# Guardianship Proceedings in Massachusetts Probate Courts for Health Care Facilities: The Not-so-Uniform Probate Code

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## Introduction

On January 15, 2009, Massachusetts joined 18 other states in adopting the Uniform Probate Code ("UPC").[1] Article V of the UPC went into effect on July 1, 2009, making sweeping substantive and procedural changes to guardianship law, aiming to grant greater protections to the civil rights of incapacitated persons.[2] Further changes to the UPC were adopted in April of 2012, mostly relative to intestate succession and estate administration.

In theory, Article V of the UPC was designed to streamline procedural requirements for appointing surrogate decision makers while protecting the civil rights of the incapacitated by crafting decrees and orders specifically tailored to address particular areas of incompetency. In practice, however, so far the UPC has led to a significant increase in petitions, motions and return appearances being filed by health care facilities for incompetent patients at a time of diminished Probate Court system resources. Under the UPC, health care facilities are more frequently securing the appointment of guardians and seeking specific and modified court orders for admission to skilled nursing facilities, treatment plans for patients unable to give informed consent, non-routine medical decisions and end-of-life decisions. They are doing so for a broader scope of medical conditions and transfer situations, and finding that Probate Court judges, in applying the UPC, are often limiting the authority of guardians to give consent for treatments unless further court review and approval are secured.

The UPC instructs Probate Court judges not to confer more authority over a person than is necessary.[3] The balance between an incapacitated patient's civil rights and the altruistic discretion of hospitals and other treating facilities has been fundamentally altered by the UPC as Probate Court judges are now clearly required to make orders only to the extent necessitated by the protected person's limitations and other conditions.[4]

Furthermore, the variability of the Massachusetts Probate Courts in applying the UPC often adds delay and unnecessary cost for health care institutions and consequently their ability to efficiently and effectively treat the very individuals that the UPC was intended to protect. For example, the cost-effective health care system is designed to move patients out of an acute care setting as quickly as possible when sub-acute level care is more appropriate and a bed placement has opened up for the patient. In order to authorize the transfer of an incompetent patient, who has no involved family members and never appointed a health care agent before becoming incompetent, Massachusetts acute care hospitals are often forced to keep such a patient in the acute care setting pending the appointment of a guardian or the modification of the existing guardianship to authorize transfer to a skilled nursing facility, which is specifically required under the new law.[5] This new aspect of the law results in extended stays in acute settings for extra weeks or months, exposing patients to greater risk of infection and relapse, often without access to needed rehabilitation and long term care services. This occurs while the hospital counsel or family attorney navigates the various courts' processes, subject to the courts' overburdened schedules and lack of personnel.

Additionally, health care institutions pursuing guardianships will often encounter the challenge of being in the middle of a dispute with or among the incapacitated individual's family members about whether a guardian is needed, who will serve as guardian, and decisions as to treatment or treatment discontinuation. More often than not, a facility facing adversarial family members especially needs to petition for guardianship to secure a court order approving the recommended treatment plan. The facility is forced to bear the financial burden of pursuing a guardianship that is significantly delayed by the objecting family members.

Venue limitations under the UPC and inconsistent guardianship proceedings among Massachusetts Probate Courts also challenge health care facility petitioners who must obtain guardians and court orders for treatment and transfers for the growing number of incapacitated

patients lacking duly appointed surrogate decision makers and/or any involved family members. Clearly, the demographic trends of people in the U.S. living longer are impacting the number of patients in Massachusetts who need a legal surrogate to make health care decisions. The current backlog of cases pending in the underfunded and overburdened Probate Courts across the Commonwealth further delays guardianship proceedings and can lead to great variation of process among the Probate Courts.

## General Overview Of Guardianship Law and Procedure Under The UPC

A. Understanding Guardianship Substantive Requirements:

Under the UPC, a guardian may be granted an array of general powers that effectuate the guardian's ability to act as a medical decision maker on behalf of an incapacitated person. The guardian's powers fall into three general categories, and each category necessitates distinct procedural and substantive requirements under the Code. Generally, the first category is known to practitioners as "ordinary medical decision making," the second is "placement authority," and the third is commonly referred to as "extraordinary medical decision making" or "substituted judgment" proceedings, which necessitate the appointment of a public defender paid by the Committee for Public Counsel Services who is specifically trained to advocate for the patient in these types of cases.

