2018 Elder Law Update

February 14, 2018
Suffolk Bar Association
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QUICK REFERENCE 2018

Individual Resource Limit	$15,150.00
Couple Resource Limit	$22,200.00
Income Limits - Individual (plus spend down program)	$862.00
Income Limits - Couple (plus spend down program)	$1,253.00
Community Spouse Income Allowance:	$3,090.00
Personal Needs Allowance - Chronic budgeting for Community Case	$391 [if only 1 on Medicaid, & income of both spouses is less than approx 3481, pooled trust not needed]
Minimum Community Spouse Resource Allowance	$74,820.00 if total resources are $149,640 or less (or ½ total countable resources up to $123,600)
2017 Transfer Penalty Divisor - Long Island	$13,053.00
2017 Transfer Penalty Divisor - Northern Metro	$12,428.00
2017 Transfer Penalty Divisor - New York City	$12,319.00
Home Equity Limit for 2018	$858,000.00
Basic Part B premium - indiv yearly income in 2016 controls what you pay in 2018	<=$85,000: $134 $85K - 107k: $187.50 $107-133k: $267.90 $133.5-$160: $348.30 $160k-214k: $348.30 > $160K: $428.60
Skilled NH co payment	$167.50 /day
Rx Benchmark1	$40.99
SSI payment	$750 individual; $1125 couple
Federal Estate Tax exclusion Tax Rate: **40% of excess** NYS 2014 NYS 2015 NYS 2016 NYS 2017 NYS 2018 cliff: 105%	$11.2 million $2,062,500 $3,125,000 $4, 187,500 $5,250,000 ($5,512,500)

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Federal Trust & Estate Income Tax: >$12,500: pay $3011.50 + 37% of excess		Gift tax excl: $15,000	
Married, filing Jt	& surv. Spouses		
Taxble Income	**Pay**	**+ % on Excess**	**of the amt more than:**
0 - $19,050	0	10%	0
19,050 - 77,400	1,905	12%	19,050
77,400 - 165,000	8,907	22%	77,400
165,000 - 315,000	28,179	24%	165,000
315,000 - 400,000	64,179	32%	315,000
400,000 - 600,000	91,379	35%	400,000
600,000 +	161,379	37%	600,000
Unmarried [other than head	of household &	surviving spouse]	
Taxble Income	**Pay**	**+ % on Excess**	**of the amt more than:**
0 - 9,525	0	10%	0
9525 - 38,700	952.50	12%	9,525
38,700 - 82,500	4453.50	22%	38,700
82,500 - 157,500	14,089.50	24%	82,500
157,500 - 200,000	32,089.50	32%	157,500
200,000 - 500,000	45,689.50	35%	200,000
500,000 +	150,689.50	37%	500,000

TO:	Local District Commissioners, Medicaid Directors
FROM:	Judith Arnold, Director Division of Eligibility and Marketplace Integration
SUBJECT:	2018 Medicaid Levels and Other Updates
EFFECTIVE DATE:	January 1, 2018
CONTACT PERSON:	Local District Support Unit Upstate (518) 474-8887 NYC (212) 417-4500

The purpose of this General Information System (GIS) message is to advise local departments of social services (LDSS) of the income levels and figures used to determine Medicaid eligibility, effective January 1, 2018.

Due to a 2.0 percent (%) cost of living adjustment (COLA) for Social Security Administration (SSA) payments effective January 1, 2018, figures used to determine Medicaid eligibility must be updated. With an increase in the Supplemental Security Income (SSI) benefits level, the Medically Needy income and resource levels will also be adjusted accordingly.

The standard monthly premium for Medicare Part B enrollees will be $134 for 2018, the same as in 2017. A statutory "hold harmless" provision applies each year to about 70 percent of Medicaid Part B enrollees. For enrollees protected by the "hold harmless" provision, any increase in Part B premiums in 2018 must be less than or equal to their increase in Social Security benefits. Due to the SSA 2% COLA, some beneficiaries who were held harmless against Part B premium increases in 2016 and 2017 will have a premium increase in 2018. An estimated 42 percent of all Part B enrollees are protected by the hold harmless provision in 2018, but will pay the full monthly premium of $134 because the increase in their Social Security benefits will be greater than or equal to the increase in their Part B premium. A percentage of Part B enrollees will be subject to the hold harmless provision in 2018 and will pay less than the full monthly premium of $134 because the increase in their Social Security benefits is not large enough to cover the full Part B premium increase.

Medicare Part B enrollees not subject to the "hold harmless" provision in 2018 include:

- beneficiaries who do not receive Social Security benefits;
- those who enroll in Part B for the first time;
- those who are directly billed for their Part B premium;
- those who are dually eligible for Medicaid and have their premium paid by Medicaid; and
- those who pay an income-related premium.

A chart with the 2018 Medicaid levels is attached. MBL will be programmed to use these figures when a "From" date of January 1, 2018, or greater is entered. Also attached is a chart with the updated reduction factors for calculating Medicaid eligibility under the Pickle Amendment.

Note: Budgets with a "From" date of January 1, 2018, or later, that utilize a Federal Poverty Level (FPL) must be calculated with the 2017 Social Security benefit amount and Medicare Part B premium amount until the 2018 FPLs are available on MBL. Upstate districts should separately identify these cases for re-budgeting once the 2018 FPLs are available as these cases will not be included in Phase Two of Mass Re-budgeting. In New York City, the 2018 Social Security benefit amounts and Part B premium should be used until Phase Two of Mass Re-budgeting. Upstate districts are instructed to update Social Security benefit amounts and Medicare Part B premium amounts for budgets that do utilize a FPL at the next contact with the consumer or at recertification, whichever occurs first.

The following figures are effective January 1, 2018.

1. Medically Needy Income and Resources Levels.

HOUSEHOLD SIZE	MEDICALLY NEEDY INCOME LEVEL		RESOURCES
	ANNUAL	MONTHLY	
ONE	10,100	842	15150
TWO	14,800	1,233	22,200
THREE	17,020	1,418	1,418
FOUR	19,240	1,603	1,603
FIVE	21,460	1,788	1,788
SIX	23,680	1,973	1,973
SEVEN	25,900	2,158	2,158
EIGHT	28,120	2,343	2,343
NINE	30,340	2,528	2,528
TEN	32,560	2,713	2,713
EACH ADD'L PERSON	2,220	185	185

2. The Supplemental Security Income federal benefit rate (FBR) for an individual living alone is $750/single and $1,125/couple.
3. The allocation amount is $391, the difference between the Medicaid income level for a household of two and one.

4. The 249e factors are .969 and .156.
5. The SSI resource levels remain $2,000 for individuals and $3,000 for couples.
6. The State Supplement is $87 for an individual and $104 for a couple living alone.
7. The Medicare Part A Hospital Insurance Base Premium is $232/month for people having 30-39 work quarters and $422/month for people who are not otherwise eligible for premium-free hospital insurance and have less than 30 quarters.
8. The standard Medicare Part B monthly premium for beneficiaries with income less than or equal to $85,000 is $134.
9. The Maximum Federal Community Spouse Resource Allowance is $123,600.
10. The Minimum State Community Spouse Resource Allowance is $74,820.
11. The community spouse Minimum Monthly Maintenance Needs Allowance (MMMNA) is $3,090.
12. Maximum Family Member Allowance remains $677 until the FPLs for 2018 are published in the Federal Register.
13. Family Member Allowance formula number remains $2,030 until the FPLs for 2018 are published in the Federal Register.
14. Personal Needs Allowance for certain waiver participants subject to spousal impoverishment budgeting is $391.
15. Substantial Gainful Activity (SGA) is: Non-Blind $1,180/month, Blind $1,970/month and Trial Work Period (TWP) $850/month.
16. SSI-related student earned income disregard limit of $1,820/monthly up to a maximum of $7,350/annually.
17. The home equity limit for Medicaid coverage of nursing facility services and community-based long-term care is $858,000.
18. The special income standard for housing expenses that is available to certain individuals who enroll in the Managed Long Term Care program (See 12 OHIP/ADM-5 for further information) vary by region. For 2018, the amounts are: Northeastern $467 (a decrease from 2017 figure); Central $417; Rochester $424; Western $365; Northern Metropolitan $935; Long Island $1,274; and New York City $1,305.

Please direct any questions to the Local District Support Unit at 518-474-8887 for Upstate and 212-417-4500 for NYC.

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NEW YORK STATE | Department of Health | Office of Health Insurance Programs

NEW YORK STATE INCOME AND RESOURCE STANDARDS FOR NON-MAGI POPULATION
EFFECTIVE JANUARY 1, 2018

HOUSE HOLD SIZE	MEDICAID INCOME LEVEL		100% FPL		120% FPL		133% FPL		135% FPL		150% FPL		185% FPL		200% FPL		250% FPL		RESOURCES	
	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY		
ONE	10,100	842	12,060	1,005	14,472	1,206	16,040	1,337	16,281	1,357	18,090	1,508	22,311	1,860	24,120	2,010	30,150	2,513	15,150	1
TWO	14,800	1,233	16,240	1,354	19,488	1,624	21,600	1,800	21,924	1,827	24,360	2,030	30,044	2,504	32,480	2,707	40,600	3,384	22,200	2
THREE	17,020	1,418	20,420	1,702			27,159	2,264			30,630	2,553	37,777	3,149	40,840	3,404				3
FOUR	19,240	1,603	24,600	2,050			32,718	2,727			36,900	3,075	45,510	3,793	49,200	4,100				4
FIVE	21,460	1,788	28,780	2,399			38,278	3,190			43,170	3,598	53,243	4,437	57,560	4,797				5
SIX	23,680	1,973	32,960	2,747			43,837	3,654			49,440	4,120	60,976	5,082	65,920	5,494				6
SEVEN	25,900	2,158	37,140	3,095			49,397	4,117			55,710	4,643	68,709	5,726	74,280	6,190				7
EIGHT	28,120	2,343	41,320	3,444			54,956	4,580			61,980	5,165	76,442	6,371	82,640	6,887				8
NINE	30,340	2,528	45,500	3,792			60,515	5,043			68,250	5,688	84,175	7,015	91,000	7,584				9
TEN	32,560	2,713	49,680	4,140			66,075	5,507			74,520	6,210	91,908	7,659	99,360	8,280				10
EACH ADD'L PERSON	2,220	185	4,180	349			5,560	464			6,270	523	7,733	645	8,360	697				+

SPOUSAL IMPOVERISHMENT	INCOME	RESOURCES
Community Spouse	$3,090.00	$123,600
Institutionalized Spouse	$50	$15,150
Family Member Allowance	$2,030 (150% of FPL for 2) is used in the FMA formula the maximum allowance is $677.	N/A

SPECIAL STANDARDS FOR HOUSING EXPENSES					
REGION	Amount	REGION	Amount	REGION	Amount
Central	$417	Northeastern	$467	Northern Metropolitan	$935
Rochester	$424	Long Island	$1,274		
Western	$365	New York City	$1,305		

*In determining the community resource allowance on and after January 1, 2018, the community spouse is permitted to retain resources in an amount equal to the greater of the following $74,820 or the amount of the spousal share up to $123,600. The spousal share is the amount equal to one-half of the total value of the countable resources of the couple as of the beginning of the most recent continuous period of institutionalization of the institutionalized spouse on or after September 30, 1989.

Revised November 1, 2017

NEW YORK STATE | Department of Health | Office of Health Insurance Programs

NON-MAGI POPULATION						
CATEGORY	INCOME COMPARED TO	HOUSEHOLD SIZE 1	HOUSEHOLD SIZE 2	RESOURCE LEVEL 1	RESOURCE LEVEL 2	SPECIAL NOTES
UNDER 21, ADC-RELATED	MEDICAID LEVEL	842	1,233	NO RESOURCE TEST		
SSI-RELATED	MEDICAID LEVEL	842	1,233	15,150	22,200	Household size is always one or two.
Qualified Medicare Beneficiary (QMB)	AT OR BELOW 100% FPL	1,005	1,354	NO RESOURCE TEST		Medicare Part A & B, coinsurance, deductible and premium will be paid if eligible.
COBRA CONTINUATION COVERAGE	100% FPL	1,005	1,354	4,000	6,000	A/R may be eligible for Medicaid to pay the COBRA premium.
AIDS INSURANCE	185% FPL	1,860	2,504	NO RESOURCE TEST		A/R must be ineligible for Medicaid, including COBRA continuation.
QUALIFIED DISABLED & WORKING INDIVIDUAL	200% FPL	2,010	2,707	4,000	6,000	Medicaid will pay Medicare Part A premium.
SPECIFIED LOW INCOME MEDICARE BENEFICIARIES (SLIMBS)	OVER 100% BUT BELOW 120% FPL	1,005	1,354	NO RESOURCE TEST		If the A/R is determined eligible, Medicaid will pay Medicare Part B premium.
		1,206	1,624			
QUALIFIED INDIVIDUALS (QI-1)	GREATER THAN OR EQUAL TO	1,206	1,624	NO RESOURCE TEST		If the A/R is determined eligible, Medicaid will pay Medicare Part B premium.
	120% BUT LESS THAN 135% FPL	1,357	1,827			
MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES (MBI-WPD)	250%	2,513	3,384	20,000	30,000	Countable retirement accounts are disregarded as resources effective 10/01/11.

Section 503 of Public Law 94-566, referred to as the Pickle Amendment, protects Medicaid eligibility for all recipients of Retirement Survivors and Disability Insurance (RSDI) who were previously eligible for SSI benefits concurrently. These recipients are individuals who would be eligible for SSI, if all RSDI Cost of Living Allowances (COLAs) received since they were last eligible for and receiving RSDI and SSI benefits concurrently, were deducted from their countable income. (See 85 ADM-35 for further information). The reduction factors in the chart below, "REDUCTION FACTORS FOR CALCULATING MEDICAID ELIGIBILITY UNDER THE PICKLE AMENDMENT", should be used when determining such individuals Medicaid eligibility under the provisions of the Pickle Amendment.

If SSI was terminated during this period:	Multiply 2018 Social Security income by:	If SS was terminated during this period:	Multiply 2018 Social Security income by:	If SSI was terminated during this period:	Multiply 2018 Social Security income by:
May – June 1977	0.240	Jan. 1990 – Dec. 1990	0.515	Jan. 2003 – Dec. 2003	0.736
July 1977 – June 1978	0.254	Jan. 1991 – Dec. 1991	0.542	Jan. 2004 – Dec. 2004	0.752
July 1978 – June 1979	0.270	Jan. 1992 – Dec. 1992	0.562	Jan. 2005 – Dec. 2005	0.772
July 1979 – June 1980	0.297	Jan. 1993 – Dec. 1993	0.579	Jan. 2006 – Dec. 2006	0.804
July 1980 – June 1981	0.339	Jan. 1994 – Dec. 1994	0.594	Jan. 2007 – Dec. 2007	0.830
July 1981 – June 1982	0.377	Jan. 1995 – Dec. 1995	0.611	Jan. 2008 – Dec. 2008	0.849
July 1982 – Dec. 1983	0.405	Jan. 1996 – Dec. 1996	0.627	Jan. 2009 – Dec. 2011	0.899
Jan. 1984 – Dec. 1984	0.420	Jan. 1997 – Dec. 1997	0.645	Jan. 2012 – Dec. 2012	0.931
Jan. 1985 – Dec. 1985	0.434	Jan. 1998 – Dec. 1998	0.659	Jan. 2013 – Dec. 2013	0.947
Jan. 1986 – Dec. 1986	0.448	Jan. 1999 – Dec. 1999	0.667	Jan. 2014 – Dec. 2014	0.961
Jan. 1987 – Dec. 1987	0.454	Jan. 2000 – Dec. 2000	0.684	Jan. 2015 – Dec. 2016	0.977
Jan. 1988 – Dec. 1988	0.473	Jan. 2001 – Dec. 2001	0.708	Jan. 2017 – Dec. 2017	0.980
Jan. 1989 – Dec. 1989	0.492	Jan. 2002 – Dec. 2002	0.726		

Note: This updates the Reduction Factors included in the Medicaid Reference Guide (MRG). The MRG table should no longer be used.

Revised December 27, 2017

New York State Department of Health: Library of Official Documents

https://www.health.ny.gov/health_care/medicaid/reference/index.htm

Regional Rates:

GIS 17 MA/019: Medicaid Regional Rates for Calculating Transfer Penalty Periods for 2018

Northeastern $10,719 (covers Albany, Clinton, Columbia, Essex, Delaware, Fulton, Greene, Hamilton, Montgomery, Otsego, Saratoga, Schenectady, Schoharie, Warren, Washington

Western $10,239 (covers Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming)

Rochester $11,692 (covers Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates

Central $9,722 (covers Broome, Cayuga, Chenango, Cortland, Herkimer, Madison, Jefferson, Lewis, Oneida, Onondaga, Oswego, Tioga, St. Lawrence, Tompkins)

New York City $12,319 (cover Bronx, Kings, New York, Richmond, Queens)

Long Island $13,053 (covers Nassau, Suffolk)

Northern Metropolitan $12,428 (covers Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester)

	2015	increase	2016	increase	2017	increase	2018
Northeast	$9,414	$392.00	$9,806.00	$436.00	$10,242.00	$477.00	$10,719.00
Western	$9,442	$188.00	$9,630.00	$448.00	$10,078.00	$161.00	$10,239.00
Rochester	$10,660	$485.00	$11,145.00	$92.00	$11,237.00	$455.00	$11,692.00
Central	$8,768	$484.00	$9,252.00	$259.00	$9,511.00	$211.00	$9,722.00
NYC	$11,843	$186.00	$12,029.00	$128.00	$12,157.00	$162.00	$12,319.00
Long Island	$12,390	$243.00	$12,633.00	$178.00	$12,811.00	$242.00	$13,053.00
Northern Metro	$11,445	$323.00	$11,768.00	$430.00	$12,198.00	$230.00	$12,428.00

2017 Life Expectancy Table

Age	Male Life Expectancy	Female Life Expectancy	Age	Male Life Expectancy	Female Life Expectancy
60	21.55	24.56	90	4.08	4.85
61	20.79	23.72	91	3.79	4.50
62	20.04	22.89	92	3.52	4.18
63	19.30	22.07	93	3.27	3.88
64	18.57	21.25	94	3.05	3.61
65	17.84	20.44	95	2.85	3.37
66	17.12	19.63	96	2.68	3.16
67	16.40	18.84	97	2.53	2.96
68	15.70	18.06	98	2.39	2.79
69	15.01	17.29	99	2.27	2.63
70	14.32	16.53	100	2.15	2.48
71	13.66	15.78	101	2.04	2.33
72	13.00	15.05	102	1.93	2.19
73	12.36	14.34	103	1.83	2.06
74	11.73	13.63	104	1.73	1.93
75	11.11	12.94	105	1.63	1.81
76	10.51	12.26	106	1.54	1.69
77	9.93	11.60	107	1.45	1.58
78	9.36	10.96	108	1.36	1.47
79	8.81	10.33	109	1.28	1.37
80	8.28	9.73	110	1.20	1.27
81	7.76	9.14	111	1.13	1.18
82	7.27	8.58	112	1.05	1.09
83	6.80	8.04	113	0.98	1.01
84	6.34	7.52	114	0.92	0.93
85	5.91	7.01	115	0.86	0.86
86	5.50	6.53	116	0.79	0.79
87	5.11	6.08	117	0.74	0.74
88	4.74	5.64	118	0.68	0.68
89	4.40	5.23	119	0.63	0.63

2017 Life Expectancy Table

Age	Male Life Expectancy	Female Life Expectancy	Age	Male Life Expectancy	Female Life Expectancy
0	76.33	81.11	30	47.86	52.06
1	75.81	80.54	31	46.93	51.10
2	74.84	79.57	32	46.00	50.13
3	73.86	78.59	33	45.07	49.17
4	72.88	77.60	34	44.15	48.21
5	71.89	76.61	35	43.22	47.25
6	70.90	75.62	36	42.29	46.29
7	69.91	74.63	37	41.37	45.34
8	68.92	73.64	38	40.44	44.39
9	67.93	72.64	39	39.52	43.44
10	66.94	71.65	40	38.60	42.49
11	65.94	70.66	41	37.68	41.55
12	64.95	69.66	42	36.76	40.61
13	63.96	68.67	43	35.85	39.67
14	62.97	67.68	44	34.95	38.74
15	61.99	66.69	45	34.04	37.81
16	61.02	65.70	46	33.15	36.88
17	60.05	64.72	47	32.26	35.96
18	59.08	63.73	48	31.38	35.05
19	58.13	62.75	49	30.51	34.14
20	57.18	61.77	50	29.64	33.24
21	56.24	60.80	51	28.79	32.34
22	55.30	59.82	52	27.94	31.45
23	54.37	58.85	53	27.11	30.57
24	53.44	57.87	54	26.29	29.70
25	52.51	56.90	55	25.47	28.83
26	51.58	55.93	56	24.67	27.96
27	50.65	54.96	57	23.87	27.10
28	49.72	53.99	58	23.09	26.25
29	48.79	53.03	59	22.32	25.40

Wage Parity 2017 Rates for CDPAS

Nassau, Suffolk and Westchester Counties

For the period of July 1, 2017 through December 30, 2017, the minimum rate for home care aide total compensation (Total Compensation) will be $13.22 per hour.

