs Pooled Trust, a trust program serving individuals with developmental and learning disabilities. In 2009 and again in 2013, he received the Marie Ivancich Memorial Award from the Brain Injury Association of New York State for professional commitment to the organization's mission of advocacy for individuals living with brain injuries.

He is a member and former President of the Special Needs Alliance, www.specialneedsalliance.org, an invitation-only, national network of attorneys dedicated to the practice of special needs trusts and public benefits law. The Alliance provides support for individuals with disabilities and their families, for attorneys involved in personal injury and medical malpractice litigation, and for trustees of special needs trusts.

Ed is a member of the National Academy of Elder Law Attorneys, and the New York State Bar Association's Elder Law and Special Needs Law Section. In 2019, Ed was recognized by the New York State Bar Association Elder and Special Needs Law Section for his involvement in litigation which has advanced the rights of individuals with disabilities.

Ed is a contributing author to various publications of the New York State Bar Association, including Representing People with Disabilities, and Planning for Incapacity, and Guardianship Practice in New York State. He lectures frequently to attorneys and other professionals on special needs trusts and estate planning for individuals and their families.