THE MASSNAELA ADVOCATE

A Publication of the Massachusetts Chapter of the National Academy of Elder Law Attorneys

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From the President:

Change—it can be thrilling and exciting. It can also be scary and unsettling. At some point in most long-lived organizations change is needed to keep them relevant and responsive to the needs of their constituents. For these reasons, this year will be one of many changes within MassNAELA.

MassNAELA just celebrated its first quarter century. Starting as a handful of highly dedicated attorneys we are now close to 500 members and Elder Law is a recognized estate planning specialty. As other estate planning types shrink, Elder Law grows. We are poised on the cusp of a generational wave, and we are ready.

At our core, we seek to educate our members and advocate on behalf of vulnerable seniors and persons with special needs.

"Education is the most powerful weapon which you can use to change the world."

— Nelson Mandela

Education: In the beginning we educated our members with dinner meetings. Today, we offer members a variety of educational programs and events. In addition to our regular dinner meetings, we've added:

- Multi-site breakfast meetings - held all over the state
  This year's program will be held on March 1, 2018 on the topic of housing options for seniors and persons with special needs
- Elder Law Institute – all-day session held at the Federal Reserve Building
  The next one is March 16, 2018 and will cover emerging issues in obtaining Medicaid eligibility.

- Paralegal program
- Litigation Workshops
- Webinars – often more niche topics scheduled throughout the year

Even if you cannot attend the dinner meetings, there are many ways to engage and grow professionally.

"Never doubt that a small group of thoughtful, committed, citizens can change the world. Indeed, it is the only thing that ever has." – Margaret Mead

Advocacy: Initially, MassNAELA focused on building relationships with regulators and the legislators. Now we need to litigate cases. We need to be smart about how we go about it and we need to broaden these efforts. It's not just about Medicaid. We have clients who are disabled and are being forced to live in institutions because there is no state funding to develop appropriate housing. We have clients who are being kicked out of their homes because the organization that promised to take care of them is abandoning them. The need to fight back grows and so we must prepare by developing the skills to address these challenges.

But we cannot do it all. We must be vigilant with our litigation budget in order to be able to take on "the big issue" in the forum best suited to it. This has already resulted in one very difficult decision related to our working relationship with Northeast Justice Center and our contract with John Ford. Though we hope to utilize John's considerable expertise in the future on select cases, we have revised our contract so as to limit our commitment. This difficult choice provides funds that can be used in support of our broader litigation efforts.

We must also ensure that our litigation efforts do not sabotage our regulatory and legislative advocacy efforts. Starting this year, MassNAELA will be adopting a topic-oriented approach to addressing issues affecting our clients. Instead of Public Policy addressing the regulatory and legislative issues of a topic and a separate Litigation Committee determining how to litigate the same issue, these previously distinct groups will work together around a topic. Our work advocating to preserve Pooled Trusts for persons over 65 is an example of this restructuring. The Pooled Trust work group has litigation and regulatory/legislative advocacy perspectives well represented. The members of this team coordinate their efforts to gain insights and efficiencies, as well as to avoid conflicts in their various approaches.

We are also finding that most of the work done by these small groups is being done outside of the "Public Policy" and "Litigation Committee" meetings. Teams are getting things done by having regular conference calls and coordinating by email. This allows for greater engagement throughout the state.

MassNAELA hopes to reap huge benefits from these changes to how we work. However, it will also create additional challenges. Organizationally, how do we best support and stay current on the progress of these independent, self-organizing groups? What are the best ways to keep our membership up to date on the progress, challenges, and engagement opportunities across these teams? What else can we do to promote and support engagement?

Timely and effective communication and just enough coordination will be key. To facilitate this communication and coordination need, we created the "Advocacy Group," a new committee that will oversee and support our more ninja-like topic-oriented work groups. The Advocacy Group must reach all of our members, not just those who can attend our Dinner meetings. One of my goals this year is to develop the organizational supports needed to ensure that the Advocacy Group is successful in its mission.