This consists of a cash portion (Base Wage) of at least $10.00 per hour and a benefit portion (Supplemental Wages) of up to $3.22 per hour.

Wages	Per hour
Base Wage	$10.00
Supplemental Wages	$ 3.22
Total Compensation	$13.22

Overtime	Per hour
FLSA (*1½ times regular rate*) (*if regular rate equals Base Wage*)	$15.00

Total Compensation may be satisfied entirely through wages, or through a combination of wages and supplemental wages, with the following limitations:

The Base Wage is the minimum amount of the Total Compensation that must be paid in cash wages directly to the home care aide as regular hourly wages for all hours worked.

Supplemental Wages are the amount of Total Compensation that employers may satisfy indirectly, for example, by providing education, pension benefits, or health insurance required by federal law. The Supplemental Compensation portion of Total Compensation can be satisfied by increasing the Base Wage rate by a corresponding amount.

Overtime is required at 1½ times the regular rate of compensation under the Fair Labor Standards Act (FLSA) as well as under the New York State Labor Law's provisions for minimum wage and for domestic workers. The exceptions to this general rule that applied to most employers of home care aides and to certain non-profits prior to 2015 no longer apply to third party employers, such as home care agencies, as a result of FLSA overtime Home Care Final Rules issued on October 31, 2013, amending 29 C.F.R. § 552 at 3, 6, 102 and 110. For more information visit www.dol.gov/whd/homecare.

Notice Regarding Overtime Pay under Wage Parity

This notice is provided to clarify the extent to which overtime pay can be used to satisfy the Total Compensation requirements of the Wage Parity Law. While overtime pay can be used to satisfy the Total Compensation requirement for a given hour of overtime, it cannot be used more generally to also satisfy the Total Compensation requirement for non-overtime hours. Thus, for example, if a home care aide's regular rate is $11 and they are paid $16.50 for an hour of overtime, payment of that $16.50 for that hour can be used to satisfy the Total Compensation rate for that hour. In that example, if the Total Compensation rate is $15.09, then the requirement to pay or provide $15.09 is fully satisfied by payment of $16.50, for that same hour of overtime. By contrast, however, no part of the $16.50 paid for a given hour of overtime can be used to satisfy the Total Compensation rate for all hours, generally, or for non-overtime hours, specifically.

To the extent that FAQ number 7 from May 2014 can be read to say that overtime paid during a given hour of overtime work cannot be used to satisfy the Total Compensation requirement for that hour, FAQ number 7 is superseded by this notice.

2018 Elder Law Update

Suffolk Academy of Law
February 14, 2018

Janna P. Visconti, Esq.
Jennifer S. Raguso, Esq.

1

Main Topics

1. **Proposed Legislation**
2. **Social Security**
3. **Medicare**
4. **Tax**
5. **Able Act**
6. **Medicaid (GIS & ADMS)**
7. **Fair Hearings & Case law**

2

Proposed Legislation

3

2018-9 NYS Executive Budget

Helpful Links:
https://www.nysenate.gov/newsroom/articles/get-facts-2018-nys-executive-budget-plan
https://www.budget.ny.gov/pubs/archive/fy19/exec/fy19book/BriefingBook.pdf

Health & Mental Hygiene proposals

- Pub Health Law (PHL) §2807 2-a: increase cap on PT from 20 to 40 / year
- PHL §2808: impose annual 2% Medicaid payment penalty on nursing homes w 1-star rating
- PHL §4403-f: Higher standards to qualify for MLTC: must score 9+ on UAS & req.≥ 120 consecutive days of community based services.
- PHL §4403-f: Bans Members from changing MLTC more than 1x per year.

4

2018-9 NYS Executive Budget

- PHL §4403-f: NH carve-out from MLTC after 7 months; fee for service will take over.
- Soc Serv Law §366(3)(a): Elimination of Spousal Refusal, and replace w spousal ref only for spouse of "institutionalized spouse" as in SSL §366-c and (a) assignment of support rule UNLESS (b) the community spouse is not or in incapable of signing or there is a hardship, or is not residing in A/R's household.
- Spousal refusal wd apply to community spouse for NH or MLTC or a spouse that is absent & lives separately.

5

2018-9 NYS Executive Budget

- Soc Serv Law §366-c Reduces CSRA to Federal Minimum: $24,180.
- Soc Serv Law §365-l: special needs MLTC to work with home health providers to achieve target enrollments

6

Proposed: NYS Power of Attorney law

- S06501A Senator Kemp Hannon - in committee
- A09033 Assembly Member Helene Weinstein - passed the Assembly in 2017
- Substantial conformity to the form instead of strict adherence
- Monetary damages v. 3rd parties that unreasonably refuse to honor

Link to Bill: **https://tinyurl.com/yc6tvlh3**

7

Proposed: Banking Law

- S6736 Senator David Valesky: authorizes banks temporarily to refuse or delay disbursement from the account of a vulnerable elderly person if certain criteria are met. Link: **https://tinyurl.com/y76xo9ho**

- Referred to Senate's Aging Committee 1/3/18
- A6099A - similar bill - referred to Assembly's Aging Committee 1/3/18

- A6395 Assembly Donna Lupardo - to develop guidelines for reporting financial abuse - passed Assembly, rejected by Senate.

8

SCPA - Surrogate's Ct Proc Act 17-A

Article 17-A - Law Revision Commission is reviewing issues of concern.

9/21/2016 Disability Rights NY filed suit in SDNY seeking to enjoing NYS from appointing guardianships pursuant Art. 17-A, on the basis of the 5th & 14th Amendments of US Constitution, Americans w Disabilities Act & Section 504 of the Rehabilitation Act of 1973.

Claims 17-A discriminates: permits termination of decision making rights, where to live, associates, medical treatment, marriage, procreation, voting, work. Case was dismissed because it would interfere w ongoing court proceedings and the state judicial system

9

SCPA - Surrogate's Ct Proc Act 1750-b

Health Care Decisions Act - governs decisions to withdraw or withhold life-sustaining treatment from persons with developmental disabilities.

Disparities between Health Care Decisions Act and the Family Health Care Decisions Act.

NYS Task Force on Life & the Law - studying how to address disparities.

10

Aid in Dying

Pending Legislation:

S3151 / A2383 establish procedure for competent individuals to receive medical assistance in ending life.
Currently both bills are in the respective Health Committees of the Senate and Assembly.

Link: https://www.nysenate.gov/legislation/bills/2017/S3151

Ct of Appeals: Myers v. Schneiderman, 29 NY 3d 987 (2017)
a physician who "assists a suicide" by prescribing lethal doses of drugs is subject to criminal prosecution for second degree manslaughter; no constitutional right to assisted suicide
Link: **https://tinyurl.com/y7fzrlq5**

11

Bed Holds for Medicaid Recipients

- Prior law: 14 days/yr Medicaid reimbursement for residents in NH at least 30 days & NH vacancy rate was <5%.
- Effective 4/1/2017: bed hold payments were repealed
- Many NH's warned residents they would have to pay privately for bed holds
- Many patients refused hospitalization
- 5/12/17: NYS DOH letter to NH: they must continue to reserve the same bed to Medicaid patientfor 14 days, regardless of the availability of reimbursement, but bed hold payments were reinstated by postponing changes in the law until regs are promulgated.
- S6559 to reinstate reimbursement to NH: passed both houses, and VETOED 12/18/17.

12

Social Security

13

Social Security Wages

Wages subject to Social Security taxation

2017: $127,200

2018: $128,400

Link:
https://www.ssa.gov/news/press/releases/2017/#11-2017-1

14

Social Security COLA

The Cost of Living Adjustment has increased SS Benefits by 2% for 2018.

Link:
https://www.ssa.gov/news/press/releases/2017/#10-2017-1

15

SS: Online Access

Social Security online access: You can create an account at www.socialsecurity.gov/myaccount.

Can get replacement SS Card on-line; apply for Medicare

Can check entire work history

Learn about the Representative Payee program: www.socialsecurity.gov/payee.

Link: www.socialsecurity.gov/myaccount

16

Medicare

17

New Medicare Cards

From April, 2018 through April 2019, new Medicare cards, without Social Security numbers will be sent out .

Everyone will be given a unique Medicare Number

Make sure Medicare has your correct address

Link to Medicare Handbook:
www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf

Link to Medicare deductibles and co-pay:
https://www.medicare.gov/Pubs/pdf/11579-Medicare-Costs.pdf

18

Medicare Co-Ins & Ded: SNF & Pt A

Co-insurance for skilled nursing rehabilitation:
Days 1-10: 0
21-100: $167.50

Part A - Hospitalization
Part A Hospital inpatient: $1340 deductible for each benefit period
Days 1-60: 0 co insurance
Days 61-90 $335/day
Days 91+ $670/ for each lifetime reserve day after day 90 for each benefit period. (60 days maximum for lifetime)

19

Medicare Part B

Standard Medicare Part B premium: $134 (no change)

- You enroll in Part B for the first time in 2018.
- You don't get Social Security benefits.
- You're directly billed for your Part B premiums.
- You have Medicare and Medicaid, and Medicaid pays your premiums. (Your state will pay the standard premium amount of $134 in 2018.)
- Your modified adjusted gross income as reported on your IRS tax return from 2 years ago is < $85/$170k. If higher, you'll pay the standard amount plus an extra amount: Income Related Monthly Adjustment Amount (IRMAA).

20

Medicare Part B - Hold Harmless

The hold harmless rule protects you from having your previous year's Social Security benefit level reduced by an increase in the Part B premium so long as:

1. You are entitled to Social Security benefits for November and December of the previous year (2017);
2. The Part B premium will be or was deducted from your Social Security benefits in November 2017 through January 2018;
3. You don't already pay higher Part B premiums because of Income-Related Monthly Adjustment Amount (IRMAA) eligibility;
4. And, you do not receive a Cost of Living Adjustment (COLA) large enough to cover the increased premium. COLA is a change in the dollar amount of Social Security benefits to protect against inflation decreasing the benefit's purchasing power. The COLA in 2018 will be 2% of your Social Security benefit.

21

Medicare Hold Harmless - Example 1

Here are examples of how the 2% COLA can affect the Part B premium:

- In 2017, Geoff's Social Security income was $1,500, and his Part B premium was $109.
- In 2018, Geoff's COLA increase will be 2% of $1,500, or $30. The increase in his Part B premium, from $109 to $134, is $25.
- Geoff will not be affected by the hold harmless provision this year, so he will pay $134 for the Part B premium, and will see a net increase of $5 in his monthly Social Security earnings.

22

Medicare Hold Harmless - Example 2

- In 2017, Louisa's SS was $950, and her Part B premium was $104.
- In 2018, the 2% COLA will increase her Social Security award by $19.
- Louisa's premium will be raised by the dollar amount of her COLA, making it $123 in 2018. There will be no increase to Louisa's Social Security award once the Part B premium has been deducted.

23

24

Tax Issues - Gift Tax

Gift Tax Exclusion: Increased to $15k per person, per year

IRS Notice 2017-15 provides guidance on the application of the decision in United States v. Windsor, 570 U.S. ___, 133 S. Ct. 2675 (2013), as they relate to certain gifts, bequests, and generation-skipping transfers by (or to) same-sex spouses.

This notice provides special administrative procedures allowing certain taxpayers' estates to recalculate a taxpayer's remaining applicable exclusion amount and remaining GST exemption to the extent an allocation of that exclusion or exemption was made to certain transfers made while the taxpayer was married to a person of the same sex.

Link: **https://tinyurl.com/ycja6bsy**

25

Tax Cuts and Jobs Act

The Act keeps the seven income tax brackets but **lowers tax rates**. Employees will see changes reflected in their withholding in their February 2018 paychecks. These rates revert to the 2017 rates in 2026.

Doubles the standard deduction, A single filer's deduction increases from $6,350 to $12,000.The deduction for Married and Joint Filers increases from $12,700 to $24,000. It reverts back to the current level in 2026.

It **eliminates personal exemptions**. Before the Act, taxpayers subtracted $4,150 from income for each person claimed.

The Act **eliminates most itemized deductions.** That includes moving expenses, except for members of the military. Those paying alimony can no longer deduct it, while those receiving it can. This change begins in 2019 for divorces signed in 2018.

26

Tax Cuts and Jobs Act

Taxpayers can **deduct up to $10,000 in state and local taxes**. They must choose between property taxes and income or sales taxes. This will harm taxpayers in high-tax states like New York and California.

Expands the deduction for medical expenses for 2017 and 2018.
It allows taxpayers to deduct medical expenses that are 7.5 percent or more of income. Before the bill, the cutoff was 10 percent for those born after 1952. Seniors already had the 7.5 percent cutoff. At least 8.8 million people used the deduction in 2015.

Repeals the Obamacare tax on those without health insurance in 2019.

27

Tax Cuts and Jobs Act

It **keeps the Alternative Minimum Tax**. It increases the exemption from $54,300 to $70,300 for singles and from $84,500 to $109,400 for joint. The exemptions phase out at $500,000 for singles and $1 million for joint. The exemption reverts to pre-Act levels in 2026.

Increases the Child Tax Credit from $1,000 to $2,000. Even parents who don't earn enough to pay taxes can claim the credit up to $1,400. It increases the income level from $110,000 to $400,000 for married tax filers.

Allows parents to use **529 savings plans** for tuition at **private and religious** K-12 schools. They can also use the funds for expenses for home-schooled students.

Allows a **$500 credit for each non-child dependent.** The credit **helps families caring for elderly parents.**

28

Tax Cuts and Jobs Act

The Act **lowers the maximum corporate tax rate** from 35 percent to **21 percent**,

It **raises the standard deduction to 20 percent** for **pass-through businesses**. This deduction ends after 2025. Pass-through businesses include sole proprietorships, partnerships, limited liability companies, and S corporations. The deductions phase out for service professionals once their income reaches $157,500 for singles and $315,000 for joint filers.

The corporate cuts are permanent, while the individual changes expire at the end of 2025.

29

Achieving a Better Life Experience (ABLE) Act of 2014

- Allows those with disabilities to save for qualified disability expenses without the risk of losing benefits from SSI and Medicaid.
- An "eligible individual", parent, legal guardian, or an agent under power of attorney can open an ABLE account for the beneficiary and anyone can contribute to an ABLE account.

What is an "eligible individual"?

a. New York resident;
b. Disabled prior to age 26; and
c. At least one of the following must be met:

i. Because of this disability, the individual is eligible for SSI, or

ii. Written diagnosis from a licensed physician documenting a medically determinable physical or mental impairment which results in marked and severe functional limitations, that can be expected to last for at least a year or can cause death, or

iii. The individual is blind (as defined in the Social Security Act), or

iv. The individual has a disability that is included on the SSA's List of Compassionate Allowances Conditions

30

Able Act

- A beneficiary can only have one ABLE account and the maximum account balance is $100,000.
- The Third party who transfers money to an ABLE account is not protected for their own governmental benefit planning and maybe subject to penalties; it is not like transferring money to an exempt disabled child.
- There is a web page for Able Accounts

https://www.mynyable.org/
https://tinyurl.com/y8kfzpq7

31

Ahlborn update

- *Arkansas Department of Health and Human Services et al. v. Ahlborn (Ahlborn) held:* Medicaid could only seek reimbursement from Medicaid enrollees from the portion of a settlement attributable to medical costs.
- In 2013, the Bipartisan Budget Act (BBA) granted Medicaid a right of first recovery for full reimbursement of covered medical costs before plaintiffs could receive any recovery for lost wages, non-economic damages, or any other type of recovery.
- Implementation of BBA was delayed twice, and finally expired in October, 2017
- Repeal of this BBA provision was finally repealed in the budget deal reached by the House and Senate this week.
- Link to American Assoc for Justice announcement: **https://tinyurl.com/ybgy3wk4** (attached)

32

Medicaid GIS & ADM

33

GIS 17 MA/02 Social Security Number for Non-Citizens

Non-citizens applying for Medicaid are no longer required to document that they applied for and/or were denied an SSN.

They must:

- ❑ Provide an SSN, if they have one; or
- ❑ Attest that they will apply for an SSN; or
- ❑ Attest that they are in the process of applying for an SSN; or
- ❑ Attest that they are not eligible for an SSN, due to their immigration status

Link: **https://tinyurl.com/y7gqtcwt**

34

GIS 17 MA/008: Policy Change for Trusts Established for Disabled Individuals Under Age 65

- Section 5007 of the 21st Century Cures Act amended Section 1917(d)(4)(A) of the Social Security Act to allow "exception trusts" created for the benefit of disabled individuals under age 65 to be established by the disabled individual. Previously it could only be created by a parent, grandparent, legal guardian, or the court .
- A bill has been introduced in the Legislature to make conforming changes to Section 366(2)(b)(2)(iii) of the Social Services Law (SSL).
- Effective immediately, in the case of a certified disabled Medicaid applicant/recipient, districts must not consider as available income or resources the corpus or income of a trust established by such disabled individual when he or she was under 65 years of age, provided the trust otherwise complies with the "exception trust" provisions in 96 ADM-8, "OBRA '93 Provisions on Transfers and Trusts."

Link: **https://tinyurl.com/ybhedyr4**
SB 4779 http://legislation.nysenate.gov/pdf/bills/2017/S4779

35

GIS 17 MA/009 & 10: Approval of 1915(c) Home & Community Based Services Care at Home(CAH) I/II Waiver Program & Application

- The request to renew the Care at Home (CAH) I/II Waiver Program has been approved by CMS
- Provides services to children 0-17 years old, who have physical disabilities and require either a skilled nursing facility or hospital level of care, and are living at home with parents or legal guardians.
- The waiver will transition into managed care via the 1115 authority on January 1, 2018.

Links:
https://www.health.ny.gov/health_care/medicaid/publications/gis/17ma009.htm and
https://www.health.ny.gov/health_care/medicaid/publications/gis/17ma010.htm

36

GIS 17 MA/011: Treatment of Federal Income Tax Refunds and Advanced Payments

- The disregard of federal income tax refunds and earned income tax credit payments (advance payments) for all Medicaid categories was made permanent under the provisions of the American Taxpayer Relief Act of 2012.
- For purposes of determining Medicaid eligibility for all categories of assistance, and for post-eligibility treatment of income for institutionalized individuals, these funds/payments are not countable income.
- Tax refunds and advance payments are also exempt as an available resource for 12 months following the month in which the payment was received. If retained longer, it becomes a countable resource.
- Since they are an exempt resource for 12 months, there can be no transfer penalty.

Link: **https://tinyurl.com/y7fxtmqk**

37

GIS 17 MA/016: 2017 Update to the Actuarial Life Expectancy Table

- The life expectancy table issued by SSA is required to be used in evaluating whether an annuity purchased by or on behalf of an applicant/recipient on or after February 8, 2006 is actuarially sound.
- The table is also used in determining whether the repayment term for a promissory note, loan or mortgage is actuarially sound.

Link to GIS: **https://tinyurl.com/y8j3oqrc**

Link to Table: **https://tinyurl.com/ycw9952z (attached)**

38

GIS 17 MA/017: Introduction to Form DOH-5247 - Medicaid Authorized Representative Designation/Change Request

- A new Medicaid form: DOH-5247
- may be used when a consumer wishes to assign, change or discontinue an authorized representative at renewal or at any time following application.
- If the representative is the person signing the application, the district must obtain authorization from the applicant or evidence of legal guardianship or a power of attorney. Once received, the designation of an authorized representative continues until it is revoked by the consumer or Medicaid coverage ends.
- If an applicant indicates that another person should get copies of notices and correspondence, the district must send the notices and correspondence to both the applicant and that person

Link: **https://tinyurl.com/ydaozt2n** (form attached)

39

GIS 17 MA/018: Fair Hearing Language Informing Consumers of the Availability of Specific Policy Materials Needed to Prepare for FH

- Informs A/Rs of their right to review their case file and to receive copies of documents from their file & policy materials needed to prepare for a fair hearing.
- Policy materials include: ADMs; GIS messages; Informational Letters; sections of the MRG; DOH *Medicaid Update* newsletters and Local Commissioner Memorandums.
- Requests for documents may be made in writing, or verbally, including telephone

Districts may satisfy this requirement in one of the following ways:

- 1) Advise the A/R to log onto the DOH website or offer to e-mail the policy material to the A/R. However, if the A/R requests that materials be mailed, the materials must be mailed within a reasonable time; BUT, if there is insufficient time for mailing before the hearing date, documents may be presented at the hearing instead of being mailed; or
- 2) A district may provide a time and place where the A/R may view the materials. This viewing may be by paper copy or at an electronic terminal. If electronic, the district should provide any necessary assistance needed to access the material.

