NEW YORK STATE BAR ASSOCIATION

# ANNUAL MEETING 2019

## The New York State Bar Association Elder Law and Special Needs Section Gratefully Acknowledges the Support of Our Sponsors

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# NEW YORK STATE BAR ASSOCIATION

## FORM FOR VERIFICATION OF PRESENCE AT THIS PROGRAM

Pursuant to the Rules pertaining to the Mandatory Continuing Legal Education Program for Attorneys in the State of New York, as an Accredited Provider of CLE programs, we are required to carefully monitor attendance at our programs to ensure that certificates of attendance are issued for the correct number of credit hours in relation to each attendee's actual presence during the program. Each person may only turn in his or her form—you may not turn in a form for someone else. Also, if you leave the program at some point prior to its conclusion, you should check out at the registration desk. Unless you do so, we may have to assume that you were absent for a longer period than you may have been, and you will not receive the proper number of credits.

Speakers, moderators, panelists and attendees are required to complete attendance verification forms in order to receive MCLE credit for programs. Faculty members and attendees, please complete, sign and return this form to the registration staff **before you leave** the program.

**PLEASE TURN IN THIS FORM AT THE END OF THE PROGRAM.**

**Elder Law & Special Needs Section Annual Meeting**
**Keeping Current in the Practice of Elder Law and Special Needs Planning**
**January 15, 2019 | New York Hilton Midtown, New York City**

Name:_____
(please print)

I certify that I was present for the entire presentation of this program

Signature:_____Date:_____

**Speaking Credit**: In order to obtain MCLE credit for speaking at today's program, please complete and return this form to the registration staff before you leave. **Speakers** and **Panelists** receive three (3) MCLE credits for each 50 minutes of presenting or participating on a panel. **Moderators** earn one (1) MCLE credit for each 50 minutes moderating a panel segment. Faculty members receive regular MCLE credit for attending other portions of the program.

NYSBA

# Keeping Current in the Practice of Elder Law and Special Needs Planning

**Elder Law and Special Needs Section**

January 15, 2019

**New York Hilton Midtown**

New York, NY

This program is offered for educational purposes. The views and opinions of the faculty expressed during this program are those of the presenters and authors of the materials, including all materials that may have been updated since the books were printed or distributed electronically. Further, the statements made by the faculty during this program do not constitute legal advice.

# MCLE INFORMATION

Program Title: **Elder Law & Special Needs Section Annual Meeting Program**
Date/s: January 15, 2019 Location: New York, NY

Evaluation: https://www.nysba.org/am2019-eld0
This evaluation survey link will be emailed to registrants following the program.

Total Credits: **5.0 New York CLE credit hours**

**Credit Category:**
4.0 Areas of Professional Practice
1.0 Ethics and Professionalism

This course is approved for credit for **both** experienced attorneys and newly admitted attorneys (admitted to the New York Bar for less than two years). Newly admitted attorneys participating via recording or webcast should refer to www.nycourts.gov/attorneys/cle regarding permitted formats.

## Attendance Verification for New York MCLE Credit

In order to receive MCLE credit, attendees must:

1) **Sign in** with registration staff
2) Complete and return a **Form for Verification of Presence** (included with course materials) at the end of the program or session. For multi-day programs, you will receive a separate form for each day of the program, to be returned each day.

**Partial credit for program segments is not allowed.** Under New York State Continuing Legal Education Regulations and Guidelines, credit shall be awarded only for attendance at an entire course or program, or for attendance at an entire session of a course or program. Persons who arrive late, depart early, or are absent for any portion of a segment will not receive credit for that segment. The Form for Verification of Presence certifies presence for the entire presentation. Any exceptions where full educational benefit of the presentation is not received should be indicated on the form and noted with registration personnel.

## Program Evaluation

The New York State Bar Association is committed to providing high quality continuing legal education courses, and your feedback regarding speakers and program accommodations is important to us. Following the program, an email will be sent to registrants with a link to complete an online evaluation survey. The link is also provided above.

# ADDITIONAL INFORMATION AND POLICIES

Recording of NYSBA seminars, meetings and events is not permitted.

## Accredited Provider

The New York State Bar Association's **Section and Meeting Services Department** has been certified by the New York State Continuing Legal Education Board as an accredited provider of continuing legal education courses and programs.

## Credit Application Outside of New York State

Attorneys who wish to apply for credit outside of New York State should contact the governing body for MCLE in the respective jurisdiction.

## MCLE Certificates

MCLE Certificates will be emailed to attendees a few weeks after the program, or mailed to those without an email address on file. **To update your contact information with NYSBA**, visit www.nysba.org/MyProfile, or contact the Member Resource Center at (800) 582-2452 or MRC@nysba.org.

## Newly Admitted Attorneys—Permitted Formats

Newly admitted attorneys (admitted to the New York Bar for less than two years) may not be eligible to receive credit for certain program credit categories or formats. For official New York State CLE Board rules, see www.nycourts.gov/attorneys/cle.

## Tuition Assistance

New York State Bar Association members and non-members may apply for a discount or scholarship to attend MCLE programs, based on financial hardship. This discount applies to the educational portion of the program only. Application details can be found at www.nysba.org/SectionCLEAssistance.

## Questions

For questions, contact the NYSBA Section and Meeting Services Department at SectionCLE@nysba.org, or the NYSBA Member Resource Center at (800) 582-2452 (or (518) 463-3724 in the Albany area).

# Elder Law and Special Needs Section

## Keeping Current in the Practice of Elder Law and Special Needs Planning

**Tuesday, January 15, 2019** | 1:30 p.m. – 6:30 p.m.
New York Hilton Midtown | NYC

**5.0 Credits:** 1.0 Ethics | 4.0 Areas of Professional Practice
*This program is transitional and is suitable for all attorneys including those newly admitted.*

**Trianon Ballroom, Third Floor**

| | |
|---|---|
| 1:30 p.m. – 2:00 p.m. | **Welcoming Remarks, Business Meeting and Awards**<br>Judith D. Grimaldi, Esq., Section Chair<br>Christopher Bray, Esq., Program Co-Chair<br>Joan L. Robert, Esq., Program Co-Chair |
| 2:00 p.m. – 2:50 p.m. | **Annual Elder Law Update**<br>• New York State and National Legislation<br>• Case Law Updates<br>• Directives Affecting the Practice of Elder Law<br>**Speaker:**<br>**Louis W. Pierro, Esq.** \| Pierro, Connor & Strauss, LLC \| Latham, NY<br>*(1.0 Credit in Areas of Professional Practice* |
| 2:50 p.m. – 3:15 p.m. | **Veteran's Benefits Update**<br>Changes in Qualifying for Veteran's Benefits<br>**Speaker:**<br>**Felicia Pasculli, Esq.** \| Futterman, Lanza & Pasculli, LLP \| Bay Shore, NY<br>(*0.50 Credit in Areas of Professional Practice)* |
| 3:15 p.m. – 4:05 p.m. | **Lawyer as Employer**<br>• Rules concerning hiring and firing employees<br>• Paying overtime, sick days<br>• Rules regarding hours and compensation<br>**Speaker:**<br>**Domenique Camacho Moran, Esq.** \| Farrell Fritz PC \| Uniondale, NY<br>*(1.0 Credit in Areas of Professional Practice)* |
| 4:05 p.m. – 4:25 p.m. | Refreshment break |

4:25 p.m. – 5:40 p.m. **Judicial Panel – Article 81 Judges**

- What are the most common mistakes made by attorneys for petitioners, court evaluators and attorneys for Alleged Incapacitated Persons?
- Budgets and final accountings
- Supplemental Needs Trusts

**Moderator:**
**Ira Salzman, Esq.** | Goldfarb, Abrandt, Salzman & Kutzin, LLC | New York, NY

**Panelists:**
**Hon. Arthur M. Diamond** | New York State Supreme Court | Mineola, NY
**Hon. David H. Guy** | Broome County Surrogate's Court | Binghamton, NY
**Hon. Tanya R. Kennedy |** NYS Supreme Court | New York, NY
**Hon. Bernice D. Siegal** | Supreme Court, Queens County | Jamaica, NY

*(1.5 Credit in Areas of Professional Practice)*

5:40 p.m. – 6:30 p.m. **Ethical Considerations in the Special Needs Practice: Unique Challenges in Representing the Trustee and Beneficiary**

How to apply the ethical rules when advising both a trustee and trust beneficiary

**Speaker:**
**Edward V. Wilcenski, Esq.** | Wilcenski & Pleat PLLC | Clifton Park, NY

*(1.0 Credit in Ethics)*

**Offsite Reception**
6:45 p.m. – 8:00 p.m. | The Warwick New York Hotel | 65 West 54th Street | New York, NY

**SECTION CHAIR**
**Judith D. Grimaldi, Esq.** | Grimaldi & Yeung, LLP | Brooklyn, NY

**PROGRAM CO-CHAIRS**
**Christopher Bray, Esq.** | Rheinhardt & Bray, PC | Ilion, NY
**Joan L. Robert, Esq.** | Kassoff, Robert & Lerner LLP | Rockville Centre, NY

# Lawyer Assistance Program 800.255.0569


NYSBA

## Q. What is LAP?

**A.** The Lawyer Assistance Program is a program of the New York State Bar Association established to help attorneys, judges, and law students in New York State (NYSBA members and non-members) who are affected by alcoholism, drug abuse, gambling, depression, other mental health issues, or debilitating stress.

## Q. What services does LAP provide?

**A.** Services are **free** and include:

- Early identification of impairment
- Intervention and motivation to seek help
- Assessment, evaluation and development of an appropriate treatment plan
- Referral to community resources, self-help groups, inpatient treatment, outpatient counseling, and rehabilitation services
- Referral to a trained peer assistant – attorneys who have faced their own difficulties and volunteer to assist a struggling colleague by providing support, understanding, guidance, and good listening
- Information and consultation for those (family, firm, and judges) concerned about an attorney
- Training programs on recognizing, preventing, and dealing with addiction, stress, depression, and other mental health issues

## Q. Are LAP services confidential?

**A.** Absolutely, this wouldn't work any other way. In fact your confidentiality is guaranteed and protected under Section 499 of the Judiciary Law. Confidentiality is the hallmark of the program and the reason it has remained viable for almost 20 years.

**Judiciary Law Section 499 Lawyer Assistance Committees Chapter 327 of the Laws of 1993**

Confidential information privileged. The confidential relations and communications between a member or authorized agent of a lawyer assistance committee sponsored by a state or local bar association and any person, firm or corporation communicating with such a committee, its members or authorized agents shall be deemed to be privileged on the same basis as those provided by law between attorney and client. Such privileges may be waived only by the person, firm or corporation who has furnished information to the committee.

## Q. How do I access LAP services?

**A.** LAP services are accessed voluntarily by calling **800.255.0569** or connecting to our website **www.nysba.org/lap**

## Q. What can I expect when I contact LAP?

**A.** You can expect to speak to a Lawyer Assistance professional who has extensive experience with the issues and with the lawyer population. You can expect the undivided attention you deserve to share what's on your mind and to explore options for addressing your concerns. You will receive referrals, suggestions, and support. The LAP professional will ask your permission to check in with you in the weeks following your initial call to the LAP office.

## Q. Can I expect resolution of my problem?

**A.** The LAP instills hope through the peer assistant volunteers, many of whom have triumphed over their own significant personal problems. Also there is evidence that appropriate treatment and support is effective in most cases of mental health problems. For example, a combination of medication and therapy effectively treats depression in 85% of the cases.

## Personal Inventory

Personal problems such as alcoholism, substance abuse, depression and stress affect one's ability to practice law. Take time to review the following questions and consider whether you or a colleague would benefit from the available Lawyer Assistance Program services. If you answer "yes" to any of these questions, you may need help.

1. **Are my associates, clients or family saying that my behavior has changed or that I don't seem myself?**
2. **Is it difficult for me to maintain a routine and stay on top of responsibilities?**
3. **Have I experienced memory problems or an inability to concentrate?**
4. **Am I having difficulty managing emotions such as anger and sadness?**
5. **Have I missed appointments or appearances or failed to return phone calls? Am I keeping up with correspondence?**
6. **Have my sleeping and eating habits changed?**
7. **Am I experiencing a pattern of relationship problems with significant people in my life (spouse/parent, children, partners/associates)?**
8. **Does my family have a history of alcoholism, substance abuse or depression?**
9. **Do I drink or take drugs to deal with my problems?**
10. **In the last few months, have I had more drinks or drugs than I intended, or felt that I should cut back or quit, but could not?**
11. **Is gambling making me careless of my financial responsibilities?**
12. **Do I feel so stressed, burned out and depressed that I have thoughts of suicide?**

# There Is Hope

**CONTACT LAP TODAY FOR FREE CONFIDENTIAL ASSISTANCE AND SUPPORT**

The sooner the better!

**1.800.255.0569**

NEW YORK STATE BAR ASSOCIATION

# JOIN OUR SECTION

☐ As a NYSBA member, **PLEASE BILL ME $30 for Elder Law & Special Needs Section dues.** (law student rate is $15)

☐ I wish to become a member of the NYSBA (please see Association membership dues categories) and the Elder Law & Special Needs Section. **PLEASE BILL ME for both.**

☐ I am a Section member — please consider me for appointment to committees marked.

Name _____

Address _____

_____

City _____ State _____ Zip _____

The above address is my ☐ Home ☐ Office ☐ Both

Please supply us with an additional address.

Name _____

Address _____

City _____ State _____ Zip _____

Office phone ( _____ ) _____

Home phone ( _____ ) _____

Fax number ( _____ ) _____

E-mail address _____

Date of birth _____ /_____ /_____

Law school _____

Graduation date _____

States and dates of admission to Bar: _____

*Please return this application to:*

**MEMBER RESOURCE CENTER,**
New York State Bar Association, One Elk Street, Albany NY 12207
Phone 800.582.2452/518.463.3200 • FAX 518.463.5993
E-mail mrc@nysba.org • www.nysba.org

# JOIN A ELDER LAW & SPECIAL NEEDS SECTION COMMITTEE(S)

Please designate in order of choice (1, 2, 3) from the list below, a maximum of three committees in which you are interested. You are assured of at least one committee appointment, however, all appointments are made as space availability permits.

___ Client and Consumer Issues (ELD4000)
___ Diversity (ELD6800)
___ Elder Abuse (ELD7600)
___ Estates, Trusts and Tax Issues (ELD1200)
___ Ethics (ELD7300)
___ Financial Planning and Investments (ELD4400)
___ Guardianship (ELD1600)
___ Health Care Issues (ELD3600)
___ Legal Education (ELD1900)
___ Legislation (ELD2300)
___ Liaison to Law Schools (ELD6300)
___ Mediation (ELD7400)
___ Medicaid (ELD2900)
___ Membership Services (ELD1040)
___ Mental Health Law (ELD6100)
___ Mentoring (ELD7500)
___ Practice Management (ELD3300)
___ Publications (ELD6600)
___ Real Estate and Housing (ELD3900)
___ Special Ed (ELD8000)
___ Special Needs Planning (ELD3800)
___ Sponsorship (ELD6500)
___ Task Force on Challenges to Medicaid Practice (ELD8010)
___ Task Force on Unauthorized Practice of Law (ELD7700)
___ Technology (ELD7800)
___ Veteran's Benefits (ELD6700)

## 2019 ANNUAL MEMBERSHIP DUES

Class based on first year of admission to bar of any state. Membership year runs January through December.

### ACTIVE/ASSOCIATE IN-STATE ATTORNEY MEMBERSHIP

| | |
|---|---|
| Attorneys admitted 2011 and prior | $275 |
| Attorneys admitted 2012-2013 | 185 |
| Attorneys admitted 2014-2015 | 125 |
| Attorneys admitted 2016 - 3.31.2018 | 60 |

### ACTIVE/ASSOCIATE OUT-OF-STATE ATTORNEY MEMBERSHIP

| | |
|---|---|
| Attorneys admitted 2011 and prior | $180 |
| Attorneys admitted 2012-2013 | 150 |
| Attorneys admitted 2014-2015 | 120 |
| Attorneys admitted 2016 - 3.31.2018 | 60 |

### OTHER

| | |
|---|---|
| Sustaining Member | $400 |
| Affiliate Member | 185 |
| Newly Admitted Member* | FREE |

**DEFINITIONS**

Active In-State = Attorneys admitted in NYS, who work and/or reside in NYS
Associate In-State = Attorneys not admitted in NYS, who work and/or reside in NYS
Active Out-of-State = Attorneys admitted in NYS, who neither work nor reside in NYS
Associate Out-of-State = Attorneys not admitted in NYS, who neither work nor reside in NYS
Sustaining = Attorney members who voluntarily provide additional funds to further support the work of the Association
Affiliate = Person(s) holding a JD, not admitted to practice, who work for a law school or bar association
*Newly admitted = Attorneys admitted on or after April 1, 2018

NYSBA

# Annual Elder Law Update

**Louis W. Pierro, Esq.**
**Pierro, Connor & Strauss, LLC | Latham, NY**

# 2019 NEW YORK STATE ELDER LAW AND SPECIAL NEEDS UPDATE

Presented by: Louis Pierro, Esq.,
Founding Partner, Pierro, Connor & Strauss, LLC.

PIERRO, CONNOR & STRAUSS, LLC
*Trusted Counsel*

# MEDICAID UPDATE

# MEDICAID UPDATE

## Exempt Assets

- Individual resource allowance ($15,450)
- Home equity ($878,000 limit)
- Automobile
- Prepaid burial and funeral services
- Income producing property – business assets
- Life insurance – face value less than $1,500
- IRA in "Periodic Payment Status"
  - Roth?

# MEDICAID UPDATE

## IRA Exemption- Fair Hearing #7844813Q | December 19, 2018

- Agency denied eligibility due to excess resources- an IRA
- Amount of distribution was at issue
- ALJ held "Even if it were found that the agency was correct to include this IRA as a resource as the monthly distribution was effective until October, 2018, the fact remains that based on appellants age she is required to be in payment status."

**Implication:** Required Minimum Distributions under IRS tables at age 70 ½ qualify as "Periodic Payments"

# MEDICAID UPDATE

## Monthly Income

| | |
|---|---|
| Individual (at home) | $859 (+$20) (was $842) |
| Couple (both at home) | $1,267 (+$20) (was $1,233) |
| MMMNA | $3,160.50 (was $3,090) |

## Resources

| | |
|---|---|
| Individual | $15,450 (was $15,150) |
| Couple (both at home) | $22,800 (was $22,200) |
| Comm. Spouse Resource Allowance | $74,820 (no change) |

(or the spousal share of 1/2 combined resources up to a maximum of $126,420 [was $123,600])

# MEDICAID UPDATE

| Household Size | Medically Needy Income Level | | Resources |
|---|---|---|---|
| | Annual | Monthly | |
| One | 10,300 | 859 | 15,450 |
| Two | 15,200 | 1,267 | 22,800 |
| Three | 17,480 | 1,457 | 25,013 |
| Four | 19,760 | 1,647 | 28,275 |
| Five | 22,040 | 1,837 | 31,539 |
| Six | 24,320 | 2,027 | 34,800 |
| Seven | 26,600 | 2,217 | 38,064 |
| Eight | 28,880 | 2,407 | 41,325 |
| Nine | 31,160 | 2,597 | 44,588 |
| Ten | 33,440 | 2,787 | 47,850 |
| Each Add'l Person | 2,280 | 190 | 3,263 |

# MEDICAID UPDATE

*Provided courtesy of NYLAG and Valerie Bogart*

## Shift to Managed Care Plans

Since 2011, NYS has required most Medicaid recipients to access Long Term Care (LTC) services cited above through a managed care plan, with some exceptions.

- **Medicaid recipients without Medicare** – Most are required to enroll in "mainstream" Medicaid managed care plans (MMC) – which deliver PCS, CDPAP, CHHA and Private Duty Nursing along with all medical care. Includes SSI recipients, seniors without Medicare
- **Dual Eligibles** > age 21 – most are required to enroll in Managed Long Term Care (MLTC) plans if determined to need home care/LTC > 120 days.

Plans must give **same amount, duration & scope** of services as in "Fee for Service" Medicaid

# MEDICAID UPDATE

## Long-Term Care Services

One

### Financial Eligibility

*-If you don't need long term care, **stop here*** 


Two

### Conflict-Free Eligibility Determination "CFEEC"

Maximus assessment

Three

### Schedule Assessments with Health Plans (MLTC)

You have 75 days to enroll or CFEEC expires. DOH MLTC Policy 16.08

Four

### Enrollment

Enroll by 19th of month for enrollment 1st of next mo.

Five

### Get Care

Plan makes coverage determinations; these are appealable

# MEDICAID UPDATE

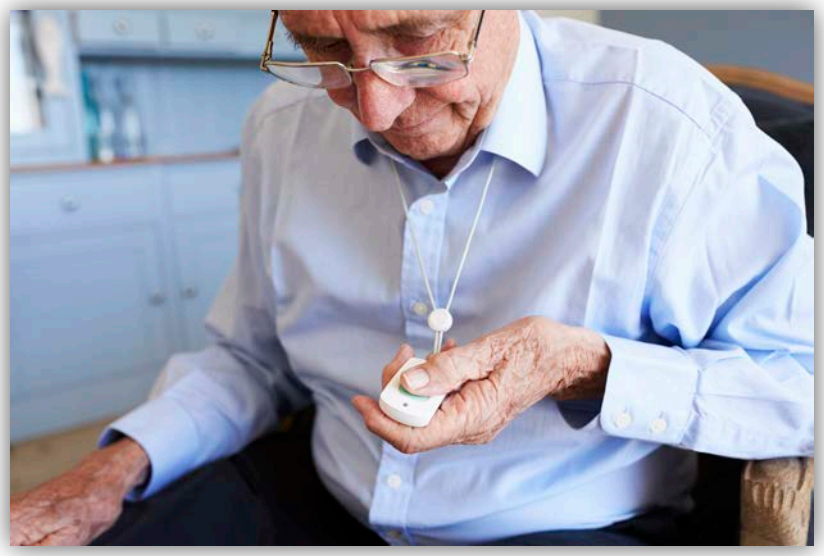
Various types of home care (More than 120 days):

- Personal Care (home attendant and housekeeping)
- Consumer-Directed Personal Assistance Program (CDPAP)
- Home Health Aide, PT, OT (CHHA Personal Care)
- Private Duty Nursing

- Adult day care – medical & social
  - But social day care alone is not enough for MLTC

# MEDICAID UPDATE

- Medical alert button, home-delivered meals, congregate meals
- Medical equipment, supplies, prostheses, orthotics, hearing aids, eyeglasses, respiratory therapy, home modifications
- 4 doctors—Podiatry, Audiology, Dental, Optometry
- Non-emergency medical transportation
- Nursing home **(CHANGING!!)**



# MEDICAID UPDATE

Most people want to keep their chosen Medicare coverage – whether Original Medicare or Medicare Advantage – for primary and acute care. MLTC is separate. But still should know options – FIDA, MAP and PACE.

SEPTEMBER 2018 –

**MLTC** 215,292 members PARTIAL CAPITATION 90% of all people in MLTC-type plans

**PACE** 5,718 members

**MAP** 11,832 members FULL CAPITATION 10% of all member

**FIDA** 3,774 members

**TOTAL** 236,616 members

# MEDICAID UPDATE

Statewide, an adult Medicare beneficiary 21+ who needs community-based long-term home care encounters long delays applying for Medicaid and then enrolling in an MLTC plan

1. Apply for Medicaid at the County DSS/HRA **(up to 45 days)**
2. Get a "Conflict Free Eligibility" evaluation from Maximus (NY Medicaid Choice)* **(approx. 5-7 days)**
3. Pick a plan - MLTC, Medicaid Advantage Plus, PACE or FIDA plan (Nassau/NYC only)
    1. Schedule an in-home assessment with plan **(up to 30 days)**
    2. Pick a plan and enroll
    3. Enrollment paperwork must be submitted by 19th of month for enrollment to start 1st of next month. No mid-month pick-up dates **(10-41 days)**

## APPROXIMATELY 4 MONTHS TOTAL

# MEDICAID UPDATE

## New "exhaustion" requirement for MANAGED CARE APPEALS

Since May 1, 2018, a managed care or MLTC member may not request a Fair Hearing against a plan until AFTER BOTH OF THESE OCCUR:

1. Member has requested a plan appeal (internal appeal) of an Initial Adverse Determination to reduce or deny hours or services, and

2. The plan has EITHER
   a) Issued a Final Adverse Determination (appeal decision). 42 CFR 438.402(c) OR
   b) Has failed to make a Final Adverse Determination in the required time ("Deemed Exhaustion).

3. Deadlines are:
   a) 30 days or
   b) 72 hours if appeal "Fast Tracked"
   c) Either the 30 days or 72 hours may be EXTENDED by up to 14 additional days if plan gave member required notice

Not enough just to do #1 -- request the plan appeal – must wait for 2(a) or (b) before you request a Fair Hearing.

# MEDICAID UPDATE

## NEW Appeals Process and Vocabulary | *Red equals change from previous deadlines*

1
- Plan "INITIAL Adverse Determination" notice (IAD)
- Deadline (if member requested new or increased service):
- 14 calendar days/ 72 hours fast track*

2
- Member Requests Plan Appeal
- Deadline: 10 days for Aid Continuing; 60 days other

3
- Plan "FINAL Adverse Determination" notice (FAD)
- Deadline: **30 calendar days** (was 45)/ 72 hours Fast Track*

4
- Member Requests Fair Hearing
- Deadline: 10 days for Aid Continuing; **120 days** (was 60) other
- Optional: External Appeal request if medical necessity but no Aid Continuing

** Plan may extend 14 days if need more info & in member's interest*

# MEDICAID UPDATE

## Focus on REDUCTIONS

These rules apply in all of these situations:

- Plan is proposing to reduce hours it previously authorized.
- Plan is proposing to reduce hours for a member who transferred to this plan – whether assigned to the new plan or selected it -- after:
  - Another plan CLOSED
  - Member transitioned to MLTC after received IMMEDIATE NEED services for 120 days or other home care services from CASA/HRA/DSS
  - Member was in a mainstream Medicaid managed care plan which provided home care, then transferred to MLTC because became enrolled in Medicare or for other reasons.

# MEDICAID UPDATE

## Focus on REDUCTIONS

- Couple received home care from one plan, and one spouse died or entered Nursing Home. Now plan wants to reduce hours for remaining spouse. See FH 7239884k, 5895095P, 5661376N
- Plan refuses to reinstate your services after a hospitalization or rehab stay at the same level you had previously. GIS 96 MA-023

# MEDICAID UPDATE

## Key Rights in Reductions or Discontinuance

- ADVANCE NOTICE of REDUCTION sent at least 10 days before the "Effective Date" of the proposed reduction.
- ADEQUATE NOTICE must specify a justification for the reduction if member appeals before the Effective Date of the reduction, plan must give AID CONTINUING. This means continuing the same services unchanged while the appeal is decided. Reduction does not go into effect.
  - But if notice not timely or adequate – can argue for Aid Continuing even if miss effective date. FH #7165494N
- Plan must give advance notice with right to Aid Continuing, even if plan mischaracterizes action as "denial" -- not a reduction. FH #7331553Q
- Now member must appeal quickly within the 10-day window TWICE to obtain and keep AID CONTINUING:
  - When receives INITIAL adverse determination → request PLAN APPEAL
  - When receives FINAL adverse determination →request FAIR HEARING

# MEDICAID UPDATE

## Reductions: What If No Written IAD Notice From Plan – Or Late Notice Sent < 10 Days Before Reduction?

- If VERBAL NOTICE from plan rep or the home care agency that the hours are being cut, but no written notice – or notice postmarked < 10 days before reduction.
- In the past, clients could request a Fair Hearing and Aid Continuing, based on lack of written notice or late notice.

