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The Year in Review and Trends for 2022

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I am grateful for serving as the editor of The Elder Law Report, Including Special Needs Planning, for the past four years, and very excited to pass the baton to two very capable and talented new editors, Letha Sgritta McDowell (*https://hooklawcenter.com/firm/letha-sgritta-mcdowell/*) and Shannon Laymon-Pecoraro (*https://hooklawcenter.com/firm/shannon-laymon-pecoraro/*), both of Hook Law Center!

Here is a look back at some significant developments over the past year and the opportunities for advocacy and client service these changes present.

Media coverage of Britney Spears' California conservatorship has been inescapable. The Princess of Pop has become the international face of a movement away from restrictive, protective arrangements like guardianships and conservatorships, and in the direction of supportive decision making arrangements. With the Commission on Aging of the American Bar Association and the National Conference on Supportive Decision Making, and now Brit, these issues have garnered increased attention. The traction this movement has gained is evident in recent state law changes, for instance, the passage of Virginia HB 2330, in March of 2021. Under the new Virginia law, the state's Department of Behavioral Health and Developmental Services is required to integrate supportive-decision making within the framework of its client services. The Department is charged with developing and implementing a program to educate individuals with intellectual and developmental disabilities, their families and others, regarding the availability of supportive-decision making agreements, how they can enter into a supported-decision making agreement, and to teach them about the rights and responsibilities of the parties to a supportive decision-making agreement. The Department is also charged with making available a model supported decision making agreement and related training opportunities. It is heartening to see a trend in favor of self-actualization of disabled individuals, however, there will continue to be situations (such as in cases of financial fraud and abuse) where only a full blown guardianship will protect the alleged incapacitated person and/or his or her estate.

The trend away from protective arrangements can also be seen in the courtroom. Restoration of capacity cases used to be rare, but this year, courts seemed more open to lifting or relaxing protective arrangements. Cases included *In the matter of William Charles Hamm,* 487 Mass. 394 (2021)(noting that in a 2014 Florida judicial proceeding, the guardianship was terminated by the agreement of the parties; *In the Guardianship of Tyler Murray, an Incapacitated Person,* No. 13-19-00646-CV (Tx. Ct. App., 13th Dist. Corpus Christi, Edinburg, August 19, 2021)(trial court had discretion to appoint guardian ad litem, who investigated abuse allegations and ultimately

recommended termination of the guardianship and partial restoration of capacity); cf. *In re E.M.G., an alleged incapacitated person*, No. 47 EDA of 2021, (Pa. Super. August 16, 2021)(denying pro se petition to terminate guardianship where alleged incapacitated person exercised limited judgment in keeping her living quarters clean, had rotten food in her refrigerator, declined mental health services, and had untreated periodontal disease). These decisions suggest that where the client seeks to end or modify a guardianship which is already in place and probably should not be, the tools in the elder or disability law attorney's arsenal include a petition to revoke or modify the guardianship, calling Adult Protective Services, and seeking the appointment of a guardian ad litem.

We have also embarked on an era of increased need for advocacy for disability rights and inclusivity for seniors. Sadly, it is common for seniors to struggle to find affordable housing and reasonable accommodations, and senior members of the disability communities are particularly hard hit. S*outhwest Fair Housing Council v. WG Chandler Villas SH LLC,* S No. CVI-19-00178-TUC-RM (D.Ariz. March 22, 2021) drew attention to the need for reasonable accommodations for deaf residents of private pay senior living communities. In that case, the federal district court denied summary judgment to the defendant/assisted living provider on the plaintiff's claim for discrimination on the basis of disability in violation of the Americans With Disabilities Act, 42 U.S.C 12181. The court found that by failing to provide a flashing doorbell to a prospective deaf resident of the assisted living facility, the facility denied the prospective resident effective communication, full and equal enjoyment, and a meaningful opportunity to participate in and benefit from defendant's residential and health services.