Link: **https://tinyurl.com/yaozvp74**

40

GIS 17 MA/019 - Medicaid Regional Rates for Calculating Transfer Penalty Periods for 2018

Long Island	$13,053
New York City	$12,319
Northern Metro	$12,428
Central	$9,722
Northeastern	$10,719
Western	$10,239
Rochester	$11,692

https://www.health.ny.gov/health_care/medicaid/publications/gis/17ma019.htm

41

17 OHIP/ADM-01 Medicare Enrollment at Age 65

The following Medicaid A/Rs must apply for Medicare as a condition of Medicaid eligibility:

- Eligible Medicaid A/Rs (income at or below the applicable income level) and
- A/Rs with income at or below 120% of the Federal Poverty Level, who are age 65 or older, or turning age 65 within the next 3 months,
- Chronic Renal Failure or
- Amyotrophic Lateral Sclerosis (ALS);

Nursing home residents must show proof of Medicare application at the time of application or renewal.

Most immigrants and non-citizens are excluded. Only lawful permanent residents who have lived in the U.S. continuously for five years must apply for Medicare as a condition of Medicaid eligibility.

42

17 OHIP/ADM-02 Asset Verification System

Federal Requirement:

Federal law at 42 U.S.C. § 1396w requires states to implement a program for verifying assets for Medicaid eligibility for aged (age 65 or over), certified blind and certified disabled A/Rs.

Requests must be sent to financial institutions other than those identified by A/Rs, based on logic that includes a bank's geographic proximity to the individual's home address, or other reasonable factors; and

The inquiries must include a request for information on both open and closed accounts, going back up to five years as determined by the State.

The AVS will check financial account information with national, regional and local financial institutions (banks), and real property information with public records databases.

43

AVS - Authorization

An SSI-related A/R and his/her spouse must authorize the electronic verification of their assets as a condition of Medicaid eligibility.

Exception: Incapacitated individuals, not capable of authorizing AVS and who do not have another person authorized to sign on their behalf. However, for Community & Chronic Medicaid, the A/R must submit paper documentation to verify resources, unless a petition for guardianship has been filed.

The A/R's signature on the Medicaid application and renewal form is sufficient authorization to verify assets through AVS.

A Medicaid application that is filed on behalf of a deceased individual must be signed by the decedent's surviving spouse or by the legally appointed representative of the decedent's estate.

A legally responsible spouse is also required to provide authorization for Medicaid to electronically verify his/her assets as a condition of eligibility for an SSI-related A/R.

44

AVS

For individuals applying for Medicaid coverage of nursing home care, the AVS will:

• Verify the A/R's and the spouse's accounts held in banking institutions for the month of application and the 60-month look-back period, including accounts that were closed during this period, and identify months in which a potential transfer of assets is detected; and

• Conduct searches on real property owned by the A/R or the A/R's spouse during the month of application and the 60-month look-back period, including any property that was sold or transferred during this period.

AVS only reports on banks

AVS cannot be used to verify stocks, bonds, securities, and mutual funds purchased through a brokerage firm, or life insurance policies and annuity products issued by insurance companies

45

Pooled Trust Notification Bill

- Signed into law 12/18/17
- Medicaid applicants and recipients who have a spend-down must be given notice in plain language that explains the availability of SNT to eliminate the spend-down. The notice must include information on how to enroll in a trust and how to request the local DSS to rebudget income.
- Effective date: 6/18/18 - but could be delayed pending regulations
- Amends Social Services Law § 366, subd. 5(f) and (g)
- 2017 - A5175 for bill and legislative history

46

Fair Hearing Rights for MLTC and Managed Care Members

- "Exhaustion" requirement: Members must "exhaust" the plan's internal appeal procedure, and receive an adverse appeal decision BEFORE requesting a fair hearing.
- There is a narrow exception: Deemed exhaustion
- A previous exhaustion requirement was eliminated in July, 2015
- Plan only has to give 10 days notice of reduction in service
- AID CONTINUING RIGHTS WHEN PLAN IS REDUCING OR STOPPING SERVICES - member will now have to request an INTERNAL PLAN APPEAL within a short 10-day window (including mail time, weekends and holidays)
- Oral Appeals Must be Followed up by a Written Signed appeal request, unless the enrollee requests an expedited resolution.

(DOH memo attached)

47

Free Access to Medical Records

September 2017

- Governor Cuomo signs bill into law which eliminates medical record fees for those seeking government benefits.

- The amendment to New York's public health and mental hygiene law eliminates any fees associated with providing requested medical records for residents applying for Social Security disability or Medicaid benefits.

- Providers must supply records free of charge in either electronic or paper form at the request of the state or a patient.

- Effective immediately.

http://legislation.nysenate.gov/pdf/bills/2017/s6078 (attached)

48

1115 Waivers Limit Medicaid Programs

Section 1115 of the Social Security Act authorizes the Secretary of Health and Human Services (HHS) to waive a number of Medicaid requirements to the extent necessary to allow a state to undertake an "experimental, pilot, or demonstration project" that is likely to assist in promoting the objectives of Medicaid. This portion of the waiver being used to limit Medicaid.

1/11/2018 - CMS issued letter to all State Medicaid directors:

- New policy permitting states to adopt requirements for continuing Medicaid eligibiltiy for adults (non-elderly, non- pregnant, not disabled)
- Community service, caregiving, education, job training, substance use disorder treatment
- https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf

1/12/18 Kentucky - first state allowed to impose Medicaid work requirement

2/2/2018 Indiana is 2nd state to impose Medicaid work requirement, Will block coverage for 3 months if paperwork showing continued eligibility Is Late; also has "lockouts" for failure to make monthly premium payments.

49

50

Fair Hearing

FH # 7672051J, Suffolk County, January 23, 2018 (attached)

The Managed Care Plan's determination to deny reimbursement for prescription costs totaling $1,020 incurred is correct. Although the Appellant contends that he never received formal notice from the Managed Care Plan of the coverage change, Appellant was duly advised by the pharmacy of the change in network status and advised prior to filling the prescription that the Managed Care Plan would not cover prescriptions dispensed by the pharmacy.

51

Fair Hearing

FH # 7650403J, Suffolk County, January 17, 2018 (attached)

The determination by the Managed Care Agency to deny the Appellant's request for reimbursement for the out-of-pocket expense for the $165 prescription on the grounds that the pharmacy was a non-participating provider was not correct and reversed.

Appellant submitted credible evidence verifying that the medication in question was covered and paid for by the Managed Care Agency at the Appellant's pharmacy, up until the date in question. Also, Appellant testified that she did not receive any written or oral notification that her pharmacy was a non-participating pharmacy.

52

Fair Hearing

FH # 7345219J, Suffolk County, February 17, 2017 (attached)

The Agency argued that the language of the irrevocable trust, which held the Appellant's and community spouse's house in the community, conveyed a life estate.

The Trust reserved the Appellant and his spouse the right to reside in the residence during their lifetime, and required them to pay housing expenses. However, the Appellant and his spouse did not have all of the rights accorded to a life tenant. Therefore, they were found not entitled to the actuarial value of a life estate interest for the proceeds of the sale of the house and the Medicaid transfer penalty was reduced accordingly.

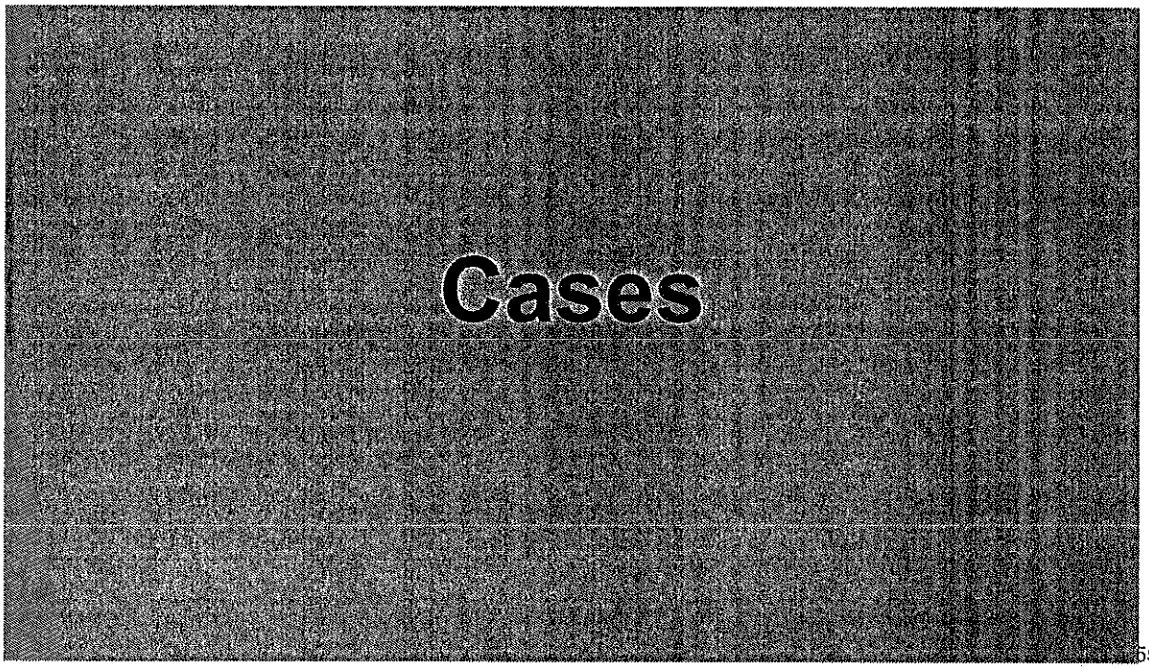
53

Fair Hearing

FH # 7674989K, Suffolk County, January 24, 2018 (attached)

The Agency's determination to discontinue the Appellant's application for Medical Assistance for failure to apply for Medicare was correct. Appellant was pended for verification from Social Security that he applied for Medicare. Appellant acknowledged receipt of pend but provided letters (at fair hearing) that he thought were sufficient. What he provided was proof that he had applied for SSI and was denied.

54



55

Case Law On 24-Hour Pay For Aides

Tokhtaman v. Human Care, LLC, 149 AD 3d 476 - NY: Appellate Div., 1st Dept. 2017

Andryeyeva v. New York Health Care, Inc., 2017 NY Slip Op 6421 - NY: Appellate Div., 2nd Dept. 2017

Moreno v. Future Care Health Servs., Inc., 2017 NY Slip Op 6439 - NY: Appellate Div., 2nd Dept. 2017

*Decisions enclosed

56

Tokhtaman v. Human Care, LLC, 149 AD 3d 476 - NY: Appellate Div., 1st Dept. 2017

- April 11, 2017 - 1st Dep't, Appellate Division rejected the "13-hour rule" for live-in aides who are non-residential employees. They held that the 2010 DOL Opinion Letter conflicts with the plain language of the Wage Order Regulation and that the question of whether or not a live-in aide is a residential or nonresidential employee is a question of fact that would be determined in the future by a trial court.

- November 21, 2017 - Motion by the NYS Assoc. Of Health Care Providers, et al, for leave to appear amici curiae on the motion for leave to appeal was granted and the brief was filed.

- November 28, 2017 - Upon reading the filed brief, the Court denied the motion for rehearing.

57

Andryeyeva v. New York Health Care, Inc., 2017 NY Slip Op 6421 - NY: Appellate Div., 2nd Dept. 2017

September 23, 2017 - Court affirmed class certification. The class consists of approximately 1,063 home attendants who had worked 24-hour shifts for NYHC between December 28, 2007 and March 8, 2013. The 2nd Dep't agreed with the 1st Dep't , that the DOL's interpretation is neither rational nor reasonable, because it conflicts with the plain language of the Wage Order.

58

Moreno v. Future Care Health Servs., Inc., 2017 NY Slip Op 6439 - NY: Appellate Div., 2nd Dept. 2017

Appellate Division held that the 2010 DOL's opinion letter fails to distinguish between residential and nonresidential employees and therefore conflicts with the plain meaning of the Wage Order (12 NYCRR 142-2.1(b)). The lower court's decision was reversed and Appellant's were granted their motion for class certification.

59

NYDOL Response to Case Holdings

On October 6, 2017, NYDOL issued an emergency amendment to the Amended Wage Order:

(b) The minimum wage shall be paid for the time an employee is permitted to work, or is required to be available for work at a place prescribed by the employer, and shall include time spent in traveling to the extent that such traveling is part of the duties of the employee. However, a residential employee–one who lives on the premises of the employer–shall not be deemed to be permitted to work or required to be available for work:

(1) during his or her normal sleeping hours solely because he is required to be on call during such hours; or

(2) at any other time when he or she is free to leave the place of employment.

Notwithstanding the above, this subdivision shall not be construed to require that the minimum wage be paid for meal periods and sleep times that are excluded from hours worked under the Fair Labor Standards Act of 1938, as amended, in accordance with sections 785.19 and 785.22 of 29 C.F.R. for a home care aide who works a shift of 24 hours or more.

12 N.Y.C.R.R. 142.2.1(b) https://labor.ny.gov/formsdocs/wp/CR142.pdf

60

Concerns for Live-in Cases

- The NYDOL Amended Wage Order is temporary and unclear
- Potential back-pay liability for the last 6 years
- Issue of staffing live-in cases
- Sufficient funding for home care agencies and the future of community Medicaid providing live-in non-residential aides

61

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62

Today's action ensures Medicaid recipients retain access to the courts.

AMERICAN ASSOCIATION for JUSTICE®

Linda A. Lipsen
Chief Executive Officer

Dear AAJ Members,

2.9.18

I am pleased to announce that after years of hard work, we were able to secure a **permanent and retroactive repeal** of the Bipartisan Budget Act (BBA) language that overturned the Supreme Court decision *Arkansas Department of Health and Human Services et al. v. Ahlborn (Ahlborn)*.

In a 9-0 decision, the Court held in *Ahlborn* that Medicaid could only seek reimbursement from Medicaid enrollees from the portion of a settlement attributable to medical costs. The *Ahlborn* decision was universally lauded as promoting fair and proportionate settlements for Medicaid recipients. But, in 2013, the BBA was enacted and included a provision overturning *Ahlborn*. This granted Medicaid a right of first recovery for full reimbursement of covered medical costs before plaintiffs could receive any recovery for lost wages, non-economic damages, or any other type of recovery.

AAJ worked hard to delay implementation of the harmful BBA provision and it was initially delayed until October 2016. We secured a second delay which ran through October 1, 2017, but expired, effectively overturning *Ahlborn*. Since the expiration of the second delay, AAJ has been working around the clock to secure a permanent and retroactive repeal of the harmful BBA provision. This repeal was finally realized in the budget deal reached by the House and Senate this week.

We believe this is a great victory that will ensure Medicaid recipients retain access to the courts. I want to thank the AAJ staff, especially Sarah Rooney, who worked tirelessly to secure this incredible result!

Thank you for your support and engagement in AAJ advocacy. If you have any questions about the repeal or Medicaid third party liability generally, please contact Sarah at sarah.rooney@justice.org.

Sincerely,

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Medicaid Authorized Representative Designation/Change Request

Applicant/Recipient

Name _____

Address _____ (Street) _____ (Apt#)

_____ (City) _____ (State) _____ (Zip)

Date _____

Case Number _____

If you have not previously provided an Authorized Representative to act on your behalf and would like to do so, please provide his/her name and address.

Name _____

Address _____ (Street) _____ (Apt#)

_____ (City) _____ (State) _____ (Zip)

Phone # (_____) _____ – _____ ☐ home ☐ work ☐ cell ☐ other

If you previously provided an Authorized Representative and would like to discontinue or change to someone new:

☐ Discontinue Current Authorized Representative

Name _____

Address _____ (Street) _____ (Apt#)

_____ (City) _____ (State) _____ (Zip)

Phone # (_____) _____ – _____ ☐ home ☐ work ☐ cell ☐ other

☐ Designate New Authorized Representative

Name _____

Address _____ (Street) _____ (Apt#)

_____ (City) _____ (State) _____ (Zip)

Phone # (_____) _____ – _____ ☐ home ☐ work ☐ cell ☐ other

I understand my designated Authorized Representative will have access to my personal health information.
I would like my Authorized Representative to (check all that apply):

☐ Apply for and/or renew Medicaid for me

☐ Discuss my Medicaid application or case, if needed

☐ Get notices and correspondence

I understand this designation will remain in effect until I change or discontinue it.

_____ (Signature of Applicant/Recipient) _____ (Date)

NEW YORK STATE OF OPPORTUNITY. | Department of Health

New York State Medicaid Managed Care Enrollee Right to Fair Hearing and Aid Continuing for Plan Service Authorization Determinations

December 15, 2017

Federal Medicaid managed care rules published in May 6, 2016 amended procedures for service authorization, appeals, fair hearings, and aid continuing. Medicaid managed care plans, including mainstream, HIV Special Needs Plans and Health and Recovery Plans, must continue to comply with requirements in NYS statute, NYS regulation, and the Medicaid Managed Care Model Contract where not superseded by federal rule, including but not limited to the provision of evidence packets, appearance at state fair hearings, and compliance with the Office of Administrative Hearings directives and decisions.

Right to Fair Hearing regarding plan services authorization determinations:

1) 42 CFR §§438.402(c)(1)(i) and 438.408(f)(1) establish that enrollees may request a state fair hearing after receiving an appeal resolution (Final Adverse Determination) that an adverse benefit determination (Initial Adverse Determination) has been upheld.

2) 42 CFR §§438.402(c)(1)(i)(A), 438.408(c)(3), and 438.408(f)(1)(i) provide that an enrollee may be deemed to have exhausted a plan's appeals process and may request a state fair hearing where notice and timeframe requirements under 42 CFR 438.408 have not been met. Deemed exhaustion applies when:

- an enrollee requests a Plan Appeal, verbally or in writing, and does not receive an appeal resolution notice or extension notice from the plan;
- an enrollee requests a Plan Appeal, verbally or in writing, and does not receive an appeal resolution notice or extension notice from the plan within State-specified timeframes; or
- a plan's appeal resolution or extension notice does not meet noticing requirements identified in 42 CFR §438.408.

3) 42 CFR §438.408(f)(2) provides the enrollee no less than 120 days from the date of the adverse appeal resolution (Final Adverse Determination) to request a state fair hearing.

4) Pursuant to 42 CFR §438.424(a), if OAH determines to reverse the MMC decision, and the disputed services were not provided while the appeal and hearing were pending, the plan must authorize or provide the disputed services promptly and as expeditiously as the enrollee's condition requires but no later than 72 hours from the date the plan receives the OAH fair hearing decision.

Right to Aid Continuing

Pursuant to requirements in 42 CFR §438.420, NYS Social Services Law §365-a(8), and 18 NYCRR §360-10.8, Medicaid Managed Care (MMC) enrollees may receive continuation of benefits, known as Aid Continuing (AC), under certain circumstances. Enrollees must meet filing requirements identified in 42 CFR §438.420.

The enrollee must receive notice regarding the right to AC in the timeframes required by 42 CFR §438.404(c)(1) (10 day notice, with some exceptions) when:

- The plan makes a determination to terminate, suspend, or reduce a previously authorized service during the period for which the service was approved; or

- For an enrollee in receipt of long term services and support or nursing home services (short or long term), the plan makes a determination to partially approve, terminate, suspend, or reduce level or quantity of long term services and supports or a nursing home stay (long-term or short-term) for a subsequent authorization period of such services.

NYS MMC plans are required to provide AC:

- **immediately** upon receipt of a Plan Appeal disputing the termination, suspension or reduction of a previously authorized service, filed verbally or in writing within 10 days of the date of the notice of adverse benefit determination (Initial Adverse Determination), or the effective date of the action, whichever is later, unless the enrollee indicates they do not wish their services to continue unchanged.

- **immediately** upon receipt of a Plan Appeal disputing the partial approval, termination, suspension or reduction in quantity or level of services authorized for long term services and supports or nursing home stay for a subsequent authorization period, filed verbally or in writing within 10 days of the initial adverse determination, or the effective date of the action, whichever is later, unless the enrollee indicates they do not wish their services to continue unchanged.

