

# Ethical And Public Policy Considerations Related To Medicaid Planning

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## ABSTRACT

*This paper discusses moral, ethical, and public-policy issues regarding Medicaid planning—transferring or converting assets of a long-term care consumer to create Medicaid eligibility. The author argues that it is not unethical to qualify a nursing-home resident for Medicaid by means of asset transfers where the resident will receive the same service under Medicaid as he or she would receive as a private-pay patient. The author further contends that an applicant's lawyer would have an ethical and moral obligation to the client and the client's family to maximize Medicaid payments for nursing care where it is clear that the client would want Medicaid to cover the cost of care. Finally, the author urges that the state's or commonwealth's fiscal concerns should not be given priority by a court above a Medicaid candidate's legitimate desire to preserve his or her wealth in the face of ruinously expensive nursing home costs.*

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## INTRODUCTION

Much of Elder Law practice is concerned with long-term care: finding the best living arrangement when older clients must downsize their habitation, protecting the resident's or patient's rights in residential and care facilities, advising clients and their families about hiring, employing and supervising care providers, and protecting and balancing the fiscal interests of clients, their families and the state or commonwealth in long-term care financing decisions. A core component of this last area of practice is what is called "Medicaid planning," transferring or converting assets of a long-term care consumer to create Medicaid eligibility.

### **Transferring or converting assets of a long-term care consumer to create Medicaid eligibility raises delicate public-policy and ethical issues.**

There are six constituencies who are involved in or affected by planning steps that advance the point at which a nursing home resident becomes eligible for government assistance with the cost of care:

- Legislators and public welfare administrators, who are responsible for fiscal program integrity;
- public welfare caseworkers, who implement the law and policy promulgated by the first constituency;
- nursing facility owners and administrators, whose profits are affected by the mix of private- and government-paid residents;
- lawyers, who apply the laws and rules to their clients' circumstances;
- judges, who decide disputes between various combinations of the above classes; and
- commentators, who analyze the literature generated by all of the above and try to both spot and affect trends.

This paper is primarily intended to be of interest to lawyers and judges, to assist them in analyzing the issues implicit in Medicaid cases and controversies. Arguments on pages 142 and 143 may also be of interest to legislators and administrators in considering how to make Medicaid more accessible to those who need it, while maintaining program integrity.

Katherine C. Pearson's seminal article in the January 2005 issue of the Pennsylvania Bar Association Quarterly, "The Lawyer's Ethical Considerations in Medicaid Planning for the Elderly: Representing Smith and Jones,"<sup>1</sup> examines the ethical questions that are internal to the attorney-client relationship. She explores the questions that arise in determining the identity of the "client" and sorting out the conflicting interests of the client and family members who act as surrogate decision-makers. However, there is another area of ethical, moral and policy conflict that she does not address: When is it appropriate to impoverish the client to qualify for Medicaid and other government benefits? This implicates a bundle of knotty issues:

- ethical hurdles to qualifying a nursing home resident for a welfare program;
- the lawyer's obligation to maximize Medicaid payments for the benefit of the claimant's family; and

1. [http://law.psu.edu/\\_file/Pearson/LawyersEthicalConsiderationsInMedicaidPlanningJan2005.pdf](http://law.psu.edu/_file/Pearson/LawyersEthicalConsiderationsInMedicaidPlanningJan2005.pdf).

- whether the court has a duty to protect the Medicaid program and the public fisc.

## **QUALIFYING A NURSING HOME RESIDENT FOR MEDICAID**

Qualifying a nursing home resident for Medicaid is often criticized as resulting in substandard care. Where planning for Medicaid eligibility would result in a degraded quality of life or restricted options in placement, there is a valid ethical objection to planning that would impoverish the client. This would be more likely where the client is not presently a nursing-home resident or where there is a reasonable likelihood of rehabilitation and return to a less restrictive environment. However, in most cases the nursing care would be the same, without regard to source of payment.