# MEDICAID UPDATE

## Reductions: What If No Written IAD Notice From Plan – Or Late Notice Sent < 10 Days Before Reduction?

- Now must request Plan Appeal, and ask Plan to give Aid Continuing, which means recognizing its own notice was defective.
- If plan does not accept the appeal request or does not provide Aid Continuing --
  - Immediately Request a Fair Hearing with Aid Continuing. DOH said in meeting on 4/16/18 that MUST still request plan appeal but do not have to wait for appeal decision. Deemed exhausted.
  - Complain to DOH MLTC or mainstream Complaint lines
  - Call ICAN

# MEDICAID UPDATE

## Does Member Have to Repay Cost of Services Provided as Aid Continuing?

- Plans may ask member to repay cost of services during Aid Continuing period, 42 CFR 438.404(b)(6), but only:
  - after FAD is issued and member fails to request a hearing within the 10-day Aid Continuing period.
  - NYLAG thinks plan can't start recovery until 120 days after FAD sent, if member did not request FH (that's when statute of limitations expires). DOH says plan may start recovery if FH not requested within 10 days after notice sent, but must stop if requests FH within 120 days.
- If member wins, plan can't recover! Most Fair Hearings on reductions of services are in FAVOR OF THE MEMBER (> 90%). See Medicaid Matters NY report and NYT. The potential liability should not deter member from appealing.

# MEDICAID UPDATE

## Right to present new evidence in plan appeal

- Plan must consider new evidence submitted in appeal. 42 CFR 438.406(b)(2)(iii)
- Must provide enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The plan must inform the enrollee of the limited time available for this sufficiently in advance of the resolution time frame for appeals. 438.406(b)(4)
- **TIP:** On the Appeal Request Form that plans must attach to their IAD notice, there is a checkbox if you want to include additional documents with the appeal request, or if you want to give information in person. You could also write in that you would like time to submit additional documentation.

# MEDICAID UPDATE

## Former standards for assessing hours in FFS/DSS (CASA) apply in MLTC

- All managed care plans must make services available to the same extent they are available to recipients of fee-for- service Medicaid.
  42 USC § 1396b(m)(1)(A)(i); 42 CFR §§ 438.210(a)(2), (a)(4)(i). The Model Contract states: "Managed care organizations may not define covered services more restrictively than the Medicaid Program."
- In other words, **there has been NO CHANGE in the amount or type of services available under MLTC versus under PCA/CHHA as it was administered before** by DSS/CASA offices.
- If medically appropriate for 24-hour care (even split-shift) under the PCA regulations, then should receive 24-hour care under MLTC.

# MEDICAID UPDATE

## If needs 24-hour care, show how meets regulatory definitions

- 2015 amendments to regs defining two types of 24-hour care for those who, because of medical condition, need assistance daily with toileting, walking, transferring, turning or positioning. No longer require that need "total" assistance.
  - Split Shift – "uninterrupted care, by more than one personal care aide, for more than 16 hours in a calendar day for a patient who …needs assistance with such frequency that a live-in 24-hour PCA would be unlikely to obtain, on a regular basis, 5 hours daily of uninterrupted sleep during the aide's eight hour period of sleep."
  - Live-in – "care by one personal care aide for a patient …whose need for assistance is sufficiently infrequent that a live-in 24-hour personal care aide would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep."
- Home must have adequate sleeping accommodations for aide.

# MEDICAID UPDATE

## MLTC Lock-In

- **LOCK-IN** –After Dec. 1, 2018, anyone who joins an MLTC plan for the 1st time, or switches plans after that date:
  - May change plans **ONCE** within 1st 90 days;
  - After that, they are locked into that plan for the next 9 months (the rest of the 12-month year) unless they have good cause.
- **GOOD CAUSE** may include (from proposed DOH notice to members, copy in Appendix):
  - the enrollee is moving from the plan's service area
  - the plan fails to furnish services, or
  - it is determined the enrollment was non-consensual
  - to continue being cared for by home care worker

Public Health Law § 4403-F (b)(7)(vii)

# MEDICAID UPDATE

## MLTC Lock-In *cont'd/*

- After the 12 months, individual may change plans any time, but then after a 3-month grace period in new plan – again locked in for 9 months.
  - WARNING: In a "voluntary" transfer, new plan not required to give same hours! Don't transfer without written plan of care that is adequate!

Does not apply to Medicaid Advantage Plus, FIDA, or PACE. Only regular MLTC.

PROCEDURE NOT CLEAR to request good cause

https://www.health.ny.gov/health_care/medicaid/program/update/2018/2018-06.htm#mltc

# MEDICAID UPDATE

## Fast Track Medicaid Application if in Immediate Need for Personal Care or CDPAP (Can't Wait Out 4+ Month MLTC Process)

- 2015 Law requires new procedures to process a Medicaid application in SEVEN DAYS for any applicant with an immediate need for personal care (PCS) or consumer-directed personal assistance (CDPAP) services & to approve PCS/CDAP in 12 days. NY Soc. Serv. L. §366-a(12);

18 NYCRR 505.14(b)(7) and (8) and 505.28(k) (7/2016)

DOH 16-ADM-02 - Immediate Need for PCS & CDPAP

HRA Procedures 10/19/16 - http://www.wnylc.com/health/download/615/

# MEDICAID UPDATE

## What to Include in Immediate Need Application

- Cover Sheet / Transmittal Form (in NYC)
- COMPLETE Medicaid application (or approval Notice if already have Medicaid)
- Physician's order for personal care (M11q)- 18 NYCRR 505.14(b)
- Signed "Attestation of Immediate Need" Form
- HIPPA RELEASE - OCA Form No. 960
- Cover letter describing Immediate need circumstances

# MEDICAID UPDATE

## Attestation Form - Immediate Need

"Attestation of Immediate Need" Form – OHIP-0103.

https://www.health.ny.gov/health_care/medicaid/docs/ohip_form-0103.pdf and attached to 16-ADM-2 .

Must attest that the applicant:

- Has no informal caregivers available, able and willing to provide or continue to provide care;
- Is not receiving needed help from a home care services agency;
- Has no adaptive or specialized equipment or supplies in use to meet your needs; and
- Has no third party insurance or Medicare benefits available to pay for needed help.
- (Arguably, even if Medicare, hospice or private services in place, explain why not enough to provide "NEEDED" help, or that won't continue etc.)

- Form says may be submitted while hospitalized or in nursing home.

# MEDICAID UPDATE

## Spousal Impoverishment available with IMMEDIATE NEED Medicaid

- Under 16 ADM-02, a married person may request Spousal Impoverishment budgeting with a Medicaid application based on IMMEDIATE NEED for personal care or CDPAP. Spouse cannot be in an MLTC plan.
- With a regular Medicaid app, may NOT request this budgeting. Must wait until enrolled in MLTC to request Spousal Impoverishment Budgeting. So regular applicants for MLTC, if married, must initially apply using regular Medicaid rules – combining both spouse's income using couple level of $1233/mo. and asset level of $22,200 -- or use Spousal Refusal. Soc. Serv. L. § 366.3(a).
  - This is because NYS sees Spousal Impoverishment as a "post-eligibility" budgeting methodology. GIS 14 MA/025 - Spousal Impoverishment Budgeting with Post-Eligibility Rules Under the Affordable Care Act.
- With spousal impoverishment, if couple's combined net income is under $3,165.50 (after deducting Medigap premiums), and countable assets under $74,820 – spouse should be eligible without any spend-down or spousal refusal.

# MEDICAID UPDATE

## Timeline for Immediate Need Processing

- **7 calendar days** after receipt of complete Application w/ Attestation form & M11q, DSS must determine **Medicaid eligibility.**
- DSS must request missing documents within 4 calendar days after receipt of physician's order & Attestation of Immediate Need.
- Within **12 calendar days** of receiving complete Medicaid app, Attestation form and M11q, DSS must:
  - Conduct social & nursing assessments
  - Determine eligibility for & **authorize PCS/CDPAP and Number of hours**
  - "Promptly notify" the recipient of the amount authorized
- DSS arranges for services to be provided "as expeditiously as possible." 18 NYCRR 505.14(b)(8)(ii).
  - DSS contracts with home care agencies to provide care or approves CDPAP

# MEDICAID UPDATE

## 2-3 MLTC plans closing in early 2019

- **GUILDNET** – all 3 plans closing in NYC January 2019; 8,228 members received notices mid-October that they must select and enroll in another plan or they will be auto-assigned to another plan Jan. 2019 – sample notice in Appendix.
  - Guildnet Medicaid Advantage Plus — 478 members
  - Guildnet Gold Plus (FIDA) — 418 members
  - Guildnet MLTC — 7,332 members
- **UNITEDHEALTH MLTC** – closing in UPSTATE counties Feb. 2019. Will remain in NYC.
- **ICS** has been rumored to close for months. Not official. — 6,100 members

# MEDICAID UPDATE

## Advocacy Tip:

If member of a closing plan experiences a reduction in hours or other services from the NEW plan, either before or after the 120-day transition period:

- Request an **Internal Plan Appeal** right away with Aid Continuing
- Should receive Aid Continuing even if new plan does not characterize the change as a "reduction" – it may say it's a "denial" or just an authorization
- If plan doesn't give Aid Continuing -- contact ICAN and request a Fair Hearing.

ICAN
Independent Consumer Advocacy Network

- Use same strategies as for other reductions – see "exhaustion" discussion.

# MEDICAID UPDATE

## 2018 NYS Budget - Nursing Home residents excluded from MLTC after 3 months of "permanent placement"

In the budget enacted April 1, 2018, those **"permanently placed in nursing homes for 3 consecutive months or more"** will no longer be eligible for MLTC enrollment. This impacts 3 groups – each discussed further below.

1. People in MLTC who are in NH. 23,000 current NH residents are in MLTC plans will be disenrolled. If they can return home within 6 months of disenrollment, a new CFEEC not required. But still must get plan to enroll them
2. People not in MLTC who are in NH. New Nursing Home residents who were not previously in an MLTC plan will no longer be required to enroll in MLTC. No more auto-assignment to an MLTC plan.
3. People in MLTC, who are not in NH. MLTC members in community will be at risk of being disenrolled from plan if placed in NH even temporarily; more at risk of being placed in NH's if plans deny adequate hours

# MEDICAID UPDATE

## Having Trouble Getting Live-In Care?

A state court threw out a NYS "emergency" labor regulation allowing home care aides to be paid for 13 hours for a 24-hour live-in shift. The Court held that the State did not prove a valid "emergency" existed to justify issuing an "emergency" regulation instead of a regular regulation -- the State didn't prove that the home care industry would collapse if they had to pay hourly rate x 24 hours for live in cases. Chinese Staff Assn. v. Reardon (Supreme Ct. N.Y. Co. 9/25/18) 2018 NY Slip Op 32391(U).

# MEDICAID UPDATE

## Having Trouble Getting Live-In Care?

The State issued the regulation to moot out earlier court rulings that said 24-hour case home care workers must be paid for all 24 hours if they are "nonresidential," meaning they do not live with the client as their exclusive residence. Tokhtaman v. Human Care, LLC, 52 N.Y.S.3d 89 (1st Dept. April 2017). That ruling said the policy allowing 13 hours pay for live-in shift was not a valid regulation.

Now status of law in flux. Expected State Labor Dept will issue a permanent regulation, and more litigation. Until then, some home care agencies fear being sued for overtime over 13 hours/day so won't give live-in.

# MEDICARE UPDATE

# MEDICARE UPDATE

## Medicare Part A

- Part A hospital inpatient deductible, for up to 60 days: $1,364, up from $1,340.
- Part A hospital inpatient coinsurance, for days 61-90: $341 per day, up from $335.
- Part A skilled nursing facility coinsurance, for days 21-100: $170.50 per day, up from $167.50.
- Part A monthly premium for those with insufficient Social Security earnings to qualify for premium-free Part A: $437, up from $422.

## Medicare Part B

- Standard monthly premium is $135.50 for 2019
- Part B annual deductible: $185, up from $183.

# VETERANS BENEFITS UPDATE

# VA BENEFITS UPDATE

## Veterans Pension- RIN 2900-AO73- Net Worth, Asset Transfers, and Income Exclusions for Needs-Based Benefits

VA | U.S. Department of Veterans Affairs

- Initial Proposed Rule appeared in Federal Register on **January 23, 2015**
- The VA finally released draft final rule on **September 18, 2018**
- Effective Date- **October 18, 2018**
- **Not retroactive**-very important
- 36 month lookback period (same as proposed)
- Penalty Period up to 5 years (proposed rule- 10 years) on transfers of "covered assets"

**Calculation:**

- Amount transferred divided by MAPR for married veteran rate at time of application
- $100,000/ $2,169= 46 months
- Final rule avoids disparate treatment of surviving spouses (with lowest pension rate)
- Final rule provides guidance on curing and reducing penalty periods

# VA BENEFITS UPDATE

## Veterans Pension

### Net Worth- equivalent to Medicaid CSRA ($123,600)

- Penalizes those with higher expenses with no adjustment upward in net worth
- Increases will track SSA COLA increase
- **Sum** of claimant's assets **plus** annual income
- Eliminates guesswork re: asset limit

### Primary Residence

- Not counted **even if claimant lives outside the home** (i.e, nursing home or ALF- change from existing policy- although inconsistently applied)
- If primary residence is sold, net sales proceeds not counted as an asset if used to purchase new home within same calendar year
- Timing of sale is of utmost importance

# VA BENEFITS UPDATE

## Veterans Pension

### Covered Assets

- An asset that was part of the claimant's net worth, was transferred for less than FMV, and if not transferred, would have caused or partially caused the claimant's net worth to exceed the net worth limit
- Spenddown- a claimant may decrease assets without penalty by spending them on an item or service for which FMV is received

### Trust and Annuities

- Specifically identified in the new rule as instruments the VA considers transfers for less than FMV
- However, above will not apply if claimant retains ability to liquidate entire balance of trust or annuity
- Lump sum SPIAs are now ineffective
- Veterans Asset Protection Trusts still viable

# VA BENEFITS UPDATE

## Veterans Pension


### Medical Expenses

- How VA calculates income for VA purposes remains the same
- However, medical expenses only include items that are
  - Medically necessary
  - Improve a disabled person's functioning, or
  - Prevent, slow or ease an individuals functional decline

### Medical Expenses- Examples

- Payments to a health care provider
- Prescription and non-prescription medication
- Payments for adaptive services (including certain payments for service animals)

### Medicaid Nursing Home VA Benefit- remains at $90/month

- Beneficiary not liable for any pension payments in excess of $90 by reason of the VA failure to reduce payments, unless the beneficiary willfully conceals the overpayment of the VA

# TAX UPDATE

# TAX UPDATE

## Individual Tax Rates

| Income Tax Rates | Taxable Income Not Over | |
|---|---|---|
| | Single | Joint |
| 10% | $9,525 | $19,050 |
| 12% | $38,700 | $77,400 |
| 22% | $82,500 | $165,000 |
| 24% | $157,500 | $315,000 |
| 32% | $200,000 | $400,000 |
| 35% | $500,000 | $600,000 |
| 37% | $500,000 | $600,000 |

*New rate structure expires after 2025 |*
Planning: Marriage penalty only in start of top bracket

## Capital Gains

2018: Retain 0, 5 and 20% rates

- 15% rate at $38,600 for single filers; $77,200 for joint filers
- 20% rate at $425,800 for single filers; $479,000 for joint filers

Administration proposing indexing for inflation

# TAX UPDATE

## Standard Deduction and Personal Exemptions

Doubling standard deduction to $12,000 for singles; $18,000 for head of household, $24,000 for joint filers


- Adjusted for inflation after 2018
- Expires after 2025
- IRS issued revised withholding tables

Elimination of personal exemptions

- Doubling standard deduction may not offset loss of personal exemptions for some taxpayers, especially New Yorkers
- Less itemization may mean less incentive for home ownership, charitable giving
- Planning: determine if likely to still benefit from itemizing

# TAX UPDATE

## Itemized Deductions

### State and local taxes

- Eliminates, except preserves deduction up to $10,000 ($5,000 married filing separately)
- Marriage penalty in $10,000 limit; no limit if expenses related to a business or investment property
- Charitable contribution: Proposed regulations limit charitable deduction
- Payroll deduction

- Casualty loss deduction repealed, but preserved for federal disasters
  - Need to include FEMA declaration number and location of property
- Expires after 2025

# TAX UPDATE

## Miscellaneous Itemized Deductions

- No deductions that were subject to 2% floor
- Employee unreimbursed business expenses
- Planning for ongoing deprecation of equipment
- Investment expenses
- Legal fees *(Do your clients have an LLC or Trust?)*
- Tax Preparation fees
- Deductions not subject to 2% floor, like gambling expenses, survive!

# TAX UPDATE

## Medical Expense Deductions

- Deduction for qualified out-of-pocket medical expenses (includes home care)
- Originally was slated to be eliminated entirely
- New law preserves the deduction
- For taxpayers who itemize
- Applies to expenses that exceeded 7.5% of AGI for 2017 and 2018
- 10% floor in 2019 and after
- Planning opportunity for IRD items

## Personal and Elderly Exemptions

- The blind and elderly deduction has remained under the new law- a single filer over age 65 can claim an additional $1,600 deduction ($1,300 if married and only one deduction, $2,6000 if both are filing for deduction)

## Tax Consequences of Trusts: Income Taxes

### Calculating Taxable Income

- In general, income earned by trust property is income earned by the trust
- Party responsible for trust income taxes can be the:
  - Trust itself where trust receives the income
  - Income Beneficiaries (can be Grantor or some other party who receives income)
  - Grantor in the case of a "Grantor Trust" (a.k.a IDGT)
- Trusts are taxed like individuals (however, brackets are compressed and reach 37% at $12,500 of income)
  - Trusts may have tax exempt income
  - Personal Exemptions apply
  - No standard deduction, but Trusts may deduct certain expenses

## Tax Consequences of Trusts: Income Taxes

### Calculating Taxable Income (continued)

Allowable Trust Deductions are generally the same as those once allowed for an individual

- Examples of allowable deductions
  - Administrative expenses (e.g. trustee fees, bank fees, brokerage fees, etc..)
  - State, local and real estate taxes
  - Estate expenses (check the governing instrument)
  - Miscellaneous itemized deductions (2% floor of AGI)
    - Legal fees
    - Accounting fees

# TAX UPDATE

## Estate and Gift Tax Exemption Amounts

- Federal estate and gift tax exemption amount was **doubled, and adjusted for inflation,** to $11.40 million for ad individual (effectively $22.80 million for a married couple due to portability)
- The exemption increase is scheduled to sunset and revert back to $5 million on December 31, 2025, adjusted for inflation
- Annual exclusion remains $15,000

# TAX UPDATE

## Should individuals and couples still do planning?

- Gifting opportunities in New York- No Gift Tax!
- NYS estate tax exemption is $5.49 million (up from $5.25)
- A "Cliff" applies at 1.05% of exemption- total estate subject to tax
  - Use marital, charitable deductions in drafting to avoid the cliff
- 3 year throwback rule eliminated
  - Death bed gifts again possible

# TAX UPDATE

## 529 Plan Expansion

- A 529 Plan is a tax-advantaged method of saving for future college expenses
- Previously the IRS restricted 529 Plans to colleges and universities that were eligible to participate in federal student aid programs
- Under the new tax law, parents can withdraw tax free funds from a 529 account to pay for elementary through high school tuition as well. However:
  - Withdrawals are limited to $10,000 per year per student
  - Can be public, private or religious school
  - New York has not yet conformed

# SPECIAL NEEDS PLANNING UPDATE

# SPECIAL NEEDS PLANNING UPDATE

## SI 01130.740 Achieving a Better Life Experience (ABLE) Accounts

- An Achieving a Better Life Experience (ABLE) account is a type of tax-advantage savings account that an eligible individual can use to pay for qualified disability expenses
- The eligible individual is the owner and the designated beneficiary of the ABLE account
  - An eligible individual may establish an ABLE account provided that the individual is blind or disabled by a condition that began before the individual's 26th birthday

# SPECIAL NEEDS PLANNING UPDATE

## Utilizing a Special Needs Trust with an ABLE Account

- **NOTE:** A transfer of funds from a trust, of which the designated beneficiary is the beneficiary and which is not considered a resource to him or her, to the designated beneficiary's ABLE account generally will be considered a third party contribution for ABLE purposes

- The contribution is deemed made by a person or entity other than the designated beneficiary (namely, the trustee), and it is a 3rd party contribution because the designated beneficiary does not legally own the trust

# SPECIAL NEEDS PLANNING UPDATE

## Qualified Disability Expenses

| | | | | |
|---|---|---|---|---|
| Assistive technology & related services | Housing | Transportation | Employment training & support | Education |
| Personal support services | Health | Prevention and wellness | ABLE account oversight & monitoring | Financial management, Legal fees |

## Housing Expenses Include:

| | | | | |
|---|---|---|---|---|
| Mortgage (including property insurance required by the mortgage holder) | Real property taxes | Rent | Heating Fuel | Gas |
| Electricity | Water | Sewer | Garbage removal | |

# SPECIAL NEEDS PLANNING UPDATE

## Do Not Count ABLE Account Distributions as Income

- A distribution from an ABLE account is not income but is a conversion of a resource from one form to another See SI 0110.600B.4
- Do not count it as income of the designated beneficiary, regardless of whether the distributions are for a QDE not related to housing, for a housing expense, or for a non-qualified expense

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*Trusted Counsel*

# Thank you!

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# New York State Elder Law and Special Needs Update

Compiled and Presented by:

Louis W. Pierro, Esq.

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# Table of Contents

# I. Medicaid Update

2019 Medicaid Levels and Other Updates
Source: Office of Health Insurance Programs

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, 2019.

Due to the 2.8 percent (%) cost of living adjustment (COLA) for Social Security Administration (SSA) payments effective January 1, 2019, 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 resources levels will also be adjusted accordingly.

The following figures are effective January 1, 2019.

1. Medically Needy Income and Resources Levels.

| HOUSEHOLD SIZE | MEDICALLY NEEDY INCOME LEVEL | | RESOURCES |
|---|---|---|---|
| | ANNUAL | MONTHLY | |
| ONE | 10,300 | 859 | 15,450 |
| TWO | 15,200 | 1,267 | 22,800 |
| THREE | 17,480 | 1,457 | 25,013 |
| FOUR | 19,760 | 1,647 | 28,275 |
| FIVE | 22,040 | 1,837 | 31,539 |
| SIX | 24,320 | 2,027 | 34,800 |
| SEVEN | 26,600 | 2,217 | 38,064 |
| EIGHT | 28,880 | 2,407 | 41,325 |
| NINE | 31,160 | 2,597 | 44,588 |
| TEN | 33,440 | 2,787 | 47,850 |
| EACH ADD'L PERSON | 2,280 | 190 | 3,263 |

2. The Supplemental Security Income federal benefit rate (FBR) for an individual living alone is
   $771/single and $1,157/couple.
3. The allocation amount is $408, the difference between the Medicaid income level for a household of two and one.
4. The 249e factors are .970 and .152.
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. If you buy Part A, and you paid Medicare taxes for less than 30 quarters, the Standard Part A premium is $437. If you paid Medicare taxes for 30-39 quarters, the standard Part A premium is $240.

8. The standard Medicare Part B monthly premium for beneficiaries with income less than or equal to $85,000 is $135.50.
9. The Maximum federal Community Spouse Resource Allowance is $126,420.
10. The Minimum State Community Spouse Resource Allowance is $74,820.
11. The community spouse Minimum Monthly Maintenance Needs Allowance (MMMNA) is
$3,160.50.
12. Maximum Family Member Allowance remains $686 until the FPLs for 2019 are published in the Federal Register.
13. Family Member Allowance formula number remains $2,058 until the FPLs for 2019 are published in the Federal Register.
14. Personal Needs Allowance for certain waiver participants subject to spousal impoverishment budgeting is $408.
15. Substantial Gainful Activity (SGA) is: Non-Blind $1,220/month, Blind $2,040/month and Trial Work Period (TWP) $880/month.
16. SSI-related student earned income disregard limit of $1,870/monthly up to a maximum of
$7,550/annually.
17. The home equity limit for Medicaid coverage of nursing facility services and community- based long-term care is $878,000.
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 2019, the amounts are: Northeastern $462; Central $412; Rochester
$419; Western $360; Northern Metropolitan $930; Long Island $1,269; and New York City
$1,300. All regions had a decrease from the 2018 figure.

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

## *The Following Materials from NYLAG regarding new rules for MLTC Appeals and other MLTC updates are Provided Courtesy of Valerie Bogart*

# The New Exhaustion Rules for Appeals in Medicaid Managed Care and MLTC

## Implementation in NYS

**Valerie Bogart, Director, Evelyn Frank Legal Resources Program, NYLAG**

## APPENDIX

**Revised Federal Regulations**



**Form Notices and Appeal Request Forms -- Exhaustion of Internal Appeals**



**Advocacy Documents**

Grievances and Appeals, available at http://www.healthlaw.org/publications/browse-all-publications/Brief-2-MMC-Final-Reg

**NYS Policy / Public Education documents**

1. NYS DOH **Draft** of Fact Sheet on Exhaustion ..... 36
2. NYS Webpage on Exhaustion - *Service Authorization and Appeals for Mainstream Medicaid Managed Care Plans, HARP, and HIV SNP, at* https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm - oriented to training mainstream plans. Includes FAQs, a PowerPoint, policy, notice templates. .....
3. DOH MLTC Webpage MRT 90 – links to model contracts, MLTC policies, etc. https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/index.htm
   - https://www.health.ny.gov/health_care/managed_care/plans/appeals/42_cfr_438.htm - Webinars, FAQs, notice templates on Exhaustion .....