- **immediately** as directed by the NYS Office of Administrative Hearings (OAH). The enrollee has a right to AC when they have exhausted the plan's appeal process and have filed a request for a state fair hearing disputing a termination, suspension or reduction of a previously authorized service, or for all long term services and supports and all nursing home stays, partial approval, termination, suspension or reduction in quantity or level of services authorized for a subsequent authorization period. (The OAH may determine other circumstances warrant the provision of AC, including but not limited to a home bound individual who was denied an increase in home care services.)

The MMC plan must continue the enrollee's services provided under AC until one of the following occurs:

- the enrollee withdraws the request for aid continuing, the plan appeal or the fair hearing;
- the enrollee fails to request a fair hearing within 10 days of the plan's written adverse appeal resolution notice (Final Adverse Determination)[1];
- OAH determines that the Enrollee is not entitled to aid continuing;
- OAH completes the administrative process and/or issues a fair hearing decision adverse to the Enrollee; or
- the provider order has expired, except in the case of a home bound enrollee.

Where the final resolution upon plan appeal or fair hearing is to uphold an adverse benefit determination, the enrollee may be held liable for services in accordance with 42 CFR §438.420(d).

[1] Services authorized under AC must be continued for at least 10 days from when the Final Adverse Determination is sent.

S T A T E O F N E W Y O R K

6078

2017-2018 Regular Sessions

I N S E N A T E

May 11, 2017

Introduced by Sen. VALESKY -- read twice and ordered printed, and when printed to be committed to the Committee on Health

AN ACT to amend the public health law and the mental hygiene law, in relation to health record access for a government benefit or program

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. The first undesignated paragraph of section 17 of the public health law, as amended by chapter 576 of the laws of 1998, is amended to read as follows:

Upon the written request of any competent patient, parent or guardian of an infant, a guardian appointed pursuant to article eighty-one of the mental hygiene law, or conservator of a conservatee, an examining, consulting or treating physician or hospital must release and deliver, exclusive of personal notes of the said physician or hospital, copies of all x-rays, medical records and test records including all laboratory tests regarding that patient to any other designated physician or hospital provided, however, that such records concerning the treatment of an infant patient for venereal disease or the performance of an abortion operation upon such infant patient shall not be released or in any manner be made available to the parent or guardian of such infant, and provided, further, that original mammograms, rather than copies thereof, shall be released and delivered. Either the physician or hospital incurring the expense of providing copies of x-rays, medical records and test records including all laboratory tests pursuant to the provisions of this section may impose a reasonable charge to be paid by the person requesting the release and deliverance of such records as reimbursement for such expenses, provided, however, that the physician or hospital may not impose a charge for copying an original mammogram when the original has been released or delivered to any competent patient, parent or guardian of an infant, a guardian appointed pursuant to article eighty-one of the mental hygiene law, or a conservator of a conservatee and

EXPLANATION--Matter in ITALICS (underscored) is new; matter in brackets [ ] is old law to be omitted.

LBD11636-02-7

provided, further, that any charge for delivering an original mammogram pursuant to this section shall not exceed the documented costs associated therewith. However, the reasonable charge for paper copies shall not exceed seventy-five cents per page. A release of records under this section shall not be denied solely because of inability to pay. NO CHARGE MAY BE IMPOSED UNDER THIS SECTION FOR PROVIDING, RELEASING, OR DELIVERING MEDICAL RECORDS OR COPIES OF MEDICAL RECORDS WHERE REQUESTED FOR THE PURPOSE OF SUPPORTING AN APPLICATION, CLAIM OR APPEAL FOR ANY GOVERNMENT BENEFIT OR PROGRAM, PROVIDED THAT, WHERE A PROVIDER MAINTAINS MEDICAL RECORDS IN ELECTRONIC FORM, IT SHALL PROVIDE THE COPY IN EITHER ELECTRONIC OR PAPER FORM, AS REQUIRED BY THE GOVERNMENT BENEFIT OR PROGRAM, OR AT THE PATIENT'S REQUEST.

S 2. Paragraph (e) of subdivision 2 of section 18 of the public health law, as amended by chapter 576 of the laws of 1998, is amended to read as follows:

(e) The provider may impose a reasonable charge for all inspections and copies, not exceeding the costs incurred by such provider, provided, however, that a provider may not impose a charge for copying an original mammogram when the original has been furnished to any qualified person and provided, further, that any charge for furnishing an original mammogram pursuant to this section shall not exceed the documented costs associated therewith. However, the reasonable charge for paper copies shall not exceed seventy-five cents per page. A qualified person shall not be denied access to patient information solely because of inability to pay. NO CHARGE MAY BE IMPOSED UNDER THIS SECTION FOR PROVIDING, RELEASING, OR DELIVERING PATIENT INFORMATION OR COPIES OF PATIENT INFORMATION WHERE REQUESTED FOR THE PURPOSE OF SUPPORTING AN APPLICATION, CLAIM OR APPEAL FOR ANY GOVERNMENT BENEFIT OR PROGRAM, PROVIDED THAT, WHERE A PROVIDER MAINTAINS PATIENT INFORMATION IN ELECTRONIC FORM, IT SHALL PROVIDE THE COPY IN EITHER ELECTRONIC OR PAPER FORM, AS REQUIRED BY THE GOVERNMENT BENEFIT OR PROGRAM, OR AT THE PATIENT'S REQUEST.

S 3. Paragraph 6 of subdivision (b) of section 33.16 of the mental hygiene law, as amended by chapter 165 of the laws of 1991 and as renumbered by chapter 233 of the laws of 1991, is amended to read as follows:

6. The facility may impose a reasonable charge for all inspections and copies, not exceeding the costs incurred by such provider. However, the reasonable charge for paper copies shall not exceed seventy-five cents per page. A qualified person shall not be denied access to the clinical record solely because of inability to pay. NO CHARGE MAY BE IMPOSED UNDER THIS SECTION FOR PROVIDING, RELEASING, OR DELIVERING CLINICAL RECORDS OR COPIES OF CLINICAL RECORDS WHERE REQUESTED FOR THE PURPOSE OF SUPPORTING AN APPLICATION, CLAIM OR APPEAL FOR ANY GOVERNMENT BENEFIT OR PROGRAM, PROVIDED THAT, WHERE A PROVIDER MAINTAINS CLINICAL RECORDS IN ELECTRONIC FORM, IT SHALL PROVIDE THE COPY IN EITHER ELECTRONIC OR PAPER FORM, AS REQUIRED BY THE GOVERNMENT BENEFIT OR PROGRAM, OR AT THE PATIENT'S REQUEST.

S 4. This act shall take effect immediately.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: December 19, 2017
[redacted]
AGENCY: Suffolk
FH #: 7672051J

In the Matter of the Appeal of

[redacted]

from a determination by the Suffolk County Department of Social Services

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on January 18, 2018, in Suffolk County, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Managed Care Plan

Managed Care Plan appearance waived by the Office of Administrative Hearings

ISSUE

Was the Managed Care Plan's determination to deny reimbursement for prescription costs totaling $1020 incurred on September 21, 2017 and October 19, 2017 correct?

FINDINGS OF FACT

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. The Appellant, age 60, was in receipt of Medicaid through Health Insurance Plan of Greater New York/EmblemHealth (hereinafter Managed Care Plan) for September and October 2017.

2. On or about November 29, 2017, the Appellant submitted a Managed Care Pharmacy Benefit Services Prescription Drug Claim Form requesting reimbursement for prescription drug costs paid out of pocket in the amount of $510 each on September 21, 2017 and October 19, 2017, for total out of pocket expenses of $1020.00.

3. By notice dated December 14, 2017, the Managed Care Plan denied reimbursement on the grounds that the prescription was filled at a nonparticipating retail pharmacy and therefore the plan does not cover the claim.

4. On December 19, 2017, the Appellant requested this fair hearing.

APPLICABLE LAW

Department Regulations at 18 NYCRR 360-7.5(a) set forth how the Medical Assistance Program will pay for medical care. Generally, the Program will pay for covered services which are necessary in amount, duration and scope to providers who are enrolled in the Medical Assistance program, at the Medical Assistance rate or fee which is in effect at the time the services were provided.

The United State Department of Health and Human Services (Health Care Finance Administration) has granted the State of New York a waiver under Section 1115 of the Social Security Act to permit the operation of a demonstration waiver program for Managed Care Programs in which certain eligible Medicaid recipients are subject to mandatory enrollment. An "Operational Protocol" (Protocol) has been approved by the Health Care Finance Administration as required by the Terms and Conditions governing the demonstration waiver. Such Protocol details the day-to-day operations of the managed care program for Medicaid.

The Medicaid managed care model contract advises in relevant part:

21.1 Network Requirements

a) The Contractor will establish and maintain a network of Participating Providers.

i) In establishing the network, the Contractor must consider the following: anticipated Enrollment, expected utilization of services by the population to be enrolled, the number and types of providers necessary to furnish the services in the Benefit Package, the number of providers who are not accepting new patients, and the geographic location of the providers and Enrollees.

ii) The Contractor's network must contain all of the provider types necessary to furnish the prepaid Benefit Package, including but not limited to: hospitals, physicians (primary care and specialists), mental health and substance abuse providers, allied health professionals, ancillary providers, DME providers, home health providers, and pharmacies, if applicable.

DISCUSSION

The Appellant stated that he had been utilizing [redacted] Drug store for several years while receiving Medicaid through EmblemHealth Managed Care Plan. The Appellant added that he has a chronic, life threatening diagnosis causing severe pain for which he receives ongoing prescriptions from his treating physician. However, the Appellant stated that upon arriving at the drug store to pick up his prescriptions on September 21, 2017, the pharmacist advised that the Managed Care Plan was no longer covering medications dispensed by the store and that the Appellant would need to pay out of pocket to obtain his medication.

The Appellant stated that due to his illness, it was inconvenient to locate another drug store. The Appellant stated that he therefore returned to his original drug store after obtaining a loan to pay for the medication on September 21, 2017. The Appellant also stated that he again paid for the medication at the same drug store in October, 2017 while awaiting reassignment to another Managed Care Plan which utilizes his preferred drug store.

The Appellant asserted that EmblemHealth never notified him directly that he could no longer utilize his preferred drug store. The Appellant further asserted that the notice denying reimbursement was insufficient because it did not state why his preferred drug store had become a non-participating pharmacy.

Medicaid recipients enrolled in Managed Care are required to utilize in-network providers. Network status is conferred by contract between the provider and the Managed Care Plan.

In this case, the Managed Care Plan submitted pertinent pages from the Member Handbook, stating that prescriptions must be filled at any pharmacy that participates in the plan or through mail order, with a phone number for member services for information on pharmacy options. The Appellant did not dispute this evidence and further stated that he was duly advised by the pharmacy of the change in network status and advised that the Managed Care Plan would not cover prescriptions dispensed by the pharmacy. The Appellant also stated that he chose to pay out of pocket rather than locating another participating drug store.

For all of the foregoing reasons, the hearing record supports the Managed Care Plan's determination to deny reimbursement on the grounds that the prescription was filled at a nonparticipating retail pharmacy.

DECISION

The Managed Care Plan's determination to deny reimbursement for prescription costs totaling $1020 incurred on September 21, 2017 and October 19, 2017 is correct.

FH# 7672051J

DATED: Albany, New York
01/23/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee

STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: November 17, 2017
[redacted]
AGENCY: Suffolk
FH #: 7650403J

In the Matter of the Appeal of

[redacted]

from a determination by the Suffolk County Department of Social Services

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on January 11, 2018, in Suffolk County, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Social Services Agency

Agency appearance waived by the Office of Administrative Hearings

ISSUE

Was the determination by the Managed Care Agency to deny the Appellant's request for reimbursement for the Appellant's out-of-pocket expense for a prescription in the amount of $165.00 on the grounds that the pharmacy was a non-participating provider correct?

FINDINGS OF FACT

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. The Appellant, age 49, has been in receipt of medical coverage through the Managed Care Agency, EmblemHealth for herself only.

2. Effective October 1, 2017, the Appellant began receiving Medical Assistance coverage from another managed care agency, United Healthcare.

3. On September 23, 2017, the Appellant requested reimbursement from the Managed Care Agency for the Appellant's out-of-pocket expense for the prescription Lyrica in the amount of $165.00.

4. On November 6, 2017, the Managed Care Agency denied the Appellant's request for reimbursement for the Appellant's out-of-pocket expense for the prescription [redacted] in the amount of $165.00 because the prescription Lyrica was filled at a nonparticipating retail pharmacy, therefore, the plan does not cover this claim.

5. The Appellant did not request an appeal of the denial of the claim.

6. The Appellant requested a Medical Appeal of the denial of the claim.

7. On November 17, 2017, the Appellant requested this fair hearing.

8. On January 2, 2018, the Managed Care Agency issued a final denial of authorization.

APPLICABLE LAW

In general, a recipient of Public Assistance, Medical Assistance or Services (including child care and supportive services) has a right to a timely and adequate notice when the Agency proposes to discontinue, suspend, reduce or change the manner of payment of such benefits. 18 NYCRR 358-3.3(a).

Section 365-a of the Social Services Law provides in part: "Medical Assistance" shall mean payment of part or all of the cost of care, services and supplies which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with his capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with this title, and the regulations...

This paragraph continues, in part, by stating: "Such care, services and supplies shall include the following medical care, services and supplies, together with such medical care, services and supplies provided for in subdivisions three, four and five of this section, and such medical care, services and supplies as are authorized in the regulations of the department

> (g-1) drugs provided on an inpatient basis, those drugs contained on the list established by regulation of the commissioner of health pursuant to subdivision four of this section, and those drugs which may not be dispensed without a prescription as required by section sixty-eight hundred ten of the education law and which the commissioner of health shall determine to be reimbursable based upon such factors as the availability of such drugs or alternatives at

low cost if purchased by a Medicaid recipient, or the essential nature of such drugs as described by such commissioner in regulations, provided, however, that such drugs, exclusive of long-term maintenance drugs, shall be dispensed in quantities no greater than a thirty day supply or one hundred doses, whichever is greater; provided further that the commissioner of health is authorized to require prior authorization for any refill of a prescription when less than seventy-five percent of the previously dispensed amount per fill should have been used were the product used as normally indicated; provided further that the commissioner of health is authorized to require prior authorization of prescriptions of opioid analgesics in excess of four prescriptions in a thirty-day period in accordance with section two hundred seventy-three of the public health law; medical assistance shall not include any drug provided on other than an in-patient basis for which a recipient is charged or a claim is made in the case of a prescription drug, in excess of the maximum reimbursable amounts to be established by department regulations in accordance with standards established by the secretary of the United States department of health and human services, or, in the case of a drug not requiring a prescription, in excess of the maximum reimbursable amount established by the commissioner of health pursuant to paragraph (a) of subdivision four of this section;

Subsection 4 of this section of the Social Services Law provides, in part:

Any inconsistent provision of law notwithstanding, medical assistance shall not include, unless required by federal law and regulation as a condition of qualifying for federal financial participation in the Medicaid program, the following items of care, services and supplies:

(a-1). (i) a brand name drug for which a multi-source therapeutically and generically equivalent drug, as determined by the federal food and drug administration, is available, unless previously authorized by the department of health. The commissioner of health is authorized to exempt, for good cause shown, any brand name drug from the restrictions imposed by this subparagraph;

(ii) notwithstanding the provisions of subparagraph (i) of this paragraph, the commissioner is authorized to deny reimbursement for a generic equivalent, including a generic equivalent that is on the preferred drug list or the clinical drug review program, when the net cost of the brand name drug, after consideration of all rebates, is less than the cost of the generic equivalent, unless prior authorization is obtained under section two hundred seventy-three of the public health law;

Section 364-j (1)(c) of the Social Services Law defines "Managed Care Program" as a program in a social services district in which Medicaid recipients enroll on a voluntary or mandatory basis to receive Medicaid services, including case management, directly or indirectly (including by referral) from a managed care provider ("Medicaid Managed Care Health Plan"), or, if applicable, from a mental health special needs plan or a comprehensive HIV special needs plan.

Pursuant to Chapter 59 L. 2011, Part H, Section 5, Social Services Law Sections 365-i and 369-dd, which provided that prescription drug payments shall not be included in the

capitation payment for services and supplies provided to Medical Assistance recipients by health maintenance organizations, were repealed effective October 1, 2011. Pharmacy benefits for Medical Assistance recipients enrolled in managed care plans will be provided through their managed care plan, effective October 1, 2011.

The United State Department of Health and Human Services (Health Care Finance Administration) has granted the State of New York a waiver under Section 1115 of the Social Security Act to permit the operation of a demonstration waiver program for Managed Care Programs in which certain eligible Medicaid recipients are subject to mandatory enrollment. An "Operational Protocol" (Protocol) has been approved by the Health Care Finance Administration as required by the Terms and Conditions governing the demonstration waiver. Such Protocol details the day-to-day operations of the managed care program for both Medicaid and Family Health Plus.

Chapter Four of the Protocol describes the Medicaid services covered under the Managed Care Program. Managed care enrollees will be entitled to the same benefits and coverage as are available under the fee-for-service program. The capitated health care benefits package will be comprehensive for HMOs and PHSPs. Emphasis will be on primary, preventive, and acute episodic care. MCOs must provide all services included in the capitated benefit package, to the extent that such services are medically necessary. "Medically necessary" is defined in Social Services law as medical, dental, and remedial care, services and supplies which are necessary to prevent, diagnose, and correct or cure conditions in the person that may cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity or threaten some significant handicap [see Social Services Law 365-a(2)]. Also, by statute, EPSDT and family planning services are "deemed" medically necessary and therefore are, by definition, covered.

Appendix K2 section 10(a) of the Medicaid/FHP managed care model contract advises in part regarding Prescription and Non-Prescription (OTC) Drugs, Medical Supplies and Enteral Formulas for Medicaid managed care only: Enrollees are covered for prescription drugs through the Medicaid fee-for-service program through September 30, 2011, except for pharmaceuticals and medical supplies routinely furnished or administered as part of a clinic or office visit and self-administered injectable drugs (including those administered by a family member and during a home care visit) not included on the Medicaid outpatient formulary, which are covered by the Contractor. Effective October 1, 2011, medically necessary prescription and non-prescription (OTC) drugs, medical supplies, hearing aid batteries and enteral formula are covered by the Contractor when ordered by a qualified provider.

Appendix K.1 of the managed care model contract advises in part that prescriptions, non-prescription OTC drugs, medical supplies, and enteral formulas are covered services in the Medicaid managed care prepaid benefit package as of 10/1/11, including pharmaceuticals and medical supplies routinely furnished or administered as part of a clinic or office visit.

Appendix K2 section 10(c) of the Medicaid/FHP model contract advises that for Medicaid Managed Care and Family Health Plus, effective October 1, 2011:

i) Prescription drugs may be limited to generic medications when medically acceptable. All drug classes containing drugs used for preventive and therapeutic purposes are covered, as well as family planning and contraceptive medications and devices, if Family Planning is included in the Contractor's Benefit Package.

18 NYCRR section 505.1 delineates the types of services available to recipients of Medical Assistance, including those enrolled in a Managed Care Plan. Pursuant to section 505.1, all enrollees are generally eligible for medical services and supplies within the scope of the Medicaid program (18 NYCRR section 505.1(b)), except when: (1) medical services and supplies, in accordance with the regulations of the department, routinely require: (i) prior approval of a local professional director; or (ii) prior authorization of the social services official; or (iii) certification by the Commissioner of Health or his designee; (2) the identification card on its face: (i) restricts an individual recipient to a single provider; or (ii) requires prior authorization for all ambulatory medical services and supplies except emergency care; or (3) the service exceeds benefit limitations as established by the department.

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The EmblemHealth Enhanced Care (Medicaid Managed Care) Member Handbook at page 19 states in pertinent part:

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- You have a choice in where you fill your prescriptions. You can go to any Pharmacy that participates with our plan or you can fill your prescriptions by using a mail order pharmacy. For more information on your options, please contact member services at **1-855-283-2146.**

DISCUSSION

At the hearing, the Appellant contended that the Agency packet presented for the instant fair hearing was not from the correct agency. The Appellant explained that she has been in receipt of medical coverage from the Managed Care Agency for approximately ten years. The Appellant asserted that there were too many issues with the coverage, so she switched to United Healthcare, which covers all her medications without issue. The Appellant stated that she needed an explanation from the Managed Care Agency as to why they denied payment for her prescription for Lyrica on September 23, 2017, while she was in receipt of all her other numerous medications approved by the Managed Care Agency through October 1, 2017. The instant fair hearing was adjourned to allow the Managed Care Agency to address the issue of the fair hearing.