In an unusual case, an adult protective services worker originated a complaint in 2007 on Mabel Mirabel after an Elder Law attorney qualified her for Medicaid using a spousal-annuity trust to protect marital assets for her husband. The APS worker stated that the woman was being abused because she was in a Medicaid four-bed ward instead of a private room, as a private-pay resident. Ironically, a geriatric-care consultant who evaluated the woman stated that she was better off in the four-bed ward because the constant activity kept her mind active. Six years later she was still in the four-bed ward and doing well there. If she had been in a private room she would have quickly exhausted the funds, unless she was sooner bored to death.

The APS worker's attempt to establish a case of neglect was not merely misguided, it was legally wrong. Considering that A) every Medicaid bed is certified by the state as meeting the standards for nursing care; and B) facilities are legally prohibited from discriminating against Medicaid recipients, it would be disingenuous to argue that qualifying a resident for Medicaid is abusive.

Federal law clearly requires facilities to "establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services . . . regardless of source of payment."<sup>2</sup> Furthermore, admission decisions may not be grounded on Medicaid eligibility or future eligibility.<sup>3</sup> The federal Medicaid regulatory agency, Centers for Medicare and Medicaid Services (CMS), prohibits facilities from requiring a period of private-pay as a prerequisite to admission:

Facilities may not accept additional payment from residents or their families as a prerequisite to admission or to continued stay in the facility. Additional payment includes deposits from Medicaid-eligible residents or their families, or any promise to pay private rates for a specified period of time.<sup>4</sup>

Despite the legal mandate of equal access to quality care, there are situations where a particular long-term care candidate who must rely only on Medicaid will have a difficult time securing a preferred placement. However, with the assistance

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2. *Linton v. Commissioner*, 65 F3d 508 (6th Cir. 1995); 42 USCA §1396r(c)(4).

3. 42 USCA §1396r(c)(5).

4. Centers for Medicare and Medicaid Services Transmittal 19, June 1, 2006, SUBJECT: Revisions to Appendix PP – Guidance to Surveyors for Long Term Care Facilities, interpreting 42 CFR §483.12(d)(3). [www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R19SOMA.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R19SOMA.pdf) (Accessed July 23, 2013).

of an attorney those cases are rare. More commonly, the placement follows a three-day inpatient hospital stay and the patient transfers to a skilled-care facility for rehabilitation. Once there, the patient has the right to remain in the facility as a Medicaid resident. Even when the patient is in a bed that is dually-certified for Medicare and Medicaid, a facility may falsely tell the family that there is a waiting list for Medicaid. In those cases, the Medicaid-planning attorney plays an important role in protecting the patient's rights.

Nursing facilities that discriminate based on source of payment present a separate problem. In this paper, the discussion is limited to Medicaid-planning cases where the resident will be in the same facility, receiving equivalent services despite the transition from Medicare or private pay to Medicaid. Where that is the case, there would be no ethical bar to qualifying a client for Medicaid by means of legal divestment.

## **LAWYER'S OBLIGATION TO MAXIMIZE CLIENT'S MEDICAL PAYMENTS FOR NURSING CARE**

Here is what Hon. Lawrence J. Bracken, of the New York Appellate Division, has to say about planning to get the best possible result from a punitive, complex program:

The complexities of the Medicaid eligibility rules. . . . should never be allowed to blind us to the essential proposition that a man or a woman should normally have the absolute right to do anything that he or she wants to do with his or her assets, a right which includes the right to give those assets away to someone else for any reason or for no reason.

\* \* \* \* \*

[N]o agency of the government has any right to complain about the fact that middle-class people confronted with desperate circumstances choose voluntarily to inflict poverty upon themselves when it is the government itself which has established the rule that poverty is a prerequisite to the receipt of government assistance in the defraying of the costs of ruinously expensive, but absolutely essential, medical treatment.<sup>5</sup>

Where the nursing home resident is competent and expresses the desire to preserve assets for the family or there is clear evidence that the incapacitated resident would desire Medicaid planning to proceed, the attorney's obligation is to devise and implement a plan to achieve the greatest possible protection for the resident's estate.<sup>6</sup> Any moral compunction the attorney may have about achieving eligibility for someone who is not "truly needy" must not affect the attorney's exercise of his or her ethical duty to pursue the client's interests, as expressed by the client.