With regard to the first category, a guardian appointed without any additional authority is generally authorized to make decisions about routine, non-invasive medical procedures. Once appointed by the court, such a guardian may have the authority to "make decisions regarding the incapacitated person's support, care, education, health and welfare . . . and the guardian shall act in the incapacitated person's best interest and exercise reasonable care, diligence, and prudence."[6] Such "ordinary decision making" authority generally gives consent to treatment and arranging appropriate medical inpatient or outpatient care that does not involve any antipsychotic medications. A guardian need not seek explicit orders for each "ordinary care" decision, so long as the guardian is appointed by the court and is acting in the incapacitated individual's best interest. Also, guardians are the duly appointed legal surrogates who have authority over the use and disclosure of the health information[7] for the "person in need of services."[8]

The second category, placement authority, requires an explicit court order allowing the guardian to consent to placement in a skilled nursing facility or other health care facility.[9] The court, rather than the guardian, after a hearing on the matter, will apply the "best interest" standard in determining whether such authority, and thereby placement, is appropriate. This authority is required for admission of any person under guardianship to any facility licensed as a skilled nursing facility, whether for long term care or any short term rehabilitation, even if only for several days. The requirement also applies regardless of who the guardian is, including those who are spouses, children or other family members as opposed to professional or institutional guardians. Issues also arise regarding persons from out of state and whether the foreign decrees authorize admissions to skilled nursing facilities in the Commonwealth.

Finally, a guardian can only make "extraordinary medical decisions" upon an explicit court order authorizing the specific treatment in question. Extraordinary medical procedures generally fall into two categories: (1) administration of antipsychotic medication, known as "*Rogers* authority;"[10] and, (2) all other invasive treatments. For both types of extraordinary medical procedures, probate courts apply the "substituted judgment" standard, whereby the Court weighs various factors in order to determine the decision that the incapacitated individual would have made if competent.[11] The drafters of the UPC did not specify an exhaustive list of such extraordinary authorities, accounting for and leaving flexibility to adapt to evolving medical techniques and standards.[12] The UPC has, however, codified the following common examples of extraordinary treatment: "[t]reatment with antipsychotic medication, sterilization, abortion, electroconvulsive therapy, psychosurgery and removal of artificial maintenance of nutrition or hydration."[13] The UPC is not clear as to whether a guardian may consent to a "Do Not Resuscitate", "Do Not Intubate" or "Do Not Hospitalize" order without specific court authority. Prior to the adoption of the UPC, Massachusetts courts suggested that a substituted judgment finding is required for the guardian to enter a DNR/DNI order.[14] An exception to this requirement may exist when the patient is in acute medical distress, the guardian/family/physician all agree that there is no choice to be made, and avoiding resuscitation or lifesaving measures will not hasten death.[15]

### *B. Understanding Guardianship Procedural Requirements*

Any person "interested in the welfare of the incapacitated" may petition for a determination of incapacity and/or the appointment of a guardian over the incapacitated person (hereinafter "Respondent").[16] The

UPC contains venue rules that require the petitioner to file in the Probate Court of the county where the Respondent resides at the time the proceeding is commenced.[17] Pre-UPC guardianship procedure was more lenient in permitting Massachusetts health care facilities to file petitions of permanent appointment and motions for temporary appointment in the Probate Court located in the County where the facility was located.

Upon receiving a petition for guardianship, the Probate Court issues a citation, which is to be served in hand upon the Respondent as well as the heirs at law at least two weeks prior to the return date listed on the citation.[18] Where there are no heirs at law or the interested parties do not receive notice, a publication must occur in the County where the proceeding is pending at least seven days prior to the return date. G.L. c. 190B §1-401(3). The "return date" is, in effect, a deadline by which interested persons to the case may file an objection. This date is usually about 4-6 weeks from the date of filing of the petition with the Court. A permanent guardianship cannot be completed until this date passes and proof of service upon all interested parties and/or publication is filed with the Court.

While the permanent petition is pending, a petitioner may file a verified motion for the appointment of a temporary guardian if "an incapacitated person has no guardian, and the court finds that waiting during the longer time frame to secure a permanent appointment under UPC procedures will likely result in immediate and substantial harm to the health, safety or welfare of the person alleged to be incapacitated occurring prior to the return date, and no other person appears to have authority to act in the circumstances."[19] A temporary guardian appointment is effective for 90 days, at which time it will be reviewed and new medical documentation will be required.[20] On a temporary motion, the Petitioner must give seven days in-hand notice to the Respondent and the same by mail to any heirs at law.[21] If the Court finds that an immediate emergency exists requiring the appointment of a guardian, it may waive or shorten the notice requirements, provided that the Respondent is notified of the proceeding as directed by the Court, and the Respondent and heirs at law receive notice after the proceeding instructing them that they may vacate the order.[22, 23]

If a petitioner requests ordinary authority or skilled nursing home authority, the court must determine whether such placement is in the best interest of the Respondent.[24] The Court may appoint counsel to represent the interests of the incapacitated person, or a guardian ad litem (GAL) to investigate and provide a report to the Court.[25] If a petitioner seeks extraordinary authority or authority to consent to administration of antipsychotic medication ("*Rogers* authority"), the courts will always appoint counsel for the Respondent.