**Consumer Advocates Fact Sheets, Resources on Exhaustion**

1. Consumer advocate suggested edits of NYS DOH **Draft** of Fact Sheet on Exhaustion ..... 39
2. Graphic of steps in appeals and fair hearings – one for denials, one for reductions..... 41
3. Flow Chart with Suggested Script by OTDA Fair Hearing Request Intake Staff ..... 42
4. Chart to log key dates to determine whether exhaustion may be "deemed" – Consumers suggested this as a tool for OTDA, but also useful for consumer advocates ..... 43

**Other Online Resources**

1. *Mis-Managed Care: Fair Hearing Decisions on Medicaid Home Care Reductions by Managed Long Term Care Plans*, July 2016, issued by Medicaid Matters NY and New York Chapter of the National Academy of Elder Law Attorneys, (available at http://medicaidmattersny.org/cms/wp-content/uploads/2016/08/Managed-Long-Term-Care-Fair-Hearing-Monitoring-Project-2016-07-14-Final.pdf)
2. *Article on Managed Care Appeal Procedures* – check for updates http://www.wnylc.com/health/entry/184/
3. **Fax, phone and email contact info** to request appeals for all MLTC plans will be posted here when available - http://www.wnylc.com/health/entry/179/

**HOTLINES/ COMPLAINTS**

1. **NYS DOH MLTC/FIDA Complaint Hotline** 1-866-712-7197 mltctac@health.ny.gov
2. **NYS DOH Mainstream managed care complaints --** 1-800-206-8125 managedcarecomplaint@health.ny.gov
3. **ICAN – Independent Consumer Advocacy Network –** Helps with MLTC and mainstream appeals on long term services and supports -- TEL 844-614-8800 TTY Relay Service: 711 Website: icannys.org ican@cssny.org

**Article on Exhaustion Submitted to NYSBA Elder Law & Special Needs Journal**

1. "Exhaustion" of MLTC Plan Appeal Required Before Requesting a Fair Hearing – Starts April 1, 2018," Article Draft, by Valerie Bogart ..... 42

**SEE OUR http://nyhealthaccess.org Health Care Advocacy Webpage**

**ELECTRONIC CODE OF FEDERAL REGULATIONS**

**e-CFR data is current as of June 23, 2017**

Title 42 → Chapter IV → Subchapter C → Part 438 → Subpart F

Title 42: Public Health
PART 438—MANAGED CARE

## Subpart F—Grievance and Appeal System

**Contents**



SOURCE: 81 FR 27853, May 6, 2016, unless otherwise noted.

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### §438.400 Statutory basis, definitions, and applicability.

(a) *Statutory basis.* This subpart is based on the following statutory sections:

(1) Section 1902(a)(3) of the Act requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

(2) Section 1902(a)(4) of the Act requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(3) Section 1932(b)(4) of the Act requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(b) *Definitions.* As used in this subpart, the following terms have the indicated meanings:

*Adverse benefit determination* means, in the case of an MCO, PIHP, or PAHP, any of the following:

(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

(2) The reduction, suspension, or termination of a previously authorized service.

(3) The denial, in whole or in part, of payment for a service.

(4) The failure to provide services in a timely manner, as defined by the State.

(5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

(6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.

(7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

*Appeal* means a review by an MCO, PIHP, or PAHP of an adverse benefit determination.

*Grievance* means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision.

*Grievance and appeal system* means the processes the MCO, PIHP, or PAHP implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.

*State fair hearing* means the process set forth in subpart E of part 431 of this chapter.

(c) *Applicability.* This subpart applies to the rating period for contracts with MCOs, PIHPs, and PAHPs beginning on or after July 1, 2017. Until that applicability date, states, MCOs, PIHPs, and PAHPs are required to continue to comply with subpart F contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.

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**§438.402 General requirements.**

(a) *The grievance and appeal system.* Each MCO, PIHP, and PAHP must have a grievance and appeal system in place for enrollees. Non-emergency medical transportation PAHPs, as defined in §438.9, are not subject to this subpart F.

(b) *Level of appeals.* Each MCO, PIHP, and PAHP may have only one level of appeal for enrollees.

(c) *Filing requirements*—(1) *Authority to file.* (i) An enrollee may file a grievance and request an appeal with the MCO, PIHP, or PAHP. An enrollee may request a State fair hearing after receiving notice under §438.408 that the adverse benefit determination is upheld.

(A) *Deemed exhaustion of appeals processes.* In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in §438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.

(B) *External medical review.* The State may offer and arrange for an external medical review if the following conditions are met.

(*1*) The review must be at the enrollee's option and must not be required before or used as a deterrent to proceeding to the State fair hearing.

(*2*) The review must be independent of both the State and MCO, PIHP, or PAHP.

(*3*) The review must be offered without any cost to the enrollee.

(*4*) The review must not extend any of the timeframes specified in §438.408 and must not disrupt the continuation of benefits in §438.420.

(ii) If State law permits and with the written consent of the enrollee, a provider or an authorized representative may request an appeal or file a grievance, or request a State fair hearing, on behalf of an enrollee. When the term “enrollee” is used throughout subpart F of this part, it includes providers and authorized representatives consistent with this paragraph, with the exception that providers cannot request continuation of benefits as specified in §438.420(b)(5).

(2) *Timing*—(i) *Grievance.* An enrollee may file a grievance with the MCO, PIHP, or PAHP at any time.

(ii) *Appeal.* Following receipt of a notification of an adverse benefit determination by an MCO, PIHP, or PAHP, an enrollee has 60 calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the managed care plan.

(3) *Procedures*—(i) *Grievance.* The enrollee may file a grievance either orally or in writing and, as determined by the State, either with the State or with the MCO, PIHP, or PAHP.

(ii) *Appeal.* The enrollee may request an appeal either orally or in writing. Further, unless the enrollee requests an expedited resolution, an oral appeal must be followed by a written, signed appeal.

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**§438.404 Timely and adequate notice of adverse benefit determination.**

(a) *Notice.* The MCO, PIHP, or PAHP must give enrollees timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below and in §438.10.

(b) *Content of notice.* The notice must explain the following:

(1) The adverse benefit determination the MCO, PIHP, or PAHP has made or intends to make.

(2) The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.

(3) The enrollee's right to request an appeal of the MCO's, PIHP's, or PAHP's adverse benefit determination, including information on exhausting the MCO's, PIHP's, or PAHP's one level of appeal described at §438.402(b) and the right to request a State fair hearing consistent with §438.402(c).

(4) The procedures for exercising the rights specified in this paragraph (b).

(5) The circumstances under which an appeal process can be expedited and how to request it.

(6) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the enrollee may be required to pay the costs of these services.

(c) *Timing of notice.* The MCO, PIHP, or PAHP must mail the notice within the following timeframes:

(1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in §§431.211, 431.213, and 431.214 of this chapter.

(2) For denial of payment, at the time of any action affecting the claim.

(3) For standard service authorization decisions that deny or limit services, within the timeframe specified in §438.210 (d)(1).

(4) If the MCO, PIHP, or PAHP meets the criteria set forth for extending the timeframe for standard service authorization decisions consistent with §438.210(d)(1)(ii), it must—

(i) Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and

(ii) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

(5) For service authorization decisions not reached within the timeframes specified in §438.210(d) (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire.

(6) For expedited service authorization decisions, within the timeframes specified in §438.210(d)(2).

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**§438.406 Handling of grievances and appeals.**

(a) *General requirements.* In handling grievances and appeals, each MCO, PIHP, and PAHP must give enrollees any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

(b) *Special requirements.* An MCO's, PIHP's or PAHP's process for handling enrollee grievances and appeals of adverse benefit determinations must:

(1) Acknowledge receipt of each grievance and appeal.

(2) Ensure that the individuals who make decisions on grievances and appeals are individuals—

(i) Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.

(ii) Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.

(A) An appeal of a denial that is based on lack of medical necessity.

(B) A grievance regarding denial of expedited resolution of an appeal.

(C) A grievance or appeal that involves clinical issues.

(iii) Who take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

(3) Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.

(4) Provide the enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The MCO, PIHP, or PAHP must inform the enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c) in the case of expedited resolution.

(5) Provide the enrollee and his or her representative the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c).

(6) Include, as parties to the appeal—

(i) The enrollee and his or her representative; or

(ii) The legal representative of a deceased enrollee's estate.

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**§438.408 Resolution and notification: Grievances and appeals.**

(a) *Basic rule.* Each MCO, PIHP, or PAHP must resolve each grievance and appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this section.

(b) *Specific timeframes*—(1) *Standard resolution of grievances.* For standard resolution of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 90 calendar days from the day the MCO, PIHP, or PAHP receives the grievance.

(2) *Standard resolution of appeals.* For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 30 calendar days from the day the MCO, PIHP, or PAHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.

(3) *Expedited resolution of appeals.* For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 72 hours after the MCO, PIHP, or PAHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.

(c) *Extension of timeframes.* (1) The MCO, PIHP, or PAHP may extend the timeframes from paragraph (b) of this section by up to 14 calendar days if—

(i) The enrollee requests the extension; or

(ii) The MCO, PIHP, or PAHP shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the enrollee's interest.

(2) *Requirements following extension.* If the MCO, PIHP, or PAHP extends the timeframes not at the request of the enrollee, it must complete all of the following:

(i) Make reasonable efforts to give the enrollee prompt oral notice of the delay.

(ii) Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.

(iii) Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

(3) *Deemed exhaustion of appeals processes.* In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.

(d) *Format of notice*—(1) *Grievances.* The State must establish the method that an MCO, PIHP, and PAHP will use to notify an enrollee of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at §438.10.

(2) *Appeals.* (i) For all appeals, the MCO, PIHP, or PAHP must provide written notice of resolution in a format and language that, at a minimum, meet the standards described at §438.10.

(ii) For notice of an expedited resolution, the MCO, PIHP, or PAHP must also make reasonable efforts to provide oral notice.

(e) *Content of notice of appeal resolution.* The written notice of the resolution must include the following:

(1) The results of the resolution process and the date it was completed.

(2) For appeals not resolved wholly in favor of the enrollees—

(i) The right to request a State fair hearing, and how to do so.

(ii) The right to request and receive benefits while the hearing is pending, and how to make the request.

(iii) That the enrollee may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's adverse benefit determination.

(f) *Requirements for State fair hearings*—(1) *Availability.* An enrollee may request a State fair hearing only after receiving notice that the MCO, PIHP, or PAHP is upholding the adverse benefit determination.

(i) *Deemed exhaustion of appeals processes.* In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in §438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.

(ii) *External medical review.* The State may offer and arrange for an external medical review if the following conditions are met.

(A) The review must be at the enrollee's option and must not be required before or used as a deterrent to proceeding to the State fair hearing.

(B) The review must be independent of both the State and MCO, PIHP, or PAHP.

(C) The review must be offered without any cost to the enrollee.

(D) The review must not extend any of the timeframes specified in §438.408 and must not disrupt the continuation of benefits in §438.420.

(2) *State fair hearing.* The enrollee must request a State fair hearing no later than 120 calendar days from the date of the MCO's, PIHP's, or PAHP's notice of resolution.

(3) *Parties.* The parties to the State fair hearing include the MCO, PIHP, or PAHP, as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.

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**§438.410 Expedited resolution of appeals.**

(a) *General rule.* Each MCO, PIHP, and PAHP must establish and maintain an expedited review process for appeals, when the MCO, PIHP, or PAHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

(b) *Punitive action.* The MCO, PIHP, or PAHP must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal.

(c) *Action following denial of a request for expedited resolution.* If the MCO, PIHP, or PAHP denies a request for expedited resolution of an appeal, it must—

(1) Transfer the appeal to the timeframe for standard resolution in accordance with §438.408(b)(2).

(2) Follow the requirements in §438.408(c)(2).

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**§438.414 Information about the grievance and appeal system to providers and subcontractors.**

The MCO, PIHP, or PAHP must provide information specified in §438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract.

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**§438.416 Recordkeeping requirements.**

(a) The State must require MCOs, PIHPs, and PAHPs to maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy.

(b) The record of each grievance or appeal must contain, at a minimum, all of the following information:

(1) A general description of the reason for the appeal or grievance.

(2) The date received.

(3) The date of each review or, if applicable, review meeting.

(4) Resolution at each level of the appeal or grievance, if applicable.

(5) Date of resolution at each level, if applicable.

(6) Name of the covered person for whom the appeal or grievance was filed.

(c) The record must be accurately maintained in a manner accessible to the state and available upon request to CMS.

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**§438.420 Continuation of benefits while the MCO, PIHP, or PAHP appeal and the State fair hearing are pending.**

(a) *Definition.* As used in this section—

*Timely files* means files for continuation of benefits on or before the later of the following:

(i) Within 10 calendar days of the MCO, PIHP, or PAHP sending the notice of adverse benefit determination.

(ii) The intended effective date of the MCO's, PIHP's, or PAHP's proposed adverse benefit determination.

(b) *Continuation of benefits.* The MCO, PIHP, or PAHP must continue the enrollee's benefits if all of the following occur:

(1) The enrollee files the request for an appeal timely in accordance with §438.402(c)(1)(ii) and (c)(2)(ii);

(2) The appeal involves the termination, suspension, or reduction of previously authorized services;

(3) The services were ordered by an authorized provider;

(4) The period covered by the original authorization has not expired; and

(5) The enrollee timely files for continuation of benefits.

(c) *Duration of continued or reinstated benefits.* If, at the enrollee's request, the MCO, PIHP, or PAHP continues or reinstates the enrollee's benefits while the appeal or state fair hearing is pending, the benefits must be continued until one of following occurs:

(1) The enrollee withdraws the appeal or request for state fair hearing.

(2) The enrollee fails to request a state fair hearing and continuation of benefits within 10 calendar days after the MCO, PIHP, or PAHP sends the notice of an adverse resolution to the enrollee's appeal under §438.408(d)(2).

(3) A State fair hearing office issues a hearing decision adverse to the enrollee.

(d) *Enrollee responsibility for services furnished while the appeal or state fair hearing is pending.* If the final resolution of the appeal or state fair hearing is adverse to the enrollee, that is, upholds the MCO's, PIHP's, or PAHP's adverse benefit determination, the MCO, PIHP, or PAHP may, consistent with the state's usual policy on recoveries under §431.230(b) of this chapter and as specified in the MCO's, PIHP's, or PAHP's contract, recover the cost of services furnished to the enrollee while the appeal and state fair hearing was pending, to the extent that they were furnished solely because of the requirements of this section.

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**§438.424 Effectuation of reversed appeal resolutions.**

(a) *Services not furnished while the appeal is pending.* If the MCO, PIHP, or PAHP, or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO, PIHP, or PAHP must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.

(b) *Services furnished while the appeal is pending.* If the MCO, PIHP, or PAHP, or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO, PIHP, or PAHP, or the State must pay for those services, in accordance with State policy and regulations.

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**ELECTRONIC CODE OF FEDERAL REGULATIONS**

**e-CFR data is current as of June 23, 2017**

Title 42 → Chapter IV → Subchapter C → Part 438 → Subpart D → §438.210

Title 42: Public Health
PART 438—MANAGED CARE
Subpart D—MCO, PIHP and PAHP Standards

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**§438.210 Coverage and authorization of services.**

(a) *Coverage.* Each contract between a State and an MCO, PIHP, or PAHP must do the following:

(1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.

(2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid, as set forth in §440.230 of this chapter, and for enrollees under the age of 21, as set forth in subpart B of part 441 of this chapter.

(3) Provide that the MCO, PIHP, or PAHP—

(i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.

(ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.

(4) Permit an MCO, PIHP, or PAHP to place appropriate limits on a service—

(i) On the basis of criteria applied under the State plan, such as medical necessity; or

(ii) For the purpose of utilization control, provided that—

(A) The services furnished can reasonably achieve their purpose, as required in paragraph (a)(3)(i) of this section;

(B) The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the enrollee's ongoing need for such services and supports; and

(C) Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with §441.20 of this chapter.

(5) Specify what constitutes “medically necessary services” in a manner that—

(i) Is no more restrictive than that used in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and

(ii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services that address:

(A) The prevention, diagnosis, and treatment of an enrollee's disease, condition, and/or disorder that results in health impairments and/or disability.

(B) The ability for an enrollee to achieve age-appropriate growth and development.

(C) The ability for an enrollee to attain, maintain, or regain functional capacity.

(D) The opportunity for an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

(b) *Authorization of services.* For the processing of requests for initial and continuing authorizations of services, each contract must require—

(1) That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.

(2) That the MCO, PIHP, or PAHP—

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.

(ii) Consult with the requesting provider for medical services when appropriate.

(iii) Authorize LTSS based on an enrollee's current needs assessment and consistent with the person-centered service plan.

(3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs.

(c) *Notice of adverse benefit determination.* Each contract must provide for the MCO, PIHP, or PAHP to notify the requesting provider, and give the enrollee written notice of any decision by the MCO, PIHP, or PAHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For MCOs, PIHPs, and PAHPs, the enrollee's notice must meet the requirements of §438.404.

(d) *Timeframe for decisions.* Each MCO, PIHP, or PAHP contract must provide for the following decisions and notices:

(1) *Standard authorization decisions.* For standard authorization decisions, provide notice as expeditiously as the enrollee's condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if—

(i) The enrollee, or the provider, requests extension; or

(ii) The MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

(2) *Expedited authorization decisions.* (i) For cases in which a provider indicates, or the MCO, PIHP, or PAHP determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO, PIHP, or PAHP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service.

(ii) The MCO, PIHP, or PAHP may extend the 72 hour time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

(3) *Covered outpatient drug decisions.* For all covered outpatient drug authorization decisions, provide notice as described in section 1927(d)(5)(A) of the Act.

(e) *Compensation for utilization management activities.* Each contract between a State and MCO, PIHP, or PAHP must provide that, consistent with §§438.3(i), and 422.208 of this chapter, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

(f) *Applicability date.* This section applies to the rating period for contracts with MCOs, PIHPs, and PAHPs beginning on or after July 1, 2017. Until that applicability date, states are required to continue to comply with §438.210 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.

[81 FR 27853, May 6, 2016, as amended at 82 FR 39, Jan. 3, 2017]

ACME MLTC PLAN
100 Acme Lane – New York, NY 10000
1-800-MCO-PLAN

# INITIAL ADVERSE DETERMINATION
# NOTICE TO REDUCE, SUSPEND OR STOP SERVICES

April 1, 2018

Jane Doe
111 Consumer Lane
New York, NY 11111

Enrollee Number: 5555
Coverage Type: Managed Long Term Care
Service: Personal Care services
Provider: Helping Hands Home Care
Plan Reference Number: 222222

Dear Jane Doe:

This is an important notice about your services. Read it carefully. If you think this decision is wrong, you can ask for a Plan Appeal by **May 31, 2018. If you want to keep your services the same until your Plan Appeal is decided, you must ask for a Plan Appeal by April 11, 2018.** You are not responsible for payment of covered services and this is not a bill. Call this number if you have any questions or need help: 1-800-MCO-PLAN.

## Why am I getting this notice?

You are getting this notice because ACME MLTC Plan is reducing the service(s) you are getting now.

Before this decision, from April 1, 2017 to April 11, 2018, the plan approved:
12 hours/day x 7 days/week of personal care services – total 84 hours/week

On April 11, 2018 the plan approval **changes** to:
8 hours/day x 5 days/week and 4 hours/day x 2 days/week – total 48 hours/week
From April 11, 2018 to October 11, 2018.

We will review your care again in six months.

This service will be provided by a participating provider. You are not responsible for any extra payments, but you will still have to pay your regular co-pay if you have one.

## Why did we decide to reduce your service?

ACME MLTC Plan is taking this action because the service is not medically necessary.

- Your personal care services will be reduced because:
  - Your social circumstances have changed since the previous authorization was made.
  - On January 1, 2018, your daughter, with whom you live, retired from her job.
- You no longer meet the criteria for your current level of service because:

- Your daughter is ready, willing and able to take care of you during some of the time that you previously had personal care services.

## What if I don't agree with this decision?

If you think our decision is wrong, you can tell us why and ask us to change our decision. This is called a **Plan Appeal.** There is no penalty and we will not treat you differently because you asked for a Plan Appeal.

### If you want to keep your services the same

- **You must ask for a Plan Appeal within 10 calendar days or by the date this decision takes effect, whichever is later.**
- **The last day to ask for a Plan Appeal and keep your services the same is April 11, 2018,**
- Your services will stay the same until we make our decision. If the Plan Appeal is not decided in your favor, you may have to pay for the services you got while waiting for the decision.

You have a total of **60 calendar days** from the date of this notice to ask for a Plan Appeal. The deadline to ask for a Plan Appeal is **May 31, 2018.**

## Who can ask for a Plan Appeal?

You can ask for a Plan Appeal, or have someone else ask for you, like a family member, friend, doctor, or lawyer. If you told us before that someone may represent you, that person may ask for the Plan Appeal. If you want someone new to act for you, you and that person must sign and date a statement saying this is what you want. Or, you can both sign and date the attached Plan Appeal Request Form. If you have any questions about choosing someone to act for you, call us at: 1-800-MCO-PLAN. TTY users call TTY.

You can also call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. Contact ICAN to learn more about their services:

**Phone**: 1-844-614-8800 (**TTY Relay Service**: 711)
**Web**: www.icannys.org | **Email**: ican@cssny.org]

## How do I ask for a Plan Appeal?

You can call, write or visit us to ask for a Plan Appeal. You or your provider can ask for your Plan Appeal to be **fast tracked** if you think a delay will cause harm to your health. **If you need help, or need a Plan Appeal right away, call us at 1-800-MCO-PLAN.**

**Step 1 – Gather your information.**

When you ask for a Plan Appeal, or soon after, you will need to give us:

- Your name and address
- Enrollee number

- Service you asked for and reason(s) for appealing
- Any information that you want us to review, such as medical records, doctors' letters or other information that explains why you need the service.

If your Plan Appeal is fast tracked, there may be a short time to give us information you want us to review.

To help you prepare for your Plan Appeal, you can ask to see the guidelines, medical records and other documents we used to make this decision. You can ask to see these documents or ask for a free copy by calling 1-800-MCO-PLAN.

**Step 2 – Send us your Plan Appeal.**
Give us your information and materials by phone, fax, email, mail, online, or in person**:**

Phone…….. 1-800-MCO-PLAN
Fax…….. 1-800-MCO-EFAX
Email…….. appeals@acme.com
Mail or In Person …..…….. ACME MLTC PLAN, 100 Acme Lane, New York, NY 10000 ATTENTION: APPEALS
On Line…….. [web portal]

If you ask for a Plan Appeal by phone, unless it is fast tracked, you must also send your Plan Appeal to us in writing. To send a written Plan Appeal, you may use the attached Appeal Request Form, but it is not required. Keep a copy of everything for your records.

## What happens next?

We will tell you we received your Plan Appeal and begin our review. We will let you know if we need any other information from you. If you asked to give us information in person, ACME MLTC Plan will contact you (and your representative, if any).

We will send you a free copy of the medical records and any other information we will use to make the appeal decision. If your Plan Appeal is fast tracked, there may be a short time to review this information.

We will send you our decision in writing. If fast tracked, we will also contact you by phone. If you win your Plan Appeal, your service will be covered. If you lose your Plan Appeal, we will send you our Final Adverse Determination. The Final Adverse Determination will explain the reasons for our decision and your appeal rights. If you lose your appeal, you may request a Fair hearing and, in some cases, an External Appeal.

## When will my Plan Appeal be decided?

**Standard**– We will give you a written decision as fast as your condition requires but no later than 30 calendar days after we get your appeal.

**Fast Track** –We will give you a decision on a fast track Plan Appeal within 72 hours after we get your appeal.

Your Plan Appeal will be fast tracked if:
- Delay will seriously risk your health, life, or ability to function;

- Your provider says the appeal needs to be faster;
- You are asking for more of a service you are getting right now;
- You are asking for home care services after you leave the hospital;
- You are asking for more inpatient substance abuse treatment at least 24 hours before you are discharged; or
- You are asking for mental health or substance abuse services that may be related to a court appearance.

If your request for a Fast Track Plan Appeal is denied, we will let you know in writing and will review your appeal in the standard time.

**For both Standard and Fast Track -** If we need more information about your case, and it is in your best interest, it may take up to 14 days longer to review your Plan Appeal. We will tell you in writing if this happens.

You or your provider may also ask the plan to take up to 14 days longer to review your Plan Appeal.

## Can I ask for a State Fair Hearing?

You have the right to ask the State for a Fair Hearing about this decision, **after** you ask for a Plan Appeal **and:**

- You receive a Final Adverse Determination. You will have 120 days from the date of the Final Adverse Determination to ask for a Fair Hearing;

**OR**

- The time for us to decide your Plan Appeal has expired, including any extensions. **If you do not receive a response to your Plan Appeal or we do not decide in time, you can ask for a Fair Hearing**. To request a Fair Hearing call 1-800-342-3334 or fill out the form online at http://otda.ny.gov/oah/FHReq.asp.

## Do I have other appeal rights?

You have other appeal rights if your plan said the service was: 1) not medically necessary, 2) experimental or investigational, 3) not different from care you can get in the plan's network, or 4) available from a participating provider who has correct training and experience to meet your needs.

For these types of decisions, if we do not answer your Plan Appeal on time, the original denial will be reversed.

For these types of decisions, you may also be eligible for an External Appeal. An External Appeal is a review of your case by health professionals that do not work for your plan or the State. You may need your doctor's help to fill out the External Appeal application.

Before you ask for an External Appeal:

- You must file a Plan Appeal and get the plan's Final Adverse Determination; or
- If you ask for a Fast Track Plan Appeal, you may also ask for a Fast Track External Appeal at the same time; or
- You and your plan may jointly agree to skip the Plan Appeal process and go directly to the External Appeal.

You have 4 months to ask for an External Appeal from when you receive your plan's Final Adverse Determination, or from when you agreed to skip the Plan Appeal process.

To get an External Appeal application and instructions:

- Call ACME MLTC Plan at1-800-MCO-PLAN; or
- Call the New York State Department of Financial Services at 1-800-400-8882; or
- Go on line: www.dfs.ny.gov

The External Appeal decision will be made in 30 days. Fast track decisions are made in 72 hours. The decision will be sent to you in writing. If you ask for an External Appeal and a Fair Hearing, the Fair Hearing decision will be the final decision about your benefits.

## Other help:

You can file a complaint about your managed care at any time with the New York State Department of Health by calling for MLTC complaints 1-866-712-7197.

You can call ACME MLTC PLAN at 1-800-MCO-PLAN if you have any questions about this notice.

Sincerely,

ACME MLTC Plan

Enclosure: Appeal Request Form

cc: Requesting Provider

At your request, a copy of this notice has been sent to:

John Doe –Authorized Representative
Chris Roe – Legal Guardian

**ACME MLTC PLAN APPEAL REQUEST FORM**
**FOR SERVICES BEING REDUCED, SUSPENDED, OR STOPPED**

**Mail To**:
ACME MLTC Plan
[Address]
[City, State Zip]

**Fax to**: 1-800-MCO-EFAX

Today's date: April 1, 2018

**DEADLINE:**

- **If you want to keep your services the same** until the Plan Appeal decision, you must ask within 10 calendar days of the date of this notice, or by the date the decision takes effect, whichever is later. **(**If you lose your appeal you may have to pay for services you got while waiting for the decision.)
- **The last day to ask for a Plan Appeal to keep your services the same is April 11, 2018**
- You have a total of 60 calendar days from the date of this notice to ask for a Plan Appeal. **The last day to ask for a Plan Appeal for this decision is May 31, 2018. If you want a Plan Appeal, you must ask for it on time.**

---

**Enrollee Information**
Name: Jane Doe]
Enrollee ID: 5555
Address: 111 Consumer Lane, New York, NY 11111
Home Phone: 1-212-111-1111 Cell Phone: [Cell Phone]
Plan Reference Number: 222222
Service being reduced, suspended or stopped: Personal Care Services

**I think the plan's decision is wrong because:**

_____

_____

_____

Check all that apply:

☐ **I do NOT want my services to stay the same** while my Plan Appeal is being decided.

☐ I request a Fast Track Appeal because a delay could harm my health.

☐ I enclosed additional documents for review during the appeal.

☐ I would like to give information in person.