A tax attorney would not hesitate to exploit all possible tax exemptions, deductions, credits and offsets, no matter how wealthy the client is. Similarly, it is the Medicaid-planning attorney's duty to explain the options for achieving Medicaid eligibility and allow the client or the client's surrogate to decide whether to move forward with any particular plan.

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5. *In re Shah* (N.Y. App. Div. 2 1999), 257 A.D.2d 275, 694 N.Y.S.2d 82.

6. ABA Model Rules of Prof. Conduct, Preamble ¶ 2.

## LONG-TERM CARE CONSUMER'S JUSTIFICATION TO SEEK GREATEST BENEFIT FROM PUBLIC FUNDING FOR CARE

Timothy L. Takacs and David L. McGuffey, in "Medicaid Planning: Can It Be Justified?, Legal and Ethical Implications of Medicaid Planning,"<sup>7</sup> (Takacs and McGuffey) explore the moral and public policy concerns raised by using legal strategies to create Medicaid eligibility for long-term care residents who do not initially meet the financial qualifications.

Takacs and McGuffey state, "Although many nations, and the World Health Organization, regard health care as a fundamental human right, the United States does not."<sup>8</sup> For this proposition they cite a New York Appellate Division case in which the court observed that since this country has no system of public health insurance, citizens are required to pay for their own care.<sup>9</sup> As a result, the authors write:

Health care services are bought and sold on the "free market." The market is competitive, largely amoral, and (in theory) governed by the free market's "invisible hand," within a framework of public laws and regulations by non-governmental organizations (for example, accrediting organizations such as the Joint Commission on Accreditation of Healthcare Organizations, which accredits the majority of the country's medical facilities).<sup>10</sup>

Since consumers of long-term care services must compete in an open market, Takacs and McGuffey argue, it is unreasonable to expect them "to refrain from self-interested conduct, while other market players, such as health care providers and insurers, remain free to condition health care access on payment (and profit)."<sup>11</sup> It is unfair to require them to meet a moral or ethical duty above the legal requirements set forth by Congress.

Morris Udall, Arizona Congressman, made this prescient comment in 1975:

[O]lder Americans must devote 80% of their income to food, shelter, health care and transportation . . . . Being old in America means taking the leftovers from a health care system that caters to the young. The 10% of our people over 65 account for 28% of the nation's total medical bill. Yet Medicare—for all the good it has done—pays less than 40% of the medical bills of its recipients, and the proportion has been declining. The strength of the medical lobby has prevented needed changes in the health care delivery system, perpetuating needless inefficiencies that drive the costs of Medicare skyward. . . . [W]e [must] alleviate the heavy medical bill burden now borne by the elderly.<sup>12</sup>

Most older Americans are at least as financially pressed today as they were 38 years ago. While there is an emotional appeal to the mantra that Medicaid is only for the "truly needy," more than half the senior population would be financially dev-

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7. 29 William Mitchell Law Review 111 (2002); [http://www.wmitchell.edu/lawreview/Volume29/Issue1/04\\_Takacs\\_McGuffey.pdf](http://www.wmitchell.edu/lawreview/Volume29/Issue1/04_Takacs_McGuffey.pdf).

8. *Id.* at 117.

9. *In re Gonzalez*, 586 N.Y.S.2d 861, 865 (App. Div. 1992).

10. Takacs and McGuffey at 117.

11. Takacs and McGuffey at 132.

12. Morris K. Udall, Public Policy and the Future of Aging, Address given before the National Council on Aging (Sept. 30, 1975), [http://www.library.arizona.edu/branches/spc/udall/aging\\_htm.html](http://www.library.arizona.edu/branches/spc/udall/aging_htm.html).

astated by two years in a nursing home. This is particularly troubling as it relates to community spouses. To restrict the ability of older citizens to protect their net worth and qualify more easily for Medicaid, state and commonwealth Medicaid agencies and legislatures and Congress have created labyrinthine regulations to thwart asset transfers by nearly anyone over 55.

