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Reflecting on Scope of Guardianship Petitions and Appointments

Nancy Levitin and Moriah Adamo

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Nancy Levitin

Moriah Adamo

Health care providers who are not being paid for the services they are rendering to their incapacitated patients are among the most frequent users of the guardianship statute.[1] In these cases, the Alleged Incapacitated Person (AIP) who is the subject of the guardianship proceeding has no way of paying the petitioning provider for the care that he or she is receiving.

Institutionalized residents who are the subject of guardianships filed by the nursing homes in which they reside often have no treatment decision to be made, no assets to be managed, and no dependents to protect. Frequently, the sole need for guardianship is that the resident who is the subject of the proceeding has an unpaid nursing home bill that is putting him or her at risk of discharge from the facility.

Non-payment is one of the permissible bases for an involuntary nursing home discharge. Under regulations promulgated by the Department of Health, a resident shall not be transferred or discharged unless "(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid for) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid."[2]

Mentally compromised nursing home residents, at risk of not receiving necessary in-patient care due to non-payment, are appropriate candidates for guardianship. The Mental Hygiene Law empowers judges to appoint a guardian for a person upon a finding that "the appointment is necessary to provide for the…health care, or safety and/or to manage the property and financial affairs of that person."[3]

Despite the statutory support for a nursing home petitioner asking a court to appoint a guardian to secure a payment source for an at-risk incapacitated resident's nursing home care, guardianship judges seem to look askance at these Article 81 petitions. Anecdotally, guardianship judges have been known to express concern that they are being used as a collection vehicle for the nursing home.

As counsel for skilled nursing facilities, we regularly encounter judicial discomfort with appointing guardians for the limited purpose of getting an incapacitated resident's nursing home bill paid. Judges disinclined to appoint guardians just to get nursing homes paid want to ensure that the residents whose fate they are deciding also have an appropriate fiduciary in place to handle personal care decisions, and any other issues that may arise.

There is only one reason why nursing home petitioners get concerned when a guardianship judge makes an expansive appointment that anticipates a resident's potential future needs, rather than a limited appointment that addresses the resident's single known present need (i.e., being able to pay for necessary medical care to ensure continued receipt of that care). Nursing homes care about the scope of guardianship appointments, especially with low-asset residents, because nursing homes often end up indirectly paying guardians to serve on behalf of their residents.

For nursing home residents with savings below the Medicaid resource allowance,[4] the only source of money available to cover a guardian's compensation is the resident's income. Nursing home residents on Medicaid owe their income to the facility to defray the cost of their care.[5] Therefore, each month that an incapacitated resident's income is used to pay a guardian instead of the nursing home is a month the facility does not receive full payment on that resident's account.

This article addresses the relationship between the skilled nursing facilities that care for large numbers of incapacitated people, and the guardianship statute that protects the interests of those vulnerable individuals. Particular attention will be paid to the nursing home's motivation in filing for guardianship, and the facility's obligation to cover guardianship-related fees and expenses.

Types of Guardians

Guardians with limited short-term powers cost less than guardians with long-term far-reaching powers. Support for circumscribed guardianship appointments, which are often sought by nursing home petitioners, can be found in the Mental Hygiene Law.

The range of powers that can be delegated to court-appointed guardians fall into two general categories. Property management guardians can make an array of financial decisions,[6] while personal needs guardians can make personal care decisions, including decisions that "consent to or refuse generally accepted routine or major medical or dental treatment…"[7]

A guardian who must remain in place for an indefinite period of time to address any personal needs that may arise will be entitled to more ample compensation than a property management guardian who is appointed for a limited period of time and given carefully prescribed responsibilities.

By law, the powers delegated to any court-appointed guardian must be tailored to meet the particular personal and property management needs of the person who has been adjudicated to be incapacitated (i.e., the Incapacitated Person or IP).[8] First, the judge must make a finding of capacity. Second, the judge must identify the specific powers that need to be delegated to the guardian to compensate for the IP's precise deficits.

For purposes of appointing a personal needs guardian, judges must find (1) "that the appointment is necessary to provide for the personal needs of that person, including food, clothing, shelter, health care, or safety..."[9] and (2) that there is no dispositional alternative less restrictive than a guardianship appointment to assist the IP in providing for his or her personal needs.[10]

Every individual who is the subject of a guardianship proceeding does not have a personal care decision that needs to be made. Furthermore, when an incapacitated individual has a personal care decision of a medical nature to be made, the appointment of a personal needs guardian may not be the least restrictive alternative.

New York State provides two legal vehicles for surrogate health care decision-making. There is the Family Health Care Decisions Act (FHDA)[11] and the Health Care Agents and Proxies (HCP)[12] law. Both statutes authorize someone to make a health-care decision for a patient who is incapable of making that decision for him or herself.

The FHDA sets forth a list of surrogates legally authorized to make medical decisions for others.[13] The so-called Health Care Proxy law affords every competent adult the legal right to appoint a health care agent to make any and all health care decisions on the principal's behalf that the principal could make.[14]

Interesting issues swirl around the interplay among Article 81 of the Mental Hygiene Law, under which judges can appoint personal needs guardians to make health care choices, and the HCP and FHDA statutes that also provide methods for substitute medical decision-making.