Upon reconvening, the Appellant presented a packet from the Managed Care Agency, dated January 2, 2018, which addressed the issue and which stated that the Appellant was using a non-participating pharmacy. The Appellant argued that the Managed Care Agency's argument

was not correct because she had coverage with them until October 1, 2017, and her letter of approval for Lyrica from the Managed Care Agency was included in the Agency's packet. The Appellant then explained that she has been going to the same pharmacy for years and the Managed Care Agency covered all her prescriptions, including Lyrica, at that pharmacy. The Appellant presented a pharmacy printout, reflecting dates of July 20, 2017 to September 20, 2017, which verified that the Managed Care Agency covered all her prescriptions, including Lyrica, at that particular pharmacy. The Appellant added that in her numerous conversations with the Managed Care Agency, she was informed that the Managed Care Agency ceased her prescription coverage as of September 13, 2017, yet the printout submitted by the Managed Care Agency indicated prescription coverage after September 13, 2017 by the Managed Care Agency.

Moreover, the Appellant argued that she never received any written notification of which pharmacies were approved and which were non-participating pharmacies and further argued that no such notice was included in the Agency's packet. The Appellant stated that she finally paid for the week of medication in question because without the medication, she is bedridden and is in constant pain. The Appellant stated that she is respectfully requesting reimbursement for the Appellant's out-of-pocket expense for the prescription Lyrica in the amount of $165.00 incurred on September 23, 2017, prior to the expiration of the Managed Care Agency's coverage.

The Appellant's statements and evidence presented were both credible and persuasive. It was noted that the Managed Care Agency failed to provide any evidence that the Appellant was advised that her pharmacy of choice was a non-participating pharmacy. In addition, the Managed Care Agency did not include any documentation to show that the Appellant's pharmacy was not on the list of participating pharmacies or when it was taken off of the list. The Appellant credibly stated that she had been a participant with the same Managed Care Agency for the past ten years and has always used the same pharmacy. She added that when she went to get her last prescription of Lyrica for the week of September 23, 2017, they declined coverage and later sent the denial letter, saying it was a non-participating pharmacy.

The Appellant's submission verified that the medication in question was covered and paid for by the Managed Care Agency at the Appellant's pharmacy, up until the date in question. The Appellant credibly testified that she did not receive any written or oral notification that her present pharmacy was a non-participating pharmacy. Based on the foregoing, the Managed Care Agency's determination to deny the Appellant reimbursement for the Appellant's out-of-pocket expense for the prescription Lyrica in the amount of $165.00 on the grounds that the pharmacy was a non-participating provider was not correct and is reversed.

DECISION AND ORDER

The determination by the Managed Care Agency to deny the Appellant's request for reimbursement for the Appellant's out-of-pocket expense for a prescription in the amount of $165.00 on the grounds that the pharmacy was a non-participating provider was not correct and is reversed.

The Managed Care Agency is directed to:

1. Approve the request for reimbursement for the Appellant's out-of-pocket expense for the prescription [redacted] in the amount of $165.00.

Should the Agency need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is requested, the Appellant must provide it to the Agency promptly to facilitate such compliance.

As required by 18 NYCRR 358-6.4, the Agency must comply immediately with the directives set forth above.

DATED: Albany, New York
01/17/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee

STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: July 15, 2016
[redacted]
AGENCY: Suffolk
FH #: 7345219J

In the Matter of the Appeal of

[redacted]

from a determination by the Suffolk County Department of Social Services

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on January 23, 2017, in Suffolk County, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Social Services Agency

Ms. Murphy, Fair Hearing Representative

ISSUE

Was the Agency's determination that the Appellant was not eligible under Medical Assistance ("Medicaid") for nursing facility services because the Appellant transferred assets for less than fair market value correct?

Was the Agency's determination to impose a penalty period of 6.18 months, during which the Appellant may not receive Medicaid coverage for the cost of nursing facility services correct?

FINDINGS OF FACT

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. On December 30, 2015, an application for Medicaid was made by or on behalf of the Appellant.

2. The Appellant is 85 years of age, and has been receiving nursing facility services in a local nursing facility, [redacted], since December 15, 2015. The Appellant was represented by the Law Offices of [redacted] and the nursing home for the purposes of the Medical Assistance application process. The nursing home requested an eligibility date of January 4, 2016.

3. Previously, on January 9, 2008, the Appellant and his spouse (the [redacted]) created an irrevocable trust, The [redacted] Family Irrevocable Trust, and immediately executed a deed conveying 100 percent of their interest in their homestead located at [redacted] to the trust. Said trust provided that the net income of the trust is payable to the [redacted], but prohibited the trustee of the trust from distributing principal of the trust to the [redacted]. In accordance with the Estates, Powers and Trust Law Section 7-1.6, the trust provided that the Court may not direct the trustees to distribute any trust principal to the [redacted].

4. The Article First of the [redacted] Family Trust states in pertinent part, "Additionally, in the event that the principal of the trust contains real property which serves as either of the [redacted]' primary residence, such residence shall continue to be held by the Trustee and made available to the Grantor or [redacted] as the [redacted]' primary residence for the duration of both of the [redacted]' lives, unless this provision is waived, in writing, by the [redacted] or the [redacted]' legal representatives…Such written waiver by the [redacted] may include binding instructions to the Trustee for the Trustee to pur[redacted] another residence, of either the [redacted]' own choosing, to be used by either of the [redacted] as a primary residence. During the period of either Grantor's residence in such primary residence, the [redacted] shall be responsible for paying all expenses of said residence, including, but not limited to, real estate taxes."

5. On or about May 31, 2014, the Appellant and his spouse, signed a lease agreement for an Independent Living Facility and ceased living in the residence, [redacted] in August 2014. Said residence was subsequently sold by the Trustee on January 15, 2015 to a third party, for $490,000.00, with the entire net proceeds of the sale deposited into the trust account.

6. The applicable Appellant actuarial value of a life estate interest in the residence in question, when sold on January 15, 2015 for $490,000.00, is $67,281.90. This was not in dispute.

7. By notice dated May 20, 2016, the Agency determined that the Appellant was not eligible under Medicaid for nursing facility services because the Appellant transferred assets valued at $82,633.38 for less than fair market value.

8. The Agency has been informed that the Appellant recently transferred certain property for less than its fair market value, and has evaluated that property as follows:

Date of Transfer	Description of Property	Value
October 23, 2013	**Cash to [redacted]**	**$10,000.00**
January 15, 2015	**Life Estate Sale**	**$67,281.90**
December 18, 2015	**Cash to [redacted]**	**$9,000.00**
December 30, 2015	**NYSARC Deposit**	**$10,000.00**
	Total	**$96,281.90**

Givebacks	Description of Property	Value
December 23, 2015	**½ amt. from Ms. [redacted] Since deposited back to C/S's only account**	**$4,500.00**
	Total	**$4,500.00**

9. The Agency computed the Appellant's uncompensated transfers as follows:

Total Transfers	$96,281.90
Less Resource Deficit	-$13,648.52
Uncompensated Transfers	$82,633.38
Less Givebacks	-$4,500.00
Total Transfers	$78,133.38
Divided by the Regional Rate	/$12,633.00
Penalty Period	6.18 months
Full Penalty Months	6 mos. x $12,633.00= $75,798.00
Total Transfers	$78,133.38
Less 6 mos. Penalty Amount	-$75,798.00
Partial Penalty Amount	$2,335.38

Transfer Penalty Begins	January 2016
Partial Penalty Month	July 2016

10. The Agency determined to impose a penalty period of 6.18 months, during which the Appellant may not receive Medicaid coverage for the cost of nursing facility services by dividing $78,133.38, the uncompensated value of transferred assets, by $12,633.00, the applicable regional rate.

11. On July 15, 2016, this fair hearing was requested on behalf of the Appellant.

APPLICABLE LAW

Sections 360-4.1 and 360-4.8(b) of 18 NYCRR (herein referred to as "the Regulations") provide that all income and resources actually or potentially available to a Medicaid applicant or recipient must be evaluated, but only such income and/or resources as are found to be available may be considered in determining eligibility for Medicaid. A Medicaid applicant or recipient whose available non-exempt resources exceed the resource standards will be ineligible for Medicaid coverage until he or she incurs medical expenses equal to or greater than the excess resources.

Under Section 360-4.4 of the Regulations, "Resources" are defined to include any liquid or easily liquidated resources in the control of an applicant or recipient, or anyone acting on his or behalf, such as a conservator, representative, or committee. Certain resources of a Medicaid-qualifying trust, as described in Section 360-4.5 of the Regulations, may also be counted in evaluating Medicaid eligibility.

Section 366.5(d) of the Social Services Law and Section 360-4.4(c)(2) of the Regulations govern Transfers of Assets made by an applicant or recipient or his or her spouse) on or after August 11, 1993. Section 366.5(e) governs transfers made on or after February 8, 2006.

Generally, in determining the Medicaid eligibility of a person receiving nursing facility services, either as an in-patient in a nursing facility (including an intermediate care facility for the mentally retarded), as an in-patient in a medical facility at a level of care such as is provided in a nursing facility, or as a recipient of care, services, or supplies at home pursuant to a waiver under section 1915(c) of the federal Social Security Act ("waivered services"), any transfer of assets for less than fair market value made by the person or his or her spouse within or after the "look-back period" will render the person ineligible for nursing facility services.

Pursuant to GIS 07 MA/018 if an individual applies for Medicaid coverage of home and community based waiver services, the applicant is only required to provide documentation of his/her current resources. The individual is not subject to a transfer of assets look-back period nor is the individual subject to a transfer penalty period.

For applications filed on or after August 1, 2006, for Medical Assistance coverage of nursing facility services, the "look-back period" is the period immediately preceding the date that an institutionalized individual is both institutionalized and has applied for Medical Assistance. Beginning February 1, 2009 the look back period will increase from 36 months to 37 months and

each month thereafter it will increase by one month until February 1, 2011 when a 60 month look-back period will be in place for all types of transfers of assets. 06 OMM/ADM-5. The uncompensated value of an asset is the fair market value of such asset at the time of transfer less any outstanding loans, mortgages, or other encumbrances on the asset, minus the amount of the compensation received in exchange for the asset. Social Services Law 366.5(e).

Section 366.5(e) of the Social Services Law provided that in the case of a trust established by the individual, any payment, other than a payment to or for the benefit of the individual, from a revocable trust is considered to be a transfer of assets by the individual and any payment, other than to or for the benefit of the individual, from the portion of an irrevocable trust which, under any circumstance, could be made available to the individual is considered to be a transfer of assets by the individual and, further, the value of any portion of an irrevocable trust from which no payment could be made to the individual under any circumstances is considered to be a transfer of assets by the individual for purposes of this section as of the date of establishment of the trust, or, if later, the date on which the payment to the individual is foreclosed.

Sections 366.5(d) and (e) of the Social Services Law provide that an individual will not be ineligible for Medicaid as a result of a transfer of assets if:

(a) the asset transferred was other than a homestead and was a disregarded or exempt asset under Section 360-4.4(d), 360-4.6, and/or 360-4.7 of the Regulations; or

(b) the asset transferred was a home, and title to the home was transferred to:

(1) the individual's spouse; or

(2) the individual's child, who is blind, disabled, or under the age of 21; or

(3) the individual's sibling, who has an equity interest in the home and was residing in the home for a period of at least one year immediately before the date the person became an institutionalized individual, or

(4) the individual's child, who was residing in the home for a period of at least two years immediately before the date the person became an institutionalized individual, and who provided care to the person which permitted her or him to continue residing at home rather than enter into an institution or facility; or

(c) the asset was transferred:

(i) to the individual's spouse or to another for the sole benefit of the spouse; or

(ii) from the individual's spouse to another for the sole benefit of the spouse; or

(iii) to the individual's child who is blind or disabled, or to a trust established solely for the benefit of such child; or

(iv) to a trust established solely for the benefit of a disabled person under 65 years of age.

(d) a satisfactory showing is made that:

(i) the individual or his or her spouse intended to dispose of the asset either at fair market value, or for other valuable consideration; or

(ii) the asset was transferred exclusively for a purpose other than to qualify for Medicaid; or

(iii) all assets transferred for less than fair market value have been returned to the individual.

A transfer for less than fair market value, unless it meets one of the above exceptions, will cause an applicant or recipient to be ineligible for nursing facility services for a period of months equal to the total cumulative uncompensated value of all assets transferred during or after the look-back period, divided by the average cost of care to a private patient for nursing facility services in the region in which such person seeks or receives nursing facility services, on the date the person first applies or recertifies for Medicaid as an institutionalized person. For purposes of this calculation, the cost of care to a private patient in the region in which the person is seeking or receiving such long-term care will be presumed to be 120 percent of the average Medicaid rate for nursing facility care for the facilities within the region. The average regional rate is updated each January first.

For uncompensated transfers made on or after February 8, 2006, the penalty period starts the first day of the month during or after which assets have been transferred for less than fair market value, or the first day of the month the otherwise eligible individual is receiving services for which Medical Assistance would be available but for the transfer penalty, whichever is later, and which does not occur during any other period of ineligibility. Social Services Law 366.5(e).

DISCUSSION

The Appellant did not appear or testify in this fair hearing. The issue to be decided is a matter of law, not fact, thereby obviating the requirement of a home hearing pursuant to Varshavsky v. Perales.

The Agency stipulated that the balance of [redacted] Acct. #[redacted] attributed to the Appellant as of January 1, 2016 should be $714.61, instead of $1,181.48, as utilized on the Agency's

snapshot. The Agency further stipulated that a credit of $9,005.00 should be deducted from the transfers in question, representing the payment made by the Appellant's pooled exception trust for the benefit of the Appellant. Said stipulations will reduce the transfer of assets penalty period, and will be implemented after the issuance of the Decision After Fair Hearing in the instant matter.

At the hearing, the Appellant's representative first contended that the Agency erred in its determination that the Appellant made an uncompensated transfer of his former residence pursuant to the family irrevocable trust. The representative explained that back on January 9, 2008, prior to the five year look-back period, the residence in question was placed into an irrevocable trust. The representative argued that pursuant to the Social Services Law Section 366(5)(e)(7) the transfer of assets by the individual for purposes of this section is considered as of the date of establishment of the trust. Therefore, the transfer of the residence in question was in 2008, well beyond the look-back period required for Medical Assistance eligibility determinations.

Next, the Appellant's representative argued that the imposition of a penalty period for failing to distribute a portion of the sale proceeds to the [redacted] would create a double penalty for the transfer of the same asset. The representative stated that under the provisions dealing with trusts, the 100 percent transfer of the Appellant's former residence was an uncompensated transfer on January 9, 2008. The representative asserted that the Agency erred in its determination to impose a transfer penalty on the portion of the residence, consisting of the actuarial value of a life estate interest in the residence in question, pursuant to the sale of the residence on January 15, 2015. The representative argued that an imposition of a transfer penalty of such transfer is in direct contradiction of Social Services Law Section 366(5)(e)(7). The representative based the aforementioned argument on the Department of Health and Human Services Healthcare Financing Administrative Transmittal No. 64, specifically Section 3259.6(G).

Third, the Appellant's representative contended that there was no life estate reserved in the deed of conveyance to the trust. While the Appellant and his spouse were allowed to reside in the residence pursuant to the trust instrument, such language in the trust did not create a life estate interest for the Appellant. The representative argued that the trust instrument clearly dictated that neither the Appellant nor his spouse could receive any principal from the trust. The representative stressed that the trust, in compliance with the Estates, Trusts and Powers Law, indicated that the Courts were also prohibited from any invasion of the trust principal for the benefit of the [redacted]. The representative stated that such irrevocable trust prohibited any principal to be given to the [redacted] and as such, the Appellant is not entitled to receive the actuarial value of a life estate interest in the residence in question.

The Appellant's representative asserted that the trust simply conveyed the [redacted] a limited right of occupancy. The representative explained that the trust clearly dictated that the Trustee is only required to continue to hold the residence as long as it serves as the [redacted] primary residence. The representative further explained that a life estate has additional rights, the right to exclude others from possession of the residence during lifetime, right to lease and

collect rents, and under certain circumstances, the right to force the sale of real property and collect the value of the life estate over the objections of the remaindermen. The Appellant's representative argued that the Appellant had none of those rights.

The representative added that the paying of expenses pertaining to the residence while it served as the [redacted] primary residence, does not elevate the right of occupancy to a life te [redacted]. The representative distinguished the Decision After Fair Hearing number 7373285Y which was cited by the Agency. The Appellant's representative noted that in the cited case, the life estate was created by the deed, and here, no life estate of the real property in question was created by the deed of conveyance to the trust. The representative submitted Decision After Fair Hearing number 5750910H, which held that language written in a trust, reserving onto the grantor the exclusive life use of said premises for so long as he shall continue to permanently reside thereon, is too indefinite to qualify as a life estate and instead constituted life use, which is extinguished by law once the grantor moved out of the home. It was further held that the Appellant was not entitled to be compensated from the proceeds of the sale.

The Appellant's representative also distinguished Decision After Fair Hearing, number 6952361Q, wherein, the representative stated that a husband and wife transferred their real property by quitclaim deed to themselves for life and the remaindermen, their two children. After the couple no longer resided in the real property, they paid the property taxes and utility bills. It was held that the Appellant had a life estate in the property. The representative stated that the issue for the instant fair hearing is different, as the former fair hearing focused on whether the payments of the property taxes and utility bills in question were uncompensated transfers, while here, it is whether the Appellant would be entitled to receive the actuarial value of a life estate interest upon the sale of property that had been conveyed to a trust without reservation of a life estate in the deed. As such, he maintained that the determination in the Decision After Fair Hearing number 6952361Q was not relevant.

The Appellant's representative then argued that the transfer of $10,000.00 to [redacted] and her spouse, was a gift from the Appellant to his granddaughter. The Appellant's daughter testified that she has two daughters. When her older daughter bought her first home, she received $10,000.00 from the Appellant as a gift towards her new home. The Appellant's daughter stated because her younger daughter was buying her first home, she also received a $10,000.00 gift from the Appellant, who always made sure that he treated both granddaughters equally. That $10,000.00 gift was the October 20, 2013 transfer in question. The representative argued that the gift was made exclusively for the purpose of treating his two grandchildren equally and not for the purpose of obtaining Medical Assistance benefits. The representative added that the gift of $10,000.00 did not leave the Appellant insolvent.

Last, the Appellant's representative stated that the $9,000.00 transfer to the Appellant's daughter, Ms. [redacted], was returned to the Appellant and was not subject to a transfer penalty. The representative explained that the Appellant's spouse received a Required Minimum Distribution in the amount of $9,675.57, and after taxes, $8,708.01 was deposited into an account owned jointly by the Appellant's spouse, the Appellant and the Appellant's daughter. In error, the Appellant's daughter withdrew $9,000.00 from said account and deposited it into an account in

her name only. Five days later, after realizing her error, she transferred the $9,000.00 from her account to an account held jointly by the Appellant's spouse and herself only. The representative asserted that $8,708.01 belonged to the Appellant's spouse and the deposit into the Appellant spouse's account constituted the return of Appellant spouse's funds to her from the person to whom they were transferred. All monies were returned to the Appellant's spouse in its entirety.

Based on the aforementioned arguments, the Appellant's representatives requested the Agency be directed to re-evaluate the Appellant's Medical Assistance budget without the imposition of a transfer penalty pertaining to the actuarial value of a life estate interest of the Appellant's former residence from the [redacted] Family Irrevocable Trust, the $10,000.00 gift and the $9,000.00 transfer, as such monies were returned to the person from whom they were transferred in its entirety.

The Agency noted that the residence placed into the irrevocable trust was the primary residence of the Appellant and his spouse. On January 15, 2015, the residence was sold for $490,000.00 and actuarial value of the life estate interest was $67,281.90, but the Appellant did not receive any of the proceeds of the sale. The Agency further noted that the deed did not make any reference to reserving a life estate for the Appellant or his spouse, but there is no law limiting the establishment of a life estate only through a deed. The Agency stated that the language of the trust instrument conveyed a life estate upon the Appellant and his spouse. The Agency submitted Decision After Fair Hearing, number 7373285Y, where it was held that the language of a trust instrument did create a life estate interest. The Agency explained that pursuant to the trust instrument, the only way to relinquish the life estate interest, is for the [redacted] to waive, in writing, the provision that the property be held for their use, which, to date, has not been provided to the Agency.

The Agency next contended that the $10,000.00 transfer from the Appellant to his Granddaughter was an uncompensated transfer and the burden of proof rests with the Appellant's representatives to rebut such presumption.