The Deficit Reduction Act of 2005<sup>13</sup> severely restricts Medicaid benefits for long-term care if an application is filed within five years of a transfer for less than full consideration.<sup>14</sup> These provisions were added to the Social Security Act due to the perception that many middle-class individuals and families hide or give away large amounts of property to qualify for government assistance in paying for long-term care and that this is exacerbating the growth of the cost of this care to the government. However, societal factors—low and decreasing median net worth and the declining purchasing power of fixed senior citizen income—are driving Medicaid costs up, not manipulation of individual estates to accelerate eligibility.

### NURSING HOME COSTS AND BUDGETS NOT AFFECTED BY MEDICAID PLANNING

Medicaid planning—i.e. the gentrification of long-term care Medicaid—is not a major cause of the growth of Medicaid spending. Wealthy middle-class families are not sheltering large sums of money in abusive financial arrangements, nor are they bankrupting the program. The increase in the cost to the government of paying for care of nursing home residents is caused, first of all, by inflation and the large number of low-income, low-net worth nursing home residents.

The argument that middle-class nursing home patients are gaming the system is that the majority of nursing home residents are receiving Medicaid, despite the fact that only 30% of Americans are in poverty. The logic is this: If 30% of Americans are poor, but 70% of nursing home residents are on Medicaid, then 57% of those receiving Medicaid in nursing homes are not poor and must have sheltered their wealth. While this seems logical, it is not consistent with two basic principles of American wealth and long-term care utilization: Poverty is much more pervasive than most people realize or government officials admit. Furthermore, the greater a disabled elderly person’s income and assets, the less likely the person will enter a nursing home.

| Mean and Median Net Worth in Constant (2010) Dollars by Selected Characteristics of Families |            |            |            |            |              |            |            |            |
|--|------------|------------|------------|------------|--------------|------------|------------|------------|
|  | 2001       |            | 2004       |            | 2007         |            | 2010       |            |
|  | Net worth  |            | Net worth  |            | Net worth    |            | Net worth  |            |
|  | Mean       | Median     | Mean       | Median     | Mean         | Median     | Mean       | Median     |
| <i>Age of family head:</i>   |            |            |            |            |              |            |            |            |
| 55 to 64 years old   | \$ 888,800 | \$ 227,200 | \$ 978,400 | \$ 290,000 | \$ 988,700   | \$ 266,200 | \$ 880,500 | \$ 179,400 |
| 65 to 74 years old   | \$ 831,400 | \$ 217,800 | \$ 795,100 | \$ 218,800 | \$ 1,084,100 | \$ 250,800 | \$ 848,300 | \$ 206,700 |
| 75 years old and over  | \$ 574,800 | \$ 190,300 | \$ 807,700 | \$ 187,700 | \$ 668,800   | \$ 223,700 | \$ 677,800 | \$ 216,800 |
| Net worth, 55 and up   | \$ 788,287 | \$ 211,787 | \$ 793,087 | \$ 232,187 | \$ 906,533   | \$ 248,900 | \$ 802,200 | \$ 200,967 |

13. Pub. L. No. 109-171.

14. Deficit Reduction Act of 2005, §§6011, 6012, 6014 and 6016.

Through the past decade, the concentration of wealth among affluent White Americans was striking, a trend that extends to the present and is likely to continue unless there is a drastic change in the federal tax code or the wealth gap is narrowed by some other social mechanism.<sup>15</sup> The Net Worth table shows that the net worth of American families was three or more times the median and net worth is lower in higher age brackets.