## Variability of Guardianship Proceedings Among Massachusetts Probate Courts

After a new guardianship petition and motion for temporary guardian is filed it can take two weeks to several months to have the first hearing date depending on which Probate Court the guardianship petition is filed. This length of time, particularly for petitions filed by acute care hospitals, is extremely problematic, costly, and can pose imminent harm to Respondents. The lack of sufficient funding for the Massachusetts Probate Courts has caused cuts to staff and most recently, a limitation on the hours that the Courts are open to consider petitions and motions.[26] This contraction of service is happening at the same time that the UPC is requiring the Probate Courts to adapt to entirely new rules and process on estate administration while still handling the normal work load. The increasing amount of incapacitated patients is also resulting in significantly more demands on the Probate Courts with more guardianship case filings.

### *A. Venue Requirements*

The UPC provides that a guardianship petition shall be filed where the Respondent resided prior to hospitalization.[27] This venue requirement seems warranted if the patient has family or friends residing in the same County who are involved with the patient's care and can provide information about the patient's preferences prior to his incapacity. However, a growing number of patients are homeless or have resided alone without any known heirs or acquaintances prior to hospitalization. Requiring health care facility petitioners to file in a Court that may be a long distance from the facility, causes undue delay, burdens the facility, the guardian, the court appointed counsel, and testifying physicians. Further, an incapacitated individual has the right to attend any hearing, and in *Rogers* cases, must attend a hearing absent extraordinary circumstances.[28] As written, the UPC does not acknowledge exceptions to the venue rule where the patient has no ties to his previous residence.

For example, a Boston tertiary care hospital that must seek a guardianship appointment to secure an order to approve a discharge plan to a sub-acute facility for a patient found homeless in Barnstable County is expected to file the matter in Barn-

stable County Probate Court. Previously, such a case could have been filed in Suffolk County Probate Court, nearer to the patient, the physicians, and attorneys who may be involved with the case. To require a patient, who likely already has limitations and requires hospital transport, to travel long distances makes no sense and adds unnecessary cost to the health care system.

There is great variation among the Probate Courts on the strict adherence to this venue rule. As applied, courts vary as to permitting filing in the venue where the health care facility is located. More troubling, it seems that a Probate Court's financial constraints and perceptions about other Counties' practices drive judicial decisions to reject filings. Anecdotally, it has been reported among regular guardianship petitioner counsels that some judges have stated that because another County will not accept cases involving their residents, they will not waive the venue rule for a petitioning local health care facility and accept a case involving an incapacitated person whose last known residence is from the other County.

There clearly needs to be greater discretion granted to Judges to have legal authority to waive venue requirements and allow filings in the County where the petitioning facility is located if circumstances warrant, for patient and family convenience and/or to realize economy in the use of resources of an already overburdened health care system.

### *B. Docketing the Petition*

Once a petitioner overcomes the venue obstacle, the petitioner must file the paperwork, have it docketed, and obtain a hearing date for the temporary guardianship motion. Like most guardianship procedural hurdles, the method for docketing a file and obtaining a hearing significantly varies with each Probate Court and presents further delays and expense. One common trend is that few of the Probate Courts will now process a file and assign it a docket number and hearing date on the day of filing. In the best case scenario, new matters are docketed within a few days and hearing dates are generally being scheduled ten days from filing. Guardianship cases, even those including motions for temporary appointments, will languish in some Probate Courts. If not pushed as life-or death emergencies, these cases will be placed in a pile of back-logged cases and not processed for several weeks, nor heard for several months.

In other cases, the court will not assign a case a court date. Instead, the petitioner must determine which Judge will hear the matter and when that Judge is available, and then attempt to contact the Probate Court to obtain a court date. A date obtained in this manner is often times weeks out, at best.

### *C. Appointment of Counsel*

Even if a petitioner is successful in docketing within a few days of filing, most of the Probate Courts will not mark-up a hearing date until approximately seven to ten days from filing, which is consistent with proper notice under Mass. G.L. c. 190B §1-401(3). Although judges hold weekly motion days, clerks in many of the busiest Probate Courts are unable or unwilling to schedule new cases less than a few weeks after the docketing of the case, if at all.