The Agency then contended that the $9,000.00 withdrawn from the Appellant, his spouse and his daughter's bank account, was subsequently returned to an account owned only by the Appellant's spouse and daughter, therefore, only half of the monies, $4,500.00, can be considered a give-back.

In the instant case, there was no dispute that the trust instrument reserved the Appellant and his spouse the right to reside in the residence during their lifetime, and required them to pay housing expenses for the residence such as real property taxes. However, the Appellant and his spouse did not have all of the rights accorded a life tenant, such as the right to rent out the property or to convey any additional rights with respect to the property in question.

The prior Decision After Fair Hearing number 7373285Y cited by the Agency is distinguishable from the instant case in that the cited decision found that payments for taxes and maintenance on property in which the appellant and his spouse were granted an exclusive right to

use and occupy were not transfers that were undertaken for the purpose of qualifying for Medical Assistance.

Regarding the remaining transfers, the Appellant's daughter testified that the Appellant gave her older daughter a $10,000.00 gift when she bought her first house and the transfer in question of $10,000.00 gift to his second granddaughter for the same purpose, was made not for the purposes of qualifying for Medical Assistance, but only as a gift with the Appellant's intent on treating his two granddaughters equally. The Appellant representatives did not submit any evidence of the prior $10,000.00 gift made by the Appellant to his first granddaughter, such as a statement from the first recipient. The burden of proof lies with the Appellant's representatives to rebut the presumption of a transfer. In this case; no pattern of gift-giving was established.

Finally, the Appellant representative's argument that the $9,000.00 was not an uncompensated transfer because the monies in question were returned to the Appellant spouse from the person to whom they were transferred in its entirety was not persuasive. The Appellant's daughter withdrew the monies in question from the joint account of the Appellant, his spouse and herself. She placed the monies into an account where she was the sole owner. The Appellant's daughter then withdrew the monies, but deposited them into an account owned by herself and the Appellant spouse only. Only half of the monies, $4,500.00 can be counted as a giveback. Had the Appellant's daughter placed the monies back into the account from which she originally withdrew the funds, only then it would be considered a $9,000.00 giveback.

Accordingly, the Agency's determination that the Appellant was not eligible under Medical Assistance ("Medicaid") for nursing facility services because the Appellant transferred assets for less than fair market value was proper. However, the Agency incorrectly determined to impose a penalty period of 6.18 months during which the Appellant may not receive Medicaid coverage for the cost of nursing facility services. In addition to the terms of its stipulation set forth above, the Agency should disregard the amount of $67,281.90 from January 15, 2015 that it included in determining amount assets transferred by the Appellant without compensation.

DECISION AND ORDER

Pursuant to an agreement between the parties, the Agency is directed to, if it has not already done so:

1. The Agency is directed to re-calculate the Appellant's Medical Assistance budget by correcting the balance of [redacted] Acct. #[redacted] attributed to the Appellant as of January 1, 2016 should be $714.61, instead of $1,181.48, as utilized on the Agency's snapshot.

2. The Agency is directed to re-calculate the Appellant's Medical Assistance eligibility by providing a credit of $9,005.00 which should be deducted from the transfers in question, representing the payment made by the Appellant's pooled exception trust for the benefit of the Appellant.

The Agency's determination that the Appellant was not eligible under Medical Assistance ("Medicaid") for nursing facility services because the Appellant transferred assets for less than fair market value is not correct and is reversed.

1. The Agency is directed to disregard the amount of $67,281.90 from January 15, 2015 that it included in determining assets transferred by the Appellant without compensation.

Should the Agency need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is requested, the Appellant must provide it to the Agency promptly to facilitate such compliance.

As required by 18 NYCRR 358-6.4, the Agency must comply immediately with the directives set forth above.

DATED: Albany, New York
02/17/2017

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissione[redacted]

STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: December 29, 2017
[redacted]
AGENCY: Suffolk
FH #: 7674989K

In the Matter of the Appeal of

[redacted]

from a determination by the Suffolk County Department of Social Services

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on January 23, 2018, in Suffolk County, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Social Services Agency

Ms. Wolanski, Fair Hearing Representative

ISSUE

Was the Agency's determination to discontinue the Appellant's Medical Assistance for failure to apply for Medicare correct?

FINDINGS OF FACT

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. The Appellant, age 74, has been in receipt of Medical Assistance for himself.

2. The Appellant was advised by the Agency on November 13, 2017 to submit the following documentation to the Agency by December 11, 2017:

Verification from Social Security that he applied for Medicare.

3. The Appellant failed to submit the following requested documents:

Verification from Social Security that he applied for Medicare.

4. On November 13, 2017, the Agency sent a Notice of Intent setting forth its determination to discontinue the Appellant's Medical Assistance because the Appellant had failed to apply for Medicare.

5. On December 29, 2017, the Appellant requested this fair hearing.

APPLICABLE LAW

Regulations at 18 NYCRR 360-2.3(c)(1) provide that, in determining whether an applicant for or recipient of Medical Assistance is financially eligible therefor, the social services district must review all sources of income and resources available or potentially available to the applicant/recipient. To be eligible for Medical Assistance, the applicant must pursue any potential income and resources that may be available.

Administrative Directive (OHIP/ ADM) 17 OHIP/ ADM-01, dated October 24, 2017, provided local departments of social services (LDSS) with information and guidance regarding the requirement for certain Medicaid applicants/recipients (A/Rs) to apply for Medicare as a condition of Medicaid eligibility. Some individuals get Medicare automatically and others must sign up for it.

Pursuant to this directive, effective November 1, 2017, local districts must ensure that Medicaid A/Rs age 65 or older, or turning age 65 within the next three months, apply for Medicare unless otherwise excluded. Individuals who fail to meet this requirement will have their Medicaid eligibility denied or discontinued following timely notice, as appropriate.

To facilitate a process for the identification of individuals who are required to apply for Medicare as a condition of Medicaid eligibility, the Department has made enhancements to the Welfare Management System (WMS) to identify individuals turning age 65 who appear to meet the requirements for Medicare and to automate a notice requiring the individuals to submit proof of application for Medicare. If an individual does not provide the required verification by the designated due date, Medicaid coverage will be automatically discontinued following timely notice.

This requirement applies to individuals who are eligible for payment of their premiums either through the Medicare Savings Program or as a fully eligible Medicaid recipient (without deducting the premium payment from income). These Medicaid A/Rs are required to apply for Medicare as these benefits will reduce the costs incurred by the Medicaid program. Individuals presumptively eligible, individuals who are not fully eligible for Medicaid and individuals who have income above 120% of the FPL are excluded from the requirement to apply for Medicare as

a condition of Medicaid eligibility. Most immigrants and non-citizens are excluded from this requirement. Only lawful permanent residents who have lived in the U.S. continuously for five years must apply for Medicare as a condition of Medicaid eligibility.

Pursuant to GIS Message 13 MA/012, local departments of social services were reminded that individuals having access to third party health insurance must pursue and enroll in TPHI that is free or cost effective as a condition of Medicaid eligibility. When an applicant has access to health insurance at the time of application or renewal, the individual must provide information needed to determine if the insurance is cost effective. Failure to cooperate in pursuing and enrolling in third party health insurance will result in discontinuance or denial of benefits for the applicant/recipient who is also the policy holder.

DISCUSSION

At the hearing, the Agency representative argued that as Appellant was over sixty-five years old, the Appellant was required to apply for Medicare because the cited regulations state that he must pursue any potential income and resources.

The Appellant acknowledged at the hearing that he received the Document Request letter dated November 13, 2017. The Appellant stated that he believed that his application for Social Security Retirement benefits in 2014 and denial letter dated March 15, 2014 established he applied for Medicare. In support of this he submitted the letter time stamped December 6, 2017, contending it establishes he has earned 12 work credits and needs 40 work credits to be eligible for Social Security Retirement benefits. It was noted that the subject letter stated that in 2014 he was short of the required 40 work credits. On inquiry, the Appellant stated he did not earn any more work credits and is not eligible for Social Security but he applied for Supplemental Security Income (SSI) with a letter of January 8, 2018, for which he has an appointment on February 13, 2018. He has not submitted the SSI letter until this fair hearing and believes this establishes he applied for Medicare.

The Appellant's letters do not establish an application for Medicare. They do establish he applied for and was denied for Social Security Retirement benefits for lack of the required work credits and that he applied for SSI in January 2018 but no record of an application or denial of Medicare. The Appellant's contentions did not establish an application or a valid basis for the Appellant's failure to provide the requested documentation. The Appellant's statements were also uncorroborated by any documentary evidence to show timely request of the benefits such as a copy of the application and or receipt of application for Medicare.

Under the authority cited above, to be eligible for Medical Assistance, an applicant for or a recipient of Medical Assistance must apply for Medicare. In addition, an applicant or recipient must pursue any potential income and resources that may be available, including any potential third-party health insurance. The Appellant did not establish good cause for not applying for Medicare.

Accordingly, the Agency's discontinuance of Appellant's Medical Assistance is

sustained.

DECISION

The Agency's determination to discontinue the Appellant's application for Medical Assistance for failure to apply for Medicare was correct.

DATED: Albany, New York
01/24/2018

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee

149 A.D.3d 476 (2017)
2017 NY Slip Op 02759
52 N.Y.S.3d 89

NINA TOKHTAMAN, Respondent,

v.

HUMAN CARE, LLC, Appellant, et al., Defendants.

3671, 151268/16.

Appellate Division of the Supreme Court of New York, First Department.

Decided April 11, 2017.

Order, Supreme Court, New York County (Carol R. Edmead, J.), entered August 23, 2016, which denied defendant Human Care, LLC's motion to dismiss the complaint, unanimously affirmed, without costs.

Concur — Sweeny, J.P., Andrias, Moskowitz, Kahn and Gesmer, JJ.

Defendants are not entitled to dismissal of the minimum wage, overtime, and failure to pay wages claims. The merit of these claims depends on whether plaintiff, who was employed by defendants as a home health care attendant, falls within the category of employees who need only be paid for 13 hours of every 24-hour shift. We find that plaintiff has sufficiently alleged that she does not fall within that category.

Department of Labor Regulations (12 NYCRR) § 142-2.1 (b) provides that the minimum wage must be paid for each hour an employee is "required to be available for work at a place prescribed by the employer," except that a "residential employee — one who lives on the premises of the employer" need not be paid "during his or her normal sleeping hours solely because he is required to be on call" or "at any other time when he or she is free to leave the place of employment"
477 (12 NYCRR 142-2.1 [b] [1], [2]). A March 11, 2010 Department of Labor (DOL) *477 opinion letter provides further guidance regarding this regulation, advising that "live-in employees," whether or not they are "residential employees," "must be paid not less than for thirteen hours per twenty-four hour period provided that they are afforded at least eight hours for sleep and actually receive five hours of uninterrupted sleep, and that they are afforded three hours for meals" (NY St Dept of Labor Op No. RO-09-0169 at 4 [Mar. 11, 2010]).

"[C]ourts are not required to embrace a regulatory construction that conflicts with the plain meaning of the promulgated language" (*Matter of Visiting Nurse Serv. of N.Y. Home Care v New York State Dept. of Health*, 5 NY3d 499, 506 [2005]), or that is "irrational or unreasonable" (*Samiento v World Yacht Inc.*, 10 NY3d 70, 79 [2008] [internal quotation marks omitted]).

We find that the DOL opinion conflicts with 12 NYCRR 142-2.1 (b) insofar as the opinion fails to distinguish between "residential" and "nonresidential" employees, and should thus not be followed in this respect (*see Lai Chan v Chinese-American Planning Council Home Attendant Program, Inc.*, 50 Misc 3d 201, 213-216 [Sup Ct, NY County 2015]; *Andryeyeva v New York Health Care, Inc.*, 45 Misc 3d 820, 826-833 [Sup Ct, Kings County 2014]; *see also Kodirov v Community Home Care Referral Serv., Inc.*, 35 Misc 3d 1221[A], 2012 NY Slip Op 50808[U], *2 [Sup Ct, Kings County 2012]). As such, if plaintiff can demonstrate that she is a nonresidential employee, she may recover unpaid wages for the hours worked in excess of 13 hours a day.

Plaintiff alleges that she "maintained her own residence, and did not `live in' the homes of Defendants' clients." Although plaintiff admitted that she "generally worked approximately 168 hours per week" (or 24 hours a day, 7 days a week), it cannot be said at this early stage, prior to any discovery, that she lived on her employers' premises as a matter of law.

Because the viability of plaintiff's "spread of hours" claim (*see* Dept of Labor Regulations [12 NYCRR] § 142-2.4 [a]) likewise turns on whether plaintiff is entitled to be paid for the full 24 hours worked or only 13 of those hours, the motion court correctly denied the motion to dismiss as to that claim.

Defendants are not entitled to dismissal of the breach of contract claim. Plaintiff has standing to sue as a third-party beneficiary of the alleged contracts requiring defendants to pay plaintiff certain wages pursuant to Public Health Law §

3614-c (*see* Cox v NAP Constr. Co., Inc., 10 NY3d 592, 601-603 [2008]; *Moreno v Future Care Health Servs., Inc.*, 43 Misc
478 3d 1202[A], *478 2014 NY Slip Op 50449[U], *23-25 [Sup Ct, Kings County 2014]). The breach of contract allegations give sufficient notice of the nature of the claim (*JP Morgan Chase v J.H. Elec. of N.Y., Inc.*, 69 AD3d 802, 803 [2d Dept 2010]; *see also* Second Source Funding, LLC v Yellowstone Capital, LLC, 144 AD3d 445, 446 [1st Dept 2016]). Although the complaint does not specifically identify the contracts or government agencies at issue, its citation to Public Health Law § 3614-c makes clear that the contracts referenced are those required for every company providing health care services that seek reimbursement from Medicaid or Medicare (*see* Public Health Law § 3614-c; *Matter of* Concerned Home Care Providers, Inc. v State of New York, 108 AD3d 151, 153-154 [3d Dept 2013], *appeal dismissed* 22 NY3d 946 [2013], *lv denied* 22 NY3d 859 [2014]; *Moreno*, 2014 NY Slip Op 50449[U], *23-25).

2017 NY Slip Op 06421

LILYA ANDRYEYEVA, INDIVIDUALLY AND ON BEHALF OF ALL OTHERS SIMILARLY SITUATED, ET AL., Respondents,

v.

NEW YORK HEALTH CARE, INC., DOING BUSINESS AS NEW YORK HOME ATTENDANT AGENCY, ET AL., Appellants.

2014-09087, Index No. 14309/11.

Appellate Division of the Supreme Court of New York, Second Department.

Decided September 13, 2017.

In a putative class action to recover damages for violations of Labor Law article 19, the defendants appeal from an order of the Supreme Court, Kings County (Demarest, J.), dated September 16, 2014, which granted the plaintiffs' renewed motion for class certification pursuant to CPLR article 9.

Cohen Tauber Spievack & Wagner P.C., New York, NY (Stephen Wagner, Sari E. Kolatch, and Jackson S. Davis of counsel), for appellants.

Beranbaum Menken LLP, New York, NY (Jason Rozger, of counsel), for respondents.

Littler Mendelson, P.C., Melville, NY (Lisa M. Griffith of counsel), for amici curiae Home Care Association of New York State, LeadingAge New York, and Home Care Association of America.

Hodgson Russ, LLP, New York, NY (Peter C. Godfrey, John M. Godwin, and Emina Poricanin of counsel), for amicus curiae New York State Association of Health Care Providers, Inc.

Before: Ruth C. Balkin, J.P., L. Priscilla Hall, Hector D. Lasalle, Betsy Barros, JJ.

DECISION & ORDER

ORDERED that the order is affirmed, with costs.

The plaintiffs were employed by the defendant New York Health Care, Inc., doing business as New York Home Attendant Agency (hereinafter NYHC), as home health care attendants for NYHC's elderly and disabled clients. The plaintiffs allegedly worked at the clients' residences in 24-hour shifts. They alleged that they did not "live in" the homes of NYHC's clients and that they were not "working in the home of their employer," NYHC. The plaintiffs were paid an hourly rate for the 12 daytime hours of their 24-hour shifts and a flat rate for the 12 nighttime hours. The plaintiffs commenced this action, contending that they were entitled to the minimum wage for each hour of their 24-hour shifts and that NYHC's payment practice violated the Labor Law and 12 NYCRR 142-2.1(b) (hereinafter the Wage Order) because it resulted in a regular hourly wage that was below the minimum wage.

In February 2014, after the Supreme Court had initially denied, as premature, the plaintiffs' motion to certify the action as a class action, the plaintiffs made a renewed motion to certify a class of approximately 1,063 home attendants who had worked 24-hour shifts for NYHC between December 28, 2007, and March 8, 2013. In opposition, the defendants contended that they were not required to pay home attendants for each hour of a 24-hour shift, but were permitted to exclude 8 hours of sleep time and 3 hours of meal time from the home attendants' wages, so long as that time for sleep and meals was actually afforded. In support of their contention, the defendants relied on, among other things, an opinion letter issued by the New York State Department of Labor (hereinafter DOL), which interpreted the Wage Order. The defendants thus contended that, contrary to the plaintiffs' contention, the members of the class could not simply rest on proof that they worked 24-hour shifts; they would each also be required to prove that they had not been afforded their sleep and meal times during those shifts. In light of the need for such a fact-intensive inquiry as to each member of the putative class, the defendants contended that the plaintiffs could not meet the numerosity, commonality, and typicality requirements for class certification,

and that class certification should therefore be denied. The Supreme Court granted the renewed motion for class certification. The defendants appeal, and we affirm.

As relevant here, subsection (b) of the Wage Order (12 NYCRR 142-2.1 ["Basic minimum hourly wage rate and allowances"]) provides: "The minimum wage shall be paid for the time an employee is . . . required to be available for work at a place prescribed by the employer. . . . However, a residential employee—one who lives on the premises of the employer—shall not be deemed to be . . . required to be available for work . . . during his or her normal sleeping hours solely because he or she is required to be on call during such hours; or . . . at any other time when he or she is free to leave the place of employment" (*see* 12 NYCRR 142-3.1[b] [substantively identical provision applicable to employees in nonprofitmaking institutions]). A March 11, 2010, DOL opinion letter advises that "live-in employees," whether or not they are "residential employees," "must be paid not less than for thirteen hours per twenty-four hour period provided that they are afforded at least eight hours for sleep and actually receive five hours of uninterrupted sleep, and that they are afforded three hours for meals" (NY St Dept of Labor, Op No. RO-09-0169 at 4 [Mar. 11, 2010]). As we have already noted, the defendants rely on this letter as support for their payment practices.

"The construction given statutes and regulations by the agency responsible for their administration, if not irrational or unreasonable, should be upheld" (*Samiento v World Yacht Inc.*, 10 NY3d 70, 79 [internal quotation marks omitted]). On this appeal, the defendants and the plaintiffs do not dispute the status of the putative members of the class as nonresidential employees. Thus, we must determine whether the DOL's interpretation of the Wage Order is rational or reasonable insofar as it permits NYHC's payment practices with respect to nonresidential aides. We agree with our colleagues in the Appellate Division, First Department, that the DOL's interpretation is neither rational nor reasonable, because it conflicts with the plain language of the Wage Order (*see Tokhtaman v Human Care, LLC*, 149 AD3d 476, 477; *see generally Matter of Visiting Nurse Serv. of N.Y. Home Care v New York State Dept. of Health*, 5 NY3d 499, 506). The plaintiffs were required to be at the clients' residences and were also required to perform services there if called upon to do so. To interpret that regulation to mean that the plaintiffs were not, during those nighttime hours, "required to be available for work" simply because it turned out that they were not called upon to perform services is contrary to the plain meaning of "available" (12 NYCRR 142-2.1[b]; *cf. Severin v Project OHR, Inc.*, 2012 WL 2357410, *8, 2012 US Dist LEXIS 85705, *24-25 [SD NY, June 20, 2012, No. 10 Civ. 9696 (DLC)]). In short, to the extent that the members of the proposed class were not "residential" employees who "live[d] on the premises of the employer," they were entitled to be paid the minimum wage for all 24 hours of their shifts, regardless of whether they were afforded opportunities for sleep and meals (12 NYCRR 142-2.1[b]; *see Tokhtaman v Human Care, LLC*, 149 AD3d at 477; *see generally Yaniveth R. v LTD Realty Co.*, 27 NY3d 186, 192-193; *Matter of Settlement Home Care v Industrial Bd. of Appeals of Dept. of Labor of State of N.Y.*, 151 AD2d 580, 581-582).