There is also a troubling shift in wealth distribution between 2007 and 2010. There was not only a large drop in net worth in all of the age groups, the bias in median net worth among age groups flipped. Until 2007, lower-aged seniors had more wealth than those in the upper age brackets. In 2010, they had markedly less. This means that as the 55-64 year-old-cohort ages, they will be less able to pay for their care than their parents were.

It is also significant that in all age groups, non-Hispanic White median and mean net worth are three to five times as high as they were for non-White and Hispanic households.<sup>16</sup> Thus, the financial burden of nursing care falls much more heavily on minorities, stripping families of meager inheritances.

The median value is the middle value. As many families have a net worth below the median as above it. The mean, however, is the average net worth. The fact that the mean is so much higher than the median indicates that there is a tremendous concentration of wealth among a few very wealthy families. It also means that the numbers of families in lower net worth strata are much greater than in higher strata.

The bottom 20% are extremely low-wage and low-net worth and it is, furthermore, an extremely narrow band. The next 20% are not much higher. As the table shows, the 50th percentile for age 75 and up in 2010 was only \$216,800, including home equity and all savings and investments. Based on current average private-pay nursing costs, a single individual in a nursing home in a commonwealth like Pennsylvania would expend \$216,800 in 31 months, assuming a 2% return on the investments and \$1,200 per month in Social Security and pension income. A couple at that net worth with \$2,200 in Social Security and pension income would be broke in 15 months. Therefore, very large numbers of low-net worth families is one reason that a large number of nursing home residents qualify for Medicaid.

The second reason for a disproportionate population of Medicaid-eligible nursing home residents is that disabled individuals with more resources will be less likely to enter a nursing home. Among the 34 million elderly in 1995, 5% were nursing home residents and 12% were living in the community with ADL (activities of daily living) or IADL (instrumental activities of daily living) limitations.<sup>17</sup> Functional

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15. U.S. Department of Commerce, Economics and Statistics Administration, U.S. Census Bureau, "Net Worth and Asset Ownership of Households: 2001 to 2010" (downloaded April 12, 2013).

16. Board of Governors of the Federal Reserve System, *Federal Reserve Bulletin*, January 2003, and unpublished data found at <<http://www.federalreserve.gov/pubs/oss/oss2/2001/scf2001home.html>>.

17. The five activities of daily living are eating, bathing, dressing, transferring (from bed to wheelchair or chair), and toileting are determinative of the need for nursing care in most states. An individual who requires assistance with two or more ADLs is medically eligible for care in a nursing home. Instrumental activities of daily living are higher-order skills that are considered necessary for the individual to function independently in the community. The skills measured are use of a telephone, shopping, food preparation, housekeeping, laundry, transportation, medication management and finance management. Lawton & Brody, "Assessment of Older People: Self-Maintaining and Instrumental Activities of Daily Living," *The Gerontologist*, 9(3), 179-86 (1969).

limitations increase substantially with age, particularly for the oldest old. However, U.S. Census figures reflect a decline in the nursing home population. Among those aged 85 and over, 24.5% were in nursing homes in 1990, 18.2% in 2000, and 10.4% in 2010. There were more than twice as many community residents with long-term care needs as nursing home residents.<sup>18</sup> Rather than relegating older citizens to nursing homes and engaging Medicaid-planning attorneys to preserve assets, families are making great sacrifices and providing substantial assistance to help them remain in the community.

**Population 65 Years and Over in Nursing Homes by Age, 1990 to 2010**

| Age             | Percent of age group |       |       | 2010      |
|-----------------|----------------------|-------|-------|-----------|
|                 | 1990                 | 2000  | 2010  |           |
| 65 yrs and over | 5.1%                 | 4.5%  | 3.1%  | 1,252,635 |
| 65 to 74 yrs    | 1.4%                 | 1.1%  | 0.9%  | 197,310   |
| 75 to 84 yrs    | 6.1%                 | 4.7%  | 3.2%  | 420,790   |
| 85 yrs and over | 24.5%                | 18.2% | 10.4% | 529,689   |

Research using National Long-Term Care Survey data found a decline in the number of family caregivers and an increase in the use of formal care provided by paid workers between 1984 and 1994. However, between 1994 and 1999, the number of spouses and children providing care to an older person with disabilities increased, while the use of formal care by older persons with disabilities who received care in the community declined. Reliance on family care increased dramatically and it may be presumed that the trend has continued.