☐ I want someone to ask for a Plan Appeal for me:
- Have you authorized this person with ACME MLTC Plan before? ☐ YES ☐ NO
- Do you want this person to act for you for all steps of the appeal or fair hearing about this decision? You can let us know if change your mind. YES ☐ NO ☐

**Requester (person asking for me):**

Name: _____ E- mail: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: (_____)_____ Fax #: (_____)_____

**Enrollee Signature:** _____ Date:_____

**Requester Signature:** _____ Date:_____

*If this form cannot be signed, the plan will follow up with the enrollee to confirm intent to appeal.*

**NOTICE OF NON-DISCRIMINATION**

**ACME MLTC PLAN** complies with Federal civil rights laws. **ACME MLTC PLAN** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

## **ACME MLTC PLAN** provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **ACME MLTC PLAN** at <toll free number>. For TTY/TDD services, call <TTY>.

If you believe that **[ACME MLTC PLAN]** has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with **[ACME MLTC PLAN]** by:

| | |
|---|---|
| Mail: | [ADDRESS], [CITY], [STATE] [ZIP CODE], |
| Phone: | [PHONE NUMBER] (for TTY/TDD services, call <TTY>) |
| Fax: | [FAX NUMBER] |
| In person: | [ADDRESS], [CITY], [STATE] [ZIP CODE] |
| Email: | [EMAIL ADDRESS] |

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

| | |
|---|---|
| Web: | Office for Civil Rights Complaint Portal at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* |
| Mail: | U.S. Department of Health and Human Services<br>200 Independence Avenue SW., Room 509F, HHH Building<br>Washington, DC 20201<br>Complaint forms are available at<br>http://www.hhs.gov/ocr/office/file/index.html |
| Phone: | 1-800-368-1019 (TTY/TDD 800-537-7697) |

| | |
|---|---|
| ATTENTION: Language assistance services, free of charge, are available to you. Call <toll free number> <TTY/TDD> . | English |
| ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al <toll free number> <TTY/TDD>. | Spanish |
| 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 <toll free number> <TTY/TDD>. | Chinese |
| ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم toll free number والبكم(رقم هاتف الصم <TTY/TDD | Arabic |
| 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다<toll free number> <TTY/TDD> 번으로 전화해 주십시오. | Korean |
| ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните <toll free number> (телетайп: TTY/TDD). | Russian |
| ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero <toll free number> <TTY/TDD>. | Italian |
| ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le <toll free number> <TTY/TDD>. | French |
| ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele <toll free number> <TTY/TDD>. | French Creole |
| אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט <toll free number/TTY/TDD. | Yiddish |
| UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer <toll free number> <TTY/TDD> | Polish |
| PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa <toll free number/TTY/TDD>. | Tagalog |
| লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১1-800-MCO-PLAN TTY: TTY | Bengali |
| KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në <toll free number> <TTY/TDD>. | Albanian |
| ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε <toll free number> <TTY/TDD>. | Greek |
| خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں <toll free number> <TTY:. | Urdu |

FINAL

APPEAL

DETERMINATION

(FAD)

With Appeal Request Form

Reduction of Home Care Services

[Ultra-Health MLTC Plan ]
[Address]
[Phone]

# FINAL ADVERSE DETERMINATION
# NOTICE TO REDUCE, SUSPEND OR STOP SERVICES

May 1, 2018

Jane Doe
10000 W. 96th St.
New York, NY 10000

Enrollee Number: xxxx
Coverage type: Personal Care Services
Plan reference number: 5555555
Provider: Happy Home Care

Dear Jane Doe:

This is an important notice about your services. Read it carefully. If you think this decision is wrong, you have **four months** to ask for an External Appeal or you can ask for a Fair Hearing by **August 28, 2018, If you want to keep your services the same until your Fair Hearing is decided, you must ask for a Fair Hearing by May 11, 2018.** You are not responsible for payment of covered services and this is not a bill. Call this number if you have any questions or need help 1-800-MCO-PLAN.

## Why am I getting this notice?

You are getting this notice because on April 5, 2018 you or your provider asked for a Plan Appeal about our decision to reduce personal are services.

On April 30, 2018 Ultra-Health decided we are changing our decision and will partially approve your service.

From April 1, 2017 to April 11, 2018, the plan approved:
12 hours/day x 7 days/week of personal care services – total 84 hours/week

On April 1, 2018 we decided to reduce your personal care services from 12 hours/day x 7 days/week starting on April 11, 2018 to:
8 hours/day x 5 days/week and 4 hours/day x 2 days/week – total 48 hours/week

On May 1, 2018, we have partially denied your Plan Appeal and:
On May 11, 2018, we will reduce your personal care services to
10 hours/day x 5 days/week and 4 hours/day x 2 days/week – total 58 hours/week

We will review your care again in 6 months.

This service will be provided by a participating provider. You are not responsible for any extra payments, but you will still have to pay your regular co-pay if you have one.

## Why did we reduce your service?

We made this decision because the service is not medically necessary

- Your personal care services will be reduced because:
  - Your personal care services will be reduced because:
    - Your social circumstances have changed since the previous authorization was made.
    - On January 1, 2018, your daughter, with whom you live, retired from her job.
  - You no longer meet the criteria for your current level of service because:
    - Your daughter is ready, willing and able to take care of you during some of the time that you previously had personal care services.

This decision was made under 42 CFR Sections 438.210 and 438.404; NYS Social Services Law Sections 364-j(4)(k) and 365-a(2); 18 NYCRR Section 360-10.8.

## What if I don't agree with this decision?

If you think this decision is wrong:

- **You can ask the State for a <u>Fair Hearing</u>** – and an Administrative Law Judge will decide your case.

- If we said your service was not medically necessary, you can **ask the State for an <u>External Appeal</u>** – this may be the best way to show how this service is medically necessary for you. Your services may change while you are waiting for an External Appeal decision.

If you ask for both a Fair Hearing and an External Appeal, the Fair Hearing decision will be the final answer about your benefits.

**<u>If you want to keep your services the same</u>**

- **You <u>must</u> ask for a Fair Hearing within 10 calendar days or by the date this decision takes effect, whichever is later.**
- **The last day to ask for a Fair Hearing and keep your services the same is May 11, 2018**
- Your services will stay the same until we make our decision. If the Plan Appeal is not decided in your favor, you may have to pay for the services provided while waiting for the decision.

**You have a total of 120 calendar days** from the date of this notice to ask for a Fair Hearing. The deadline to ask for a Fair Hearing is **August 28, 2018.**

## How Can I Ask for a Fair Hearing?

**To ask for a Fair Hearing**, you can:

- **Call:** 1-800-342-3334 (TTY call 711 and ask operator to call 1-877-502-6155)

- **Request online using the form at:** http://otda.ny.gov/oah/FHReq.asp

- **Use the Managed Care Fair Hearing Request Form that came with this notice.** Return it with this notice by mail, fax, or in person. Keep a copy of the request and notice for yourself.

  **MAIL FAIR HEARING REQUEST FORM TO:**
  New York State Office of Temporary and Disability Assistance
  Office of Administrative Hearings
  Managed Care Unit
  P.O. Box 22023
  Albany, New York 12201-2023

  **FAX FAIR HEARING REQUEST FORM TO:** 518-473-6735

OR

- **WALK IN – New York City Only:**
  Office of Temporary and Disability Assistance
  Office of Administrative Hearings
  14 Boerum Place - 1st Floor
  Brooklyn, New York 11201

**After you ask for a Fair Hearing,** the State will send you a notice with the time and place of the hearing. At the hearing you will be asked to explain why you think this decision is wrong. A hearing officer will hear from both you and the plan and decide whether our decision was wrong.

**To prepare for the hearing:**

- **We will send you a copy of the "evidence packet" before the hearing**. This is information we used to make our decision about your services. We will give this information to the hearing officer to explain our decision. If there is not time enough to mail it to you, we will bring a copy of the evidence packet to the hearing for you. If you do not get the evidence packet by the week before your hearing, you can call [1-800 MCO-PLAN] to ask for it.
- **You have the right to see your case file and other documents.** Your case file has your health records and may have more information about why your health care service was changed or not approved. You can also ask to see guidelines and any other document we used to make this decision. You can call [1-800 MCO-PLAN] to see your case file and other documents, or to ask for a free copy. Copies will only be mailed to you if you say you want them to be mailed.
- **You have a right to bring a person with you to help you at the hearing**, like a lawyer, a friend, a relative or someone else. At the hearing, you or this person can give the hearing officer something in writing, or just say why the decision was wrong. You can also bring people to speak in your favor. You or this person can also ask questions of any other people at the hearing.
- **You have the right to submit documents to support your case.** Bring a copy of any papers you think will help your case, such as doctor's letters, health care bills, and receipts. It may be helpful to bring a copy of this notice and all the pages that came with it to your hearing.
- **You may be able to get legal help** by calling your local Legal Aid Society or advocate group. To locate a lawyer, check your Yellow Pages under "Lawyers" or go to www.LawhelpNY.org. In New York City, call 311.

**After the hearing,** you will be sent a written decision about your case.

## How can I ask for an External Appeal?

You have **four months** from receipt of this notice to ask for an External Appeal.

A description of your External Appeal rights and an application is attached to this notice. To ask for an External Appeal fill out and return the application to the New York State Department of Financial Services. You may need your doctor's help to fill out the External Appeal application. You can call the New York State Department of Financial Services at 1-800-400-8882 for help.

The External Appeal decision will be made in 30 days. Your appeal will be fast tracked if your provider says the appeal needs to be faster. If your External Appeal is fast tracked, a decision will be made in 72 hours. The decision will be sent to you in writing.]

## Other Help:

You can file a complaint about your managed care at any time with the New York State Department of Health by calling for MLTC [1-866-712-7197].

You can call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. Contact ICAN to learn more about their services:

**Phone**: 1-844-614-8800 (**TTY Relay Service**: 711)
**Web**: www.icannys.org | **Email**: ican@cssny.org]

You can call [CONTACT PERSON NAME] at Ultra-Health MLTC Plan at [1-800-MCO-PLAN] if you have any questions about this notice.

Sincerely,

MCO/UR AGENT/BENEFIT MANAGER Representative

Enclosure: Managed Care Fair Hearing Request Form
External Appeal Standard Description and Application

cc: Requesting Provider

{*Plans must send a copy of this notice to parties to the appeal including, but not limited to authorized representatives, legal guardians, designated caregivers, etc. Include the following when such parties exist:*}

[At your request, a copy of this notice has been sent to:
[DAUGHTER]]

***[266] MLTC MANAGED CARE DECISION FAIR HEARING REQUEST FORM AC***

***MAIL TO:*** *NYS Office of Temporary and Disability Assistance*
*Office of Administrative Hearings*
*Managed Care Unit*
*P.O. Box 22023*
*Albany, New York 12201-2023*

***FAX TO:*** *518-473-6735*

***DEADLINE:***

- ***If you want to keep your services the same*** *until the Fair Hearing decision, you must ask within 10 calendar days of the date of this notice, or by the date the decision takes effect, whichever is later.*
- ***The last day to ask to keep your services the same is May 11, 2018***
- *You have a total of 120 calendar days from the date of this notice to ask for a Fair Hearing.* ***The last day to ask for a Fair Hearing is August 28, 2018. If you want a Fair Hearing, you must ask for it on time.***

☐ ***I want a Fair Hearing. This decision is wrong because:***

| | | | |
|---|---|---|---|
| *Enrollee* | *Name* | *Signature* | *Phone* |
| *Representative (if any)* | *Name* | *Signature* | |
| | *Relationship* | *Phone* | |

*Your service WILL NOT CHANGE until the Fair Hearing decision if you ask for a Fair Hearing by May 11, 2018 If you lose your Fair Hearing you may have to pay for services you got while waiting for the decision. Check this box only if you* ***do not want*** *to keep your health care the same:*

☐ *I* ***DO NOT want*** *to keep my health care the same. I agree that the plan can reduce, suspend or stop my services as described in this notice before my Fair Hearing decision is issued.*

| ***FOR NYS OTDA ONLY*** *MANAGED CARE DECISION FAIR HEARING REQUEST FORM* | | |
|---|---|---|
| *Notice Date [DATE]* | *Effective [DATE]* | *Service Type:[Service]* |
| *Case Name (c/o, if present) and Address:*<br>*[ENROLLEE NAME*<br>*ENROLLEE ADDRESS]*<br>*CIN: [MEDICAID CIN]* | | *[MCO/URA NAME*<br>*MCO/URA ADDRESS]*<br>*Reference No.: [MCO REFERENCE NUMBER]* |

*A Plan Appeal was filed on April 5, 2018. On May 1,2018, [Plan Name] decided we are changing our previous decision and will partially approve the service.*

*From April 1, 2017 to April 11, 2018, the plan approved:*
*12 hours/day x 7 days/week of personal care services – total 84 hours/week*

*On April 1, 2018 we decided to reduce your personal care services from 12 hours/day x 7 days/week starting on April 11, 2018 to:*
*8 hours/day x 5 days/week and 4 hours/day x 2 days/week – total 48 hours/week*

*On May 1, 2018, we have partially denied your Plan Appeal and:*
*On May 11, 2018, we will reduce your personal care services to*
*10 hours/day x 5 days/week and 4 hours/day x 2 days/week – total 58 hours/week*

# Authorization to Request Appeal or Hearing

**AUTHORIZATION – Medicaid Managed Care Requests**

I authorize the following individuals or organizations to represent me in making requests regarding my Medicaid managed care or Managed Long Term Care Services. They may, on my behalf make requests including but not limited to:

1. Request an Internal Appeal of an adverse determination by my plan;
2. Request a Fair Hearing of an adverse determination by my plan;
3. Request prior approval of a new service or of additional hours or amounts of a service that I receive ("concurrent review").
4. File a grievance with my plan.
5. File a complaint with the NYS Department of Health.

This authorization applies to my current plan, which is (NAME) _____ _____and also to any different plan I might enroll in at a later date.

**Authorized Individuals or Organizations (fill in and check one or more):**

- ☐ NAME _____ Relationship _____
  - Address _____
  - Cell phone _____ E-mail _____
  - ☐ I want this person to act for me for all steps of the appeal or fair hearing or authorize them to appoint a representative to act for me.
- ☐ ORGANIZATION NAME _____
  - Relationship (CIRCLE: senior center, case management agency, clinic, attorney, geriatric care manager) OTHER: _____
  - Contact person: _____
  - Address _____
  - Phone _____ E-mail _____
  - ☐ I want this organization to act for me for all steps of the appeal or fair hearing or authorize it to appoint a representative to act for me.
- ☐ **Independent Consumer Advocacy Network (ICAN)** - including all participating organizations in the network. Main tel 844-614-8800
  - ☐ I want this organization to act for me for all steps of the appeal or fair hearing

Signed _____ NAME (print): _____

Date of birth _____ Medicaid or Plan ID _____

Address _____ Tel _____

DATE: _____

BLANKS for

1. Requesting Plan Appeal (Internal Appeal Request)
2. Requesting Fair Hearing after Final Adverse Determination (FAD)

These are generic versions of the requests that SHOULD be attached to the Plan's IAD and FAD notices, pre-filled with client's information. If client did not receive any notice, or not this part of notice, use these

These are oriented for reductions in hours. Can adapt for other types of issues.

**MLTC APPEAL REQUEST FORM**
**FOR SERVICES BEING REDUCED, SUSPENDED, OR STOPPED**

**Mail To**: **Date**: _____
Plan Name/UR AGENT] _____ **Fax:** _____

Address _____City, State Zip _____

**DEADLINE:**

- **If you want to keep your services the same** until the Plan Appeal decision, you must ask within 10 calendar days of the date of this notice, or by the date the decision takes effect, whichever is later. **(**If you lose your appeal you may have to pay for services you got while waiting for the decision.)
- **The last day to ask for a Plan Appeal to keep your services the same is [Notice Date+10].**
- You have a total of 60 calendar days from the date of this notice to ask for a Plan Appeal. **The last day to ask for a Plan Appeal for this decision is [Notice DATE+60**]. **If you want a Plan Appeal, you must ask for it on time.**

---

**Enrollee Information**

First Name _____ Last Name_____

Enrollee ID: _____Plan Reference Number _____
Address: _____City, State, Zip _____
Home Phone: _____ Cell Phone: _____

Type of Service being reduced, suspended or stopped: _____

**I think the plan's decision is wrong because:**

_____

_____

_____

Check all that apply:

- ☐ **I do NOT want my services to stay the same** while my Plan Appeal is being decided.
- ☐ I request a Fast Track Appeal because a delay could harm my health.
- ☐ I enclosed additional documents for review during the appeal.
- ☐ I would like to give information in person.
- ☐ I want someone to ask for a Plan Appeal for me:
  - Have you authorized this person with this plan before? YES ☐ NO ☐
  - Do you want this person to act for you for all steps of the appeal or fair hearing about this decision? You can let us know if change your mind. YES ☐ NO ☐

**Requester (person asking for me):**

Name: _____ E- mail: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: (_____)_____ Fax #: (_____)_____

**Enrollee Signature:** _____ Date:_____

**Requester Signature:** _____ Date:_____

*If this form cannot be signed, the plan will follow up with the enrollee to confirm intent to appeal.*

**MANAGED CARE DECISION FAIR HEARING REQUEST FORM AC**

**MAIL TO:** NYS Office of Temporary and Disability Assistance
Office of Administrative Hearings
Managed Care Unit
P.O. Box 22023
Albany, New York 12201-2023

**FAX TO:** 518-473-6735

**DEADLINE:**

- **If you want to keep your services the same** until the Fair Hearing decision, you must ask within 10 calendar days of the date of this notice, or by the date the decision takes effect, whichever is later.
- **The last day to ask to keep your services the same is [Notice Date+10].**
- You have a total of 120 calendar days from the date of this notice to ask for a Fair Hearing. **The last day to ask for a Fair Hearing is [DATE+120**]. **If you want a Fair Hearing, you must ask for it on time.**

☐ **I want a Fair Hearing. This decision is wrong because:**

| | | | |
|---|---|---|---|
| Enrollee | Name | Signature | Phone |
| Representative (if any) | Name | Signature | |
| | Relationship | Phone | |

Your service WILL NOT CHANGE until the Fair Hearing decision if you ask for a Fair Hearing by [date+10]**.** If you lose your Fair Hearing you may have to pay for services you got while waiting for the decision. Check this box only if you **do not want** to keep your health care the same:

☐ I **DO NOT want** to keep my health care the same. I agree that the plan can reduce, suspend or stop my services as described in this notice before my Fair Hearing decision is issued.

MANAGED CARE DECISION FAIR HEARING REQUEST FORM

| Notice Date | Effective date | Service Type: |
|---|---|---|
| *Case Name (c/o, if present) and Address:* ENROLLEE ADDRESS<br><br>CIN: | | MLTC/Managed Care Plan Name:<br><br>Plan Reference No.: |

A Plan Appeal was filed on DATE: _____ Plan decided appeal by Final Adverse Determination dated: : _____

Amount/type of service plan provided before:

On DATE OF Initial Adverse Determination Notice _____, Plan proposed to reduce services to (Amount) _____ starting on DATE _____.

After the Appeal, by Final Adverse Determination NOTICE dated _____ Plan decided to reduce services to _____ starting on

DATE _____

NEW YORK LEGAL ASSISTANCE GROUP

**Consumer Concerns on Implementation of New Exhaustion Requirement April 1, 2018**

February 7, 2018

**I. Regarding OTDA implementation –**

1. **Intake of fair hearing (FH) requests** – I'm pleased to hear that OTDA and DOH are working to add a question at intake about whether the caller requested an internal appeal. It is critical that intake call center staff be trained to ask this question and explain the internal appeal requirements.

   A. **Revising online, paper and fax forms for requesting hearings** to include questions about the status of the internal appeal request and decision, if any and to inform the requester of the internal appeal requirement.

      - The templates developed by DOH for requests for internal appeal and for fair hearing could be adapted as generic templates and posted on the OTDA website. However, the existing FH request forms also need to be revised because people are already familiar with them.
      - A list of all plans, with their appeals contact info (phone, fax, email, mail) should be printed on the back of these forms, as well as be posted on the OTDA and DOH websites.
      - The forms must elicit facts that show whether "deemed exhaustion" is warranted – date of the internal appeal request, date of the final adverse decision, etc.

   B. **Front-end screening of requests for "deemed exhaustion."** If I understand your email correctly, OTDA will make no inquiry or determination about whether "deemed exhaustion" applies until the hearing is held. Respectfully, in most cases this will be too late. Especially where the issue is a reduction or termination, the appellant is entitled to request the FH and receive Aid Continuing without exhausting the internal appeal, if certain circumstances apply. In order to determine whether to order Aid Continuing, OTDA will need to review the notice, or lack of notice, and determine, where an internal appeal was requested, whether the time limit for the plan to make a final decision has passed, warranting deemed exhaustion. While we realize that this imposes a demand on OTDA staff and legal resources, we just don't see how this change can be implemented without having a front-end process for screening for "deemed exhaustion."

- **OTDA should issue policy guidance defining when "deemed exhaustion" applies, so that plans, consumers, ALJs, all know the standards. At a minimum, deemed exhaustion should apply when:**

    a. No written notice of initial adverse determination (IAD) was provided by the plan, or

    b. The IAD does not include the requisite information regarding the right to Aid Continuing, how to request an appeal, how to obtain representation, how to submit evidence, and other information in the DOH notice templates and otherwise required by law and regulation.

    c. The IAD did not incorporate necessary translation or alternative formats, was not on the required template, or did not offer auxiliary aids and services, free of cost, during the appeal, thus impeding the enrollee's time to appeal or request Aid Continuing.

    d. The IAD does not comply with other applicable requirements, ie. MLTC Policy 16.06: *Guidance on Notices Proposing to Reduce or Discontinue Personal Care Services or Consumer Directed Personal Assistance Services;*

    e. The Plan did not decide the internal appeal within 30 days from member's appeal request, or if an expedited appeal was requested, within 72 hours after the MCO receives the appeal, unless extended pursuant to the regulations by up to 14 calendar days. 42 CFR § 438.408.

C. **Special protections, at least for an initial transition period, for FH requests that involve a reduction or termination of a service -** At least during a transition period while millions of people are being educated on the new procedures:

- **The filing of the fair hearing request should be deemed the filing date of the internal appeal, for purposes of triggering Aid Continuing.** OTDA would then either assist the appellant in requesting the internal appeal, as discussed below, or, when OTDA notifies the plan through its normal procedures that the fair hearing was requested, the plan would be required to commence processing the internal appeal, as if the appellant requested it. The date of the "request" for the internal appeal would be the date of OTDA's notification to the plan, for purposes of the plan's time limit to decide the appeal. For purposes of Aid Continuing, the date of the request would be the date of the fair hearing request.

- **Alternatively, the time limit to request internal appeal should be tolled, if the hearing was requested within the aid continuing deadline for an internal appeal request**. At least for a transition period, the statute of limitations for requesting the internal appeal should be tolled from the

date of the FH request until a reasonable time after OTDA has contacted the appellant to advise them of the internal appeal requirement.

- **OTDA staff should assist with internal appeal request in these cases where the Aid Continuing time limit is imminent**. If the FH request is made by phone, the OTDA staff should do a 3-way call with the plan and the appellant as a "warm transfer" of the request to the plan for the internal appeal. (see #4 below about improved communications lines between OTDA and plan appeal units).
    - If the FH request is made by other formats, and the Aid Continuing clock is ticking, OTDA should contact the appellant within 24 hours to advise of the internal appeal requirement and assist with filing of the appeal.
- All of these requests need to be screened for "deemed exhaustion."

**D. Communications must be established between OTDA and all of the plans for OTDA to quickly ascertain whether an internal appeal was requested, when, and the status of that appeal.** The consumer cannot be told simply to call their plan. Nor can OTDA be required to call the plan member services numbers, which can take time to be routed to the appeals unit. Nor can OTDA simply ask the member for the status of their internal appeal. Some members or their representatives will know if they requested an internal appeal. But others will not understand or know the answer.

**2. Other Systems Actions That are Needed by OTDA –**

**A. Making changes to the OTDA fair hearing request web pages** - Instructions posted on the site must explain the new requirements in clear language.

- A list of all plans, with their appeals contact info (phone, fax, email, mail) should be posted on this page. This is very difficult information to obtain. Even though I've now represented consumers in MLTC for 5 years, I still don't have a good working list of appeals contacts or fax numbers for each plan. This needs to be public information accessible on DOH and OTDA websites.

**B. Revision of FH request "acknowledgement letters" and other form letters –** If a fair hearing is requested against a managed care plan, this letter is a critical opportunity to inform the requester and appellant that their fair hearing request may be dismissed if they did not request an internal appeal from the plan. If the case involves a reduction or termination of benefits, then, as discussed above, more affirmative steps should be taken by OTDA staff to ensure Aid Continuing is provided.

**C. Training ALJs** on all of the above.

**II. Regarding DOH Systems -**

1. **Educating plans** - I'm pleased to see that webinars have been conducted for mainstream MMC plans and that materials, notice templates, FAQ's and more have been posted for MMC plans on the DOH website. I do not see anything yet for **MLTC plans** on the website and would like to know if comparable materials will be posted and webinars conducted. Also, while top-level plan managers may attend these webinars, what is to ensure that all pertinent plan staff are trained, from care managers and grievance and appeal staff to call center staff. See issues re plan surveillance and readiness review below.

2. **DOH Website updates** – The implementation timeline indicates these are being done Feb – March. Will this include DOH/MLTC websites as well as the MMC? We urge that the consumer-oriented webpages be updated along with the plan-oriented webpages, including but not limited to these –

   https://www.health.ny.gov/health_care/managed_care/complaints/index.htm ,

   https://www.health.ny.gov/health_care/managed_care/mltc/mltcomplaint.htm

   https://www.health.ny.gov/health_care/managed_care/mltc/enrollee_information.htm

   https://www.health.ny.gov/health_care/managed_care/mltc/

   - **Post Plan Appeals Contacts** – DOH Websites must include information on each MCO's appeal phone number, fax, email and online portal if available. In order to have access to the appeal procedures as set out in the new federal regulations, DOH must maintain and provide this appeal contact list for the public. This list should be maintained on the DOH and OTDA websites. We suggest that Maximus also include this information on NYMedicaidChoice.com. Appeals contacts could be added to their existing lists of plan contacts.

   - **Post consumer-friendly information on the new appeal procedures**, and include samples of the plan notices, the **internal appeal and fair hearing request forms**. (below we suggest a downloadable fact sheet for consumers) We are glad to see the webpage oriented to MMC plans includes copies of the **notice templates**, but consumers won't see those. Also, would be more helpful for consumers to post samples of the forms completed in a hypothetical case, rather than the templates with all of the alternate language, which can be confusing. We posted one sample that we created for a reduction notice.