When an expeditious hearing date can be obtained, inconsistencies among the Probate Courts in counsel appointment can further delay the process and lead to vast differences in the time it takes to secure the requisite legal authority to implement a discharge and/or treatment plan. Patients needing rehabilitation or long term care services and treatment can remain unnecessarily in acute care settings.

As previously mentioned, all Probate Court judges will appoint *Rogers* counsel or counsel for the Respondent when consent to treat with antipsychotics or extraordinary authority is sought. Counsel must be notified of their appointment, accept the court appointment and have the opportunity to visit with the Respondent prior to the hearing on a proposed treatment plan. There is a limited list of Committee for Public Counsel Services ("CPCS") attorneys who can accept *Rogers* appointments. Again, due to the courts' backlog, counsels are often not appointed until days or even weeks after the filing of the petition. Often the appointed counsel for the patient does not receive notice of appointment in time for a hearing, cannot visit the patient in time, or cannot accept the appointment at all. In such instances, the initial hearing date on a motion for a temporary guardian and immediate approval of a treatment plan is continued.

Additionally complicating matters are the inconsistencies among judges in appointing counsels and GALs in non-*Rogers* cases. Where a guardian is needed to authorize the transfer out of an acute care hospital to a home care or non-acute facility setting, currently there are huge and unpredictable variances in the process among the Probate Courts and even the judges within each County. Because the UPC calls for judicial discretion for counsel appointment, some judges routinely choose to appoint counsel, or even a GAL, while others do not. Without knowing judicial preference beforehand,

clerks may fail to appoint counsel, and the petitioners may prepare for a hearing date only to receive an order requiring a counsel appointment on the day of the hearing.

### *D. Shortage of Guardians*

In guardianship cases involving patients who have no living or involved family members and never appointed a health care agent while competent, petitioning health care facilities need to identify and secure the services of some suitable person to serve as guardian. Overburdened Probate Court clerks and judges are unlikely to find a willing attorney or social worker to serve as a guardian in patient care cases filed by hospitals and nursing homes. The involvement of the Courts in helping secure guardians varies greatly from County to County. By separating the guardianship function over health care decisions from the conservator functions over financial affairs into two separate legal proceedings, the UPC makes it difficult to find willing volunteers to serve as guardians in cases involving incompetent patients with no involved family or friends who are willing to serve as guardian. For hospitals and other facilities that regularly seek guardianship appointments it has become a constant challenge to secure the services of guardians for incompetent patients. The shrinking pool of guardians is in part attributable to the increasingly complex annual reporting required under the UPC, coupled with the convoluted manner in which professional guardians are compensated for indigent patients. Under the current scheme, a professional guardian can only seek payment for serving a MassHealth patient by seeking approval from the Court to order MassHealth to adjust the amount of the patient's contribution for her care from external income sources (social security or pension).[29] This adjustment must be authorized by the Court on an annual basis, and it is a mechanism that precious few attorneys will tolerate to serve as guardians. This is a situation that will get worse and warrants a systematic fix.

### *E. Process to Affirm Health Care Agents*

As currently written, the UPC provides that a properly designated health care agent's authority under M.G.L. c. 201D takes priority over the authority of a guardian, and cannot be revoked absent court order.[30] Further, the comments to M. G.L. c. 190B §5308, state that the language of the revised UPC "should aid in preventing the mere institution of a guardianship proceeding from upsetting an arrangement for care under a health care proxy." Accordingly, it is clear that the drafters of the UPC intended to prioritize designated health care agents and respect an individual's right to prepare an advance directive.

Under M. G.L. c. 201D §5, a health care agent has broader decision making authority than a court appointed guardian. "The agent has authority to make any and all health care decisions on the principal's behalf that the principal could make, including decisions about life-sustaining treatment, subject, however, to any express limitations in the health care proxy."[31] An agent's powers are not limited to non-antipsychotic treatment plans or consenting to non-extraordinary authority, as are the guardians. Further, an agent may admit an incapacitated individual to a locked psychiatric facility,[32] whereas the under G.L. c. 190B §5-309, a guardian explicitly lacks such authority.

Despite the UPC's clear intent to uphold the broad authority of health care agents without the need for court intervention, M. G.L. c. 201D §7 makes it easier for the patient who executed a proxy when competent to render it unreliable for the health care provider by refusing treatment or to undergo a procedure authorized by the agent. M. G.L. c. 201D §7 states that "[a] principal may revoke a health care proxy by notifying the agent or a health care provider orally or in writing *or by any other act evidencing a specific intent to revoke the proxy.*"[33] In such circumstances, this section of the Massachusetts Health Care Proxy Law requires a physician who is informed of or provided with a revocation of a health care proxy to immediately record the revocation in the principal's medical record and to notify orally, and in writing, the agent and any health care providers known by the physician to be involved in the principal's care of the revocation.