The use of formal care went from 43% in 1994 to 34% in 1999, but reliance on informal care increased significantly from 57% to 66%. Nearly all the decline in help between 1994 and 1999 reflects greater use of assistive devices, such as shower or tub seats or walkers. Because of this, a larger proportion of caregivers were caring for persons with higher levels of disability in 1999 than in 1994, and caregivers and care recipients were older than in 1994, with nearly 40% of caregiving children assisting parents age 85 or older in 1999 and almost 13% of care-giving children age 65 or older.

In 1999, about 30% of children with a parent in a community residential care setting, such as assisted living, were providing care. Family caregivers provide the vast majority of the long-term care received by older persons with disabilities.<sup>19</sup>

Contrary to the perception of many legislators and welfare officials, elderly people are not trying to get into nursing homes to take advantage of Medicaid; they are

18. Robyn I. Stone, *Long-Term Care for the Elderly with Disabilities: Current Policy, Emerging Trends, and Implications for the Twenty-First Century* (2000).

19. Mary Jo Gibson, *In Brief* (AARP Public Policy Institute, 2005).



desperately trying to remain in the community. The nursing home is literally the last resort.

Therefore, if an individual has the means to remain in a community setting, he or she will do so and the greater the wealth, the longer the individual will remain in the community. Disabled elderly individuals do not generally enter nursing care, then give up their resources so they can become eligible for Medicaid. Quite the opposite seems to be happening. They go into a nursing home because they lack assets and family support or because they have expended their resources and lack other alternatives. It is lack of resources that forces many into nursing homes, so it should be no surprise that Medicaid-eligible patients predominate there.

Strict Medicaid rules will discourage some gift-giving, but the greater impact will be on low-income, low-net worth elderly persons who never made significant gifts. It will be incredibly difficult for applicants who do not have good financial records to demonstrate that modest declines in assets were not due to gifts. Many individuals and families of modest means file no income tax returns, keep no records of month-to-month expenditures, and pay their bills in cash. Particularly when an individual is suffering the effects of dementia, there may be imprudent transactions and poor record-keeping. The presumption that any reduction in the individual's net worth is due to gifts is extremely difficult to overcome. Due to the Deficit Reduction Act, there are pervasive reports of difficulty in pursuing Medicaid benefits for nursing home residents.

Nursing home social workers, attorneys, legal aid workers, and family members involved in Medicaid applications report that workers are demanding that financial affairs be documented in minute detail. Benefits are routinely denied over insignificant amounts that cannot be fully explained. The problems in applying for Medicaid for nursing care have been exacerbated by the difficulty in getting paper bank statements and copies of checks. While on-line banking is extremely convenient, not many octogenarians are comfortable doing their banking that way. Also, it can be difficult to print out legible statements that fit on an 8.5" x 11" page.

Practitioners report situations where it cost upwards of \$1,500 to purchase the five years of bank statements demanded with regard to Medicaid applications. Furthermore, many household bills are deducted from bank accounts automatically. One attorney working on a Medicaid application reported that it took many faxed, mailed and emailed requests to get the paper health insurance bill demanded by a Medicaid worker.

A recent Medicaid application took over six months to resolve. Betty Hoyt had been a nursing home resident for over six years, private pay. She had exhausted nearly all of her \$500,000 in savings and investments, without making any gifts. Despite the representative's statement that Betty had used all of her money to pay for her own care, the worker demanded five years' bank and investment records and started flyspecking the transactions. She would demand a copy of a check or a paid bill for a transaction that took place three or four years earlier. Since Draconian rules and harsh treatment in the Medicaid application process force families to seek the assistance of an attorney, it would be unreasonable not to expect them to seek a favorable economic result.