3. **DOH Policy and Guidance --**

    a. **MLTC Policy Guidance** - We strongly urge DOH to prepare a new MLTC policy to be posted on the MRT 90 website detailing the MLTC plan obligations under the new appeal process. This guidance should include requirements for using the new notices properly, timely logging in and tracking internal appeals, and providing AID CONTINUING as required. This document should set clear standards for MLTC plans regarding compliance with the federal regulations. The FAQs posted for mainstream plans provides useful guidance on issues such as requirements for sending the enrollee's case file prior to an appeal or fair hearing. MLTC policy guidance is needed to provide clear guidance to plans on their responsibilities in the hearing process.

    b. **New MMC and MLTC model contract language** regarding the exhaustion requirement must be drafted and executed. Advocates would like to know DOH's timeframe for the revisions to the model contracts and would be interested in reviewing any model language.

    c. **DOH Policy needed on reasonable accommodations required to assist members in understanding notices and requesting appeals.**

4. **Plan Readiness Review and Compliance** -- As discussed at the workgroup meetings, we were pleased to hear that DOH's surveillance unit intends to monitor MCO implementation of the new appeals process. We would like to know more about the surveillance and monitoring plan.

    a. **Specifically, what testing of MCO systems is planned before April 1st** to ensure that appeal requests are timely logged in and processed? Consumers reported to the Workgroup difficulties in navigating plan call centers, and being routed to care managers or other departments, which can all delay or even prevent logging in an appeal request. Of course where the issue is a reduction or termination, the right to Aid Continuing is threatened with any barriers or delays to filing the request, whether by phone, fax, or otherwise.

    b. Do MCOs have sufficient staff in their appeal departments to meet this obligation?

    c. Have care managers and other plan staff been trained to forward any appeal request to the correct department within the MCO to process the appeal request, so that there is "no wrong door" for a member seeking to appeal?

    d. **Systems to ensure that AID CONTINUING is ordered and implemented are particularly critical.** Before this change, plans have only had to implement an Aid Continuing directive given by OTDA. Even during the short time that exhaustion was required for MLTC, the appellant had to request a FH simultaneously with the internal appeal in order to obtain Aid Continuing. For this reason, both MMC and MLTC plans have not had the need to develop systems to INTERNALLY make a determination of whether a member is entitled

to Aid Continuing, and then implement that directive. This requires that plans develop procedures, designate staff responsible for determining when Aid Continuing applies, developing systems to ensure that a reduction or termination is not automatically implemented, merely by the passage of time (10 days from the notice), without ensuring that an internal appeal request was not filed. DOH will need to ensure that these systems are set up and ready for implementation.

e. **Is DOH checking to see that plans have implemented their new systems to allow filing appeal requests by fax, email, mail, and in some cases online?** This will need to ensure that these requests are logged in and read on a timely basis, so that Aid Continuing is directed and implemented in the short time frame required, and that requests are otherwise processed on a timely basis.

f. **Systems for sending the enrollee's case file in advance of the appeal and hearing** - Since there are new requirements for this aspect of appeal procedures, DOH should ascertain the plan's readiness to timely comply. Does the plan have adequate procedures and designated personnel for this task?

g. **Plan website updates –** We assume that plans will be **posting the revised member handbooks online** as soon as they are completed. In addition, plans need to post accessible information for members on how to request internal appeals, with downloadable forms, and complete information on how to file – fax numbers, e-mail and mail addresses, phone numbers, and online portal, if available. .

5. **Provider education -- Medicaid Update** – We're pleased to see you are planning to publish a Medicaid Update article; the timeline shows March. We would appreciate reviewing a draft and an opportunity for comments. Are there other plans to ensure that providers are up-to-date with this change? The Implementation timeline shows a "Provider/CBO Education Tool," which we'd like to learn more about, and would welcome the opportunity to review a draft.

6. **Consumer and Public education –**

   a. **Member handbook –**The implementation timeline states that updates have been in process since December and will be until March. We would very much appreciate the opportunity to review and comment on the latest drafts. (Can you confirm that this is both the mainstream and MLTC member handbooks that are being revised?). Please advise us of the timeframe for mailing these to members.

   b. **Cover letter to be mailed with handbook –** Will DOH be issuing a standardized letter to be mailed to members with the revised member handbook? We would welcome the opportunity to review a draft and provide feedback. On the letters to MLTC members, and those MMC members receiving long term care services and supports, ICAN contact information should be listed.

c. **We also encourage DOH to develop a brief fact sheet for consumers to include in the plan's mailing to members, to post on the DOH website and to distribute via list-serv**. This document should explain the appeals process in simple terms, and also define new terms such as FAD and IAD for consumers. We urge DOH to solicit advocate input in reviewing these documents before they are finalized and to include **ICAN Ombudsman program** contact information where applicable.

d. **Public Webinar** – We see that this is planned for March, according to the Implementation Timeline. Will this be oriented to mainstream or MLTC or both?

e. **Member newsletters –we see this on the implementation timeline.** Which newsletters does this reference? Is DOH releasing an article that could be completed in newsletters of CBOs and other networks that educate consumers, their families and advocates?

February 7, 2018

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**Important Change for Medicaid Managed Care and MLTC Enrollees**
**Appeals and Fair Hearing Rights**

**What is changing on May 1, 2018?**

New federal Medicaid managed care rules will take effect in New York State. These rules change the way Medicaid managed care plans and Managed Long Term Care (MLTC) plans make decisions about health care services and how you can appeal decisions by your Plan.

These rules change how and when you can ask the State for a Fair Hearing about plan decisions. Starting May 1, 2018, If your plan is reducing or stopping a service, and you want to keep your services the same, without being reduced while your case is appealed, you must first ask for a Plan Appeal and wait for the Plan's decision **before** asking for a Fair Hearing. If you think any other plan decision is wrong, you must first ask for a Plan Appeal and wait for the Plan's decision **before** asking for a Fair Hearing.

**What happens if the plan denies my request to approve a new service or a change in services?**

For some services, you have to ask the plan for approval before you get them. If the plan denies approval, it has 14 days to send you a written notice of its decision, called an "Initial Adverse Determination." If your health is at risk, your plan must fast track your request and decide in 72 hours. The decision may take up to 14 days longer if the plan needs more information. If your plan covers prescription drugs, the plan must make decisions about your prescriptions in 24 hours. If you think your plan's decision about your health care is wrong, you can ask the plan to look at your case again. This is called a Plan Appeal. This change means **you must first ask for a Plan Appeal before you ask for a Fair Hearing.** You will have 60 days to ask for a Plan Appeal.

**What happens if the plan decides to reduce or stop a service I am getting now?**

The plan must send you a written notice called an "Initial Adverse Determination" at least 10 days before the date the plan will reduce or stop any of your services. If you want to keep your services the same, without being reduced while your case is appealed, **you must first ask for a Plan Appeal** within 10 days or by the date the decision takes effect, whichever is later. Your services will stay the same as they were, until there is a decision. If you lose your Plan Appeal, and don't win your appeal at the next level (a Fair Hearing), you may have to pay for the services you received while waiting for the decision.

**Can someone ask for a Plan Appeal for me?**

If you want someone, like your medical provider, a family member, or a representative to ask for the Plan Appeal for you, you and that person must sign and date the appeal request, or you must have authorized that person to request an appeal for you in the past, or authorize them to do so now.

**How do I request a Plan Appeal?**

You can request a Plan Appeal by completing and faxing, mailing and for some plans, e-mailing the Appeal Request Form that came with the plan's Initial Adverse Determination Notice. The address, fax number and, for some plans, e-mail address should be printed on the Appeal Request Form. You can also call the Plan to request the appeal, but you need to confirm a request made by phone in writing, unless you ask your Plan Appeal to be fast tracked. Remember if the plan is reducing or stopping a

service, you must request the Plan Appeal quickly, within 10 days of the Initial Adverse Determination notice, to keep your services the same, and not reduced, while the plan decides your appeal.

**What happens after I ask for a Plan Appeal?**

After you ask for a Plan Appeal, the plan will send you and your representative your case file, with all the information they have about your request. You may submit new evidence for the Plan to consider in its review. The plan will send you its decision about your appeal within 30 days. If your health is at risk, your plan must fast track your appeal and decide in 72 hours. The decision may take up to 14 days longer if the plan needs more information. If the appeal decision denies your services, it is called a "Final Adverse Determination."

**What if the Plan does not decide my Plan Appeal on time?**

If you do not receive a "Final Adverse Determination" – a decision for your Plan Appeal -- by the time limits above, you can ask for a Fair Hearing without waiting for the plan's decision.

**What if I think the Plan Appeal decision is wrong?**

If you think the plan's decision about your appeal is wrong, you can ask for Fair Hearing. You will have 120 days to ask for Fair Hearing. If the plan said the service is not medically necessary, you can ask the State for an External Appeal. You will have four months to ask for an External Appeal. If you ask for both, the Fair Hearing decision will always be the final answer.

If the plan is reducing or stopping a service you are getting right now, and you want your services to stay the same and not be reduced during the appeal, you must ask for a Fair Hearing within 10 calendar days from the appeal decision or by the date the appeal decision takes effect, whichever is later. Your services will stay the same until the fair hearing decision. If you lose your Fair Hearing you may have to pay for services you got while waiting for the decision.

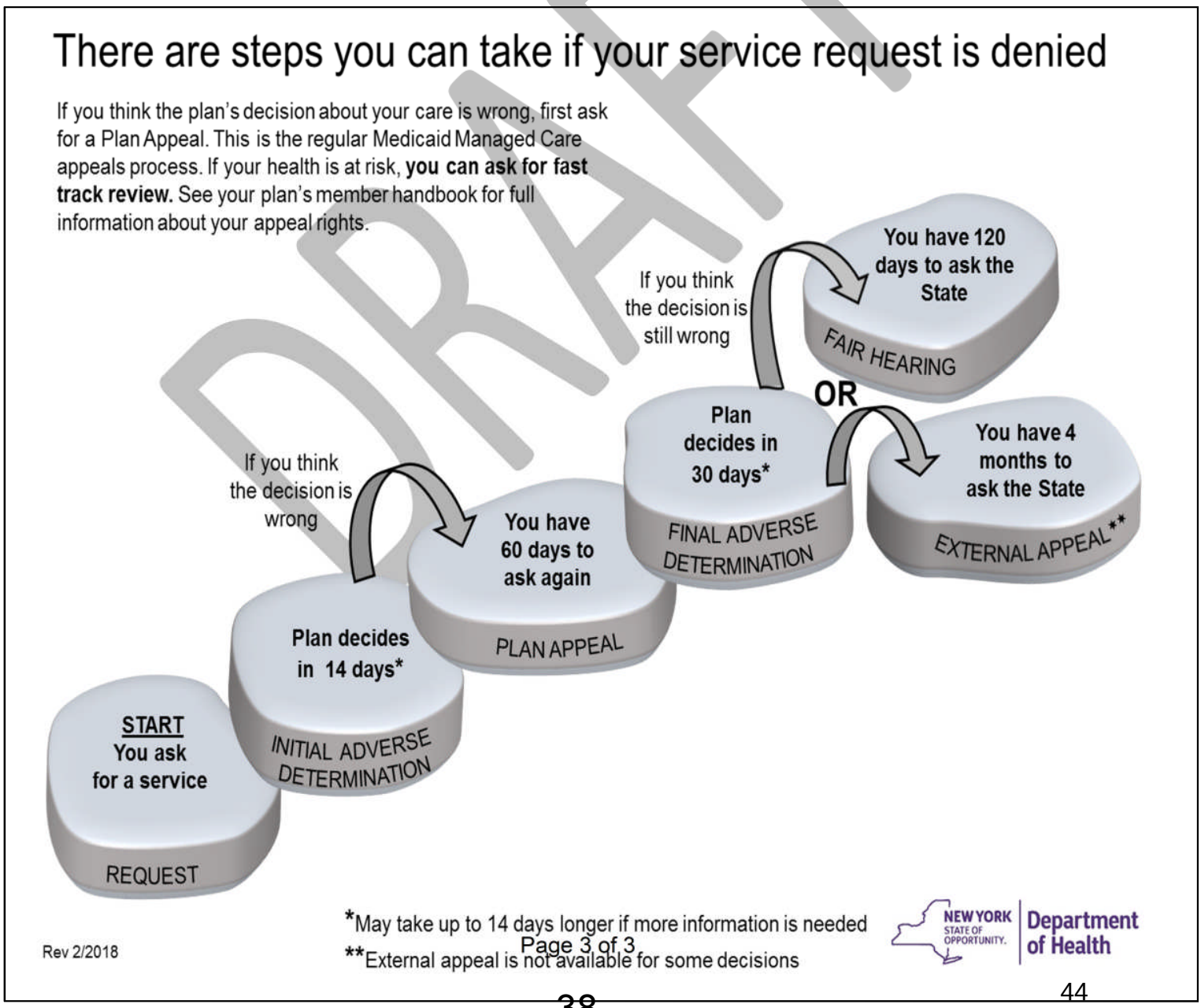
**Where can I get more information?**

You can call your plan at the number on your plan ID card. See your plan's member handbook for full information about your appeal rights.

For advice or assistance with a plan appeal or fair hearing with an MLTC plan, a HARP plan, or for Long Term Services and Supports such as home care with a Mainstream Medicaid Managed Care Plan, call **ICAN..**

.**These are steps you can take if your services are being reduced or stopped**

Need a similar diagram showing Aid Continuing deadlines..



# Important Change for Medicaid Managed Care and MLTC Enrollees Appeals and Fair Hearing Rights

**What is changing on May 1, 2018?**

New rules change how and when you can ask the State for a Fair Hearing to appeal a decision by your Medicaid managed care plan, HARP plan, or Managed Long Term Care (MLTC) plan. Starting May 1, 2018, if your plan denies, reduces or stops a service, and you think the decision is wrong, **you must first ask your plan to look at your case again. This is called a Plan Appeal**. You must then wait for the plan's decision **before** asking for a Fair Hearing.

**This is a big change**. Before May 1, 2018, you could request a Fair Hearing right away if you thought your plan's decision about your services was wrong. **Now you must first request a Plan Appeal before you can ask for a Fair Hearing.**

**What happens if the plan decides to reduce or stop a service I am getting now?**

The plan must send you a written notice called an "Initial Adverse Determination" at least 10 days before the date the plan says that it will reduce or stop any of your services. You have 60 days from the date of the plan's notice to ask for a Plan Appeal, **but if you want to keep your services the same while your case is appealed, you must ask for a Plan Appeal within 10 days** of the date of the plan's notice or by the date the notice says the change will take effect, whichever is later. If you request the Plan Appeal within 60 days but after the effective date of the reduction, you can ask the plan to "fast track" your Plan Appeal. If you lose your Plan Appeal, you may ask for a Fair Hearing. If you don't request a Fair Hearing, or if you don't win your Fair Hearing, and you received your services unchanged while waiting for the decision, you may have to pay for those services

**What happens if the plan denies my request to approve a new service or to provide more services?**

For some services, you have to ask the plan for approval before you get them. If the plan denies approval, it has 14 days to send you a notice of its decision. If your health is at risk, you or your provider may request that approval be "fast tracked." This requires the plan to decide in 72 hours. The decision may take up to 14 days longer if the plan needs more information. The plan must send you a notice explaining why it needs more information, and why the delay needed to obtain this information is in your interest. If your plan covers prescription drugs, the plan must make decisions about your prescriptions in 24 hours.

If the plan denies your request for approval, the decision is called an "Initial Adverse Determination." If you think your plan's decision is wrong, you can ask for a Plan Appeal. After May 1, 2018, **you must first ask for a Plan Appeal and wait for a plan appeal decision before you may ask for a Fair Hearing.** You have 60 days to ask for a Plan Appeal. If you disagree with the Plan Appeal decision, you may ask for a Fair Hearing.

**How do I request a Plan Appeal?**

You can request a Plan Appeal by completing and faxing or mailing the Appeal Request Form that came with the plan's Initial Adverse Determination Notice. Some plans allow you to e-mail the request. The plan's contact information for requesting the appeal should be printed on the Appeal Request Form. You can also call the plan to request the appeal, but you will then also need to mail or fax confirmation of a request made by phone, unless you ask your Plan Appeal to be "fast tracked."

**Can someone ask for a Plan Appeal for me?**

If you want someone, like your medical provider, a family member, or a representative to ask for the Plan Appeal for you, you and that person must both sign and date the appeal request. Or you must give written permission to that person to request an appeal for you, unless you gave them permission in the past.

**What happens in a Plan Appeal and How Long Does it Take?**

After you ask for a Plan Appeal, the plan will send you and your representative your case file, with all the information they have about your request. You may submit new evidence for the plan to consider in its review. The plan will send you its decision about your appeal within 30 days. If your health is at risk and you or your provider request a "fast track" appeal, your plan must decide it within 72 hours. The decision may take up to 14 days longer if the plan needs more information. The plan must send you a notice explaining why it needs more information to decide, and why the delay needed to obtain this information is in your interest. If the plan's appeal decision denies you all or some of the services you are seeking, the plan must send you a "Final Adverse Determination."

**What if the Plan does not decide my Plan Appeal on time?**

If you do not receive a "Final Adverse Determination" – a decision for your Plan Appeal -- by the time limits in the question above, you can ask for a Fair Hearing without waiting for the plan's decision.

**What if I think the Plan Appeal decision is wrong?**

If you think the plan's decision about your appeal is wrong, you can ask for Fair Hearing. You will have 120 days to ask for a Fair Hearing, but if the plan is reducing or stopping a service you are getting right now, and you want your services to stay the same and not be reduced during the appeal, **you must ask for a Fair Hearing within 10 calendar days** from the date of the appeal decision or by the date the appeal decision takes effect, whichever is later. Your services will stay the same as they were before, until the fair hearing decision. If you lose your Fair Hearing you may have to pay for services you got while waiting for the decision.

If the plan said the service is not medically necessary, you can ask the State for an External Appeal. You will have four months to ask for an External Appeal. Your services may be reduced while awaiting an External Appeal, unless you also requested a Fair Hearing in time to prevent a reduction.

You can ask for a Fair Hearing or an External Appeal or both. If you ask for both, the Fair Hearing decision will always be the final answer.

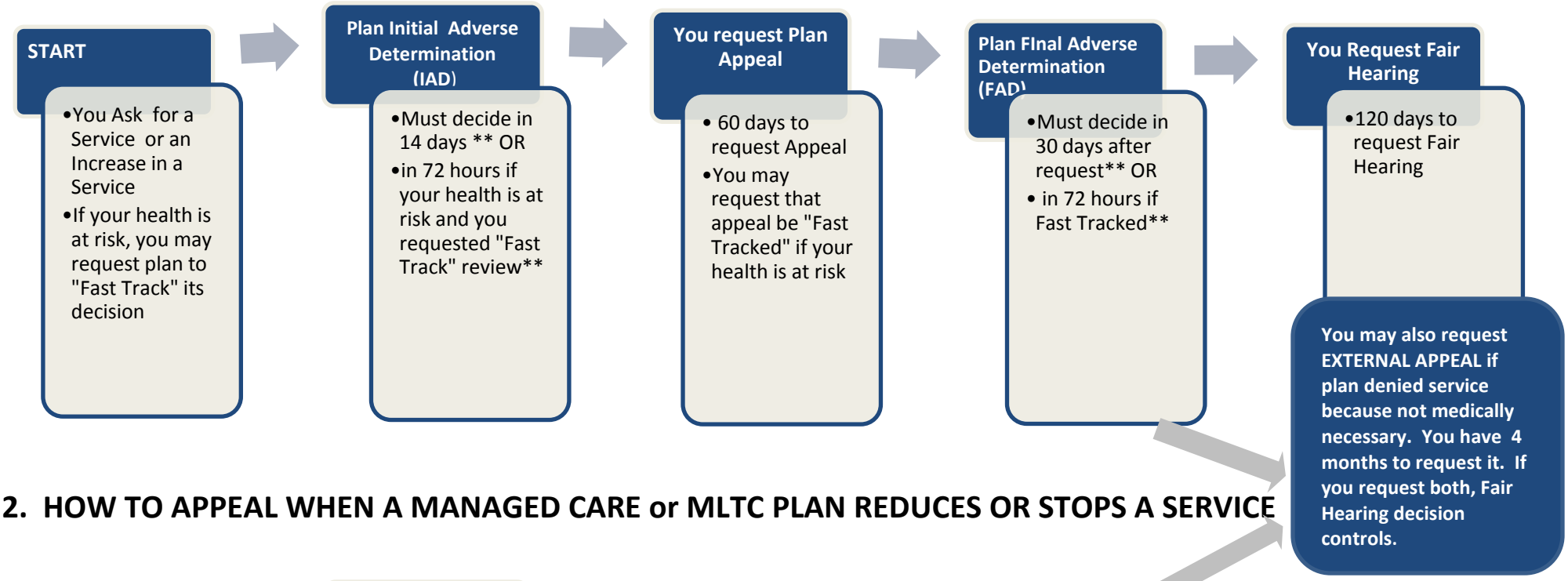
**Where can I get more information?**

You can call your plan at the number on your plan ID card. See your plan's member handbook for full information about your appeal rights.

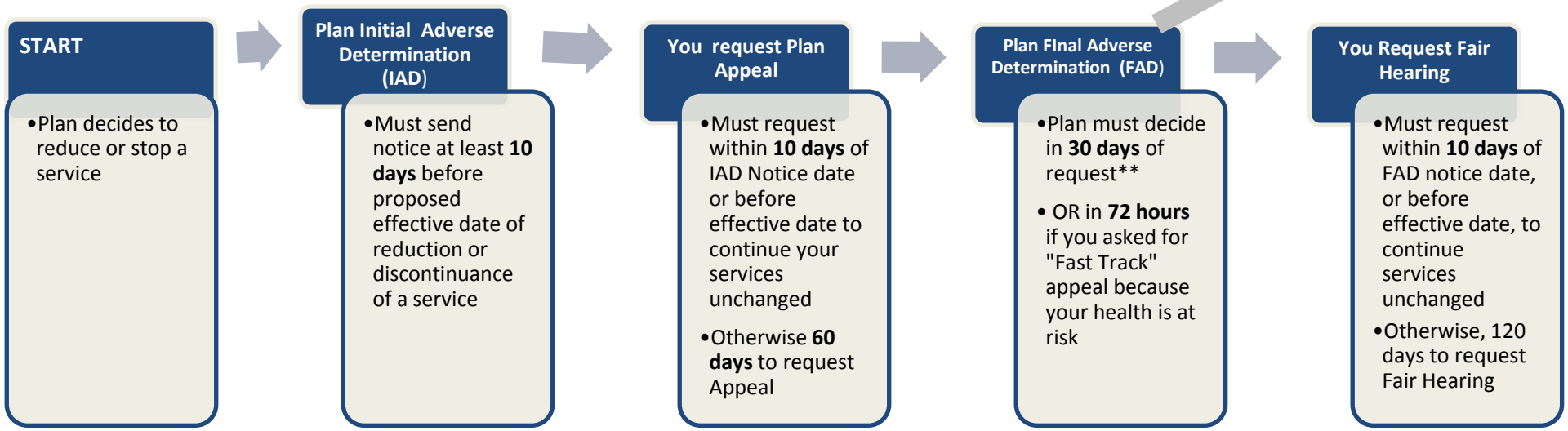
For advice or assistance with a plan appeal or fair hearing with an MLTC plan, a HARP plan, or for Long Term Services and Supports such as home care with a Mainstream Medicaid Managed Care Plan, call **ICAN –Independent Consumer Advocacy Network** Phone: **844-614-8800**

TTY Relay Service: 711 Website: icannys.org E-Mail: ican@cssny.org

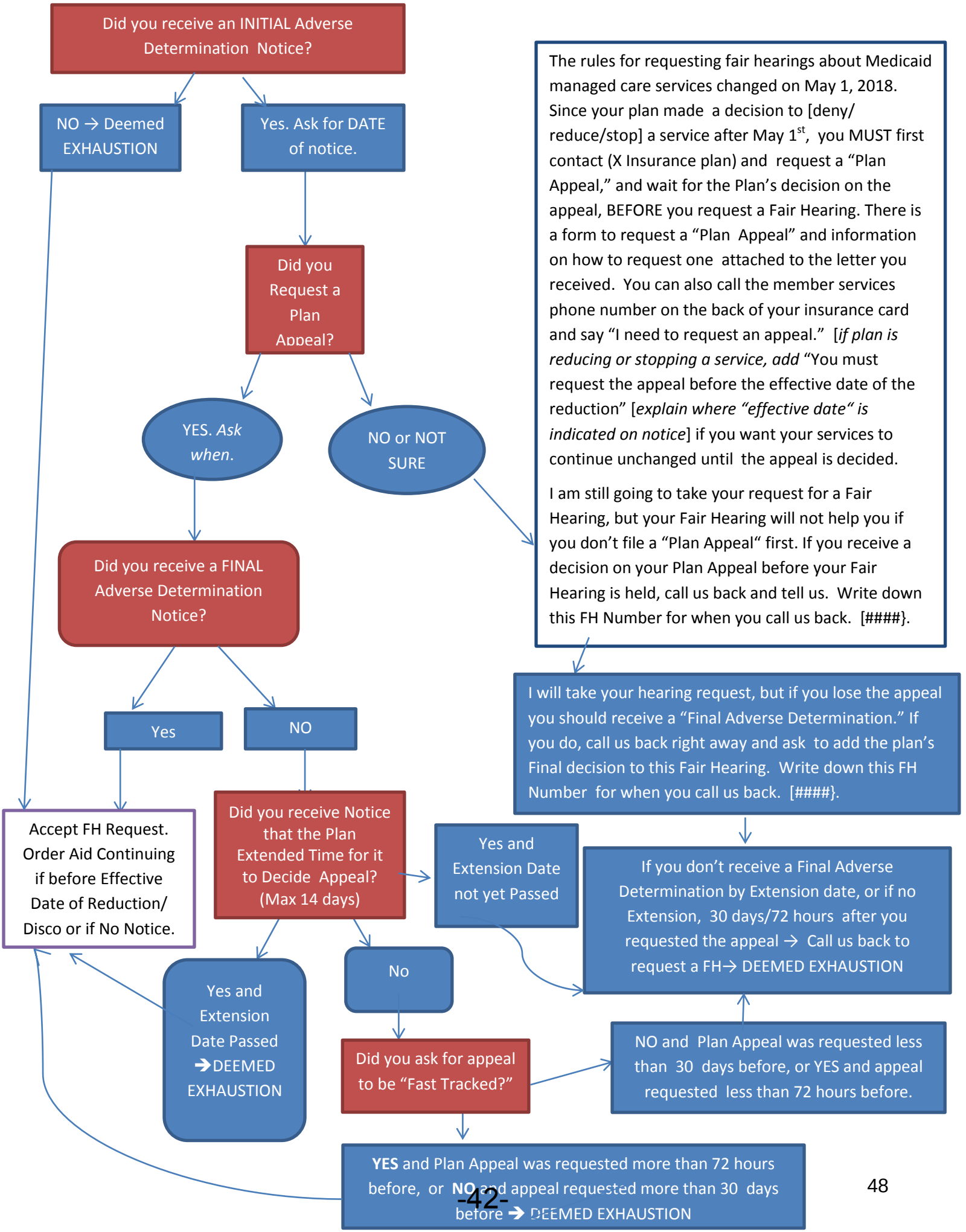
## 1. HOW TO APPEAL WHEN A MANAGED CARE or MLTC PLAN DENIES YOUR REQUEST FOR A SERVICE




## 2. HOW TO APPEAL WHEN A MANAGED CARE or MLTC PLAN REDUCES OR STOPS A SERVICE




** Plan may extend deadline up to 14 days if it needs more information, and if delay is in your interest. Plan must send you notice of why it needs more time.