Does a finding of incapacity by a guardianship judge always support the appointment of a personal needs guardian? Should the answer to this question hinge on whether the subject of the proceeding has a proxy under the HCP law? What if the subject of the proceeding only has a surrogate under the FHDA? And what if the only personal care issue looming on the horizon is a medial treatment decision?

The relationship between the Mental Hygiene Law and the HCP and FHDA is of special interest to nursing home petitioners who frequently end up indirectly paying personal needs guardians to serve on their residents' behalf.

Contrasting Situations

Nursing home petitioners certainly recognize that some incapacitated residents who have no way of paying for their care also have unmet personal care needs. These residents may need a personal needs guardian to facilitate a discharge or make a treatment decision. Where such appointments are warranted, and there are no funds with which to pay the appointee, the petitioning provider may need to cover the additional guardian compensation.

The appropriateness of appointing a personal needs guardian upon a mere finding of incapacity is not, however, self-evident. After there has been a judicial finding of incapacity, when is there a "need" sufficient to warrant the appointment of a personal needs guardian?

One can easily envision a "need" to appoint a personal needs guardian after a finding of incapacity when the patient does not have a health care proxy or an available surrogate. Providers can make some health care decisions for incapacitated patients in this situation, but the prospect of an unpaid provider making treatment decisions for a non-paying incapacitated patient is unsettling at best. The appointment of a personal needs guardian provides such patients with critical protection.

Similarly, a personal needs guardian might have to be appointed when the medical decision at issue, such as an end-of-life treatment decision, requires judicial review. A judge ruling on whether a life-sustaining treatment should be provided or withheld might well need to designate a personal needs guardian to implement that treatment decision.

Finally, the appointment of a personal needs guardian may be warranted when a personal care decision other than a health care decision covered by the FHDA or the HCP law has to be made, and the person impacted by the decision is incapacitated and unable to make the decision for him or herself.

Contrast the preceding instances of a demonstrated "need" for a personal needs guardian with the situation of a nursing home resident who has a surrogate under the FHDA, and no end-of-life or non-medical personal care decision to be made. Should a personal needs guardian still be appointed because guardians get priority decision-making status under the FHDA?

For surrogate decision-making purposes, the FHDA affords priority status to "A guardian *authorized to decide about health care* pursuant to article eighty-one of the mental hygiene law"[15] (emphasis added). A personal

needs guardian is, in other words, the first choice surrogate decision-maker for an adult patient who lacks decision-making capacity under the FHDA.

The Legislature's requirement that a guardian must be authorized "to decide about health care" to get priority under the FHDA illuminates the relationship that was likely envisioned between the Public Health Law and the Mental Hygiene Law. By specifically requiring the surrogate to be a guardian "authorized to decide about health care" the Legislature must have contemplated situations where a guardian is appointed after a finding of incapacity, but without health care decision-making powers.

In such cases, the FHDA confers medical decision-making authority on a lower priority non-guardian surrogate. Accordingly, even after a finding of incapacity, the appointment of a personal needs guardian should not be necessary where the incapacitated person has a non-guardian surrogate available to serve.

Conclusion

Where the only immediate need of the low-asset incapacitated nursing home resident is to remain at the facility, the law appears to support the appointment of a property management guardian with limited powers to secure Medicaid and/or redirect a pension. A personal needs guardian should not also be appointed, at the nursing home's expense, without evidence that a personal care decision must be made and no one is legally authorized to make it.

Paying a property management guardian to exercise limited powers to secure a payment source for an incapacitated resident's nursing home care may be an expense that rightfully falls on petitioning providers; however, paying a "just in case" guardian to stand by, ready to serve in the future should an additional need arise, is not an expense that can be fairly foisted upon the nursing home industry as a cost of doing business.

Nancy Levitin *is a partner at Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara & Einiger and a contributing author of 'Elder Law and Guardianship in New York' (Copyright 2005-2012, Thompson Reuters/West).* **Moriah Adamo** *is an elder law attorney and an associate at the firm.*

Endnotes:

1. The so-called guardianship statute is Article 81 of the Mental Hygiene Law.
2. 10 N.Y.C.R.R. §415.3(h).
3. Mental Hygiene Law, §81.02 (a) (1).
4. As of Jan. 1, 2012 the Medicaid resources allowance is $14,250.
5. 18 N.Y.C.R.R. §360-4.9.
6. Mental Hygiene Law, §81.21.
7. Mental Hygiene Law, §81.22 (a) (8).
8. Mental Hygiene Law, §81.01.
9. Mental Hygiene Law, §81.02 (a) (1).
10. Mental Hygiene Law, §81.16.
11. Public Health Law, Article 29-CC.
12. Public Health Law, Article 29-C.
13. Public Health Law, §2994-d.
14. Public Health Law, §2981 and §2982.
15. Public Health Law, §2994-d (a).