Likewise, in *Sierra v. City of Hallendale Beach, Florida*, 996 F.3d 1110 (11th Cir., 2021), a federal circuit court vacated and remanded a complaint brought by a deaf plaintiff under the Americans with Disabilities Act (ADA) and § 504 of the Rehabilitation Act to challenged videos on the city's website which did not have close captioning.

There are also increasing opportunities for advocacy and legal representation to foster diversity and inclusion. With the labor shortage, a great deal of attention has been given recently to diversity and inclusion initiatives in the area of law firm employee recruitment, while the urgent need for housing security for aging lesbian, gay, bisexual and transgender (LGBT)–seniors seems to receive less media and Internet attention. Serving this community can be a great opportunity to build a life care planning practice and a disability rights practice, as many face impermissible discrimination, particularly with respect to housing. Presently, only a minority of states have LGBT-friendly housing. The senior LGBT-friendly housing crisis only going to get worse, with the projection that there will be an estimated 7 million LGBT elders in the United States by 2030. Why not take up this worthwhile cause? SAGE, a national advocacy and services organization that has builds welcoming communities and provides support and advocacy to aging LGBT seniors, is a great place to start.

The COVID-19 pandemic is a game changer. From the proliferation of remote work arrangements, online Medicaid applications, the isolation and loss of many of our elderly clients, the many COVID-19 "long-haulers" facing anxiety, depression and disability, and an increase in psychiatric-related guardianship work, the fallout continues. No doubt this will also include litigating to overturn aggressive Medicaid denials and determinations cutting service hours for chronically ill individuals requiring 24/7 care in order to "save money for the taxpayers." Litigation, advocacy, and legislation offer the potential to reform "bad" de facto state Medicaid policies and unpopular Medicaid eligibility decisions. If you are facing this, it is very important to do whatever it takes to convince the Medicaid office that you will fight this, and that good Medicaid law (for you and your clients) can emerge from litigating cases with strong facts. Good things can come from such situations. A recent example of this came out of New York state, when the New York Supreme Court annulled a 21-month Medical Assistance penalty period

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Studies Find Racial Disparities in Nursing Home Admissions and Care

Two National Institute of Health funded studies examined the extent and impact of racial disparity in the rate of African Americans admissions to higher quality skilled nursing facilities, and their clinical interactions and care outcomes in skilled settings.

An abstract of a recent National Institute of Health-funded study concluded that there were unexplained racial disparities in the admission of residents with Alzheimer's disease and related dementia. Di Yan, Sujiu Wang, Helena Temkin-Greener, Shubing Cai, ***Admissions to High Quality Nursing Homes from Community: Racial Differences and Medicaid Policy Effects***, Health Services Research, Vol. 52:52, pp. 16 (September 15, 2021)(available online at: **https://doi.org/10.1111/1475-6773.13740**). The study analyzed the nursing home admissions records for high-quality nursing homes of newly admitted Medicare-enrolled residents from the community diagnosed with Alzheimer's disease or dementia. The cohort was comprised of individuals newly admitted to higher quality nursing homes who had no other nursing home admissions or hospitalizations within the prior thirty days. The authors sought to determine whether there were racial differences and whether any racial differences uncovered might be influenced by dementia-related state Medicaid add-on policies. The admissions records of more than 800,000 individuals admitted to over 15,000 higher rated skilled nursing facilities (as measured by the 5 point tool) between 2011 and 2017 were reviewed. The cohort was 89% Caucasian and 11% African American. The authors noted that approximately 50% of the Caucasian new admissions with Alzheimer's disease and related dementias were admitted to "higher quality" nursing homes as defined by the Nursing Home Compare tool, versus only approximately 35% of African American residents. Those African Americans who were admitted to a higher-rated nursing homes were more likely to be diagnosed with advanced cognitive impairment at the time of admission and were less likely to have exhibited aggressive behavior. African American admittees to the higher quality nursing homes were likely to reside in economically disadvantaged areas and to be Medicare-Medicaid dual eligibles. Concluding that African Americans with Alzheimer's disease and dementias were less likely to be admitted to higher quality skilled nursing facilities than whites, the authors concluded that individual differences in socio-economic status could not fully explain the racial disparity in nursing home admissions. Although not noted in the abstract, one implication of the study is that there may be opportunities for elder law and life care planning law firms to provide valuable advocacy and higher quality nursing home placement and quarterly care management services to the relatively underserved minority community, as well as in the home.