Did you receive an INITIAL Adverse Determination Notice?
NO → Deemed EXHAUSTION
Yes. Ask for DATE of notice.
Did you Request a Plan Appeal?
YES. *Ask when.*
NO or NOT SURE
Did you receive a FINAL Adverse Determination Notice?
Yes
NO
Accept FH Request. Order Aid Continuing if before Effective Date of Reduction/ Disco or if No Notice.
Did you receive Notice that the Plan Extended Time for it to Decide Appeal? (Max 14 days)
Yes and Extension Date not yet Passed
Yes and Extension Date Passed ➔DEEMED EXHAUSTION
No
Did you ask for appeal to be "Fast Tracked?"
**YES** and Plan Appeal was requested more than 72 hours before, or **NO** and appeal requested more than 30 days before ➔ DEEMED EXHAUSTION
NO and Plan Appeal was requested less than 30 days before, or YES and appeal requested less than 72 hours before.
If you don't receive a Final Adverse Determination by Extension date, or if no Extension, 30 days/72 hours after you requested the appeal → Call us back to request a FH→ DEEMED EXHAUSTION
I will take your hearing request, but if you lose the appeal you should receive a "Final Adverse Determination." If you do, call us back right away and ask to add the plan's Final decision to this Fair Hearing. Write down this FH Number for when you call us back. [####}.
The rules for requesting fair hearings about Medicaid managed care services changed on May 1, 2018. Since your plan made a decision to [deny/ reduce/stop] a service after May 1st, you MUST first contact (X Insurance plan) and request a "Plan Appeal," and wait for the Plan's decision on the appeal, BEFORE you request a Fair Hearing. There is a form to request a "Plan Appeal" and information on how to request one attached to the letter you received. You can also call the member services phone number on the back of your insurance card and say "I need to request an appeal." [*if plan is reducing or stopping a service, add* "You must request the appeal before the effective date of the reduction" [*explain where "effective date" is indicated on notice*] if you want your services to continue unchanged until the appeal is decided.
I am still going to take your request for a Fair Hearing, but your Fair Hearing will not help you if you don't file a "Plan Appeal" first. If you receive a decision on your Plan Appeal before your Fair Hearing is held, call us back and tell us. Write down this FH Number for when you call us back. [####}.

**Information to be Obtained and Provided by OTDA in FH Requests**

| | DATE | Received? Or Requested? | | NOTICE/EVENT |
|---|---|---|---|---|
| | | YES | NO | |
| 1 | | | | **Initial Adverse Determination Notice received?** If YES, enter date of notice<br>If NO – oral notice only ➔ accept FH request. Deemed Exhaustion. |
| 2 | | | | • Effective Date of Notice (if reduction) |
| 3 | | | | Was Plan Appeal Requested? If YES, Enter date of request.<br>If NO, give **Script A** below. |
| **If Plan Appeal Requested ➔ Identify if Past Deadline for Plan to Decide Plan Appeal** | | | | |
| 4 | | | | - Was Fast Track Requested? If YES, enter Fast Track Deadline (Line 3 + 72 hours). If YES, GO TO LINE 6. SKIP LINE 5. |
| 5 | | | | - Standard (Line 3 + 30) |
| 6 | | | | - Was Extension Notice Received from Plan? If YES, enter date to which review extended. (See "Review Extended" notice.) |
| 7 | | | | **Final Adverse Determination (FAD) Notice received?** IF YES, enter Date of notice |
| 8 | | | | • Effective Date of Notice (if reduction) |
| | | | | -- If NO, and Latest of DATES in Lines 4, 5, or 6 have passed, Exhaustion is Deemed. Accept FH request.<br>-- If NO, and Latest of DATES in Lines 4, 5, or 6 have not passed, accept FH request and give **Script B.** |

**SCRIPT A**

The rules for requesting fair hearings about Medicaid managed care services changed on May 1, 2018. Since your plan made a decision to [deny/ reduce/stop] a service after May 1st, you MUST first contact (X Insurance plan) and request a "Plan Appeal," and wait for the Plan's decision on the appeal, BEFORE you request a Fair Hearing. There is a form to request a "Plan Appeal" and information on how to request one attached to the letter you received from your plan. You can also call the member services phone number on the back of your insurance card and say "I need to request an appeal." [*if plan is*

*reducing or stopping a service, add* "You must request the appeal before the effective date of the reduction" [*explain where "effective date" is indicated on notice*] if you want your services to continue unchanged until the appeal is decided.

I am still going to take your request for a Fair Hearing, but your Fair Hearing will not help you if you don't file a "Plan Appeal" first. If you receive a decision on your Plan Appeal before your Fair Hearing is held, call us back and tell us. Write down this FH Number for when you call us back. [####}.

**SCRIPT B**

The rules for requesting fair hearings about Medicaid managed care services changed on May 1, 2018. Now, you must wait to receive the Plan's decision on your appeal before you request a Fair Hearing. I will take your Fair Hearing request, but if you lose the appeal you should receive a notice called a "Final Adverse Determination." If you receive this notice, call us back right away and ask to add the plan's Final Adverse Determination to this Fair Hearing. Write down this FH Number for when you call us back. [####}.

If you don't receive a Final Adverse Determination by [*Extension date – Line 6 in Chart or if no Extension, Line 4 or 5 in Chart*] → Call us back after that date and tell us you did not receive a final decision from your plan. Write down this FH Number [####] for when you call us back.

**"Exhaustion" of MLTC Plan Appeal Required Before Requesting a Fair Hearing – Starts April 1, 2018**

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New York Legal Assistance Group

Article submitted for publication by NYSBA Elder and Special Needs Law Section.



## INTRODUCTION

Beginning April 1, 2018, members of Medicaid managed care plans in New York State, which include Managed Long Term Care (MLTC) plans, who wish to appeal an adverse determination by the plan, must first request an internal "plan appeal" within their plan, and wait until the plan issues a decision on that appeal, before they may request a Fair Hearing. This is called the "exhaustion" requirement, because the member must first "exhaust" the internal appeal available within the plan before requesting a State administrative fair hearing. 42 C.F.R. §438.402(c). This article explains the new requirement, and an exception, called "deemed exhaustion," which allows a request for a fair hearing before the plan decides an internal appeal.

**WHO IS AFFECTED**: This massive change in appeal rights affects 4.7 million Medicaid recipients in New York, 200,000 of whom are members of MLTC plans. When MLTC became mandatory in 2012 and rolled out statewide gradually over the next few years, exhaustion of internal appeals was required. In July 2015, the State lifted the exhaustion requirement entirely, allowing members to seek a fair hearing immediately to appeal an adverse plan determination.[1]

The vast majority of Medicaid managed care members in New York -- 4.5 million people -- are members of "Mainstream" Medicaid Managed Care (MMC) plans, Health and Recovery Plans (HARP), or HIV Special Needs Plans (HIV SNP). Enrollment in these MMC plans is mandatory for most Medicaid recipients who do not have Medicare or other primary insurance. While most people in these plans are under 65 and have Medicaid through the Affordable Care Act, some plan members are seniors or people with disabilities who either receive SSI or have no income at all, and who are not eligible for Medicare, usually because of immigration status. These seniors and people with disabilities obtain all medical care through the MMC plan, including personal care and other Long Term Services & Supports, They will also be required to request an internal plan appeal first to contest a proposed reduction or discontinuance of any long term care services.[2] Notably, "exhaustion" has never been required in the over twenty years that managed care has been mandatory for the non-Medicare population.

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[1] See NYS Dept. of Health MLTC Policy 15.03: *End of Exhaustion Requirement for MLTC Partial Plan Enrollees,* dated July 2, 2015, available at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm

[2] The law and regulations applying to "mainstream" managed care are at N.Y. Soc. Serv. Law . § 364-j; 18 NYCRR Subpart 360-10. All managed care plans, including MLTC plans, are also regulated as Managed Care Organizations (MCO) at NYS Public Health Law Article 44 and Article 49. Federal Medicaid requirements pre-empt those under

**PRIMARY CONCERNS**:

**Educating Millions of Plan Members, their Families and Representatives**. As New York implements this new requirement, there are concerns that 4.7 million people will not be adequately informed of this huge change. While plans' notices of adverse determinations have been modified to explain the new requirement, despite attempts to make the long, dense notices understandable to consumers in English and other languages, many will not read or understand the entire notice. Many will not show the complete notice to their family or representative – or will show the representative the notice in a foreign language that the representative does not understand.

Just educating the elder law bar, legal services advocates, and private geriatric care managers is a daunting task, let alone the huge network of social workers in hospitals, senior centers, and other community-based organizations. Lawyers and other professionals in the habit of requesting a fair hearing immediately must learn to request an internal plan appeal first instead of a fair hearing.

**Barriers to Filing Appeals –Risk of Denial of Aid Continuing**. The stakes are especially high when the plan proposes to reduce or discontinue personal care or other long term care services. The right to Aid Continuing has been a key element of due process since the seminal case of *Goldberg v. Kelly*. 397 U.S. 254 (1970). It has always been a challenge to file the appeal request within the short 10-day window between the date of the notice and the effective date of the reduction. Now, the appeal must be filed with a managed care or MLTC plan that may not have trained its call center staff to route these requests to ensure timely filing. Anyone who has tried to call the member services 800 number of an insurance plan knows a call may easily be mis-routed. To date, the NYS Office of Temporary Disability Assistance [OTDA] has not pledged to educate people who mistakenly request hearings adequately about the new requirements, or assist them in requesting a plan appeal. As a result, it is likely that home care will be reduced – with no Aid Continuing – for MLTC members, whose hearing requests will ultimately be dismissed, months after they requested them, for failure to "exhaust."

There are four additional barriers to filing the appeals, putting Aid Continuing at risk, all discussed at length below.

First, requests made orally must be confirmed in writing, unless an "expedited" appeal is requested. Fortunately, the regulations provide that the date of the oral request locks in Aid Continuing. 42 C.F.R. . § 438.402(c)(3)(ii).

Second, the consumer must either sign the appeal or hearing request or designate, in writing, a representative to request the appeal or hearing. 42 C.F.R. §438.402(c)(ii). This burdensome requirement is a departure from the NYS OTDA practice of allowing anyone to request a fair hearing on an individual's behalf, whether as a "representative," or as a mere "requester." See OTDA request form at http://otda.ny.gov/hearings/forms/request.pdf.

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state Public Health Law, if the federal Medicaid requirements are more strict. For example, state law allows plans to have more than one level of internal appeal. The federal regulation allows only one internal appeal for Medicaid plans, and this controls. 42 C.F.R. § 408.402(b). .

Third, plans – and not OTDA -- are now the arbiter of whether Aid Continuing applies, at least at the initial level of the plan appeal. Will MLTC plans provide Aid Continuing where, for example, the plan's adverse notice is defective or was untimely – as OTDA has historically ruled in such cases? The federal regulations define at least one circumstances which warrant "deemed exhaustion," allowing a fair hearing request without exhausting the plan appeal. 42 C.F.R. § 438.408. That is where the plan failed to decide the internal plan appeal by the deadline. However, CMS permits states to deem exhaustion on a broader basis than does the final regulation, but the State has not done so to date. See n 5, *infra*, at p. 27510 and discussion in next section below.

Fourth, if the decision after the internal Plan Appeal decision is adverse, then the consumer must *again* appeal in the short time limit to get Aid Continuing. While the second appeal is a request for a fair hearing, which is familiar to the elder law bar, this is now a second hurdle for the consumer, requiring them to respond quickly to request appeals *two times.* Also, this request must comply with the new requirement that the consumer make or sign the hearing request or give written consent to a representative to sign it.

## 1. BACKGROUND – REVISION OF FEDERAL REGULATIONS in 2015-2016

This change in appeal rights is required by federal Medicaid regulations, as amended in 2016. In 2015, the Obama Administration initiated a formal rulemaking process to amend the Medicaid managed care regulations, which had last been amended in 2002.[3] After hundreds of comments were filed, by organizations including the National Health Law Program[4] and the New York Legal Assistance Group, the final regulations were adopted in 2016.[5] The regulations on grievances and appeals are at 42 C.F.R. Part 438. The regulations are effective on various dates in 2017. The effective date for the exhaustion requirement in New York's appeal system was extended to April 1, 2018.

The impetus for the revision was the expansion of Medicaid managed care from being a small demonstration program covering limited primary care services for families and children in the 1990's, to the principal model for delivering all Medicaid services for all populations, including Long Term Services and Supports (LTSS) for the elderly and disabled. Grievance and appeals systems are just one of many aspects of managed care affected by the amendments to the regulations. For summaries of the other changes, see the National Health Law Program series of seven issue briefs on the revisions.[6]

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[3] Notice of Proposed Rule Making, 80 Federal Register 104 at p. 31098 (June 1, 2015)

[4] NHELP comments filed in July 2015 are available at <http://www.healthlaw.org/publications/browse-all-publications/comments-managed-care>

[5] Notice of Final Rule, 81 Federal Register 88 at p. 27498 (May 6, 2016)

[6] National Health Law Program, Medicaid Managed Care Final Regulation Series, which includes seven issue briefs, available at http://www.healthlaw.org/issues/medicaid/managed-care, see in particular Issue Brief No. 2 on Grievances and Appeals, available at <http://www.healthlaw.org/publications/browse-all-publications/Brief-2-MMC-Final-Reg>

In its explanation of requiring "exhaustion" in the final regulation, CMS described its desire to align Medicaid appeals with those enrollees will experience in private health insurance as well as in Medicare Advantage.

> While we understand commenters' concerns and recommendations regarding direct access to a state fair hearing for vulnerable populations, we also have concerns regarding inconsistent and unstructured processes. We believe that a nationally consistent and uniform appeals process (particularly one consistent with how other health benefit coverage works) benefits enrollees and will better lead to an expedited resolution of their appeal.

81 Federal Register 88 at p. 27509 (May 6, 2016). The notion that Medicaid recipients flow back and forth from Medicaid to employer-based insurance to Qualified Health Plans through the ACA underlies many of the changes made, including the exhaustion requirement. Advocacy groups, including NYLAG, had opposed the exhaustion requirement, arguing that it would cause delay in accessing fair hearings, would put Aid Continuing rights at risk, and would confuse beneficiaries accustomed to requesting hearings directly on Medicaid eligibility issues. NYLAG comments pointed out that exhaustion had been confusing and harmful when it was required in New York briefly for MLTC until 2015.

CMS claimed that any delay in accessing fair hearings caused by the exhaustion requirement was mitigated by shorter deadlines for plans to decide appeals (30 calendar days, shortened from 45 days) and by "deemed exhaustion," which allows a consumer to request a fair hearing if the plan failed to decide a plan appeal within the required time limits of 42 C.F.R. § 438.408. 81 Federal Register 88 at 27510. CMS' preamble to the final regulations states, "We also note that states would be permitted to add rules that deem exhaustion on a broader basis than this final rule." Id. As of February 12, 2018, the State has not responded to advocates' request to apply deemed exhaustion in other circumstances, such as when the plan fails to send any written notice, or a notice that is timely and adequate, complying with all requirements including language access and State DOH guidance specifying notice requirements in MLTC.[7]

**2. New York State Rulemaking and Policy Guidance on New Exhaustion Requirement**

State regulations on managed care appeals have not yet been amended to incorporate the federal changes, so should not be relied upon. 18 NYCRR Part 360-10. The New York State Department of Health [DOH] convened a Service Authorizations and Appeals Stakeholder Workgroup in 2017 to elicit stakeholder input on implementing the exhaustion requirement and other federal changes. Stakeholders included representatives of the MLTC and mainstream managed care plans and consumer advocates, including NYLAG. The Workgroup was led by administrators in two different divisions of DOH – one that oversees mainstream plans, and one that oversees MLTC plans.

The Workgroup focused on revising the adverse notice templates, which are now posted on a new webpage called "Service Authorizations and Appeals," available at

[7] See MLTC Policy 16.06, *Guidance on Notices Proposing to Reduce or Discontinue Personal Care Services or Consumer Directed Personal Assistance Services (*available at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm).

https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm. These templates must be used by both mainstream managed care and MLTC plans for Initial Adverse Determinations, which must be appealed to a plan appeal, and Final Adverse Determinations, which state the plan's decision after the plan appeal, which may be appealed to a Fair Hearing. New Appeal Request Form and Fair Hearing Request Forms for MLTC and other managed care appeals are included in the new model adverse notices. Since these forms will be pre-populated with information about the client's appeal, it is recommended that they be obtained from the client and used to file the appeal request.

Beside the notice templates, other policy guidance is apparently being issued separately by the two DOH divisions that oversee the two types of Medicaid managed care plans– one for MLTC plans and one for plans for Medicaid recipients who do not also have Medicare --Mainstream Medicaid Managed Care (MMC), Health and Recovery Plans (HARP), and HIV Special Needs Plans (HIV SNP). As of February 20, 2018, only the division overseeing mainstream Medicaid managed care has conducted webinars and posted policy guidance and Frequently Asked Questions for plans. These are all available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm.

Policy guidance from the MLTC division is expected to be posted on the MRT 90 webpage at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/ - presumably under the link on that webpage for MLTC Policies. As of February 20, 2018, no guidance has been posted. However, the guidance posted for Mainstream MMC plans should be binding for MLTC plans since it is issued by the same State agency, which is the Single State Agency that administers the NY Medicaid program. 42 U.S.C. §1396a(a)(5).

Health care providers should stay tuned for a Medicaid Update article on the change, which will be posted at https://www.health.ny.gov/health_care/medicaid/program/update/main.htm.

In March 2018, members of all managed care plans should receive by mail from their plans a letter with a revised Member Handbook. DOH must revise the standardized language for this handbook, which most plans post on their websites, and which is incorporated in the Contract by which plans contract with the NYS DOH.[8]

NYLAG's article on appeals in MLTC Plans will be updated to include links to any guidance issued by NYS DOH, available at http://www.wnylc.com/health/entry/184/.

3. **Definitions and Types of Notices; Appeal vs. Grievance**

[8] The Model MLTC contract is posted on the MRT 90 Webpage cited above. Click on Health Plans, Providers and Professionals at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/hlth_plans_prov_prof.htm. Click on Model Contracts and select Partial Capitation Contract. Direct link is https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_contract.pdf (Contract 1/1/2015 - 12/31/16 is most current available). The Member Handbook is in Appendix K.

The exhaustion requirement specifically states, "An enrollee may request a State fair hearing after receiving notice under §438.408 that the adverse benefit determination is upheld." 42 C.F.R. § 438.402(c). These terms are defined below. Appeals and grievances are also distinguished.

An **Appeal** is a request to review an **adverse benefit determination** made by a plan.[9] In New York, the notice of a plan's adverse benefit determination is called an **"Initial Adverse Determination" (IAD).** The plan must use the new notice templates issued by DOH.[10] *Adverse benefit determination* means, any of the following:

> (1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
>
> (2) The reduction, suspension, or termination of a previously authorized service.
>
> (3) The denial, in whole or in part, of payment for a service.
>
> (4) The failure to provide services in a timely manner, as defined by the State.
>
> (5) The failure of a plan to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
>
> (6) For a resident of a rural area with only one plan, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.
>
> (7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities**.**

42 C.F.R. § 438.400(b). Thus an MLTC plan must issue a Notice of Initial Adverse Determination when it proposes to:

(1) Reduce or stop personal care, adult day care, or other services, or
(2) Deny a request for a new service, such as Consumer-Directed Personal Assistance Program (CDPAP) or private duty nursing
(3) Deny or partly deny a request to increase hours of personal care services or other services

If the plan decides the appeal in whole or in part adversely to the consumer, it must issue a notice of **"Final Adverse Determination" (FAD),** which explains the reason for the decision and explains the right to request a fair hearing. 42 C.F.R. § 438.408.

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[9] 42 C.F.R. . § 438.400(b).

[10] Model notices posted at https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm. Though this webpage is directed to mainstream managed care plans, the same model notices are required for MLTC plans.

***Grievance*** – which DOH is calling a "**complaint**" --means "an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by [the plan] to make an authorization decision." 42 C.F.R. §438.400(b). EXAMPLES of grievances that may be filed with MLTC plans as complaints include:

(1) The aide or transportation is late or does not show,
(2) The aide is poorly trained or otherwise does not provide quality care,
(3) Member cannot reach care manager by phone, or care manager does not respond or was rude.
(4) Member disagrees with plan's decision to extend time to decide a request for new or increased services.

Grievances/Complaints may not be appealed to a fair hearing, but may be appealed internally in a Complaint Appeal. DOH has posted a model template for a Complaint Appeal Resolution Notice and for a Complaint Resolution Notice. See https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm.

### 4. MORE ON INITIAL ADVERSE DETERMINATIONS – Reductions and Denials

Because Aid Continuing requires special notice content, timing and procedures, Initial Adverse Determinations (IAD) for plan REDUCTIONS or discontinuance of services will be discussed separately than for DENIALS of new or increased services.

#### A. FOCUS ON REDUCTIONS IN HOURS or SERVICES

After a plan sends an Initial Adverse Determination (IAD) to reduce or discontinue a service, Aid Continuing is only granted when the Plan appeal is requested before the effective date of the IAD. As has been true since *Goldberg v. Kelly*, *supra*, the plan need only mail the notice 10 days in advance of the effective date.[11] With mailing time and weekends, the consumer may well only receive the notice a day or two before the deadline to request the internal appeal. Clients should be advised to always keep the envelope in which notices are mailed. If the postmark is dated later than the mailing date, this can be a ground to obtain Aid Continuing based on untimely notice.[12] In the past, advocates successfully made that argument to OTDA. Now, the argument must be made to the plan itself – the same one that mailed the notice late.

[11] 42 C.F.R. § 438.404(c)(1) cross-references the long-standing regulations that establish timeliness of notices and other Medicaid fair hearing rights outside of managed care, 42 C.F.R. §§ 431.211 - 431.214.

[12] See, e.g. Fair Hearing No. 7182969J, dated Feb. 17, 2016, available at http://otda.ny.gov/fair%20hearing%20images/2016-2/Redacted_7182969J.pdf (notice not mailed at least 10 days before effective date, citing 42 C.F.R. §§438.404, 431.211; 18 N.Y.C.R.R. §§ 358-2.23, 360-10.8).

### i. Aid Continuing required even if the latest Authorization Period has expired

Managed care plans authorize services for specific authorization periods, which for MLTC plans may range up to six months. If a plan has authorized 24-hour x 7 day personal care services for a period that expires on December 31st, the prior federal regulations arguably allowed the plan to end or reduce that service authorization effective December 31st, precluding the consumer from receiving Aid Continuing because the authorization period expired. The amended regulations end this practice, entitling the consumer to Aid Continuing regardless of whether the authorization period for the contested service ends during the course of the appeal, as long as it had not expired at the time the appeal or hearing was requested. 42 C.F.R. §438.420(b)-(c). Additionally, to protect New York Medicaid recipients from the harshness of the former version of the federal regulations, the legislature amended the Social Services Law in 2015, to guarantee that Aid Continuing is required regardless of whether the authorization period expired. N. Y. Social Serv. L. 365-a, subd. 8.

### ii. Practitioners Should Become Familiar with the new Initial Adverse Determination (IAD) notices

The DOH templates for the IAD notices, while adopting many recommendations made by NYLAG and other advocates, may still be confusing to consumers, their families and representatives.[13] The notices are in a form of a letter, rather than as a traditional notice. Here is the first paragraph of a hypothetical reduction notice dated April 1, 2018:

> This is an important notice about your services. Read it carefully. If you think this decision is wrong, you can ask for a Plan Appeal by May 31, 2018. If you want to keep your services the same until your Plan Appeal is decided, you must ask for a Plan Appeal by April 11, 2018. You are not responsible for payment of covered services and this is not a bill. Call this number if you have any questions or need help: 1-800-MCO-PLAN.

In this example, April 11th is the effective date of the proposed action and the deadline to request the appeal to secure Aid Continuing, yet appears in the notice only *after* the plan appeal deadline – 60 days from the date of the notice or May 31st. This may mislead consumers into thinking they have plenty of time to appeal, obscuring the 10-day time limit to secure Aid Continuing. Also, the language explaining the deadline to get Aid Continuing (April 11th) is subtle – "If you want to keep your services the same until your Plan Appeal is decided…" The language may not be clear to members.

The content of a notice to reduce services must comply with other precedent that requires a change in the consumer's medical condition or other circumstances that justify the reduction. A key authority is NYS DOH MLTC Policy 16.06, see note 7, supra. This is an important directive for practitioners opposing a proposed reduction. The directive clarifies the limited reasons why a plan may reduce personal care services, and requires very specific facts in the notice justifying the reduction. Permitted reasons

[13] See template posted at https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2017-11-20_initial_reduce_services.pdf; see sample of completed reduction notice in hypothetical case posted at http://www.wnylc.com/health/download/644/.

include a change in the medical condition or social circumstances that result in needing fewer hours, not merely the fact that the plan conducted a new assessment that determined fewer hours are needed. The directive also clarifies that "mistake" may only rarely justify a reduction. The directive is rooted in a lawsuit brought against the New York City Medicaid program in the 1990's, challenging a pattern of arbitrary reductions in personal care hours. *Mayer v. Wing,* 922 F. Supp. 902 (S.D.N.Y. 1996). That decision was codified in state regulation, which applies to MLTC plans. 18 NYCRR § 505.14(b)(5)(c).

The lack of an adequate justification for reducing services, and lack of specificity of an alleged justification in the plan's notice, has been a frequent basis for reversal of proposed reductions in fair hearings.[14] Will a plan, reviewing its own proposed reduction and notice, critically review the content of the notices against the applicable standards? It seems doubtful, even though the plan employee conducting the plan appeal must have been "neither involved in any previous level of review or decision-making nor a subordinate of any such individual." 42 C.F.R. §438.406(b)(2). NYLAG and other advocates have asked the State DOH and OTDA to include an inadequate IAD as a ground for waiving exhaustion through the "deemed exhaustion" mechanism.

Plans also may fail to send any notice at all, giving only oral notice, or may send the notice less than 10 days in advance of the proposed effective date, making the notice untimely and defective. Practitioners should advise clients to keep all envelopes in which plan correspondence is mailed. The postmark may show that the notice was not mailed until days after the date of the notice. If the right to Aid Continuing is not recognized by the plan, this postmark should convince them that the notice was untimely. In such cases, if the plan will not authorize Aid Continuing, advocates should request a Fair Hearing and ask OTDA to apply "deemed exhaustion" and order Aid Continuing because the initial IAD notice was untimely. Also, complaints can be made in such cases to the NYS DOH MLTC Complaint Line: 1-866-712-7197 or e-mail mltctac@health.ny.gov. NYLAG is interested in hearing about these cases.

### B. Initial Adverse Determinations - Denial of a New Service or of an Increase in A Service

If a plan member has requested a new service, or an increase in services, such as an increase in hours of personal care services, the federal regulations specify deadlines for the plan to issue determinations on these requests, which the consumer may then appeal in a "plan appeal.'

#### i. Background- how to request an increase or a new service – "Service Authorization Request"

A "Service Authorization Request" is a request by or on behalf of a member to increase an existing service or to authorize a new service. 18 N.Y.C.R.R. §360-10.3(o). The federal regulation for managed care service authorizations was also amended in 2016. 42 C.F.R. §438.210.