The defendants' arguments regarding class certification are premised on their contention that the DOL's opinion letter is in accord with the Wage Order. Inasmuch as we reject the DOL's interpretation of the Wage Order, we also find that, on their renewed motion, the plaintiffs established the existence of the five prerequisites to class certification (*see* CPLR 901[a]; *City of New York v Maul*, 14 NY3d 499, 508, 514), and none of the factors listed in CPLR 902 warranted a denial of the motion (*see Jiannaras v Alfant*, 124 AD3d 582, 584, *affd* 27 NY3d 349; *Dowd v Alliance Mtge. Co.*, 74 AD3d 867, 869; *Argento v Wal-Mart Stores, Inc.*, 66 AD3d 930, 934). Accordingly, the Supreme Court providently exercised its discretion in granting the plaintiffs' renewed motion for class certification.

The defendants' remaining contention is without merit.

BALKIN, J.P., HALL, LASALLE and BARROS, JJ., concur.

2017 NY Slip Op 06439

ADRIANA MORENO, INDIVIDUALLY AND ON BEHALF OF ALL OTHERS SIMILARLY SITUATED, ET AL., Appellants,

v.

FUTURE CARE HEALTH SERVICES, INC., ET AL., Respondents.

Not in Source.

Appellate Division of the Supreme Court of New York, Second Department.

Decided September 13, 2017.

In a putative class action, inter alia, to recover damages for violations of Labor Law article 19, the plaintiffs appeal (1) from an order of the Supreme Court, Kings County (Schmidt, J.), dated April 24, 2015, which denied their motion for class certification pursuant to CPLR article 9, and (2), as limited by their brief, from so much of an order of the same court (Knipel, J.) dated October 27, 2015, as, upon reargument, adhered to the original determination in the order dated April 24, 2015.

Getman & Sweeney, PLLC, New Paltz, NY (Michael J. D. Sweeney and Artemio Guerra of counsel), Abbey Spanier, LLP, New York, NY (Judith L. Spanier and Nancy Kaboolian of counsel), and National Employment Law Project, New York, NY (Catherine Ruckelshaus and Sarah Leberstein of counsel), for appellants (one brief filed).

Peckar & Abramson, P.C., New York, NY (Aaron C. Schlesinger and Alexander X. Saunders of counsel), for respondents.

Before: Ruth C. Balkin, J.P., L. Priscilla Hall, Hector D. Lasalle, Betsy Barros, JJ.

DECISION & ORDER

ORDERED that the appeal from the order dated April 24, 2015, is dismissed, as that order was superseded by the order dated October 27, 2015, made upon reargument; and it is further,

ORDERED that the order dated October 27, 2015, is reversed insofar as appealed from, on the law and in the exercise of discretion, upon reargument, the order dated April 24, 2015, is vacated, and the plaintiffs' motion for class certification pursuant to CPLR article 9 is granted; and it is further,

ORDERED that one bill of costs is awarded to the plaintiffs.

The plaintiffs were employed by the defendant Future Care Health Services, Inc. (hereinafter Future Care), as home health care attendants for Future Care's disabled and elderly clients. The plaintiffs worked a number of 24-hour shifts for Future Care for which they were paid flat rates of $115 to $125 per shift, and they allegedly did not "live-in" the homes of Future Care's clients. The plaintiffs commenced this action, alleging that Future Care's practice of paying them a flat rate for their 24-hour shifts resulted in a wage that was below the minimum wage in violation of the Labor Law.

The plaintiffs moved to certify a class of home health care attendants who had worked 24-hour shifts for Future Care after February 6, 2007, and had been paid a flat daily rate instead of the minimum wage for each hour of the shift. The Supreme Court denied the motion. Relying on an opinion letter issued by the New York State Department of Labor (hereinafter DOL) on March 11, 2010, the court concluded that Future Care was not required to pay the plaintiffs for each hour of a 24-hour shift, but was permitted to exclude 8 hours of sleep time and 3 hours of meal time from the plaintiffs' wages, so long as that time was actually afforded. Based on its interpretation of the opinion letter, the court concluded that the plaintiffs had failed to establish the numerosity, commonality, and typicality requirements for class certification because a fact-intensive individualized inquiry would be required for each putative class member to determine whether each putative class member was actually afforded 8 hours of sleep time and 3 hours of meal time during each 24-hour shift. Upon reargument, the court adhered to its original determination.

To the extent that the DOL's opinion letter fails to distinguish between "residential" and nonresidential employees, it conflicts with the plain meaning of 12 NYCRR 142-2.1(b), and should not be followed (*see Andryeyeva v New York Health Care, Inc.,*

___ AD3d ___, _____ [decided herewith]; *Tokhtaman v Human Care, LLC*, 149 AD3d 476, 477). To the extent that the members of the proposed class were not "residential" employees who "live[d]" on the premises of their employer, they were entitled to be paid the minimum wage for all 24 hours of their shifts, regardless of whether they were afforded opportunities for sleep and meals (12 NYCRR 142-2.1[b]; *see Andryeyeva v New York Health Care, Inc.*, _____ AD3d at _____ [decided herewith]; *see generally Yaniveth R. v LTD Realty Co.*, 27 NY3d 186, 192-193; *Matter of Settlement Home Care v Industrial Bd. of Appeals of Dept. of Labor of State of N.Y.*, 151 AD2d 580, 581-582).

The plaintiffs established the existence of the five prerequisites to class certification (*see* CPLR 901[a]; *City of New York v Maul*, 14 NY3d 499, 508, 514), and none of the factors listed in CPLR 902 warranted a denial of the motion for class certification (*see Jiannaras v Alfant*, 124 AD3d 582, 584, *affd* 27 NY3d 349; *Dowd v Alliance Mtge. Co.*, 74 AD3d 867, 869; *Argento v Wal-Mart Stores, Inc.*, 66 AD3d 930, 934). Accordingly, upon reargument, the Supreme Court should have vacated its original determination and granted the plaintiffs' motion for class certification (*see Andryeyeva v New York Health Care, Inc.*, _____ AD3d at _____ [decided herewith]).

BALKIN, J.P., HALL, LASALLE and BARROS, JJ., concur.

New York State Department of Labor
David A. Paterson, *Governor*
Colleen Gardner, *Commissioner*

March 11, 2010

[redacted]

Re: Request for Opinion
Live-In Companions
RO-09-0169

Dear [redacted]:

I have been asked to respond to your letter dated November 23, 2009, in which you ask several questions regarding employees providing "companionship services" within the meaning of the federal Fair Labor Standards Act (FLSA) exemption for such services. Your letter asks four questions for which you request that it be assumed that your client's employees are within the FLSA companionship exemption. Each of your questions is discussed individually below.

1. *Under New York State Law, must my client pay these home health aides overtime? If so, after how many hours of work during a particular week does that obligation obtain, and under which state statute/regulation(s)?*

The New York State Minimum Wage Act, which contains the State minimum wage and overtime provisions, generally applies to all individuals who fall within its definition of "employee." (*see*, Labor Law §651 *et seq.*) Section 651(5) defines "employee" as "any individual employed or permitted to work by an employer in any occupation," but excludes fifteen categories of workers from that definition. (*see*, Labor Law §651(5)(a-o).) Subpart 2.2 of the Minimum Wage Order for Miscellaneous Industries and Occupations (12 NYCRR §142-2.2) provides, in relevant part, that all "employees" must be paid at a rate not less than one and one half times their regular rate of pay in accordance with the provisions and exceptions of the FLSA. Subpart 2.2 also provides that employees exempted under Section 13 of the FLSA must nevertheless be paid overtime at a rate not less than one and one half times the minimum wage. In short, "exempt" employees under Section 13 of the FLSA must be paid at a rate of not less than one and one half times the minimum wage for overtime hours worked unless such employees fall outside of the New York Minimum Wage Act's definition of "employee."

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Your letter requests that the Department assume that the employees in question fit within the "companionship services" exemption of the FLSA. Since that exemption is contained in Section 13 of the FLSA (29 USC §213(a)(15)), the employees described in your letter are required to be paid not less than one and one half times the minimum wage rate for all hours worked in excess of forty hours per workweek should such individuals be non-residential employees, and forty-four hours per workweek should they be residential employees.[1] However, it is worth noting that such employees are nevertheless subject to the remaining provisions of the Minimum Wage Orders including, for example, the requirement that employees be paid not less than the minimum wage, for spread of hours pay, call-in pay, and split-shift pay.

It is worth noting that Article 19 of the New York State Labor Law [Minimum Wage Act] excludes "companions" from its definition of "employee," and therefore from the coverage of the Minimum Wage Orders. (Labor Law §651(5)(a).) That provision provides that "someone who lives in the home of an employer for the purpose of serving as a companion to a sick, convalescing or elderly person, and whose principal duties do not include housekeeping" is excluded from the definition of the term "employee." (Id.) In *Settlement Home Care v. Industrial Board of Appeals*, 151 A.D.2d 580, 581 (2d Dep't 1989), the Third Department affirmed a decision of the Industrial Board of Appeals holding that "sleep-in home attendants" did not fall within the exception contained in Section 651(5)(a) and noted that the exemption may not be found applicable unless "*all* of the statutory requirements have been established." (*Id.* at 582 [Emphasis added]). The Court set forth three mandatory requirements, which it derived directly from Section 651(5)(a), to determine whether an employee fits within the "companionship exception": (1) the individual must "live in the home of an employer," (2) the individual must be employed "for the purpose of serving as a companion to a sick, convalescing or elderly person," and (3) that the individual's "principle duties do not include housekeeping." (*Id* at 582-583.) Since your letter does not request an evaluation of the applicability of that exception, or sufficient facts upon which to make such an evaluation, no opinion is offered as to its applicability at this time.

2. *Would your answer to "1," above, change if the home health care aide's hourly wage exceeded the New York State minimum wage?*

As the answer to the question above states, the employees described in your letter are not exempted from the requirement that the minimum wage be paid as no exception to the applicability of the State Minimum Wage Act has been shown to apply. However, should the employees be paid in excess of one and one half times the minimum wage rate, no premium payment is required for any overtime hours worked.

3. *Would your answer to "1," above, change if the home health aide was a licensed practical nurse?*

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[1] Residential employee is defined by 12 NYCRR §142-2.1 as "one who lives on the premises of the employer." For further discussion of "residential employees," please see the decision of the Second Department in *Settlement Home Care v. Industrial Bd. of Appeals of Dep't of Labor*, 151 A.D.2d 580 (1989).

Please be advised that licensed practical nurses do not fit within the "companionship services" exemption to the FLSA and, as such, such individuals would be subject to the overtime provisions in both the FLSA and the New York State Labor Law. (See, 29 USC §213(a)(15); 29 CFR Part 541; FLSA Fact Sheet No. 25.)

4. *Under New York State law, must my client pay the "spread" set forth at 12 NYCRR Section 142-2.4 when an aide's work exceeds 10 hours?*

Regulation 12 NYCRR §142-2.4(1) states that "[a]n employee shall receive one hour's pay at the minimum hourly wage rate, in addition to the minimum wage required by this part for any day in which: (a) the spread of hours exceeds 10 hours..." The term "spread of hours" is defined by 12 NYCRR §142-1.28 as "the interval between the beginning and end of an employee's workday. The spread of hours includes working time plus time off for meals plus intervals off duty." The "spread of hours" regulation applies to all "employees" defined in 12 NYCRR §142-2.14 regardless of whether such employees fit with a FLSA exemption for overtime pay (except those persons exempted from the definition of "employee" as set forth in Section 651(5) of the Labor Law). It is important to note that the "spread of hours" regulation does not require all employees to be paid for an additional hour, but merely that the total wages paid be equal to or greater than the total due for all hours at the minimum wage and overtime rate, plus one additional hour at the minimum wage for each day in which a "spread" is required to be paid.

As stated above, since nothing in your letter provides a basis to exclude the employees in question from the requirement of the Minimum Wage Orders, it appears that your client is required to pay the "spread" set forth in the Minimum Wage Orders as described above.

5. *Under New York State law, if a home health care aide "lives in," what hours count towards calculating a ten hour day?*

To answer this question, it is necessary to determine the number of hours worked by a live-in employee. To do so, we must distinguish between "on call" and "subject to call" time as employees must be paid for all time spent "on call." "On call" time is that time during which employees are required to remain at the prescribed workroom or workplace, awaiting the need for the immediate performance of their assigned duties. Employees who are "on call" are considered to be working during all the hours that they are confined to the workplace including those hours in which they do not actually perform their duties. "Subject to call" time is that time in which employees are permitted to leave the work room or workplace between work assignments to engage in personal pursuits and activities. In some cases, employees who are "subject to call" may be restricted to a specified area, to be reachable by telephone or otherwise, to report to the work assignments within 15 to 30 minutes, etc. In cases in which an employee is "subject to call," working time starts when they are actually ordered to a specific assignment or at the time in which they perform work for the employer.

Regulation 12 NYCRR §142-2.1 provides that the minimum wage shall be paid to employees for the time an employee is permitted to work or is required to be available to work at

a place prescribed by the employer. However, that regulation provides that "residential employees," those who live on the premises of their employer, are not deemed to be working during normal sleeping hours merely because the employee is "on call" for those hours or at any time the employee is free to leave the place of employment. Since your letter does not state the nature of the premises in which the aides in question are living, a definitive determination as to whether the individuals fall within that definition cannot be made. While this distinction is important for the purposes of determining the number of hours at which overtime is owed (44 for residential employees vs. 40 for non-residential employees), the Department applies the same test for determining the number of hours worked by all live-in employees.

In interpreting these provisions, it is the opinion and policy of this Department that live-in employees must be paid not less than for thirteen hours per twenty-four hour period provided that they are afforded at least eight hours for sleep and actually receive five hours of uninterrupted sleep, and that they are afforded three hours for meals. If an aide does not receive five hours of uninterrupted sleep, the eight-hour sleep period exclusion is not applicable and the employee must be paid for all eight hours. Similarly, if the aide is not actually afforded three work-free hours for meals, the three-hour meal period exclusion is not applicable.

Therefore, a live-in employee is required to be paid "spread of hours" pay for all days in which he or she works as a live-in employee since such employee is deemed to work, at a minimum under the rubric described above, thirteen hours per day.

This opinion is based on the information provided in your letter dated November, 23 2009. A different opinion might result if the circumstances stated therein change, if the facts provided were not accurate, or if any other relevant fact was not provided. If you have any further questions, please do not hesitate to contact me.

Very truly yours,

Maria L. Colavito, Counsel

By: Jeffery G. Shapiro
Associate Attorney

JGS:mp
cc: Carmine Ruberto

[redacted]

"facility" for purposes of being designated a caregiver. After registering, a designated caregiver facility would be authorized to possess, acquire, deliver, transfer, transport, and administer medical marihuana on behalf of a certified patient. This would help to prevent patients from experiencing adverse events associated with abrupt discontinuation of a treatment alternative that may be providing relief for the severe debilitating or life-threatening condition.

Costs:

Costs to the Regulated Entity:

Facilities seeking to register as designated caregivers would incur nominal administrative costs in registering. Pursuant to PHL Section 3363(f), there is a $50 application fee for designated caregivers to register with the department. However, the department is currently waiving the $50 application fee for all designated caregivers, including facilities registering as designated caregivers.

Costs to Local Government:

The proposed rule does not require the local government to perform any additional tasks; therefore, it is not anticipated to have an adverse fiscal impact.

Costs to the Department of Health:

The Department anticipates an increased administrative cost to support facilities seeking to register as designated caregivers, however such increase would be minimal.

Local Government Mandates:

The proposed amendments do not impose any new programs, services, duties or responsibilities on local government.

Paperwork:

No paperwork will be required to be maintained, as the registration process for designated caregivers is all done electronically. A registry identification card will be provided to the facility. The facility will be responsible for maintaining the registry identification card at all times when medical marihuana is present at the facility for the certified patient. The facility may have its own paperwork related to internal policies and procedures for possession of the registry identification card by staff members.

Duplication:

The proposed regulations do not duplicate any existing State or federal requirements.

Alternatives:

The Department could have chosen to keep the status quo and not allow patients to designate facilities as designated caregivers. The Department could have also allowed certified patients to designate an individual within the facility to be a caregiver. However, these options are not viable since patients in facilities may be cared for by multiple staff members in the course of a day. Certified patients have severe debilitating or life-threatening conditions and the regulatory amendments would help to prevent adverse events associated with abrupt discontinuation of a treatment alternative that may be providing relief for certified patients in these facilities.

Federal Standards:

Federal requirements do not include provisions for a medical marihuana program.

Compliance Schedule:

There is no compliance schedule imposed by these amendments, which shall be effective upon publication of a Notice of Adoption in the New York State Register.

Regulatory Flexibility Analysis

No regulatory flexibility analysis is required pursuant to section 202-b(3)(a) of the State Administrative Procedure Act. The proposed amendment does not impose an adverse economic impact on small businesses or local governments, and it does not impose reporting, record keeping or other compliance requirements on small businesses or local governments.

Cure Period:

Chapter 524 of the Laws of 2011 requires agencies to include a "cure period" or other opportunity for ameliorative action to prevent the imposition of penalties on the party or parties subject to enforcement under the proposed regulation. The regulatory amendment authorizing the patients to designate facilities as designated caregivers does not mandate that a facility register with the medical marihuana program. Hence, no cure period is necessary.

Rural Area Flexibility Analysis

No Rural Area Flexibility Analysis is required pursuant to Section 202-bb(4)(a) of the State Administration Procedure Act (SAPA). It is apparent from the nature of the proposed regulation that it will not impose any adverse impact on rural areas, and the rule does not impose any new reporting, recordkeeping or other compliance requirements on public or private entities in rural areas.

Job Impact Statement

No job impact statement is required pursuant to Section 201-a(2)(a) of the State Administrative Procedure Act. It is apparent, from the nature of the proposed amendment, that it will not have an adverse impact on jobs and employment opportunities.

Department of Labor

EMERGENCY RULE MAKING

Home Care Aide Hours Worked

I.D. No. LAB-43-17-00002-E
Filing No. 836
Filing Date: 2017-10-06
Effective Date: 2017-10-06

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following action:

Action taken: Amendment of sections 142-2.1(b), 142-3.1(b) and 142-3.7 of Title 12 NYCRR.

Statutory authority: Labor Law, sections 21(11) and 659

Finding of necessity for emergency rule: Preservation of public health, public safety and general welfare.

Specific reasons underlying the finding of necessity: This emergency regulation is needed to preserve the status quo, prevent the collapse of the home care industry, and avoid institutionalizing patients who could be cared for at home, in the face of recent decisions by the State Appellate Divisions that treat meal periods and sleep time by home care aides who work shifts of 24 hours or more as hours worked for purposes of state (but not federal) minimum wage. As a result of those decisions, home care agencies may cease to provide home care aides thereby threatening the continued operation of this industry that employs and serves thousands of New Yorkers by providing vital, lifesaving services and averting the institutionalization of those who could otherwise be cared for at home. Because those decisions relied upon the Commissioner's regulation, and rejected the Department's opinion letters as inconsistent with that regulation, this emergency adoption amends the relevant regulations to codify the Commissioner's longstanding and consistent interpretations that such meal periods and sleep times do not constitute hours worked for purposes of minimum wage and overtime requirements.

Subject: Home Care Aide Hours Worked.

Purpose: To clarify that hours worked may exclude meal periods and sleep times for home care aides who work shifts of 24 hours or more.

Text of emergency rule: Sections 142-2.1, 142-3.1 and 143.7 of 12 NYCRR are amended to read as follows:

§ 142-2.1 Basic minimum hourly wage rate and allowances.

(a) The basic minimum hourly wage rate shall be, for each hour worked in:

(1) New York City for

(i) Large employers of eleven or more employees
$11.00 per hour on and after December 31, 2016;
$13.00 per hour on and after December 31, 2017;
$15.00 per hour on and after December 31, 2018;

(ii) Small employers of ten or fewer employees
$10.50 per hour on and after December 31, 2016;
$12.00 per hour on and after December 31, 2017;
$13.50 per hour on and after December 31, 2018;
$15.00 per hour on and after December 31, 2019;

(2) Remainder of downstate (Nassau, Suffolk and Westchester counties)
$10.00 per hour on and after December 31, 2016;
$11.00 per hour on and after December 31, 2017;
$12.00 per hour on and after December 31, 2018;
$13.00 per hour on and after December 31, 2019;
$14.00 per hour on and after December 31, 2020;
$15.00 per hour on and after December 31, 2021,

(3) Remainder of state (outside of New York City and Nassau, Suffolk and Westchester counties)
$9.70 per hour on and after December 31, 2016;
$10.40 per hour on and after December 31, 2017;
$11.10 per hour on and after December 31, 2018;
$11.80 per hour on and after December 31, 2019;
$12.50 per hour on and after December 31, 2020.