Thus, hospitals encountering patients who refuse treatment over the authority of their agents often have no choice but to file a guardianship petition or seek a court order affirming the authority of the agent in order to secure the requisite legal authority over treatment decisions. The UPC does not provide for any process to resolve such cases. The Health Care Proxy Law does provide a process through which a petitioner, including a hospital or health care facility, may "commence a special proceeding in a court of competent jurisdiction, with respect to any dispute arising under [M. G.L. c. 201D]."[34] This language suggests that a petitioner may seek to affirm the powers of the agent, but neither M. G.L. c. 201D nor the UPC provide any further guidance on when affirmation of a proxy is appropriate or any procedural guidelines regarding affirming an agent's continuing authority under a proxy despite a pa-

tient's refusal to voluntarily submit to treatment.

Some hospitals have been successful in petitioning Probate Court judges to affirm an agent's authority on the basis of the Probate Court's general authority. Other hospitals have adopted the practice of seeking a guardianship appointment of the agent in such cases. Currently, there is a lack of uniformity on how to most expeditiously secure the minimum necessary judicial interventional while protecting the patient's rights. Arguably the patient's rights would be best served by honoring the prior broad agency appointment. But if there is evidence of unfitness of the agent or a question of sufficient competency by the patient to have the informed capacity to refuse the treatment, then some level of an evidentiary hearing may be required in many of these cases to sufficiently adjudicate the matter.

### *F. Short Order on Notice*

One mechanism that can be attempted by health care facility petitioners, and should be more widely accepted by all Massachusetts Probate Court clerks and judges, is to file motions for short orders of notice due to an exigent medical situation and the necessity of expediting the proceedings. A short order of notice allows the moving party to be heard on its motion within a period of time shorter than the required 7 days notice. Further, it allows a motion to be heard on a day that may otherwise be blacked out by those who schedule motions for the Judge due to the number of already marked up matters. There is a great variance currently among the Probate Courts as to their willingness to permit short orders of notice. In all venues, Court staff and case managers alike are understandably resistant toward any cases filed on emergency status, as it burdens an already strained system. Emergency motions are now almost always met with scrutiny and some push back.

Moreover, each County differs on its procedure to expedite appointment of counsel for matters that may be marked up more quickly. Some judges permit petitioner's counsel to propose CPCS counsel who is available on short notice. Other Judges forbid proposing counsel in a motion and instruct that counsel is appointed "off the list" where too often counsel is not appointed in time for the scheduled hearing. In some Counties, depending on the nature of the circumstances, temporary guardianship appointment may be made without appointment of counsel, and subsequent appointment is made with a short review date in order to reassess the emergency order. A broader adoption of this approach among more Counties would be helpful.

### *G. Out-of-State Patients/Jurisdictional Questions*

Another major challenge many Massachusetts health care facilities face now under the UPC is with out-of-state incompetent patients. Facilities located near the border of neighboring states, as well as Massachusetts teaching hospitals and centers of excellence, regularly treat out-of-state patients and inevitably many of them are not competent to make informed health care decisions. Many Massachusetts hospitals and sub-acute facilities have service areas that include large portions of Rhode Island, Connecticut, New York, New Hampshire and Maine.

Many out-of-state incompetent patients present without having made out an advance directive recognized by their state of residence. This leaves a major question of jurisdiction and applicable law. Clearly, a Massachusetts hospital cannot treat and discharge such a patient on a non-emergency basis without seeking the appointment of a guardian and would need to do so by filing a petition in a Massachusetts Probate Court. Many Probate Courts, however, will not accept such petitions and instruct Massachusetts health facility counsels to seek an appointment in the state court of the patient's residence.

In other situations, a patient does have a surrogate in place from another state but additional questions come up as to that out-of-state surrogate's authority to consent to antipsychotic treatment and other invasive treatments being rendered in Massachusetts.

The American Bar Association has proposed adoption by the states of the Uniform Adult Guardianship and Protective Proceedings Jurisdiction Act ("UAGPPJA"). This Act would address jurisdictional issues such as transfer, out of state jurisdiction, and multi-jurisdictional guardianships.[35] Massachusetts could resolve many of these jurisdictional issues by joining the 30 other states that adopted the Act.