[14] See V. Bogart, R. Novick, A. Lowenstein, et al., *Mis-Managed Care: Fair Hearing Decisions on Medicaid Home Care Reductions by Managed Long Term Care Plans*, July 2016, issued by Medicaid Matters NY and New York Chapter of the National Academy of Elder Law Attorneys, (available at http://medicaidmattersny.org/cms/wp-content/uploads/2016/08/Managed-Long-Term-Care-Fair-Hearing-Monitoring-Project-2016-07-14-Final.pdf) [hereafter "Medicaid Matters NY Report on MLTC Reductions"]

The deadline for the plan to issue a written Initial Adverse Determination notice on these requests depends on whether "expedited" review was requested. For standard requests, the plan decision must be issued within 14 calendar days from the date of the receipt of the request, but plan may extend that time for another 14 calendar days on the member's request or if the plan "justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest." § 438.210(d). The member, or her provider, may request that the plan expedite a decision.

> For cases in which a provider indicates, or the [plan] determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the [plan] must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service.

42 C.F.R. § 438.210(d)(2). The plan may extend the time to decide an expedited decision by up to 14 calendar days, on the same basis as extending the time for a standard request.

***ADVOCACY TIP*** – A request for an increase in hours or other services or for a new service should be made in writing, or if made orally, should be confirmed in writing. This would start the clock for the plan to make a decision following the deadlines above. Additionally, a statement from a physician or other medical professional is recommended to substantiate the increase or need for the service. The request can be made by calling Member Services or by FAX or certified mail. If the request is made in person with the care manager or at the in-home bi-annual nursing reassessment, ask the nurse or care manager to acknowledge receipt on the member's copy.

#### ii. Initial Adverse Determination of Service Authorization and Plan Appeal

The plan must use the State-required template for the IAD notice.[15] Under the new rules effective April 1, 2018, the member will have 60 calendar days to request a Plan Appeal (internal appeal) from the date of the notice. This is an increase from 45 days under the old rules before April 1, 2018.

If the plan fails to decide whether to grant a Service Authorizations, above, this constitutes a "denial," and the plan is required to send a notice "on the date that the timeframes expire." 42 C.F.R. § 438.404(c)(5). The member or her representative should check to see if the Plan extended the deadline by up to 14 days. If so, the Plan should have sent written notice of the extension. 42 C.F.R. § 438.408(c)(2). The regulation is unclear on the member's recourse if the plan sends no IAD notice and no extension notice. However, the regulation does state that failure to decide a service authorization within the timeframes "constitutes a denial and is thus an adverse benefit determination." Id. Therefore, presumably the member may request a plan appeal on or after the timeframes expired.

### C. Nuts & Bolts of Filing PLAN APPEALS of an Initial Adverse Determination (IAD)

[15] Since it does not include the Aid Continuing provisions of a reduction notice, DOH devised a separate template, available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2017-11-20_initial_denial_notice.pdf.

DOH is requiring plans to accept appeal requests by phone, fax, or mail. Plans have the option of also accepting appeal requests by e-mail or online. The phone and fax number mailing address, and at plan option, email address and online portal, should all be on the plan's IAD notice. The IAD Notice template includes a Plan Appeal Request Form, which is pre-populated with information about the member and the issue. This Appeal Request Form should be used if available. However, two new strict requirements for filing appeals must be heeded in order to ensure timely filing and, in cases of reductions, ensure Aid Continuing. First, an oral request must be confirmed in writing, unless it requests an expedited appeal. Second, the consumer must sign the written request, or authorize a representative in writing to request the appeal. Both of these new requirements are described below.

**i. Oral appeal must be confirmed in writing unless it requests expedited appeal**

"Unless the enrollee requests an expedited resolution, an oral appeal must be followed by a written, signed appeal." 42 C.F.R. § 438.402(c)(3). In other words, if a request is made by phone, unless the member, her provider or representative requests that the appeal be expedited or "fast tracked," (defined below) the phone request must be followed up by a written appeal request. Providing some relief, the regulation provides that "…oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal)." 42 C.F.R. § 438.402(c)(3). The phone call requesting the appeal, therefore, if made before the effective date of a reduction, locks in Aid Continuing.

An FAQ issued by State DOH regarding this regulation provides guidance as to the consequence of not confirming an oral appeal in writing:

> *FAQ 5. How are plans to proceed with a verbal Plan Appeal if the enrollee does not follow up in writing?*
>
> *Enrollees must follow verbal requests in writing unless the request is for an expedited Plan Appeal. Plans should always notify enrollees of the need to follow up a verbal Plan Appeal in writing when a standard Plan Appeal is filed verbally. Plans may elect to send a summary of the Plan Appeal to the enrollee, for the enrollee to sign and return. The time of the verbal filing "starts the clock" for the plan determination. The time to make a determination and notice is NOT tolled while waiting for the written Plan Appeal, and the plan must make a determination even if a written Plan Appeal is not received.*

NYS DOH FAQ No. V. 5, dated Feb. 7, 2018.[16] Note that the sole FAQs posted on the NYS DOH website were specifically issued for Mainstream Medicaid Managed Care (MMC) by the division of State DOH that has oversight over those plans. A separate division has oversight over MLTC plans, which has, as of Feb. 18, 2018, not issued any policy guidance. Since the FAQ was issued by the same state agency

[16] NYS DOH 2016 FINAL RULE 42 C.F.R. 438 Service Authorization and Appeals; *Frequently Asked Questions* for Mainstream Medicaid Managed Care (MMC), Health and Recovery Plans (HARP), and HIV Special Needs Plans (HIV SNP), revised Feb. 7, 2018 (available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/2018-02-07_2016_final_rule_faqs-jan.htm#v) [hereafter referred to as "DOH 42 C.F.R. 438 FAQ"}

that oversees MLTC, and under general principles of administrative law requiring consistency of state policy, they should be binding on MLTC plans. 42 C.F.R. § 431.10.

The federal regulation does not require written confirmation of an oral appeal request if an expedited appeal is requested. An appeal is expedited (fast-tracked) if:

> …the [plan] determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health or ability to attain, maintain or regain maximum function.

42 C.F.R. § 438.410(a). The language implies that a *provider's* request that the appeal be expedited is binding on the plan, while the plan must determine whether it agrees that a the appeal must be expedited when requested by the *member.*

**ii. Client must Sign the Appeal Request Or Give Written Authorization for a Representative to File Request**

The new federal regulations require the member to file the appeal request directly, and only allows a health care provider or an authorized representative to request an appeal , grievance, or a State fair hearing on the enrollee's behalf "with the written consent of the enrollee." §438.402(c)(1)(i) and (ii). Additionally, "providers cannot request continuation of benefits as specified in §438.420(b)(5)" – referencing Aid Continuing. Id. A legal practitioner, geriatric care manager, or even a family member must obtain the client's signature to show her consent for the representative to request the appeal or fair hearing, which will likely delay filing an appeal request. The model Appeal Request Form asks for the signature of both the enrolled and the "requester." As a result, the client could miss the deadline to request Aid Continuing and her home care hours could be reduced.

However, the DOH model Notice template states, "If you told us *before* that someone may represent you, that person may ask for the Plan Appeal."[17] The model Appeal Request Form has a checkbox to indicate "yes" or "no" to the question, "Have you authorized this person with [Plan Name] before?" If the practitioner or a family member had been authorized before, attach any written authorization or explain when and how the authorization was made on an attachment to the request.

NYLAG has created an Authorization form on which client can authorize her attorney, a family member, a neighborhood organization, the ICAN Ombudsprogram (www.icannys.org), or all of the above, to request plan appeals and fair hearings and, if applicable, represent her in such appeals. Form is available at http://www.wnylc.com/health/download/646/. The practitioner should have all clients sign the form before there is a crisis, and keep the signed copy on file, and give a copy to client and the family member. The form should be sent to the plan return receipt requested, or given to the care

[17] DOH Notice to Suspend, Reduce or Stop Services, available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/2017-11-20_initial_reduce_services.htm, under heading "Who May Ask for a Plan Appeal."

manager, with the care manager asked to sign the client's copy to acknowledge receipt. Attach a copy of the signed authorization to the appeal request, and check YES to the question, "Have you authorized this person with [Plan Name] before?"

NYS DOH has issued two FAQ's regarding the requirement that a member sign the appeal or give written consent for a representative to request an appeal. These FAQs do not expressly apply to MLTC plans, since they were issued by a separate division within DOH that oversees Mainstream Medicaid Managed Care (MMC) and not MLTC plans. However, as stated above, the policy should be binding on MLTC plans as well.

In the original FAQ issued by DOH to managed care plans, Question V. 8 provides:

> *FAQ V. 8. If a request is made for an appeal and the plan has not received written authorization for a representative, does the plan dismiss the request or process it and only responded to the enrollee?*
>
> *Plans must process the request and respond to the enrollee. Plans may use existing procedures to confirm a representative has been authorized by the enrollee, including procedures for enrollees who cannot provide written authorization due to an impairment. The plan should have a process to recognize and include an enrollee´s representative when an enrollee has authorized the representative for services authorization and appeal activities prior the decision under dispute and such authorization has not expired.*[18]

This FAQ is important for several reasons. First, the plan must process the appeal request – and presumably comply with Aid Continuing – even if it has not received the member's written authorization of the representative. Second, for members who, because of disability, cannot sign a written appeal request or an authorization of a representative, NYS DOH acknowledges the plans' duty to provide reasonable accommodations of such disabilities. These must include policies and procedures to recognize "previously designated representatives, and establishing designation of a representative where the enrollee cannot provide written authorization due to an impairment." Id. The model Appeal Request Form incorporates this policy by stating, "If this form cannot be signed, the plan will follow up with the enrollee to confirm intent to appeal."

A Supplemental FAQ, also issued by the DOH division that oversees "mainstream" Medicaid managed care plans, states that Aid Continuing will not be provided if the appeal is requested by a health care provider, unless the enrollee has authorized the provider as their representative.

> *FAQ IV. 2. Is written consent from the member or an Appointment of Representative form (AOR) required for standard appeals? Should the plan provide Aid Continuing upon receipt of a Plan Appeal from a provider?*
>
> *42 C.F.R. § 438.402(c)(1)(ii) requires the enrollee´s written consent for the provider or authorized representative to file a Plan Appeal on the enrollee´s behalf. Aid Continuing may not be provided when a provider fails to demonstrate an enrollee has authorized the provider as their*

[18] DOH 42 C.F.R. 438 FAQ, *supra*, n. 15, Question V.8

*representative for the Plan Appeal and the Aid Continuing request, as the enrollee may be held responsible for the cost of services provided during the Plan Appeal. Plans should have policies and procedures for processing expedited requests, ensuring recognition of previously designated representatives, and establishing designation of a representative where the enrollee cannot provide written authorization due to an impairment.*[19]

The prohibition on a health care provider requesting Aid Continuing, unless specifically authorized by the plan member, reflects a suspicion that providers are acting in their own interests in receiving payment for services and not in the interests of the member.

### iii. Appellant's Potential Liability to Repay Cost of Services Received as Aid Continuing – and Appeal Request Form Checkbox to indicate that Aid Continuing is not requested

It has always been true that a Medicaid recipient may be held liable to pay for services received as Aid Continuing, if the recipient is ultimately found, after a hearing, not eligible for those services. As before, the revised federal managed care regulations provide:

> (d) *Enrollee responsibility for services furnished while the appeal or state fair hearing is pending.* If the final resolution of the appeal or state fair hearing is adverse to the enrollee, that is, upholds the [plan's] adverse benefit determination, the [plan] may, consistent with the state's usual policy on recoveries under 431.230(b) of this chapter and as specified in the [plan's] contract, recover the cost of services furnished to the enrollee while the appeal and state fair hearing was pending, to the extent that they were furnished solely because of the requirements of this section.

42 C.F.R. § 438.420(d). New York's model contract for MLTC plans has language in the Member Handbook advising the member that, "if your Fair Hearing is not decided in your favor, you may be responsible for paying for the services that were the subject of the Fair Hearing."[20] Both the Initial and Final Adverse Determination Notices must "describe the circumstances, consistent with State policy, under which the enrollee may be required to pay the costs of these services." 42 C.F.R. § 438.404(b)(6).

The federal regulations arguably allow states to limit Aid Continuing to those appellants who specifically request Aid Continuing when they file the appeal. New York continues to take a more liberal view, and presumes that the appellant is requesting Aid Continuing unless they indicate otherwise. Hence, the

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[19] NYS DOH 2016 FINAL RULE 42 C.F.R. 438 Service Authorization and Appeals; SUPPLEMENTAL FINAL RULE FAQ's -- *Frequently Asked Questions* for Mainstream Medicaid Managed Care (MMC), Health and Recovery Plans (HARP), and HIV Special Needs Plans (HIV SNP), Question IV.2. revised Feb. 7, 2018 (available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/2018-02-07_2016_final_rule_faqs-feb.htm#iv [hereafter "Supplemental NYS DOH FAQ"]

[20] See Model Contract for Partial Capitation Plans, *supra* n. 8, Appendix K (pp. 145 and 147 of PDF)

model Appeal Request Form has a checkbox to indicate, "I do not want my services to stay the same while my Plan Appeal is being decided."

Though clients should be advised about the potential liability to repay services provided with Aid Continuing if they ultimately lose the Fair Hearing, they should also be advised about the high probability that they will win their appeal of a reduction, at least for personal care or CDPAP services. In a study analyzing all fair hearing decisions posted on the OTDA online archive involving reductions of home care hours by MLTC plans in the last seven months of 2015, MLTC plans prevailed in only 1.2% (13 out of 1,027) of the hearings.[21] The report explains the law and policies governing plan reductions, including the plan's burden of proof that a reduction is justified by a change in the medical condition or other circumstances. Since that Report was issued, the client's ability to defeat a proposed reduction in hours has been strengthened by additional State policy directives.[22]

DOH has also clarified that if members lose the initial Plan Appeal, plans may not recoup the cost unless and until a member fails to request a fair hearing within the statute of limitations.[23]

### D. When Must Plan Decide Standard Appeals and Expedited Appeals – and Member's Right to Request Fair Hearing if Plan Does Not Meet Deadlines (Deemed Exhaustion)

Where delay is harmful to the client, such as where the client is seeking an increase in home care hours or a new service, or does not have Aid Continuing on a reduction, the practitioner will need to monitor the plan's compliance with the regulatory deadlines for deciding the plan appeal, and oppose any extension of the deadline that does not comply with the regulations described below. Importantly, the plan's failure to comply with the deadlines set forth below constitutes grounds for "deemed exhaustion," allowing the member to request a fair hearing. 42 C.F.R. §§ 438.408(c)(3) and 408(f)(1)(i).

*The Deadlines*. A standard appeal must be decided by the plan within - within **30 calendar days** of receipt of the appeal request, subject to an extension of up to **14 calendar days** described below. 42 C.F.R. § 438.408(b). The member or her provider or representative have the right to request an expedited or "Fast Track" appeal, if "taking the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health or ability to attain, maintain or regain maximum

[21] See Medicaid Matters NY Report on MLTC Reductions, supra at n. 14.

[22] See NYS DOH MLTC Policy 16.06, *supra* , n 7, and MLTC Policy 16.07: *Guidance on Task–based Assessment Tools for Personal Care Services and Consumer Directed Personal Assistance Services,* both dated Nov. 17,2016 (both available at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm *)*

[23] DOH 42 C.F.R. 438 FAQ*, supra,* n. 16, at Section VII, Question 3 FAQ (The FAQ says plan cannot recoup losses until member "fails to request a fair hearing within 10 days of the Final Adverse Determination, which appears to be an error and is presumably meant to say within 120 days of the FAD. NYLAG has requested a correction).

function." 42 C.F.R. § 438.410. An expedited appeal must be decided within **72 hours** after the plan receives the appeal, subject to the same 14-day extension as for standard appeals. 42 C.F.R. § 438.408(b).

*Extension of the Deadline*. The Plan may extend its time to decide a standard or expedited appeal by up to 14 calendar days if the enrollee requests the extension, or if the plan "shows (to the satisfaction of the State agency, upon request)that there is need for additional information and how the delay is in the enrollee's interest." 42 C.F.R § 438.408(c). The regulation does not explain by what procedure the extension would be approved to the State agency's (State DOH) satisfaction, but presumably the enrollee would utilize the existing DOH MLTC Complaint Line – 1-866-712-7197 or email mltctac@health.ny.gov**.**

If the "… plan extends the timeframes not at the request of the enrollee, it must complete all of the following:

> (i) Make reasonable efforts to give the enrollee prompt oral notice of the delay.
>
> (ii) Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.
>
> (iii) Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

42 C.F.R §438.408(c)(2). NYS DOH has issued a model Notice of Extension for plans to use to fulfill the requirement above.[24]

If a member or her representative wishes to dispute an extension, from the regulations above, the member may file a grievance with the plan and/or file a complaint with the State DOH at 1-866-712-7197 or e-mail mltctac@health.ny.gov.

The plan's failure to comply with the deadlines set forth above constitutes grounds for "deemed exhaustion," allowing the member to request a fair hearing. 42 C.F.R. §§ 438.408(c)(3) and 408(f)(1)(i). The hearing request could be requested either 72 hours after a request for expedited review was filed, or 30 days after a standard appeal was filed, subject to the 14 day extension if warranted.

**5. Member Rights in Plan Appeal**

While practitioners may not have utilized the internal Plan Appeal process when it was optional, going instead directly to a fair hearing, now there is no choice but to use it. At best, the client will win the plan appeal and no fair hearing will be necessary. Even if not favorably decided, the plan appeal provides an opportunity to obtain the plan's case file, and provide additional documentation in support

[24] Extension notice available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2017-11-20_ext_notice.pdf

of the claim to the plan, with no harm to the client if there is Aid Continuing. At worst, the plan appeal can cause great harm to the client, adding extra delay until a Fair Hearing is held and decided, which can be harmful when an increase is being requested or services are reduced without Aid Continuing.

**i. Plan Must Provide Case File to Enrollee and Representative without Request**

In the past, the plan only had to provide the case file upon request. Under the new regulation, the plan must:

> 5) Provide the enrollee and his or her representative the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by … (or at the direction of the [plan] in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in §§438.408(b) and (c).

42 C.F.R. §438.406(b)(5). NYS DOH has issued several FAQ's to clarify the plan's duty to provide the case file while the plan appeal is pending. See *Supplemental NYS DOH FAQ*, supra, n. 19.

> *2. Is it the State´s expectation that Health Plans will send a case file upon every request for a Plan Appeal (standard and expedited) requests?*
>
> > *Yes, this requirement was added at 42 CFR 438.406(b)(5). Case files must be sent to the enrollee and their authorized representative.*
>
> *3. What are the required timeframes and methods the health plan must follow to submit the case file to the enrollee or his/her designee?*
>
> > *42 CFR 438.406(b)(5) states this information must be provided "sufficiently in advance of the resolution timeframes for appeals as specified in 438.408(b) and (c). Plans may choose to send this with the appeal acknowledgement. Unless otherwise requested by the enrollee or their representative, the case file should be sent by mail.*
>
> *4. Please clarify what is to be included in the case file for Plan Appeals. Would the case file include the same documentation that is required as part of a typical fair hearing evidence packet?*
>
> > *The case file includes all information related to the review of a Service Authorization Request, Initial Adverse Determination, and/or Plan Appeal. Upon receiving a Plan Appeal, the plan must automatically send the enrollee´s case file which includes medical records, other documents/records, and any new or additional evidence considered, relied upon, or generated in connection with the Plan Appeal. This includes internally–generated documents but does not necessarily generally include all medical records that may be in the plan´s possession. The case file is not the evidence packet. The evidence packet contains information the plan will use to support the Final Adverse Determination at the fair hearing. The evidence packet must be sent to the enrollee when the plan receives notification of the fair hearing request from OAH.*

If you want the file to be provided directly to the representative, submit a signed HIPPA release - OCA Form No. 960 - Authorization for Release of Health Information Pursuant to HIPAA , available at http://www.nycourts.gov/forms/Hipaa_fillable.pdf.

**ii. Right to present new evidence in person or in writing**

Plan must consider new evidence submitted in support of the appeal "…without regard to whether such information was submitted or considered in the initial adverse benefit determination." 42 C.F.R. § 438.406(b)(2)(iii).

The plan must provide the enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The plan must inform the enrollee of the limited time available for this sufficiently in advance of the resolution time frame for appeals. 42 C.F.R. § 438.406(b)(4)

TIP: On the Appeal Request Form that plans must attach to their IAD notice, there is a checkbox if the appellant or her representative wants to include additional documents with the appeal request, or to give information in person. The member or representative could also write on the form that they request time to submit additional written documentation.

**iii. Reasonable Accommodations to help with appeal**

The plan must give enrollees "any reasonable assistance in completing forms and taking other procedural steps relating to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have TTY/TTD and interpreter capability. 42 C.F.R. § 438.406(a).

**iv. Appeal Must be Decided by Individuals who were Not Involved in Initial Decision**

The plan appeal must be decided by individuals:

(i) Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.
(ii) Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.
(A) An appeal of a denial that is based on lack of medical necessity.
(B) A grievance regarding denial of expedited resolution of an appeal.
(C) A grievance or appeal that involves clinical issues.

42 C.F.R. §§ 438.406(b)(2)(i) and (ii).

**6. Plan's "Final Adverse Determination" (FAD) after the Plan Appeal and Request for Fair Hearing**

State DOH has issued a model notice template for a Final Adverse Determination (FAD), which is a Plan's decision after the plan appeal that is wholly or partially adverse to the member. Practitioners should note that the word "Final" on the notice means that this is the decision after the Plan's plan, meaning that the member has met the exhaustion requirement and may request a Fair hearing.

Where the appeal involves a reduction in home care hours or other services, the FAD Notice is both a decision explaining the reason for denying the appeal AND a new Notice of Reduction, which again must be provided 10 days before the effective date of the proposed reduction. A Fair Hearing must be requested within 10 days of the date of the notice, before the effective date of the action, in order to secure Aid Continuing. In the state's model FAD notice template,[25] note that the "effective date" is listed *after* the statute of limitations for requesting a fair hearing, which is now 120 calendar days. 42 C.F.R. §438.408(f)(2). This placement may cause members to delay seeking representation or requesting a fair hearing. Of course, it is crucial to request a fair hearing within 10 days of the notice date, and not wait for the 120 day statute of limitations.

Where the effective date has already lapsed by the time the member has consulted an attorney, one strategy is to obtain the postmarked envelope in which the notice was mailed. If it was not mailed 10 days in advance of the effective date, Aid Continuing should be awarded. See fn. 11, *supra*. Another strategy is to look for other defects in the notice content. See, e.g. the Medicaid Matters NY Report on MLTC Reductions, supra, n. 14 for more information.

The next step is to request a FAIR HEARING. While hearings may be requested by the same modes as in the past, see http://otda.ny.gov/hearings/request/, Just like for Plan Appeals, the new regulations require the member to SIGN the request, or authorize a representative to do so. See above recommendation to have all clients sign "authorization" to request appeal or hearing in advance to have on file, and to attach to hearing request.

It is recommended to use the new Fair Hearing Request Form that should be part of the FAD Notice from the plan, since it has pre-populated information that is useful to OTDA.

If plan does not send the FAD notice by the deadline (30 days for standard appeals / 72 hours for expedited appeals, both subject to 14 day extension) then the member may request the FAIR HEARING even though the plan has not made a decision on the Internal Appeal. This is called "Deemed Exhaustion." 42 C.F.R. § 438.402(c)(1)(A).

### 7. Optional External Appeal

The plan's FAD notice denying the Plan Appeal will explain the right to request an External Appeal, if the reason for the denial is because the plan determines the service is not medically necessary or is experimental or investigational. An external appeal, like Fair Hearings, requires exhaustion of the internal plan appeal and may only be requested after receipt of the FAD.

[25] Model FAD Notice of Reduction available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/2017-11-20_final_reduce_services.htm.

One may request an External Appeal even if one also requests a Fair Hearing, but the decision from the Fair Hearing supersedes the External Appeal decision. NY Public Health Law § 4910.

If the issue involves a plan's proposal to reduce or stop a service, the member MUST request a Fair Hearing before the effective date of the FAD in order to receive Aid Continuing.

For more information about External Appeals see
http://www.dfs.ny.gov/insurance/extapp/extappqa.htm

**8. Additional information and Contacts**

For updates on Appeal Changes in MLTC - http://www.wnylc.com/health/entry/184/

**Fax, phone and email contact info** to request appeals for all MLTC plans will be posted here when available - http://www.wnylc.com/health/entry/179/

**NYS Dept. of Health MLTC/FIDA Complaint Hotline** 1-866-712-7197 mltctac@health.ny.gov

**NYS DOH Mainstream managed care complaints --**1-800-206-8125

NYS DOH Managed care webpage on appeals
https://www.health.ny.gov/health_care/managed_care/plans/appeals/

**ICAN – Independent Consumer Advocacy Network –** Helps with MLTC and mainstream appeals on long term services and supports -- TEL 844-614-8800 TTY Relay Service: 711 Website: icannys.org
ican@cssny.org

Jane Perkins*, Issue Brief 2: Medicaid Managed Care Final Regulations Grievance & Appeals Systems*, (National Health Law Program, May 12, 2016), available at
http://www.healthlaw.org/publications/browse-all-publications/Brief-2-MMC-Final-Reg#.WoGveSXwa2w

Greetings – Here are some Medicaid updates from the Evelyn Frank Legal Resources Program, with links for where to find more information.

View this email in your browser


In this issue -



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## 1. NYS Dept. of Health Confirms Guildnet Plans Closing Jan. 1, 2019, & UnitedHealth MLTC Closing Upstate

The State Dept. of Health confirmed that the three **Guildnet** plans (MLTC, FIDA, and Medicaid Advantage Plus) will be closing effective Jan. 1, 2019. The 8,211 members of these plans, all in NYC, will receive letters in mid-October 2018 that will tell them that if they do not select and enroll in a new plan in 60 days, they will be auto-assigned to a new plan for January 2019. The plan will be assigned randomly, though NY Medicaid Choice will reportedly make some effort to keep some members with the same home care agency they have with Guildnet. It is not clear whether all members will keep their same home care agency if they are auto-assigned.

**UnitedHealth MLTC** is closing in all six upstate counties it now serves -- Albany, Broome, Erie, Monroe, Oneida, & Onondaga -- with a total of 1,463 members affected. They will receive letters in November 2018 about the plan closing in February 2019, also giving them 60 days to pick a plan or be re-assigned.

**KNOW CONSUMER "TRANSITION RIGHTS."** See this article which explains member "transition rights" when an MLTC plan closes, under State Dept. of Health MLTC Policy 17.02**.** The new plan must continue the same services provided by the closing plan for 120 days. Under previous DOH MLTC Policy 16.06, the new plan must give notice with appeal rights before reducing services after the transition period.