(4) If a higher wage is established by Federal law pursuant to 29 U.S.C. section 206 or its successors, such wage shall apply.

(b) The minimum wage shall be paid for the time an employee is permitted to work, or is required to be available for work at a place prescribed by the employer, and shall include time spent in traveling to the extent that such traveling is part of the duties of the employee. However, a residential employee--one who lives on the premises of the employer--shall not be deemed to be permitted to work or required to be available for work: (1) during his or her normal sleeping hours solely because he is required to be on call during such hours; or (2) at any other time when he or she is free to leave the place of employment.

Notwithstanding the above, this subdivision shall not be construed to require that the minimum wage be paid for meal periods and sleep times that are excluded from hours worked under the Fair Labor Standards Act of 1938, as amended, in accordance with sections 785.19 and 785.22 of 29 C.F.R. for a home care aide who works a shift of 24 hours or more.

§ 142-3.1 Basic minimum hourly wage rate.

(a) The basic minimum hourly wage rate shall be, for each hour worked in:

(1) New York City for

(i) Large employers of eleven or more employees

$11.00 per hour on and after December 31, 2016;
$13.00 per hour on and after December 31, 2017;
$15.00 per hour on and after December 31, 2018;

(ii) Small employers of ten or fewer employees

$10.50 per hour on and after December 31, 2016;
$12.00 per hour on and after December 31, 2017;
$13.50 per hour on and after December 31, 2018;
$15.00 per hour on and after December 31, 2019;

(2) Remainder of downstate (Nassau, Suffolk and Westchester counties)

$10.00 per hour on and after December 31, 2016;
$11.00 per hour on and after December 31, 2017;
$12.00 per hour on and after December 31, 2018;
$13.00 per hour on and after December 31, 2019;
$14.00 per hour on and after December 31, 2020;
$15.00 per hour on and after December 31, 2021.

(3) Remainder of state (outside of New York City and Nassau, Suffolk and Westchester counties)

$9.70 per hour on and after December 31, 2016;
$10.40 per hour on and after December 31, 2017;
$11.10 per hour on and after December 31, 2018;
$11.80 per hour on and after December 31, 2019;
$12.50 per hour on and after December 31, 2020.

(4) If a higher wage is established by Federal law pursuant to 29 U.S.C. section 206 or its successors. Such wage shall apply.

(b) The minimum wage shall be paid for the time an employee is permitted to work, or is required to be available for work at a place prescribed by the employer, and shall include time spent in traveling to the extent that such traveling is part of the duties of the employee. However, a residential employee--one who lives on the premises of the employer--shall not be deemed to be permitted to work or required to be available for work:

(1) during his or her normal sleeping hours solely because such employee is required to be on call during such hours; or

(2) at any other time when he or she is free to leave the place of employment.

Notwithstanding the above, this subdivision shall not be construed to require that the minimum wage be paid for meal periods and sleep times that are excluded from hours worked under the Fair Labor Standards Act of 1938, as amended, in accordance with sections 785.19 and 785.22 of 29 C.F.R. for a home care aide who works a shift of 24 hours or more.

§ 143.7 An hour.

The term an hour shall include each hour an employee is permitted to work, or is required to be available for work at a place prescribed by the employer, and shall include time spent in traveling to the extent that such traveling is part of the duties of the employee. However, a residential employee--one who lives on the premises of the employer--shall not be deemed to be permitted to work or required to be available for work:

(a) during such employee's normal sleeping hours solely because he or she is required to be on call during such hours;

(b) at any other time when he or she is free to leave the place of employment.

Notwithstanding the above, the term an hour shall not be construed to include meal periods and sleep times that are excluded from hours worked under the Fair Labor Standards Act of 1938, as amended, in accordance with sections 785.19 and 785.22 of 29 C.F.R. for a home care aide who works a shift of 24 hours or more.

This notice is intended to serve only as a notice of emergency adoption. This agency intends to adopt this emergency rule as a permanent rule and will publish a notice of proposed rule making in the *State Register* at some future date. The emergency rule will expire January 3, 2018.

Text of rule and any required statements and analyses may be obtained from: Michael Paglialonga, NYS Department of Labor, State Office Campus, Building 12, Room 509, Albany, NY 12240, (518) 457-4380, email: regulations@labor.ny.gov

Regulatory Impact Statement

Statutory Authority: State Administrative Procedure Act (SAPA) § 202(6) and Labor Law §§ 21(11) and 659.

Legislative Objectives: In enacting the Minimum Wage Law (Labor Law Article 19) in 1960 the Legislature mandated that the minimum wage be paid "for each hour worked" (Labor Law § 652(1)), without defining that phrase (Labor Law § 651), and delegated authority to the Commissioner of Labor ("Commissioner") to promulgate regulations as she "deems necessary or appropriate to carry out the purposes of this article and to safeguard the minimum wage" (L. 1960, Ch. 619, § 2, at Labor Law § 652(2) & (4)), to order "such modifications of or additions to any regulations as he may deem appropriate to effectuate the purposes of this article" (Labor Law § 659(2)), and to investigate hours worked (Labor Law §§ 660(b)(1) & 661). While Labor Law § 659(2) provides for rulemaking after a hearing, emergency adoption of this rulemaking is authorized "[n]otwithstanding any other law" by SAPA § 202(6).

The regulations to be amended. In 1960, based on the Legislature's delegation of authority, the Commissioner promulgated a new Minimum Wage Order for Miscellaneous Industries and Occupations (currently codified at 12 NYCRR Parts 142 and 143) ("the Wage Order"). The Wage Order contains regulations that defined the term "An hour" and provided that the requirement to pay minimum wages expressly covers time "an employee is permitted to work, or required to be available for work at a place prescribed by the employer." The Wage Order's regulations explicitly recognized that such time shall not be deemed to include sleeping time of a residential employee "solely because he or she is required to be on call during such hours" (see 12 NYCRR §§ 142-2.1(b), 142-3.1(b) & 143.7, originally promulgated as Minimum Wage Order 11 (1960), at II.A.1 (Hourly rate) and III.A.1 (Hourly rate), and Regulations (for exempt nonprofits) at IV.7 (A hour), and published at NYCRR, Supplement 15 (1963) at 344-64).

Legislative expansions to cover workers in the home. Over the years, the Legislature expanded the scope of the Minimum Wage Law as applied to domestic service and home companions. The original 1960 enactment expressly excluded any individual "employed or permitted to work (a) in domestic service in the home of the employer" (L. 1960, Ch. 691, § 2). In 1972, the Legislature removed that exclusion and replaced it with an exclusion for "service as a part time baby sitter in the home of the employer; or someone who lives in the home of the employer for the purpose of serving as a companion to a sick, convalescing or elderly person, and whose principal duties do not include housekeeping" (L. 1971, Ch. 1165, § 1). Finally, in 2010, the Legislature removed the exclusion for in-home companions as part of the Domestic Workers Bill of Rights (L. 2010, Ch. 481 § 8).

Administrative interpretations accompany statutory expansions. The above-referenced legislative expansions in 1972 and 2010 were each preceded by Commissioner's interpretations in the late 1960s and early 1980s that construed the statutory exclusions of domestic service and companions "in the home of the employer" to be inapplicable to domestic service and companions who were employed by agencies and placed in the home of a client. Such interpretations were affirmed by the Board of Standards and Appeals and its successor the Industrial Board of Appeals, and eventually by the Courts (see e.g., Settlement Home Care v. Industrial Board of Appeals, 151 A.D. 580 (2d Dept. 1989)). As the scope of minimum wage coverage expanded through administrative interpretations and legislative enactments, the Commissioner continued to interpret the statutory requirement to pay minimum wages for "each hour worked" to exclude sleep and meal periods of various categories of newly covered workers who were employed by agencies to work in the home of a client for extended periods of time. Those interpretations were set forth in investigators' manuals, formal guidelines, legal opinions, and Commissioner's determinations starting in the early 1970s, and were relied upon by the New York State Department of Health and by private agencies that employed home care aides. While the Commissioner did not amend the Wage Order's regulations to expressly codify those interpretations, she did amend it in 1986 to provide for overtime to be calculated "in the manner and methods provided for in and subject to the exemptions of" the federal Fair Labor Standards Act (FLSA) (12 NYCRR §§ 142-2.2 & 142-3.2) and, in so doing, grew to increasingly look to, and rely upon, federal FLSA regulations interpreting hours worked (29 CFR Part 785) to address meal periods (29 CFR §§ 785.18-19) and sleeping time (29 CFR §§ 785.20-23) so that hours worked were calculated consistently at the state and federal level for overtime (and other) purposes.

Needs and Benefits: This emergency regulation is necessary to preserve the status quo, prevent the collapse of the home care industry, and avoid institutionalizing patients who could be cared for at home, in the face of recent decisions by the State Appellate Divisions for the First and Second Departments that treat meal periods and sleep time by home care aides as hours worked for purposes of state (but not federal) minimum wage. Tokhtaman v. Human Care, LLC, Docket No. 3671 151268/16, 2017 NY

Slip Op 02759 (1st Dept. Apr. 11, 2017), motion to reargue and for leave to appeal denied, 2017 NY Slip Op 82713(U) (1st Dept. Aug. 15, 2017); Andryeyeva v. New York Health Care, Inc., 2017 NY Slip Op 06421 (2nd Dept. Sept. 13, 2017); and Moreno v Future Care Health Servs., Inc., 2017 NY Slip Op 06439 (2nd Dept. Sept. 13, 2017). Absent a conflict between the First and Second Departments, and a final judgement in any of these cases that would make them ripe to be heard by the Court of Appeals, the Commissioner must take action now to avert an impending crisis. Emergency adoption of this regulation is necessary for the preservation of the public health, safety, and general welfare to ensure that home care aides will be available to provide care for, and avoid the institutionalization of, those who rely on home care.

The purpose and intent of this rulemaking is to narrowly codify the Commissioner's longstanding and consistent interpretation that compensable hours worked under the State Minimum Wage Law do not include meal periods and sleep time of home care aides who work shifts of 24 hours or more. While the Commissioner's interpretations regarding meal periods and sleep time have not been limited to home care aides, the current emergency is, and thus the necessarily limited nature of this emergency rulemaking should not be taken as evidence that the Commissioner interprets hours worked to include meal periods and sleep time for all others who work shifts of 24 hours or more. Rather, the Commissioner anticipates that regulations to codify the full scope of her interpretations regarding meal periods and sleep time can be appropriately pursued through the ordinary rulemaking process, after a public hearing and a full notice and comment period.

Costs: As this rule codifies existing Federal regulations and the Commissioner's interpretations, the Department estimates that there will be no costs to the regulated community, to the Department of Labor, or to state and local governments to implement this rulemaking.

Local Government Mandate: None. Federal, state and municipal governments and political subdivisions thereof are excluded from coverage under Part 142 by Labor Law §§ 651(5)(n) and 651(5)(last paragraph).

Paperwork: This rulemaking does not impact any reporting requirements currently required in either statute or regulation.

Duplication: This rulemaking does not duplicate, overlap, or conflict with any other state or federal requirements.

Alternatives: There were no significant alternatives considered.

Federal Standards: This rule keeps New York State in conformity with existing Federal standards involving working time contained in Federal Regulations 29 C.F.R. Part 785, as applied to meal periods and sleep time for home care aides who work shifts of 24 hours or more. There are no other federal standards relating to this rule.

Compliance Schedule: This emergency rulemaking shall become effective upon filing with the Department of State.

Regulatory Flexibility Analysis

Effect of Rule: The purpose and intent of this emergency rulemaking is to narrowly codify the Commissioner's longstanding and consistent interpretation of Article 19 of the Labor Law and to make clear that the amended regulations shall not be construed to require that the minimum wage be paid for meal periods and sleep times that are excluded from hours worked under the federal minimum wage laws and regulations for home care aides who work shifts of 24 hours or more. The Department anticipates this will have a positive impact on small businesses as it will eliminate any instability introduced by decisions recently issued by the State Appellate Divisions. See Tokhtaman v. Human Care, LLC, Docket No. 3671 151268/16, 2017 NY Slip Op 02759 (1st Dept. Apr. 11, 2017), motion to reargue and for leave to appeal denied, 2017 NY Slip Op 82713(U) (1st Dept. Aug. 15, 2017); Andryeyeva v. New York Health Care, Inc., 2017 NY Slip Op 06421 (2nd Dept. Sept. 13, 2017); and Moreno v Future Care Health Servs., Inc., 2017 NY Slip Op 06439 (2nd Dept. Sept. 13, 2017).

Compliance Requirements: Small businesses and local governments will not have to undertake any new reporting, recordkeeping, or other affirmative act in order to comply with this regulation.

Professional Services: No professional services would be required to effectuate the purposes of this regulation.

Compliance Costs: As this regulation codifies existing administrative interpretations relied upon by regulators and employers, the Department estimates that there will be no costs to the small businesses or local governments to implement this regulation.

Economic and Technological Feasibility: The regulation does not require any use of technology to comply.

Minimizing Adverse Impact: The Department does not anticipate that this regulation will adversely impact small businesses or local governments. Since no adverse impact to small businesses or local governments will be realized, it was unnecessary for the Department to consider approaches for minimizing adverse economic impacts as suggested in State Administrative Procedure Act § 202-b(1).

Small Business and Local Government Participation: The Department does not anticipate that this rule will have an adverse economic impact upon small businesses or local governments, nor will it impose new reporting, recordkeeping, or other compliance requirements upon them. Nevertheless, the Department will ensure that small businesses and local governments have an opportunity to participate in the rulemaking process. In connection with a final revision to the regulation, the Department will elicit input from small businesses and local governments during the public comment period, and through a publicly scheduled hearing in accordance with Labor Law §§ 659 and 656.

Initial review of the rule pursuant to SAPA § 207: Initial review of this regulation shall occur no later than the third calendar year in which it is adopted.

Rural Area Flexibility Analysis

Types and estimated numbers of rural areas: The Department anticipates that this regulation will have a positive or neutral impact upon all areas of the state; there is no adverse impact anticipated upon any rural area of the state resulting from adoption of this regulation.

Reporting, recordkeeping and other compliance requirements: This regulation will not impact reporting, recordkeeping or other compliance requirements.

Professional services: No professional services will be required to comply with this regulation.

Costs: As this regulation codifies the Commissioner's longstanding interpretation of Article 19 of the Labor Law, consistent with federal law and regulations, the Department estimates that there will be no new or additional costs to rural areas to implement this regulation.

Minimizing adverse impact: The Department does not anticipate that this regulation will have an adverse impact upon any region of the state. As such, different requirements for rural areas were not necessary.

Rural area participation: The Department does not anticipate that the regulation will have an adverse economic impact upon rural areas nor will it impose new reporting, recordkeeping, or other compliance requirements. Nevertheless, the Department will ensure that rural areas in the state have an opportunity to participate in the rulemaking process. In connection with a final revision to the regulation, the Department will elicit input from rural areas of the state during the public comment period, and through a publicly scheduled hearing in accordance with Labor Law §§ 659 and 656.

Job Impact Statement

Nature of Impact: The Department of Labor (hereinafter "Department") projects there will be no adverse impact on jobs or employment opportunities in the State of New York as a result of this emergency rulemaking. Rather, this regulation will help to limit or eliminate any negative impact on jobs from recent court decisions affecting the home care industry. This regulation amends existing regulations to codify the Commissioner's longstanding and consistent interpretation of Article 19 of the Labor Law and clarify that the amended regulations shall not be construed to require that the minimum wage be paid for meal periods and sleep times that are excluded from hours worked under federal minimum wage laws and regulations for home care aides who work shifts of 24 hours or more. The nature and purpose of this regulation is such that it will not have an adverse impact on jobs or employment opportunities.

Categories and numbers affected: The Department does not anticipate that this regulation will have an adverse impact on jobs or employment opportunities in any category of employment. This regulation will help to ensure the stability of the jobs of home care workers who work shifts of 24 hours or more in New York State. According to the Department's Division of Research and Statistics, there are an estimated 330,650 home care aides employed across the state.

Regions of adverse impact: The Department does not anticipate that this regulation will have an adverse impact upon jobs or employment opportunities statewide or in any particular region of the state.

Minimizing adverse impact: Since the Department does not anticipate any adverse impact upon jobs or employment opportunities resulting from this regulation, no measures to minimize any unnecessary adverse impact on existing jobs or to promote the development of new employment opportunities are required.

Self-employment opportunities: The Department does not foresee a measureable impact upon opportunities for self-employment resulting from adoption of this regulation.

Initial review of the rule pursuant to SAPA § 207: Initial review of this regulation shall occur no later than the third calendar year in which it is adopted.

Assessment of Public Comment

The agency received no public comment.

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PRACTICE AREAS

Elder Law; Wills, Trusts and Estates; Medicaid; Nursing Home Qualification; Living Trusts; Estate Planning; Medicaid Planning; Asset Protection, Lecturer on Public and Legal Education.

ADMITTED:

New York State Supreme Court; Appellate Division Second Department September 7, 1977
United States District Court of the Eastern and Southern Districts
Second Circuit Court of Appeals
United States Supreme Court
Hawaii State Bar Association - 1987

LAW SCHOOL: J.D. - St. John's University School of Law - 1976

MEMBER: Past President of the Suffolk County Bar Association (2001-02). Member since 1977.
Chief Attorney for the Legal Aid Society of Suffolk County's Senior Division (1979-2009)
Past Dean of the Suffolk academy of Law
New York State Bar Association - Elder Law Section
National Academy of Elder Law Attorneys
Past chair of the Suffolk Bar Association's Elder Law and Federal Courts Committee

BIOGRAPHY: Published in Newsday, the New York State Bar Elder Law newsletter, Suffolk Lawyer, has conducted numerous continuing legal education seminars for New York State Bar Association, the Suffolk County Bar Association, the National Business Institute, and public service informational programs for senior citizens, including Senior Law Day, sponsored by NYS Assemblyman Englebright (4th L.D.), Stony Brook University and the Suffolk County Bar Association.

BORN: Queens, New York

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Janna P. Visconti, Esq.

Janna P. Visconti is a member of the law firm of Grabie & Grabie, LLP, in Smithtown, New York, with more than 35 years of legal experience. She is a graduate of St. John's University, School of Law, where she was a member of the Law Review. A former member of the law firms of Rogers & Wells (now Clifford Chance), Snell & Wilmer, and Cummings & Lockwood, she has been admitted to practice law in the States of New York, Arizona and Connecticut. She also has a certificate of Geriatric Ministry from Stony Brook University, and she has been trained as an Article 81 Guardian by the Suffolk County Bar Association.

In 2015, "Jan" was appointed as an Officer of the Suffolk Academy of Law, and is a former Co-Chairman of the Elder Law Committee of the Suffolk County Bar Association. She is also a member of the Elder Law Committee of the New York State Bar Association.

Jan is President of the Board of Directors of RSVP (Retired Senior Volunteer Program), an organization dedicated to placing retired people in volunteer positions where they can contribute their skills and expertise to our community. She has served on the Executive Board of Senior Umbrella Network of Suffolk (SUNS), where she chaired the Scholarship Committee. She has also served a on both the Public Issues Committee and the Development Committee of the Long Island Council of Churches.

A frequent speaker throughout Long Island, she lectures on Elder Law, Medicaid, and Estate Planning including Wills, Trusts, Powers of Attorney and Advance Directives.

Jan is married to The Very Rev. Canon Richard D. Visconti, and they have two children.

GRABIE & GRABIE, LLP

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Jennifer S. Raguso, Esq.

Jennifer Raguso is an associate attorney at Grabie & Grabie, LLP. She concentrates her practice in the areas of Elder Law, Medicaid qualification, estate planning, and asset protection.

Jennifer received her undergraduate degree from Binghamton University and graduated magna cum laude and with senior honors, and she received her Juris Doctor from Touro Law School. While attending Law School, Jennifer was a member of the Moot Court Honors Board of Advocates where she served as Competition Editor. Jennifer was the recipient of the Susan Dietrich Clyne Public Interest Legal Fellowship for her work with the Senior Citizens Law Program. She also received an award for her Outstanding Contribution to the Student Bar Association for the three years she served on the executive board.

Jennifer was awarded the CALI Award for Academic Excellence in Elder Law and again in the Elder Law Clinic. At graduation, she was awarded the Dean and Faculty award for Exemplary Contribution to the Quality of Student Life and an award for Exceptional Service to the Public and Community.

Jennifer is a member of the Elder Law Committee of the Suffolk County Bar Association, and a member of the Elder Law and Trusts and Estates sections of the New York State Bar Association. Jennifer is licensed to practice law in the state of New York.