Another study published on November 12, 2021, sought to determine whether there were racial disparities in care interactions and clinical outcomes in African Americans versus white nursing home residents with dementia. The cohort in this secondary data study was comprised of 553 residents of 55 nursing homes. Twenty-four (24) per cent of the residents were African American; the remaining residents were white. The study authors concluded that there were differences favoring African American residents in agitation, quality of life, inclusion of person-centered care approaches in care plans and fewer falls and hospitalizations. Differences in quality-of-care interactions favored the Caucasian residents. The authors concluded that there were no differences in depression, resistance to care, function, pain or transfers to the emergency department. Resnick, Barbara PhD, CRNP; Van Haitsma, Kimberly PhD; Kolanowski, Ann PhD; Galik, Elizabeth PhD, CRNP; Boltz, Marie PhD; Ellis, Jeanette MA; Behrens, Liza PhD; Eshraghi, Karen MSW, ***Racial Disparities in Care Interactions and Clinical Outcomes in Black Versus White Nursing home Residents with Dementia,*** Journal of Nursing Care Quality, Vol. 10: pp. 1097 (November 12, 2021).

on gifts made exclusively for another purpose before the petitioner's diagnosis with Parkinson's disease. *Matter of Underwood v. Zucker,* 2021 N.Y. Slip Op. 00951 (S.Ct. App.Div.,4th Dept., February 11, 2021). The petitioner submitted medical records showing that she was in good health prior to the Parkinson's diagnosis in 2016. She provided evidence of financial assistance to her daughter beginning before the five year Medicaid lookback period,

New Jersey's 1115 Innovative Comprehensive Demonstration Waiver Proposal

With New Jersey's current 1115 Comprehensive Demonstration Waiver scheduled to expire on June 30, 2022, the state released its innovative draft proposal for the waiver renewal. The waiver renewal application evinces a shift toward better integration of behavioral and physical health care for all Medicaid beneficiaries in a Medicaid managed care organization. My home state's proposal includes the addition of new nursing home diversion services, such as an increase in caregiver respite services from 30 days to 90 days per year, the addition of caregiver counseling services, and a pilot program to expedite Medicaid eligibility determinations for individuals served by the Office of the Public Guardian who require long-term care.

Major changes targeting the disability community include a proposed parental income disregard in determining Medicaid eligibility for children diagnosed with serious emotional disturbances who meet additional clinical and income eligibility criteria, and the availability of full Medicaid state plan services as supplement to existing health care coverage, regardless of whether the child is residing in an institutional or a community based setting.

The renewal draft also incorporates several important behavioral health initiatives, including Medicaid reimbursement of short-term "diversion beds" to avoid unnecessary long-term psychiatric hospitalizations and adjunct therapies for children under age 21 with autism spectrum disorders.

The 1115 comprehensive demonstration waiver renewal proposal reflects a recognition that there cannot be optimal health care without housing security. If the renewal proposal is approved, the comprehensive demonstration waiver as renewed will encompass the delivery of health related housing services through the Medicaid managed care delivery system, using a managed care organization housing specialist, contracted community based-organizations or other vendors. The panoply of health-related housing services will then include housing transition services (i.e., housing screening, individualized support plans, housing search and application supports or assistance finding resources to cover housing expenses) and tenancy sustaining services (i.e., education and counseling on landlord tenant matters, assistance with landlord or neighbor dispute resolution, lease renewals, budgeting and bill paying). The draft waiver proposal is available online at *https://www.state.nj.us/humanservices/dmahs/home/1115_NJFamilyCare_Comprehensive_Demonstration_Draft_Proposal.pdf*.

and also assisted her son with the payments on a commercial loan in 2014 financing his purchase of a yogurt business. The appeals court removed the penalty on an unpaid portion of a commercial loan to finance the son's purchase of the yogurt business.