### *H. Consequences of the Variability in Procedure Among Probate Courts*

The increasing length of time under current UPC Probate Court practice before a temporary or permanent guardianship is heard is problematic and does not serve the interests of the incapacitated individuals that the UPC was drafted to protect. It is important to understand that most cases initiated by health care facilities are, by their very nature, urgent situations. For patients who do not have a surrogate decision-maker but

are medically stable and ready for discharge, the current Probate Court system is causing acute care hospitals longer than is medically advisable to discharge. These patients are often at greater risk of acquiring healthcare-associated infections, also referred to as nosocomial, hospital-acquired or hospital-onset infections. These patients also remain unable to obtain appropriate rehabilitation or post-acute care, facing the likelihood that his or her condition will deteriorate. Further, proper placements cannot be held indefinitely and are often lost by the time a temporary guardian appointment with the discharge approved by the Court can be secured. Patients who must wait one month for a guardianship order often will not be accepted by the originally available post-acute care facility or program as the bed or placement has been filled. Moreover, the patient in a locked- psychiatric facility awaiting a guardianship appointment and an order approving a treatment plan must remain in the most restrictive setting, suffering the symptoms of a psychiatric illness without the ability to commence an antipsychotic treatment plan.

## Conclusion

The variability of Massachusetts Probate Courts in applying UPC requirements is currently causing unnecessary financial costs to the Massachusetts health care system, inconvenience and uncertainty to litigants and their counsel, and most importantly, is not serving the interests of the incapacitated. Some of the current challenges stem from the financial shortfalls and lack of resources in the system. Many, however, could be easily rectified by UPC amendments and/or more consistent application of procedural steps by all of the Massachusetts Probate Courts in handling guardianship petitions and motions filed by health care facilities. A re-examination of the UPC as applied by the Probate Courts and the handling of all health care intervention matters is due and should be undertaken by the Chief Administrative Justice of the Massachusetts Probate Courts. Such a process could hopefully result in more efficient, fair standardized procedural rules to ensure that the UPC's intent to create uniformity of procedure and greater rights for the incapacitated is effectively carried out in practice.

(Endnotes)

1 Mass. G.L. c. 190B §§1-101 -1-507.

2 The UPC defines an "incapacitated person" as "an individual who for reasons other than advanced age or minority, has a clinically diagnosed condition that results in an inability to receive and evaluate information or make or communicate decisions to such an extent that the individual lacks the ability to meet essential requirements for physical health, safety, or self care, even with appropriate technological assistance." Mass. G.L. c. 190B 521 § 5-101(9).

3 Mass. G.L. c. 190B, § 5-306. Under the UPC guardians no longer have any authority over the funds or estate of a person, but rather no have authority only over the person's personal/health care decisions. Court appointed surrogate authority over the financial affairs of an incapacitated person is limited to a conservator, who must be appointed through a separate legal process from a guardianship under the UPC.

4 Mass. G.L. c. 190B, § 5-407 (a), (d).

5 Mass. G.L. c. 190B § 5-309 (g). "No guardian shall have the authority admit an incapacitated person to a nursing facility except upon a specific finding by the court that such admission is in the incapacitated person's best interest." According to the note for § 5-309(g), the requirement of specific authority for admission to a nursing facility is an important new protection for the elderly.

6 Mass. G.L. c. 190B §5-309 (A).

7 45 C.F.R. §164.502 (g)(1) and (2); Mass. G.L. C 111, §70; Mass. G.L. C 112, §12C

8 The UPC replaces the reference of "ward" to "person in need of services" for adult incapacitated individuals.

9 Mass. G.L. c. 190B § 5309 (g).

10 The Court in *Rogers et al v. Commissioner of the Department of Mental Health et al.*, 390 Mass. 489 (1983) held that specific court authority must be sought to administer antipsychotic medication, whereby the court applies a "substituted judgment" standard in order to determine whether an incapacitated individual would have refused treatment if he were not incapacitated.

11 *Brophy v. New England Sinai Hospital*, 398 Mass. 417, 427 (1986) (At least six factors are weighed in making substituted judgment: the individual's express preferences regarding treatment; the strength of the individual's convictions in relation to their refusal of treatment; the impact of the decision on the individual's family; the probability of adverse side effects; the prognosis with and without treatment; and any other relevant factors); Mass. G.L. c. 190B § 5306A.

12 The Massachusetts Comment to Mass. G.L. c. 190B §5-306A states that: "The types of treatment for which a substituted judgment procedure may be required are not listed as they may vary depending on the invasiveness of the particular proposed procedure or because of advancements which reduce side effects, etc., *see In Matter of Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980)."

13 Massachusetts Comment to Mass. G.L. c. 190B §5-303.

14 *See In re Saikewicz*, 373 Mass. 728 (1977).