There are many changes happening all at once within MassNAELA. While there is risk associated with this approach, I feel it is necessary in order to evolve the organization to meet our near term goals. For better or worse, odds are good that there will be some bumps along the road over the next year. If you are impacted by one or more of these, I hope you will view them in light of the goals outlined above. I also hope that you will reach out to me or someone in leadership if you ever feel that we are heading down the wrong path.

Finally, it sounds so cliché, but perhaps clichés become clichés because they are so true. I am incredibly proud to be a part of MassNAELA and humbled to be its President in 2018, tasked with leading this great organization of "do-gooders" into it mid-century mark.

Thank you.

- Karen B. Johnson,
  President MassNAELA 2018

Introducing a New Format for Public Policy and Litigation Committee Meetings:

MEMBERS OF EACH COMMITTEE SHOULD PLAN ON A 2:30 PM ARRIVAL!

Over the last few years, MassNAELA leadership has noticed that there is a lot of overlap between the Public Policy and Litigation committees and the same issues were discussed in both forums. Leadership has come up with a plan that is intended to be a more efficient use of everyone's time. Instead of two separate meetings, there will be one combined meeting where members work on each issue together. This session will be called the "Advocacy Group Session" and will be organized by issue or topic. For example, a workgroup focusing on annuities can brainstorm and strategize from all angles-legislative advocacy, regulatory involvement and coordinated litigation on particular cases and a discussion on how members should approach the issue should they come across it in their practice.

The new meeting structure will occur in the same block as the prior meetings - from 2:30 - 5:30. The first part of the meeting will consist of reports from the various workgroups by the chair (or his/her designees) of the workgroup formed to address that issue along with legislative updates and reports on what regulatory, legislative or litigation issues members should be aware of to determine whether members need to form a new workgroup to address any identified new threats. The second part of the session will be a working meeting for the various workgroups. Members will break up into workgroups by issue. There will be two rotations, so members will have the chance to work on one issue for about an hour, and then a second issue for about an hour.

Patricia Keane Martin, who has been a key member of both the Public Policy and Litigation Committees will be leading this initiative and will oversee the structure of the session and act as its official timekeeper (watch out!). Prior to the session she will send out an agenda and touch base with the leaders of each workgroup to make sure everyone is ready for the session.

For those of you accustomed to coming at 4:00, we recognize that this will mean leaving your office earlier. We are confident that this new approach will help us all better learn from each other and more effectively advance our

issues. We understand that this change is new, we are open to all comments and suggestions, and we ask for your patience while assessing how best to coordinate our efforts to inform and engage a broader membership group, which will serve our membership well over the long term.

Update from the Probate and Family Court:

The Probate and Family Court has announced that effective immediately, Standing Order 3-17, *Fiduciary Litigation Session Pilot Project*, shall apply to cases filed in the Essex and the Plymouth divisions of the Probate and Family Court. Initially, Standing Order 3-17 applied only to cases filed in the Middlesex, Norfolk and Suffolk divisions. For more information, see https://www.mass.gov/probate-and-family-court-rules/probate-and-family-court-standing-order-3-17-fiduciary-litigation.

Featured Board of Hearings Decisions:

COUNTABILITY OF CCRC DEPOSIT FEE (FAVORABLE)

Board of Hearings Appeal Number 1718268, January 31, 2018

MassHealth denied the Appellant's application for long-term care benefits because it determined that the Appellant and his wife paid a refundable entrance deposit fee of $225,000.00 at the continuing care retirement community(CCRC) Linden Ponds, where they reside. The Appellant resides in the nursing facility component of Linden Ponds, and the Appellant's wife resides in the independent living component. MassHealth deemed the deposit fee to be countable to the Appellant, and asserted that the Appellant has access to these resources to pay for his care. The Board of Hearings found that the deposit fee is not an available resource for eligibility purposes. The agreement between Linden Ponds and the Appellant and his wife is clear that neither the Appellant nor the wife can obtain a refund of the deposit fee if at least one member of the couple remains living at Linden Ponds. In order to obtain a refund or partial refund of the fee, the Appellant would need to transfer to a different nursing facility and the wife would need to move out of Linden Ponds and find living arrangements elsewhere. The Board of Hearings agreed with the Appellant's counsel that this would place the Appellant and his wife in an untenable situation.