Another strong Medicaid case emanated from the Minnesota Court of Appeals this past summer, when an irrevocable trust from which funds had been withdrawn to pay for the petitioner's care was held unavailable under the "any circumstances" test. In *In re Geyen v. Commissioner of Minnesota Department of Human Services,* No. A20-1300 (Minn. Ct. App. July 14, 2021), the Minnesota appeals court affirmed the district court's ruling that federal law preempted a Minnesota statute providing that certain irrevocable trusts must be regarded as revocable in determining Medicaid eligibility. In that case, the petitioner in 2011 created two irrevocable trusts naming her children as Trustees and her children and grandchildren as the beneficiaries. The Trustees were authorized to exercise "full control" over the Trust property but were not permitted to loan the Trust funds or to make gifts from the Trust to the petitioner.

In 2019, she applied for elderly waiver services through Medicaid. She was determined in excess of the resource limit due to the funds in the Trusts. The Carver County Health and Human Services, relying on a state statute, determined that the Trust principal was available to the petitioner. On appeal, a human services judge concluded that the Trust assets were available to the petitioner under federal law, 42 U.S.C. 1396p(d)(3)(B), rather than under the Minnesota statute. The petitioner's request for reconsideration was denied. The petitioner then appealed the Commissioner's decision to the Minnesota district court.

Holistic, Non-Medical End-of-Life Options: Death Doulas and Dignity Therapy

Death doulas can provide non-medical, holistic, compassionate, and non-judgment end-of-life care and support to individuals facing a terminal diagnosis and their family members. Death doulas help terminally ill individuals and their families create a plan to maximize the dying individual's comfort and dignity during their last days and can fill in the gaps left by medical, palliative, or hospice care providers. The role of a death doula can be as individual as each person assisted in the terminal transition process. Experienced, well-trained, and certified death doulas can be particularly helpful to grief-stricken families confronted with the death of a child or an individual suffering from end-stage dementia. They can be a calming presence during a vigil, can facilitate the end-of-life conversation, and can help ease the anxiety and suffering of the end-of-life with holistic strategies including massage, visualizations, guided imagery, and music. To locate a death doula, consider the National End-of-Life Doula Alliance (NEDA), which offers an online listing of its members and a NEDA Proficiency Assessment.

Dignity therapy is typically provided in the home by a palliative care professional. It is a brief, individualized psychological intervention designed to reduce distress in individuals with a terminal diagnoses and their family members by increasing their senses of meaning and purpose. In dignity therapy, patients provide a narrative of the most important moments of their life and work with a therapist to create a life legacy chronicle and/or important messages for loved ones to read. For the dying, dignity therapy can facilitate self-expression, connection with loved ones, purposefulness, increased hopefulness, and can diminish depression and suicidal ideation. Cuevas PE, Davidson P, Mejilla J, Rodney T., ***Dignity Therapy for End-of-Life Care Patients: A Literature Review***. J Patient Exp. 2021 Feb 25;8:2374373521996951. doi: 10.1177/2374373521996951. PMID: 34179373; PMCID: PMC8205385.

The petitioner fell behind in her payments to her long-term care facility, which issued an involuntary discharge notice. In response, the petitioner's daughter and trustee withdrew funds from the Trusts (notwithstanding the lack of authority to do so in the Trust documents) to pay for her mother's care. The petitioner passed away. The district judge rejected the Commissioner's contention that the matter was mooted by the petitioner's death. The district judge concluded that under federal law, the Trust assets were unavailable to the petitioner and rejected the Commissioner's decision as unsupported by the record and erroneous at law.

On appeal by the Commissioner, the Minnesota appeals court concludes that the court had jurisdiction over the appeal because the petitioner was alive when she filed her appeal of the commissioner's decision in the district court and there is no deadline for party substitution under the applicable Minnesota court rules. The appeal did not become moot on the petitioner's death; the parties briefed the legal issues and the controversy remained justifiable after the petitioner's death.