15 *See In re Dinnerstein*, 6 Mass.App.Ct. 466; 380 N.E.2d 134 (1978).

16 Mass. G.L. c. 190B §5-303 (A).

17 Mass. G.L. c. 190B §5-105.

18 Mass. G.L. c. 190B §5-303, citing to G.L. c. 190B §1-401.

19 Mass. G.L. c. 190B § 5308 (A).

20 *Id.*

21 Mass. G.L. c. 190B § 5308 (c).

22 Mass. G.L. c. 190 § 5308 (d).

23 Often urgent and potentially life-threatening circumstances call for even more immediate court intervention which can be availed through the Emergency Judicial Response System.

24 Mass. G.L. c. 190B 521 § 5309 (g).

25 Mass. G.L. c. 190B 521 § 5106; Mass. G. L. c. 190B 521 § 5309 (d).

26 The current hours for Massachusetts Probate Courts are 8:30am – 3:30pm.

27 Mass. G.L. c. 190B §5-105.

28 Mass. G.L. c. 190B 521 §§ 5-106, 5-306A (d).

29 See 130 C.M.R. 520.026 (E)(3).

30 Mass. G.L. c. 190B §5-309 (e).

31 Mass. G.L. c. 201D §5

32 *Cohen v. Bolduc*, 435 Mass. 608, 609 (2002).

33 Mass. G.L. c. 201D §7 (emphasis added).

34 Mass. G.L. c. 201D § 17.

35 The National Guardianship Association describes UAGPPJA on their website, http://www.guardianship.org/uagppja.htm

**(Endnotes)**

1. All references in this article to ACA are derived from ACA's two statutes: the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). All references to Chapter 58 are derived from Chapter 58 of Acts of 2006. For ease of reading, we have not footnoted every instance when the law is referenced.

2. *See BCBSMA Foundation, Massachusetts Health Reform: A Five-Year Progress Report (Nov. 2011).*

3. *See, e.g.*, State Affordable Care Act Implementation Stakeholder Meetings at www.mass.gov/eohhs/provider/guidelines-resources/services-planning/national-health-care-reform-plan/stakeholder-meetings.

4. Implementation of many other features of ACA, including the development of Exchange rules vis-à-vis the Massachusetts Health Connector, tax changes, and insurance market rules, are well worth consideration. These five categories were chosen in light of their broad application to a wide variety of stakeholders and the public.

5. ACA provides a limited number of exceptions, for instance, on the basis of immigration status, religious beliefs, or membership in an Indian tribe.

6. Such legislative action will not be necessary if the United States Supreme Court strikes down the individual mandate in *Department of Health and Human Servs. v. Florida,* Supreme Court Docket No. 11-398.

7. *Compare* ACA with Chapter 58 of the Acts of 2006. *See* Long, Health Insurance Coverage and Access to Care in Massachusetts: Detailed Tabulations Based on the 2009 Massachusetts Health Insurance Survey, Massachusetts Division of Health Care Finance and Policy, Nov. 2009. *See also* Seifert and Cohen, Reforming Reform, University of Massachusetts Medical School Center for Health Law and Economics at 12 (table 2) (June 21, 2010).

8. *See* ACA, at §1513 and §10106.

9. *See Id. See also* Chapter 302, sections 18 and 19 of the Acts of 2008 (establishing quarterly testing instead of annual).

10. *See id. See also* 114.5 CMR 16.00 et seq.

11. *See id. See also* 114.5 CMR 17.00 et seq.

12. *See id. See also* 114.5 CMR 17.00 et seq.

13. For instance, the Chapter 58 defines "full-time" as a 35-hour work week, whereas ACA uses a definition of a30-hour work week. See supra.

14. ACA, § 2707 (a).

15. Chapter 58 of the Acts of 2006 required individuals to purchase coverage that meets minimum requirements in order to avoid paying a tax penalty to the Massachusetts Department of Revenue pursuant to M.G.L. c. 111M, Section 2. The Connector Authority defined the requirements for MCC, see 956 C.M.R. 5.00

16. Subtitle D – Available Coverage Choices for All Americans, Part I, Establishment of Qualified Health Plans, Section 1302. Chapter 58 of the Acts of 2006. [specific statutory citation required]

17. Self-insured plans that are not subject to state insurance regulation pursuant to Section 514 of the Employee Retirement Income and Security Act (ERISA) are exempt.

18. ACA, § 1302 (a) (1-3).

19. ACA, § 1302 (b).

20. Limitations on annual cost sharing are capped at Section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 (Currently $6,050 for an individual and $12,100 for a family). Section 1302(c)(1)(A). Annual limits on deductibles are capped at $2,000 for an individual and $4,000 for a family. Section 1302(c)(2)(A). ACA contains provisions for indexing of annual limits.