Contributed by: Judith M. Flynn, Falco & Associates, PC, Quincy

Summary by: Jessica S. Batsevitsky, Law Office of Jessica S. Batsevitsky, LLC, Needham

DISQUALIFYING TRANSFERS (FAVORABLE)

Board of Hearings Appeal Number 1716892, December 13, 2017

The Fair Hearing Officer ruled in Appellant's favor that $52,696 of transfers were not disqualifying. Of that amount, $31,000 were undocumented cash withdrawals from the Appellant and spouse's bank accounts. Appellant had no receipts to prove how the funds were spent. Appellant's counsel argued that the couple should not be discriminated against by MassHealth based upon their cultural norms and practices in which they used only cash

and often hired unlicensed workers on a cash basis to make repairs to their home and car, and no receipts or invoices were requested or provided. The remaining transfers of $21,696 were acknowledged to be gifts made for poor relatives in Guatemala and for the couple's son's 40th birthday. The Hearing Officer found that based upon the testimony of the spouse and son, these gifts were made exclusively for a purpose other than qualifying for MassHealth.

Contributed and summarized by: Patrick G. Curley, Curley Law Firm LLP, Wakefield

VERIFICATIONS REGARDING FINANCES (FAVORABLE)

Board of Hearings Appeal Number 1709521, December 12, 2017

MassHealth denied Appellant's application for benefits on the basis that he failed to provide verifications regarding his spouse's finances. Upon his admission to a nursing home, Appellant's spouse left him, filed for divorce, and refused to provide any verifications. Appellant's counsel provided MassHealth with verifications from the divorce proceeding, letters to the spouse demanding financial verifications, and Appellant's assignment of all spousal support rights to MassHealth. Upon receipt of the MassHealth denial notice, Appellant's counsel phoned the caseworker's supervisor, and argued that the facts of the case fit within MassHealth's spousal refusal regulations. But the MEC supervisor said that MassHealth could not and would not determine whether Appellant satisfied the spousal refusal regulations until after the Appellant had provided all requested spousal verifications. The caseworker made the same argument at the Fair Hearing. The Hearing Officer determined that Appellant satisfied 130 CMR 517(B)(1) because he "properly assigned any and all rights to support from his then-community spouse to MassHealth, and the obligation to provide asset verification was alleviated." The Hearing Officer noted that MassHealth's own legal memorandum supported this outcome.

Contributed and summarized by: Patrick G. Curley, Curley Law Firm LLP, Wakefield

Edited by: Jessica S. Batsevitsky, Law Office of Jessica S. Batsevitsky, LLC, Needham

HOME MAINTENANCE DEDUCTION (FAVORABLE)

Board of Hearings Appeal Number 1712927, November 16, 2017

The Fair Hearing Officer ruled in Appellant's favor that he was entitled to an "Amount to Maintain Home" deduction from his PPA under 130 CMR 520.026(D). MassHealth had argued that MassHealth Eligibility Operations Memo 09-09 allows such a home maintenance needs deduction for unmarried applicants, with no eligible dependents in the home, only if MassHealth receives an SC-1 form with the short-term stay block checked and a physician's signature, and a clinical eligibility approval stating short-term stay. The Hearing Officer agreed with Appellant's counsel that 130 CMR 520.026(D) requires only a statement from a "competent medical authority" regarding applicant's likelihood to return home within six months from date of admission to the facility. On cross examination, the MassHealth caseworker acknowledged she had no evidence to suggest that Appellant's PCP was not competent to opine on Appellant's ability to return home, and the Hearing Officer agreed that Appellant's own physician . . . is indisputably a "competent medical authority." The Officer further found that Operations Memo 09-09 required caseworkers to "disregard the type of statement expressly called for in the regulation," and that

MassHealth must follow the "plain language of the regulation [130 CMR 520.026(D)]." Under current regulations, the deduction is worth $1,005 per month for up to six months from the date of admission.