The appeals court also concluded that the Commissioner's determination that petitioner was ineligible for Medicaid was legally erroneous under federal law, which preempted the Minnesota statute. Because the Trust agreements specifically prohibit the Trustees from making gifts or loans from the Trust funds to the petitioner, the commissioner erred as a matter of law in concluding that the Trust funds were available to the petitioner under the "any circumstances" test. Because the Trust document prohibited the payment of funds to the petitioner, the payment of the Trust funds to the petitioner does not support the conclusion that the Trust funds were an available resource to her in determining her eligibility for Medicaid. The Minnesota statute is preempted by federal law due to its direct conflict with Congress' intended treatment of irrevocable trusts as unavailable in determining Medicaid eligibility.

Another important new case which was the product of Medicaid and special needs advocacy and litigation was *Pfoser v. Harpstead*, 953 N.W.2d 507 (2021). Therein, the Supreme Court of Minnesota affirmed the decision of the Minnesota court of appeals, upholding the district court's reversal of the Medical Assistance penalty period imposed by the Commissioner of the Minnesota Department of Human Services for the transfer of partial house sale proceeds into a

pooled special-needs trust by a disabled Medicaid recipient who was over the age of sixty-five (65). The state supreme court concluded that Pfoser demonstrated his equitable interest in his pooled special-needs Trust was approximately equal to the value of the partial house sale proceeds he transferred to a Trust sub-account. Therefore, the substantial evidence did not support the Commissioner's decision to uphold the Medicaid penalty period.

Over the past year, I have also noticed a cluster of decisions in which litigants seek to limit Medicaid estate recovery. *Cabrera v. State of Florida, Agency for Health Care Administration,* No. 1D18-755 (Fla. Dist. Ct. App., 1st Dist., March 26, 2021) upheld a Medicaid lien in the sum of $51,838.61 computed under Florida's statutory formula. The full amount expended by the state on medical costs on the plaintiff's decedent was $86,491. The plaintiff's decedent was severely injured and died the day after being injured as a passenger in a motor vehicle which had no airbags and was involved in an accident. A wrongful death action against the drivers and the companies involved in rebuilding and selling the car without the passenger side airbags was settled for the sum of $140,000, the total of all the motor vehicle policies' limits. The appellate challenged the state's computation of the statutory lien amount ($51,838.61) and contended that the lien should be reduced to the sum of $4,039.17 under A*rkansas Department of Health and Human Services v. Ahlborn*, [547 U.S. 268 (2006)]. The agency disagreed, contending that the opportunity to rebut the medical expense allocation under the Florida statute under *Alhborn* was unavailable where the Medicaid recipient was deceased. The administrative law judge dismissed the petition, concluding that petitioner could not reduce the Medicaid lien amount because his daughter was deceased when the settlement for third-party benefits was reached; therefore, the federal anti-lien provisions do not preempt the Florida Medicaid lien statute. In affirming the lower court, the Florida appeals court concludes that neither the federal anti-recovery provision nor the forced assignment provision allows the appellant to dispute the amount designated as recovered medical damages under the Florida Statute sec. 409.910(17)(b). The anti-recovery provision does not apply to limit the state's recoupment of medical costs from liable third parties. Rather, the state Medicaid agency's claim must vest during the lifetime of the Medicaid beneficiary in order for the federal anti-lien protections to apply under the Florida Medicaid statute.

In the matter of *Matter of McMillan-Hoyte, 2021 NY Slip Op 21090 (Surrogate's Court, Albany County, No. 2014-711/A, April 7, 2021),* the entire medical malpractice settlement was excluded from Medicaid estate recovery as allocable to the wrongful death claim. In that case, the petitioner's decedent died from a pulmonary embolism during surgery while unconscious and never regained consciousness. Upon his death, the petitioner left a wife and 5 minor children. Letters of limited administration issued to the widow. A settlement was negotiated and the supreme court issued an order approving the settlement amount and providing that the entire settlement was allocable to the wrongful death damages of the decedent's heirs, rather than to the estate's claims, which would have been subject to Medicaid estate recovery. The allocation was based on the court's finding that the pulmonary embolism occurred while the decedent was unconscious during surgery and that the decedent never regained consciousness. Letters of administration of the decedent's estate were issued to the widow, who petitioned for distribution of the settlement proceeds, which were already allocated 100% to the wrongful death claim. The Albany County Department of Social Services objected to the petition, and sought to re-allocate the funds to the estate, so as to offset the funds against its claim for the $72,129.60 Medicaid lien. Petitioner/wife moved for summary judgment dismissing the objections of the DSS.