21. CMS, Center for Consumer Information and Insurance Oversight, "Essential Health Benefits Bulletin," Dec. 16, 2011, at 2.

22. Cost sharing requirements are defined in a separate bulletin, *Actuarial Value and Cost-Sharing Reductions* (Feb. 24, 2012).

23. Should a state not select a benchmark plan, the default benchmark plan for the state will be the small group plan with the largest enrollment in the state.

24. DOI: http://www.mass.gov/ocabr/consumer/insurance/health-insurance/consumer-guides/mandatory-benefits-guide.html

25. ACA, § 1311(d)(3)(B).

26. *See* DOI presentation on results of survey of potential benchmark plans presented to ACA Stakeholder Working Group. March 12, 2012. Examples of differences between the small group plans include routine eye care exams, dental services, physical and occupational therapy coverage, and speech generating devices. Differences between the small group coverage and the state employees' Group Insurance Commission (GIC) include: skilled nursing and rehabilitation therapy, private duty nursing, assisted reproductive technology, early intervention, hearing aids, chiropractic therapy, and physical and occupational therapy. Most differences relate to number of visit limits.

27. *See id.* Massachusetts's mandates on Autism Coverage and Infertility not part of FEHBP.

28. 956 CMR 5.00: Minimum Creditable Coverage

29. CMS, Center for Consumer Information and Insurance Oversight, "Essential Health Benefits Bulletin," Dec. 16, 2011, at 1.

30. Subtitle E – Affordable Coverage Choices for All Americans; Part I – Premium Tax Credits and Cost Sharing Reductions; Section 1401 – Refundable Tax Credit Providing Premium Assistance for Coverage Under a Qualified Health Plan. *Amends Subpart C of IV of Subchapter A of Chapter 1 of the Internal Revenue Code of 1986 by adding a new Section 36B.*

31. *See* Department of the Treasury, Proposed Rule on Health Insurance Premium Tax Credit. 26 CFR Part 1, 76 Fed. Reg. 50931 (Aug. 17, 2011). The monthly credit amount is equal to the lesser of either the premium for the month for one or more QHPs covering the individual or family, or the excess of the adjusted monthly premium for the "benchmark" plan offered through the exchange. *See* Proposed 26 CFR 1. 36B-1.

32. 76 Fed. Reg. 50933 (August 17. 2011).

33. Provided of course that the state does not implement a Basic Health Program, which provides coverage to individuals earning between 133% and 200% FPL.

34. ACA §1421- Small Business Tax Credit. Credit for Employee Health Insurance Expenses of Small Businesses. Amending Subpart D of Part IV of Subchapter A of Chapter 1 of the Internal Revenue Code of 1986 by adding a new Section 45R.

35. To be considered a qualifying arrangement, generally the employer must pay health insurance premiums for each employee enrolled in the employer-sponsored coverage, and that employer contribution must be at least 50% of the cost of the premium. See IRS Guidance – Section 45R- *Tax Credit for Employee Health Insurance Expenses of Small Employers*. Notice 2010-44.

36. Insurance Partnership Program; G.L. c. 118E§ 9C, 130 CMR 650.

37. *See* 130 CMR 650.022 for definition of "Qualified Employee".

38. ACA § 2001(a)(1)(C) (Title II – Role of Public Programs, Subtitle A – Improved Access to Medicaid).

39. ACA, § 2001(a)(2)(A) . For definition of "Benchmark" coverage see ACA § 1937(b)(1) or "benchmark equivalent" ACA § 1937(b)(2).

40. Legal Immigrants currently receive coverage through Commonwealth Care. This program is fully funded by the state with no federal matching dollars available.

41. MassHealth programs cover adults that do not have dependent children, earn up to 100% FPL, and have been unemployed for longer than 12 months. See MassHealth eligibility 130 C.M.R. 519. The Connector's Commonwealth Care program provides coverage for adults within this income cohort that do not meet MassHealth eligibility requirements. See Comm. Care eligibility rules 955 C.M.R. 3.00.

42. *See* Connector Board Presentation: "*National Health Care Reform Update: Subsidized Health Insurance."* April 12, 2012.

43. *See* Connector Board Presentation: "*National Health Care Reform Update: Subsidized Health Insurance."* April 12, 2012.

44. See id.

45. See http://www.mass.gov/eohhs/provider/guidelines-resources/services-planning/national-health-care-reform-plan/stakeholder-meetings/previous-quarterly-stakeholder-meetings.html.

46. See id.