Contributed and summarized by: Patrick G. Curley, Curley Law Firm LLP, Wakefield

COUNTABILITY OF ANNUITY (FAVORABLE)

Board of Hearings Appeal Number 1705944, October 13, 2017

The Fair Hearing Officer ruled in Appellant's favor that her spouse's TIAA-CREF traditional annuity from a former employer was not a countable asset for the purpose of determining the community spouse's CSRA. MassHealth had argued that the annuity was a countable 401(k) and that it rendered the Appellant over assets, until such time as it was annuitized into "transfer payout" form (the fastest payout permitted under the contract terms). The Hearing Officer applied 130 CMR 520.007(J)(1), which states that "[I]f the annuity can be converted to a lump sum, the lump sum, less any penalties or costs of converting to a lump sum, is a countable asset." In this case, the Hearing Officer agreed with Appellant's counsel that there was no point at which the community spouse could have obtained a lump sum from the annuity, including before the transfer payout annuity conversion, and therefore the annuity was a noncountable asset.

Contributed and summarized by Lucy J. Budman, CELA, Curley Law Firm LLP, Wakefield

Featured Article: Must I Set Aside? Part One

By Robert P. Mascali

Of particular interest to MassNAELA members who work with personal injury attorneys to represent the interests of injured and disabled clients, Attorney Mascali investigates the issue of whether a Medicare Set Aside Account is required for future medical expenses as part of a settlement of third party liability litigation.

Like Alice as she starts her journey through Wonderland, many attorneys involved in third party liability litigation feel they are descending into a rabbit hole of chaos and confusion when confronted by the question: Is a Medicare Set Aside Account required for future medical expenses as part of a settlement? For the most part, the wariness is justified due of the lack of firm guidance on this issue from the Centers for Medicare and Medicaid Services ("CMS"). The basic premise underlying a Medicare Set Aside Account, is that once a claimant has received settlement funds from a third party that covers the costs of future medical treatment, (at least in part), Medicare, as an agency, wants to ensure that third party funds are used to pay for those expenses, before Medicare starts paying for them.

Some historical context is enlightening. Prior to the adoption of the Medicare Secondary Payer (MSP) Act, [FN 1], Medicare was the primary payer of all services covered by Medicare, except where worker's compensation provided coverage. Then in 1980, the MSP made Medicare a secondary payer to certain insurance plans and programs for beneficiaries, including auto and other third party liability insurance plans. However, enforcement did not begin until 2001 following the issuance of the Patel Memorandum [FN2], which provided that compliance with MSP was

required in worker's compensation cases. Thereafter in 2007, legislation was enacted [FN3] that required insurance companies and other payers to provide information to CMS in any settlement situation in which Medicare was, or could become, the secondary payer. This legislation captured everyone's attention; the reporting requirement meant that CMS would have the mechanism in place to track who received settlement funds and whether Medicare's interest as a secondary payer was being protected.

In all third party liability based personal injury settlements where the claimant is on Medicare, some of the available settlement funds are used to reimburse Medicare for injury related "conditional payments." Conditional payments are those that were provided for **past** medical expenses of the personal injury plaintiff. Oftentimes, a portion of the settlement funds are also allocated to cover **future** medical expenses for which Medicare would, or may be, responsible. Enter the Medicare Set Aside Account ("MSA"). The MSA is the system which ensures that the funds are used for their designated purpose, such that Medicare is not in effect paying for something for which the claimant already was compensated.

Recent years have seen many fits and starts from CMS as it grapples with how to implement and enforce this mandate. The financial pressures on the Medicare system and the obvious need to generate revenue seem to suggest that CMS will look to third party litigants for some monetary relief. In fact, CMS recently signaled that they will start taking a closer look at enforcing the MSP statute in liability cases, as it did with worker's compensation in 2001. A CMS directive issued on February 6, 2017, effective October 1, 2017, provided that Medicare contractors will be able to deny payment for items and/or services that should be paid from some form of an MSA. With this, Medicare has made known its intention to amend its internal process so that it can receive and track data related to liability cases. Simply stated, CMS is finally starting to build some teeth behind enforcement of the statute in liability cases. For the personal injury bar, a "do nothing" strategy is no longer a viable option.

What then are attorneys to do in the face of no formal guidance from CMS? What is to be done for the successful claimant who may have future medical expenses (near or far) that will be submitted for payment to Medicare because of age or status?