Some relatively well-off patients will enter nursing homes for purely physical reasons and use Medicaid planning to preserve the estate for a community spouse or

offspring; but these patients are the exception, not the rule. Medicaid planning plays a very minor part in determining the size of the Medicaid-eligible nursing home population. The large proportion of Medicaid-eligible nursing home patients is due to the unequal distribution of wealth in the United States and the inability of low-net worth disabled elderly individuals to remain in the community. These strict new rules punishing elders for making gifts were enacted to address a problem that was greatly overblown. Unfortunately, the greatest impact will be on deserving Medicaid applicants who will find it nearly impossible to demonstrate that they made no gifts in the five years preceding the filing of an application for long-term care benefits.

## JUDGE'S ETHICAL OR MORAL VIEWS NOT RELEVANT

Medicaid planning is not the threat to the public fisc that many believe it is. When ruling on a case in which a senior or the senior's agent had made gifts, the court should limit its analysis to whether the actions were legally permissible, without considering the effect on the government's Medicaid budget. When the court hears a tax case, it does not weigh the government's need for revenue; it determines whether the taxpayer complied with the letter of the tax code. Similarly, if the Medicaid applicant's financial transactions did not violate the law, a financially advantageous result should not be held to be against "public policy."

The Third Circuit Court made this point forcefully:

We begin by noting that Medicaid is established through an exhaustive set of statutes that thoroughly detail what benefits are to be available and to whom they should be provided. See 42 U.S.C. §1396 *et seq.* In this context, we do not create rules based on our own sense of the ultimate purpose of the law being interpreted, but rather seek to implement the purpose of Congress as expressed in the text of the statutes it passed.<sup>20</sup>

Medicaid planning is not a threat to the state or commonwealth fiscal integrity. The impact of such asset preservation measures on the public budget should not be used as an excuse to avoid compliance with federal Medicaid law, nor to deny applicants and their families the protection of those planning opportunities that still exist.

Where a guardian requests the court's permission to transfer assets to qualify the ward for Medicaid and there is persuasive evidence that the ward would want the estate preserved in that fashion, the court must consider the equal-protection ramifications of denying the petition. Should an incapacitated individual be denied the opportunity to divest assets to qualify for government benefits solely because of that incapacity? In the *Shah* opinion cited above, Judge Bracken observes that Mr. Shah should not lose the right to dispose of his assets as he desires "merely because he is now incapacitated and financial decisions on his behalf must necessarily be made by a surrogate."<sup>21</sup> Where the proper factual basis has been shown, the argu-

20. *James v. Richman*, 547 F.3d 214, 219 (3rd Cir. 2008).

21. *Shah*, at 282. The court relied on the New York Mental Hygiene Law §81.21, which provides the following standard to approve a gift by a guardian:

(e) The court may grant the application if satisfied by clear and convincing evidence of the following and shall make a record of these findings:

ment that the guardian of a nursing home resident should be allowed to make gifts to achieve Medicaid eligibility, as permitted by the Medicaid regulatory scheme, would be consistent with the court's duty to protect and enhance the rights of citizens with disabilities.

This discussion requires analysis of the constraints on judges' discretion in deciding cases. Are judges acting properly when they superimpose religious precepts, perceptions of public policy, or moral principles on the statutes and regulations governing cases before them?

The question is relevant because counsel representing Medicaid agencies often argue that courts should close alleged loopholes in the federal statute based on public policy against granting Medicaid to persons who are not "truly needy." They urge the court to deny Medicaid to applicants who punctiliously complied with the legal requirements because the result is too favorable to the applicant, or because it is the government that is "truly needy." Would a judge who acceded to this urging abdicate his responsibility to apply the law as it was enacted?

On one side of this conflict is the claimant, who desires the greatest benefit while preserving as much of his or her financial resources as possible. On the other is the State or Commonwealth, which seeks to advance budgetary restraint by limiting Medicaid to as few impoverished citizens as possible. In between is the judge.