The Surrogate's Court noted that the New York supreme court order of adequacy regarding the settlement attributed 100% of the settlement proceeds to the wrongful death claim. The record also support the allocation made. The court reasoned that any change to the prior allocation would have to be brought on motion to the supreme court, which the DSS failed to do. The court rejects DSS's contentions that the supreme court lacks jurisdiction to determine the wrongful death allocation and that the supreme court failed to consider important facts.

In *Executive Office of Health and Human Services v. Trocki*, No. 20-P-458 (Mass. Ct. App., August 5, 2021), Stephen Pekala was enrolled in a senior care organization run by a community health plan. At age 77, he enrolled in a Medicare advantage HMO, and was notified that he could receive additional help with his co-pays and deductibles by joining a senior care organization and he received a letter about the program. In response to the letter, his daughter contacted the Medicaid coordinator, who explained that Mr. Pekala would have to join MassHealth to enroll in the assistance program. The daughter helped her father complete the forms and the daughter made modifications to the language on the forms, crossing out the language that indicated that MassHealth could put a lien on any properly held by Mr. Pekala at the time of his death and the acknowledgement of rights and responsibilities. Mr. Pekala was determined eligible for and enrolled

in MassHealth and received the supplemental assistance. He was never notified that monthly capitated payments of $3,000 were being made for him, that such payments were subject to Medicaid estate recovery, or that the modifications made to his MassHealth enrollment forms were unacceptable. By the time of his death, nearly $180,000 in capitated payments had been made on his behalf. He died at the age of 82 and the state filed a notice of claim in his probate estate, seeking to be repaid on its estate recovery claim from his limited assets through a forced sale of the house. The daughter opposed the claim. The trial judge granted summary judgment for the state Medicaid office and the daughter appealed. On appeal, the award of summary judgment was reversed. Massachusetts appeals court ruled that the state Medicaid agency failed to comply with the requirement, in the state Medicaid Manual, HCFA Transmittal 75, § 3810.A.6 (Jan. 11, 2001), to provide the required separate notice in advance of enrollment in the MassHealth Medicaid program, that capitation payments would be subject to estate recovery upon the enrollment of the decedent in the MassHealth Medicaid program. Having failed to provide the required notice, the state's claim was barred and the award of summary judgment for the state was reversed.

These are just a few of the important trends I have noticed over the past year, and each presents its own opportunities for advocacy and service to your existing client base. Wishing you each a successful end of year and a happy, healthy 2022, and if you happen to be in the Cherry Hill, New Jersey area, please don't hesitate to connect!

KEEPING CURRENT

Civil Commitment Order Vacated Due to Conflict of Interest

In the Matter of the Civil Commitment of S.W., No. A-1044-20 (N.J App. Div., August 17, 2021). The New Jersey Appellate Division vacates a civil commitment order and remands for further proceedings.

A temporary order of civil commitment was entered against S.W., who allegedly presented a danger to herself. The judge ordered the Public Defender's office to represent S.W. and named the managing attorney in the public defender's office as S.W.'s counsel, but left the name of the specific attorney from the Public Defender's office who would represent S.W. in the hearing blank in the order.

At the civil commitment hearing, two attorneys sought to enter an appearance for S.W.: one from the public defender's office and a private attorney retained by S.W.'s sister. The trial judge did not allow the public defender to represent S.W. The private attorney entered his appearance both for the sister, who claimed to be S.W.'s guardian, and S.W. The sisters had opposing goals for the hearing; P.W. (the alleged guardian) wanted the civil commitment to continue; S.W. did not. During the hearing, S.W. stated that she did not have a guardian and she did not want to be committed.