With any luck, this article will attempt to dispel some of the chaos and confusion and provide a ready source of information for the personal injury bar when determining whether a MSA is advisable, even if not currently required.

CMS GUIDANCE IN WORKERS COMPENSATION MATTERS

As stated, above, there are no rules or regulations under the Medicare Secondary Payer Act for either third party liability or worker's compensation cases. However, CMS has promulgated several memos on the issue of the need for a MSA in worker's compensation cases that prove helpful. The memos are not binding, but they are clearly instructive in the third-party liability realm. Specifically, in a worker's compensation case an MSA is not required where three criteria are met: (1) where it is clear the award is only for past medical expenses; (2) the treating doctor can certify that to a reasonable degree of certainty there will be no need for Medicare covered expenses in the future, and (3) that there is no attempt by the claimant to maximize other portions of the settlement to the damage of Medicare's interests. On the other hand, CMS has established certain review thresholds. The thresholds are loose guidelines, and if not met, an MSA may still be required in a particular situation. Those thresholds for review are as follows:

(a) The gross settlement amount exceeds $25,000 and the claimant is currently eligible for Medicare; or
(b) The gross settlement is for more than $250,000 and the claimant can reasonably be expected to become eligible for Medicare within thirty (30) months.

In these situations, it is the total amount of the settlement that is determinative and not merely the portion attributed to future medical expenses. Also, in cases where there is a structured settlement, the stated value of the settlement and not the actual cost of the structure is determinative. Finally, it is important to note that a claimant may not attempt to waive a right to future Medicare coverage to avoid the requirement to establish a MSA—at least in worker's compensation cases.

Since 2002, there have been various policy pronouncements in which CMS has stated its position on the issue of how Medicare's interests are to be considered and protected considering the lack of formal guidance. There has been a series of conference calls with the insurance industry, handouts and policy memoranda. In addition, there have been several reported court decisions that have addressed the question of whether a MSA or some other arrangement is required in liability cases, with differing conclusions.

CASES OF INTEREST

The 2015, case of *Aranki v. Burwell* [FN4] from the U.S. District Court in Arizona caused a considerable amount of discussion and possibly some unwarranted encouragement for those who assert that MSAs are not necessary and used by overly cautious attorneys. Plaintiff's counsel filed a petition based on the failure of CMS to respond to his request to review the necessity of a MSA in a medical malpractice case. The court held that the question was not ripe for review as MSAs are not *required* for future medical expenses in third party liability cases. According to the Court:

> To comply with the provisions outlined in the MSP {Medicare Secondary Payer] statute, in worker's compensation cases CMS Mandates the creation of a 'Medicare Set Aside 'account (41C.F. R.Sec.411). The purpose of a MSA is to allocate a portion of a worker's compensation award to pay potential future medical expenses resulting from the work-related injury so that Medicare does not have to pay. However, no federal law or CMS regulation requires the creation of a MSA in personal injury settlements to cover potential future medical expenses… There may be a day when CMS requires the creation of an MSA in personal injury cases, but that day has not arrived.

But is that really the "final answer"? Not really . . .

It is beyond dispute that there is a clear federal mandate that parties to a personal injury settlement must consider the interests of Medicare [42 U.S.C. 1395y(b)(2)]. Furthermore, and possibly most important, there are potential penalties and even a malpractice case against an attorney who fails to set up a MSA when one is found to have been required. It may be malpractice if a client's future medical expenses are rejected by Medicare and, since a MSA wasn't created, there are no funds available to pay them. One can argue that penalties would not be assessed against an attorney, nor would a malpractice claimant prevail where firm guidance is lacking on the issue. But certainly, no attorney wants to be that "test case".