Judges may be perceived as agents of the state, but their agency consists of determining cases and controversies, not formulating policy. Policy is the responsibility of other agents of the state, whom we typically call legislators.

Officials acting for the State by deciding cases and controversies—judges—must do so according to rules of the legal system that are formulated by other officials—legislators—whose responsibility it is to establish the rules. Judges must not apply public policy or other considerations unless there is an ambiguity in the rules they are charged with applying.

According to Alexander Hamilton, "The courts must declare the sense of the law; and if they should be disposed to exercise WILL instead of JUDGMENT, the consequence would equally be the substitution of their pleasure to that of the legislative

1. the incapacitated person lacks the requisite mental capacity to perform the act or acts for which approval has been sought and is not likely to regain such capacity within a reasonable period of time or, if the incapacitated person has the requisite capacity, that he or she consents to the proposed disposition;
2. a competent, reasonable individual in the position of the incapacitated person would be likely to perform the act or acts under the same circumstances; and
3. the incapacitated person has not manifested an intention inconsistent with the performance of the act or acts for which approval has been sought at some earlier time when he or she had the requisite capacity or, if such intention was manifested, the particular person would be likely to have changed such intention under the circumstances existing at the time of the filing of the petition. McKinney's Mental Hygiene Law §81.21.

Pennsylvania's standard for authorizing a gift by a guardian is more restrictive than that of New York. Pennsylvania allows a guardian to make gifts if the court finds as follows:

In the exercise of its judgment for that of the incapacitated person, the court, first being satisfied that assets exist which are not required for the maintenance, support and well-being of the incapacitated person, may adopt a plan of gifts which results in minimizing current or prospective taxes, or which carries out a lifetime giving pattern. The court in exercising its judgment shall consider the testamentary and inter vivos intentions of the incapacitated person insofar as they can be ascertained. 20 Pa.C.S.A. §5536.

Therefore, absent a tax motivation, the court would need to be shown a "lifetime giving pattern" to justify a gift. These two examples reflect the variation in probate codes among the various states and commonwealths and indicate the need to analyze the court's power to approve transfers in view of the local probate code.

body.”<sup>22</sup> Federal, and presumably state, judges are prohibited from making “political decisions.”<sup>23</sup>

Sir. William Blackstone emphasized that both law and equity must be grounded in rules and precedents.<sup>24</sup> He warned that if jurisprudence “floated upon the occasional opinion which the judge who happened to preside might entertain of conscience in every particular case,” the result would be “a worse evil than any hardship that could follow from rules too strict and inflexible.”<sup>25</sup> The result would be arbitrary powers that would undermine the rule of law.<sup>26</sup> Therefore, where the claimant has organized his or her estate in conformity with Medicaid law, it would be improper for the court to consider whether the result is too favorable to the claimant at the expense of the state.

## CONCLUSION

Medicaid planning is a complicated and divisive issue that raises ethical, moral, legal, and public policy considerations. It is also a core area of Elder Law practice. It is just, mete and proper for the Elder Law attorney to protect a client’s estate against the cost of long-term care by shifting the cost to the Medicaid program, provided that the client’s care will not be adversely affected. Medicaid rules are complicated and onerous, but the citizen has the right to any advantage compliance with the law yields. While the state or commonwealth has a justifiable concern for the fiscal integrity of the Medicaid Program, the fundamental right of the citizen to direct his or her financial affairs within the parameters of the program should be the court’s focus in deciding cases that involve Medicaid planning.

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22. Hamilton, *The Federalist Papers*, No. 78, [http://thomas.loc.gov/home/histdox/fed\\_78.html](http://thomas.loc.gov/home/histdox/fed_78.html) (accessed July 24, 2013).

23. *Missouri v. Jenkins*, 515 U.S. 70, 133 (1995) (Thomas, concurring).

24. W. Blackstone, 3 *Commentaries on the Laws of England* 436 (1768).

25. *Id.* at 440.

26. 515 U.S. at 127-128.