The Appellate Division concludes that although S.W. may have had some serious mental health issues, she was able to clearly articulate her opposition to her commitment and that her sister was not her guardian. She had a right to be heard. The trial judge was required to make findings with respect to both the guardianship appointment and the scope of the guardian's authority. Counsel made no effort to oppose continued civil commitment, did not pose a single question to the state's expert on cross-examination and did not develop why any less restrictive placement option was not viable. He remained silent as S.W. struggled to speak with the court at the end of the hearing, allowing her exchange with the court to devolve into a series of interruptions and a shouting match with her sister. He failed to make a closing statement during the court not to commit S.W. to a psychiatric facility.

For the full text of this decision, go to: http://business.cch.com/elr/a1044-20_1121.pdf.

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home in the community. The annuity must name the state as the first remainder beneficiary to the extent of any Medicaid lien, must provide for equal monthly payments and no balloon payments and must be for a term which is consistent (i.e., less than) Jon's actuarial life expectancy.

PRACTICE TIPS

Strategies to Maximize Liquidity for the Community Spouse

Most community spouses want to know how much money they can keep and whether they can afford to remain in the home. Fortunately, there are strategies available to maximize the income and resources which can be retained by the healthy spouse.

If the couple's countable resources are far less than the amount set as the maximum community spouse reserve allowance, and the husband and wife are otherwise financially eligible, one option may be to take out a home equity line of credit for the purpose of maximizing the amount of funds the healthy spouse can keep. The timing is important. The home equity line of credit proceeds must be deposited into the name of the healthy spouse before the snapshot is computed by the Medicaid office. In order for this strategy to be effective, the institutionalized spouse must never have had a prior Medicaid application filed or a prior snapshot computed, because there can only ever be one Medicaid snapshot. Here is an example of how this strategy works.

> ***Example 1***. Jon Snow and Ygritte Snow are married and living in my home state of New Jersey. They are over the age of 65. Ygriette needs Medicaid supports and services in the home. Jon and Ygriette have the sum of $80,000 in non-qualified, countable assets in their name, plus the home, which is exempt. Neither Jon nor Ygriette are United States military veterans. If Ygritte is clinically eligible for Medicaid, the couple's snapshot will be computed at $80,000, meaning that Bernadette cannot keep even one penny more than the sum of $2,000 and Jon may only keep the sum of $40,000, without planning.
>
> Ygriette's interest in the home should be transferred to Jon and then Jon, if he is otherwise financially qualified according to the bank's criteria, can apply for a home equity line of credit in his name. If he is unable to qualify on his own assets and income, Jon may need an adult child with good credit to co-sign the loan application with him. If Jon takes out a home equity line of credit, and draws the sum of $80,000 from the home equity before filing a Medicaid application for Ygritte, the couple's snapshot is increased to $160,000, meaning that now Jon may keep the sum of $80,000 (comprised of the couple's original countable resources) and Ygriette's $78,000 spend down (computed at one-half the snapshot amount of $160,000, less the sum of $2,000 for Ygriette's Medicaid disregard) can be satisfied by paying off $78,000 in cash from the home equity line of credit proceeds to cancel $78,000 of the new debt on the home equity line of credit.

A home equity line of credit is generally preferable to a reverse mortgage or a private "reverse mortgage" financed by a wealthier adult child or other relative. While there are increased consumer protections for reverse mortgages, if both Jon and Ygriette should move out of the home permanently, the home will need to be sold in order to pay the reverse mortgage.

Another option for Jon and Ygritte is the Medicaid friendly annuity.

> ***Example 2***. The facts are the same as in example 1, above, except that Jon does not take out any home equity loan. Instead, Ygriette transfers all of her interest in the couple's assets except for the sum of $2,000 into Jon's name. Jon can spend down Ygriette's excess funds above the $2,000 disregard applicable in her home state of New Jersey by purchasing a Deficit Reduction Act friendly annuity in his name. Jon can keep the annuity payments after Ygriette qualifies financially for Medicaid. This can provide Jon with additional funds to remain at

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