In addition to *Aranki*, other cases from state and federal district courts in recent years do offer some guidance for the personal injury bar. Specifically, the following issues have been considered and ruled upon:

1. If medical providers can attest there will be no future medical expenses related to the injury for which compensation is paid, and Medicare acknowledges it has been reimbursed for all conditional payments related to the injury, no MSA is necessary. (*Berry v. Toyota Motor Sales, U.S.A., Inc.*) [FN 5]
2. If past and future injury related expenses have been, and reasonably will be, paid by private insurance, and considering the lack of CMS guidance on the issue, no MSA is required. (*Tye v. Upper Valley Medical Center*) [FN 6]
3. Since currently, Medicare does not require or approve MSAs they are not **required** as part of a personal injury settlement. (*Warren Frank v. Gateway Ins. Co.*) [FN 7]
4. While a court has held MSAs for future medical expenses are not required in a personal injury settlement, a court can also determine that a MSA is still appropriate for future medical expenses. (*Big R Towing, Inc.v.Trans Am Trucking, Inc.*) [FN 8]
5. A court has not only opined on the necessity for an MSA in a liability settlement, but went so far as to apply a percentage formula to determine the specific part of the settlement that should be set aside for future medical expenses. (*Benoit v. Neustrom*) [FN 9]

CONCLUSION

Given the difference between worker's compensation cases - based on a rigid formula for damage calculation, and traditional third party litigation - much more flexible in the allocation of damages, adherence to the experience in the worker's compensation field can go only so far. That said, at this point, MSA procedure in worker's compensation cases seems to be the only firm source of guidance we have. Coupled with the recent trends and decisions, it seems likely that the federal government will start to enforce compliance with the MSP in liability cases. The wise personal injury attorney should take this into consideration when discussing a prospective settlement, and should advise the client of the pros and cons of establishing a MSA where there is reasonable likelihood there will be future medical care covered by Medicare.

The second part of this article will deal with the evaluation of the funding amount, the aspects of the administration of a MSA and other practical advice.

Robert P. Mascali is an attorney admitted in Massachusetts and New York and is a consultant for The Center for Medicare Set Aside Administration a Florida organization that administers Medicare Set Aside arrangements throughout the United States. He is also a consultant for The Center for Special Needs Trust Administration, Inc. This Article was previously published in the Fall 2017 *Torts, Insurance and Compensation Law Journal of the New York State Bar Association*

FN 1-42 U.S.C 1395y(b)(2);42 CFR 46(d)(b)

FN2-Medicare Set Aside Arrangements Transmittal (Patel Memo) July 23, 2001

FN3-42 U.S.C.1305 (Medicare, Medicaid and SCHIP Extension Act of 2007)

FN4- 151 F. Supp 3rd 1038 (D.Ariz, 2015)

FN5-2015 WL 158889

FN6-2014 WL 2957037 (Ohio S.C. 2014)

FN7-2012 WL 868872

FN8-2011 WL 43219

FN9-2013 WL 1702120

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2018 Save-the-Dates

Save the dates for our Chapter dinner meetings and other educational programs in the upcoming year:

Thursday, March 1, 2018:	Scattered Site Breakfast Meetings
Wednesday, March 21, 2018:	Board and Committee Members Only
Thursday, April 26, 2018:	Dinner Meeting Schedule
Thursday, June 14, 2018:	Dinner Meeting Schedule
Thursday, September 13, 2018:	Dinner Meeting Schedule
Thursday, October 25, 2018:	Dinner Meeting Schedule
Thursday, December 6, 2018:	Dinner Meeting Schedule and Vendor Fair

SEND YOUR NEWSLETTER AND E-BULLETIN CONTRIBUTIONS TO:

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A Fond Farewell and Thank You!

With my retirement, C&Z Transitions will be closing, effective March 31, 2018. Our clients and our colleagues have been the heart of our business, and our company and its employees have been the beneficiaries of very rewarding work.

This notice is simply to say "Thank You" to the members of the Massachusetts Chapter of the National Academy of Elder Law Attorneys for giving C&Z Transitions the privilege of working with you and your clients who were facing difficult home transitions and losses.

C&Z stopped taking new clients in January, and we are referring any new business to Kate Grondin, MSW, founder of Home Transition Resource Inc. (HTR). Kate has been in the move management, home downsizing, and estate dispersal business for nearly ten years. Over the years, C&Z and HTR have shared resources and strategies for helping clients. More information on HTR may be found at the company's website at www.hometransitionresource.com.

It has been my pleasure and privilege to have worked with the members of MassNAELA over the last decade. Thank you again for many wonderful collaborations.

Joy

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