HOWEVER, it is very important that members do not panic and switch to other plans **until they receive an official letter from the plan, NY Medicaid Choice, or the NYS Dept. of Health.** People who switch plans before the mailing in mid-October may not be protected with "transition rights." Read more about transition rights here. Read about consumer advocates' concerns about the State's transition policy.

that they should change plans or that the plan is closing, please report this to ICAN or directly to the State Dept. of Health MLTC Complaint line at 1-866-712-7197 or e-mail mltctac@health.ny.gov

## 2. MLTC Plans End Contracts with Some Home Care Agencies to Comply with 2018 State Budget - Impact on Consumers

October 1, 2018 is the first deadline for MLTC plans to reduce the number of licensed home care services agencies (LHCSA) they contract with, under state law amended in April 2018. The cap is:

- For Downstate: 1 LHCSA per each 75 enrollees
- Rest of State: 1 LHCSA per each 45 enrollees

Under new guidance to plans issued August 18, 2018:

1. Plans must send **written notice** to members whose home care agency is being terminated "of any available options to stay with their current home care worker. These options may include changing to a different LHCSA if their current home care worker is moving to a new LHCSA; enrolling in a different MLTC plan if their current home care worker is employed with a LHCSA that is contracted with another plan; or, if applicable, requesting a three–month exception" that allows the plan to continue contracting with the terminated plan for 3 months, without it being counted against the new maximum number of agencies.

2. If the enrollee desires to stay with an aide due to a cultural or linguistic concern or other special service, and the plan cannot provide that cultural or linguistic competency or other special service through another LHCSA, the plan may request an Exception to the maximum number of LHCSAs through a process outlined in the directive. There is no clear procedure for the member to request this Exception. We suggest starting with the Care Manager and working your way up.

**Warning: re Possible Cut in Hours --** if the member moves to a different MLTC plan in order to retain their aide, they risk the new plan reducing their hours. The "transition rights" that require MLTC plans to continue the same services and hours the member received previously only apply when an MLTC plan is closing (see above article), or when the individual is required to join an MLTC plan (after receiving Medicaid home care services through "Immediate Need" or after being disenrolled from a "mainstream" Medicaid managed care plan when one first enrolls in Medicare.)

**Warning re Lock-In.** If a member transfers to a different MLTC plan on or after December 2018, the member will be allowed to switch plans during a 3-month grace period after their enrollment, but then will be locked in to the plan for next 9 months. Changes will be allowed only for good cause. See this article for more about this and other changes in the MLTC program enacted in the NYS Budget in April 2018.

## 3. Register for Half-Day Training & CLE Program on

## MLTC and NYS Medicaid Changes in 2018 and Advocacy Tips

NY Aging Life Care Association, Sponsor
November 14, 2018 at 1 PM - 5:30 PM
followed by Cocktail Reception 5:30 - 7 PM

NY Academy of Medicine: 1216 5th Avenue (103rd St) NY NY

Trainers: Valerie Bogart & Peter Travitsky,
NYLAG Evelyn Frank Legal Resources Program

CLE and CEU credit

Download the announcement for information about topics, fees, how to request a hardship waiver, CEU and CLE credit, and link to register online.

In August, 2018, The Legal Aid Society and Willkie Farr & Gallagher filed *Ciaramella v. Zucker* (18-cv-06945) to challenge the New York State Department of Health's rules preventing Medicaid coverage for replacement dentures within 8 years from initial placement and the ban on Medicaid coverage for dental implants. In response, DOH will be implementing changes to the dental manual to cover **dental implants** when medically necessary and to change the rules for **replacement dentures**. These changes, described in this document, will take effect on November 12, 2018. The new rule on replacement dentures imposes new documentation requirements and will be a step backward for some.

Legal Aid Society asks you to let them know of Medicaid-eligible individuals who require dental implants or replacement dentures, including those that may not be covered based on the revised policy. They also want to hear about Medicaid recipients who require other dental treatments that are not covered by Medicaid including root canals, immediate dentures, osseous surgery. Contact: Legal Aid Society Health Hotline (212) 577-3575 or email.

Read more about Medicaid dental care in NYS here.

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- Checks can be made payable to "NYLAG." Please put "EFLRP" or "Evelyn Frank" in the memo line or in a cover note and send them to:

  New York Legal Assistance Group
  Attn: Helen Murphy
  7 Hanover Square,18th Floor
  New York, NY 10004

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Greetings – Here are some Medicaid updates from the Evelyn Frank Legal Resources Program, with links for where to find more information.

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## Guildnet Announces Closing of MLTC Plan - and ICS May Follow --Consumers Need to Know Their Rights When Plans Close

**Guildnet.** On Aug. 21, 2018, the CEO of Guildnet sent a letter to all Guildnet employees stating that Guildnet MLTC plan will close effective 12/1/18. (posted here) On August 28, 2018, Crain's NY Business reported that the NYS Dept. of Health (DOH) confirmed that "GuildNet had filed a request with the state to stop offering its MLTC plan. It said the nonprofit has stopped enrolling new members. 'The department is working with GuildNet to ensure continuity of care as it finalizes particulars of this plan,' a spokeswoman said."

As of August 2018, Guildnet has 7,316 MLTC Members in its MLTC plan, 478 in its Medicaid Advantage Plus plan, and 417 in its FIDA plan - all in NYC. Crain's implies that all three plans are closing but this has not been confirmed. Guildnet's enrollment has markedly decreased recently, from being the second largest MLTC plan in NYC to the 10th largest plan currently. See this chart.

**ICS**. In July, various news outlets reported the possible closing of Independence Care System (ICS) later in 2018. See coverage by WNYC Radio and Crain's NY Business, reporting advice given by ICS in a memo to its Member Council. The State Dept. of Health has not confirmed whether and when ICS is closing. As of August 2018 ICS has 6,182 members, all in NYC. See more in this article,

**KNOW CONSUMER "TRANSITION RIGHTS."** See this article which explains member "transition rights" when an MLTC plan closes, which were announced in State Dept. of Health MLTC Policy 17.02**.** Members of a closing plan will be assigned to a new plan, if they don't pick one within 60 days after receiving notice about the closing. The new plan must continue the same services provided by the closing plan for 120 days. Under previous DOH MLTC Policy 16.06, the new plan must give notice with appeal rights before reducing services after the transition period.

It is very important that members do not panic and switch to other plans **until there is official notice from the State.** People who switch plans now will not be protected with "transition rights." Read more about transition rights here. Read about consumer advocates' concerns about the State's transition policy here.

As ICS told its member council, "It is in each ICS member's interest to stay at ICS until notification comes from DOH because the extended continuity of care will only be offered to people at ICS at the time of notification." This same advice applies to Guildnet and any other plan that may close.

**Where to Get Help**: If you have questions about how these changes affect you or your client, call the ICAN Ombudsprogram at 1-844-614-8800. If a plan employee or an employee of the home care agency that provides their MLTC home care services tells them that they should change plans or that the plan is closing, they should report this to ICAN or

## State Moves to Implement MLTC Changes Enacted in 2018 State Budget - New "Lock-In" Rule will Bar Members from Changing Plans after 90 Days

The NYS Dept. of Health is now preparing to implement various changes in the MLTC program that were enacted in the NYS Budget in April 2018.

- **Lock-In.** For new enrollments in MLTC plans on or after December 2018, MLTC members will be allowed to switch plans during a 3-month grace period after their enrollment, but then will be locked in to the plan for next 9 months. Changes will be allowed only for good cause. See this article for more about this change.
- **Nursing Home and MLTC.** Once approved by CMS, enrollment in an MLTC will no longer be mandatory for dual eligibles in nursing homes. MLTC members who are permanently placed in a nursing home for more than 3 months will be disenrolled from the MLTC plans.
- **Limit on Number of Home Care Agencies an MLTC plan may contract with –** Beginning Oct. 2018, MLTC plans must reduce the number of licensed home care services agencies (LHCSA's) they contract with to one per 75 enrollees downstate, and one per 45 enrollees upstate.
- Read about these and other MLTC changes in this article.

## New Alerts & Revised "Spousal Refusal" Form from HRA Medicaid Program

The NYC HRA Medicaid Program issues alerts announcing changes in procedures or forms. See this article for recent alerts.

Also, HRA recently issued a slightly revised version of the NYC "Spousal Refusal" form. As before, there are two alternate forms:

1. "Declaration of the Legally Responsible Relative" (MAP 2161a)(for the spouse or parent to indicate refusal/inability to support)
2. "APPLICANT/RECIPIENT DECLARATION CONCERNING THE LEGALLY LEGALLY RESPONSIBLE RELATIVE'S INCOME/ RESOURCES" (MAP 2161)(for the Medicaid recipient/applicant to indicate the spouse/parent's refusal or inability to support)

Download the current forms, issued May 11, 2018, here, combined into one PDF. A statement was added explaining how a person with a disability can request help to understand the notice or other reasonable accommodations.

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Greetings – Here are some Medicaid updates from the Evelyn Frank Legal Resources Program, with links for where to find more information.

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In this issue -



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## 1. Guildnet Members Receive Notices about Transition to new Plans after Guildnet Closes Jan. 1, 2019

This notice was sent to all Guildnet NLTC members on Oct. 19, 2018 by New York Medicaid Choice, the Medicaid managed care enrollment broker for NYS. The notices state that if Guildnet members don't select a new plan by 12/19/2018, they will be auto-assigned to a new plan for January 1st. "The Plan you select will continue to honor your current plan of care for 120 days from the date that you transfer to the new plan." These "transition rights" are required by the NYS DOH MLTC Policy 17.02 which requires continuity of care in the new plan after a plan closing.

Read about strategies for helping Guildnet members protect their rights to continuity of care and continuity of their preferred aides in this article. You can learn more about these strategies by attending our CLE/CEU Training on November 14th. See info here.

**Where to Get Help**: If you have questions about how these changes affect you or your client, call the ICAN Ombudsprogram at 1-844-614-8800. If a plan employee or an employee of the home care agency that provides their MLTC home care services tells them that they should change plans or that the plan is closing, please report this to ICAN or directly to the State Dept. of Health MLTC Complaint line at 1-866-712-7197 or e-mail mltctac@health.ny.gov

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## 2. Four FIDA Plans Close in NYC, Long Island and Westchester, including the only FIDA plan in Suffolk County

**Four FIDA plans are closing in January 2019:**

| | |
|---|---|
| 2. Village Care Max Full Advantage | NYC only (25 members) |
| 3. MetroPlus FIDA | NYC only (205 members) |
| 4. AgeWell NY FIDA plan members) | NYC, Suffolk, Nassau, & Westchester (247 |

NOTE that Agewell was the SOLE FIDA plan in Suffolk county.

Warning that as of now, MLTC Policy 17.02 described above for Guildnet MLTC, does not specifically apply to FIDA. However, if participants in terminating FIDA plans choose to switch to another FIDA plan, they will be given a 90-day transition period per the 3-way contract (§ 2.6.6.1). It is less clear what transition rights members of a closing FIDA plan have if they switch to an MLTC plan. Stay tuned for more on that. This is especially critical for Suffolk County residents, where the plan that is closing - Agewell FIDA - was the ONLY FIDA plan, so they do not have the option of switching to another FIDA plan.

Additionally, if a member of a closing FIDA plan decides to switch to an MLTC plan instead of to another FIDA plan or another "fully capitated" plan like PACE or Medicaid Advantage Plus, they must remember to select and enroll in a Medicare Part D prescription drug plan for January 1, 2019. Before, the FIDA plan covered their drugs. Now, they need to enroll in a stand-alone plan. For more info on Medicare Part D see a training manual and other info here and see NYS plans in 2019.

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## 3. Register for Half-Day Training & CLE Program on

## MLTC and NYS Medicaid Changes in 2018 and Advocacy Tips

NY Aging Life Care Association, Sponsor
November 14, 2018 at 1:00 PM - 5:30 PM
followed by Cocktail Reception 5:30 - 7:00 PM

NY Academy of Medicine: 1216 5th Avenue (103rd St) NY NY

Trainers: Valerie Bogart & Peter Travitsky,
NYLAG Evelyn Frank Legal Resources Program

CLE and CEU credit

Download the announcement for information about topics, fees, how to request a hardship waiver, CEU and CLE credit, and link to register online.

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## 4. Comments due Nov. 23rd on NYS Proposal to Exclude People Placed in Nursing Homes for 3+ Months from MLTC Plans

In late September 2018, NYS DOH submitted a request to CMS to change the MLTC program to exclude people permanently placed in a nursing home for 3 months from MLTC plans. The State's proposal and accompanying documents are posted on the State's MRT webpage here. This is a reversal of the policy in effect since 2015, described in this article.

- See the State's proposed notice to MLTC members describing the change here.
- See the State's proposed notice to be sent by NY Medicaid Choice before it disenrolls the 23,000 MLTC members who have been in nursing homes for 3 or

The deadline to submit comments to CMS was Friday Oct. 26, 2018. Many consumer advocacy organizations submitted comments which are available on the CMS website here. Click on these links for comments by NYLAG, Legal Aid Society and other organizations. NYLAG's comments on the rule state that the three-month "clock" should not start ticking toward disenrollment if the member intends to return home. Disenrollment from an MLTC plan will make it much harder to return home. The proposed procedures do state that the period in which Medicare is covering all or part of a rehab stay will not count toward the 3 months of permanent placement. Also, NYLAG and other consumer advocates urge that plans must give notice of a decision to consider them "permanently placed," which the consumer should have the right to appeal. These decisions must be made with involvement of the consumer, not unilaterally by a managed care plan or nursing home. Please see other suggests in our comments.

The State has reopened the comment period on this change. See this notice. Consumers may submit comments to the State before Nov. 23, 2018. Comments can be submitted via email to mltcinfo@health.ny.gov. In the subject line DOH asks you to please indicate "Proposed NH Benefit/Lock In 1115 Amendment Comments".

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# State Dept of Health Moves to Implement MLTC Changes Enacted in 2018-19 NYS Budget

**25 Oct, 2018**

Though the NYS legislature and Governor Cuomo agreed on a State Budget on April 1, 2018, many of the changes in the Managed Long Term Care program are still in the planning stages for implementation. Here is the status of state budget provisions affecting Medicaid for seniors and people with disabilities, as of July 5, 2018. **NEW:** See Info on lawsuit filed challenging law regarding approval of advertising by Consumer Directed Personal Assistance organizations.

**8/29/18 Update**: Policy Guidance issued on limitation on number of licensed home care services agencies that an MLTC plan may contract with. See below.

**Oct. 25, 2018 Update**: NYS has reopened the comment period until Nov. 22, 2018 on the change that will exclude people permanently residing in nursing homes for 3 months from MLTC plans. Read more here.

## WINS FOR CONSUMERS:

### The Legislature Rejected Proposals to Cut "Spousal Protections" that would have impoverished married couples, denied critical medical and home care to sick spouses and children, and increased institutionalization. See NYLAG budget testimony

a. **Spousal/Parental Refusal Remain Intact** –The Governor's bill would have eliminated spousal refusal for many needy spouses as well as children with cancer and other severe conditions whose parents cannot afford the high cost of their care. While many New Yorkers benefit from the new expanded eligibility limits under the Affordable Care Act [ACA], nearly a million low-income New Yorkers are over age 65 or have permanent disabilities. For them, Medicaid remains unchanged by the ACA, with so-called "non-MAGI" income limits well below the Federal Poverty Level - singles may have only $842/mo and couples only $1233/mo. Spousal/parental refusal provides a vital protection for vulnerable populations, including abused spouses and children.

The Governor's proposal would have maintained Spousal Refusal only for members of Managed Long Term Care (MLTC) plans, denying this protection to those same married individuals when they initially apply for Medicaid in order to enroll in an MLTC plan. Also, many people who need home care are not allowed to enroll in MLTC plans at all -- those receiving Hospice Care, and those whose disabilities are less severe, who need only "housekeeping" services." And spousal refusal would have no longer been allowed for married individuals who do not need MLTC or other home care but still need Medicaid or the Medicare Savings Program for help with Medicare out-of-pocket costs,

b. **Spousal Impoverishment Resource Allowance remains at** $74,820 instead of being reduced to the lowest allowed by the federal government -- only $24,180. This is the amount of resources that the spouse of an MLTC enrollee or a nursing home resident may keep.

### The annual cap on Physical Therapy (PT) visits was increased from 20 to 40 visits per year.

Unfortunately, the budget leaves unchanged the cap on Speech and Occupational Therapy visits at 20 per year for each type of therapy. But the increase in PT visits to 40 visits per year will improve access for those in managed care plans as well as those using Medicaid fee for service.

## Alarming Changes in the MLTC Program Enacted

The legislature rejected one of the Governor's proposals that would have excluded from MLTC plans those with an "Uniform Assessment System" score of 9 or lower. These individuals have been determined to need the least amount of personal care services. However, other changes were enacted that consumer advocates fear may be harmful to consumers. NYLAG was one of many organizations that submitted testimony opposing many of these changes. See NYLAG's 2018-19 Testimony posted here. Crain's New York Business quoted NYLAG's testimony stating that some of the changes in MLTC will "increase barriers to access" for those who need care. See "State looks to shrink financial burden for elder care" by Caroline Lewis, Feb. 21, 2018.

The State Dept. of Health sent a memorandum to MLTC plans describing many of the changes in April 2018, posted here. Please note that some of the implementation dates in that memorandum have been extended.

a. **Lock-In -** For the first time since MLTC became mandatory 5 years ago, members who enroll in a new plan after Dec. 1, 2018 will be barred from changing plans for 9 months, after the first 90 days enrolled in the plan. See this article for more about this change.

b. **People "Permanently Placed" in a Nursing Home for three or more months will no longer be able to enroll in MLTC plans, and those who are already in MLTC plans when they enter a nursing home will be disenrolled after 3 months of permanent placement.** This is a reversal of the MLTC program expansion that began in 2015. Since then, all nursing home members have been required to enroll in or remain in managed care and MLTC plans. See this article. Now, people in nursing homes will be disenrolled from their MLTC plans after 3 months of permanent placement. Consumers fear that when MLTC plans are no longer responsible for the cost of nursing home care, the plans will have an incentive to place members with high needs in nursing homes, rather than approve more hours of home care needed for the member to remain in the community.

There is also a concern that it will be more difficult for an individual in a nursing home - now disenrolled from an MLTC plan -- to obtain home care services to return to the community. To address this, NYS DOH has said that a Conflict Free Eligibility assessment will not be required if the consumer seeks to re-enroll in an MLTC plan within 6 months of the disenrollment.
**Status of Implementation:** Though DOH expected that current MLTC members permanently placed in nursing homes would be disenrolled from MLTC plans on July 1 2018, this has been postponed while procedures are developed and CMS approval is obtained. There are reportedly about 23,000 MLTC members in nursing homes.
In September 2018, DOH submitted a request to CMS to amend the 1115 waiver that governs MLTC, to exclude permanent nursing home residents from MLTC enrollment after 3 months. The State's proposal and accompanying documents are posted on the State's MRT webpage here.

- See the State's proposed notice to MLTC members describing the change here.
- See the State's proposed notice to be sent by NY Medicaid Choice before it disenrolls one of the 23,000 MLTC members who have now reportedly been in nursing homes for 3 or more months.. and members in the future. The deadline to submit comments to CMS was Friday Oct. 26, 2018. Many consumer advocacy organizations submitted comments which are available on the CMS website here. Click on these links for comments by NYLAG, the Legal Aid Society and other organizations here.

NYLAG's comments on the rule state that the "clock" should not start ticking toward three months until disenrollment if the member intends to return home. Disenrollment will make it much harder to return home. The proposed procedures do state that the period in which Medicare is covering all or part of a rehab stay will not count toward the 3 months of permanent placement. Also, NYLAG and other consumer advocates urged that plans must give notice of a decision to consider them "permanently placed," which the consumer should have the right to appeal. These decisions must be made with involvement of the consumer, not unilaterally by a managed care plan or nursing home.
The comment period to submit comments to the State on this proposal is open until November 23, 2018. Comments can be submitted via email to mltcinfo@health.ny.gov. In the subject line please indicate *Proposed NH Benefit/Lock In 1115 Amendment Comments*.

c. **Disenrollment from MLTC of a consumer who has received no home care or other MLTC services in a calendar month without the consumer having notified the plan.** The member receives notice of this involuntary disenrollment from NY Medicaid Choice, and has appeal rights.

d. **Limit on Number of Home Care Agencies an MLTC plan may contract with –** Beginning Oct. 2018, MLTC plans must reduce the number of licensed home care services agencies (LHCSA's) they contract with to one per 75 enrollees downstate, and one per 45 enrollees upstate. In 2019 the numbers go down further. This raises concerns about disruption in care -- consumers may lose longtime aides who were employed by an agency that no longer contracts with the MLTC plan. Plans may not have enough home care agencies to staff all of their cases. Consumers may lose access to aides who speak their language and understand their culture. See April 10, 2018. article in Crain's NY Business. This cap may increase barriers to consumer access, as many plans already do not have an adequate network of home care provider agencies to provide authorized services. Consumers have rights under federal regulations to adequate networks of providers.

   DOH has issued guidance to implement this legislative requirement to downsize the number of LHCSAs:

   - DOH Policy Guidance - Licensed Home Care Services Agencies (LHSCA) Contract Limitation Guidance, Aug. 17, 2018 (posted on MRT 90 webpage)
   - DOH Dear Administrator Letter DAL DHBS 18-03, Aug. 23, 2018 SUBJECT: LHCSA Regulatory Requirements (this is expected to be posted here -- until it is can be downloaded here)

   A related change is enactment of a two-year moratorium on the approval of applications seeking the licensure of Licensed Home Care Services Agencies (LHCSAs). This moratorium became effective on April 1, 2018 and will continue until March 31, 2020. Guidance on this moratorium and its exceptions, along with applicant information is at this link.

e. **Limit on Marketing by CDPAP agencies** - The "fiscal intermediaries" that provide Consumer DIrected Personal Assistance Program (CDPAP) services must now submit any marketing materials to the NYS Department of Health for approval. If they publish two or more ads that are either “false or misleading” or not approved by DOH, their license will be revoked. The law has the potential to reduce access to the CDPAP program, which has long been lauded as a cost-saving model that promotes consumer autonomy and the *Olmstead* integration mandate.
   - **The NYS Consumer Directed Personal Assistance Association (CDPAANYS) has filed a lawsuit challenging this requirement** for violating the First Amendment. See article in LegalNewsLine on July 3, 2018 here -- "Nonprofits challenging New York law regarding approval of Medicaid program advertising." See CDPAANYS information here. Among other issues, the association points out that nursing homes, hospitals and other providers are not restricted in advertising their services, but CDPAP FI's are.

## Backgrounder - NYS budget 2018-19 as proposed by Gov. Cuomo

Here is information about the originally proposed New York State budget for 2018-19. Click here to see the actual Health and Mental Hygiene (HMH) Bill and the Governor's Health and Mental Hygiene (HMH) Memorandum in Support.

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# MLTC UPDATE: Guildnet Closing Letters Sent to 7500+ Members - Learn Tips at NYLAG CLE on Nov. 14th, Nursing Home Changes in MLTC

**29 Oct, 2018**

## This is a running news article with updates on Managed Long Term Care in NYS.

**Please see archives for past articles:**

- MLTC updates 2014 - 2016
- MLTC Updates - 2012 - 2013
- Guildnet closing

## KEY CONTACTS

- **State Dept. of Health Complaint Number for MLTC Problems - 1-866-712-7197 or**
  - **e-mail mltctac@health.ny.gov**
- **Request Conflict-Free MLTC Assessment - needed to enroll in an MLTC plan**
  - call NY Medicaid Choice at 1-855-222-8350
  - complaints re Conflict-Free -- CF.Evaluation.Center@health.ny.gov
- **FIDA - call NY MEDICAID CHOICE** at 1-855-600-3432 **(1-855-600-FIDA) Fax 1-917-228-8601**
- For MLTC enrollment complaints - call NY Medicaid Choice -
  - 1-855-886-0570 (Advocates line) 1-888-401-6582 (Consumers line)
  - also e-mail **mltctac@health.ny.gov**
- ICAN - OMBUDSPROGRAM FOR FIDA & MLTC Phone: 844-614-8800
  - TTY Relay Service: 711 Website: icannys.org ican@cssny.org
- **State Webpage on MLTC Policy -- MRT 90: Mandatory Enrollment Managed Long Term Care**

## October - Nov 2018 Update -

**1. Upcoming Training & CLE Program on Managed Long Term Care - Nov. 14, 2018** at the New York Academy of Medicine. Click here for registration information. Conducted by NYLAG Evelyn Frank Legal Resources Program. CEU and CLE credits available Come to learn about the many changes described in this October 2018 update,

**2. Guildnet MLTC and 4 FIDA Plans Closing - As reported in the September update, Guildnet is closing and 4 FIDA Plans are closing Jan. 1, 2019**

- **GUILDNET MLTC - This notice was sent by New York Medicaid Choice to all Guildnet MLTC members** on Oct. 19, 2018, stating that if they don't select a new plan by 12/19/2018 they will be auto-assigned to a new plan for January 1st. The notice states, "The Plan you select will continue to honor your current plan of care for 120 days from the date that you transfer to the new plan." These "transition rights" were authorized by the NYS DOH MLTC Policy 17.02 which requires continuity of care in the new plan after a plan closing. **For Guildnet FIDA, See item #3 below.**
- **A few notes about the Guildnet closing and some tips:**
  - The notice doesn't include contact information for ICAN, the statewide Ombudsprogram to advocate for MLTC members. That is TEL 844-614-8800 TTY Relay Service: 711 Website: icannys.org ican@cssny.org
  - **Warning: Ten percent of Guildnet MLTC members already transferred to other plans from Sept. to Oct. 2018. See enrollment chart. If** the new plan has reduced services, we suggest you r**equest a PLAN APPEAL with AID CONTINUING**, and contact **ICAN** for help, and file a complaint with the NYS Dept. of Health. 1-866-712-7197 or e-mail mltctac@health.ny.gov. While it is not clear in DOH Policy 17.02 that those who transferred before the 10/19/18 letter was sent by NY Medicaid Choice are entitled to the 120-day continuity of care, we believe that they are.
- **Priority of Keeping Member's Long-time Home Care Workers.** One key factor in selecting a new plan is to pick one that contracts with the same Licensed Home Care Services Agency (LHCSA) or CDPAP Fiscal Intermediary through which the member has her home care aides. Please note that another change that went into effect October 1, 2018 is that MLTC plans were required to reduce the number of their contracts with LHCSAs, which means that many MLTC members may be losing a long-time aide. It is therefore critical to find a plan that will enable the client to maintain a longtime trusted aide. This change is described here, with links to relevant documents, including the DOH guidance posted in August 2018.
- **Another factor in selecting a plan is that the plan will continue the same hours that Guildnet has authorized after the end of the 120-day transition period, during which the new plan must continue the old hours.** While this would be desirable to confirm to prevent the need for appeals down the road, it may not be possible to obtain a plan's commitment to continue this amount of hours. Therefore, we suggest that once you identify a plan that contracts with the same home care provider agency, that the member contact NY Medicaid Choice and request to be enrolled in that plan. Under Policy 17.02, they do not have to be assessed by the new plan.. It says,

"... NYMC will subsequently process the enrollment transaction to the receiving plan.....The new plan must accept the transfer enrollment of all enrollees that select the plan. These transferring enrollees are presumed to meet the eligibility requirements for MLTC and are not required to be assessed prior to enrollment."

They might do this between November 20th and December 19th, so that the new plan enrollment will begin January 1, 2019. After that, the plan must continue the same plan of care for 120 days.

- **MLTC members - What happens after 120 days? [FIDA - 90 days, see more below]** The new plan must conduct an assessment within 30 days, but may not reduce hours until after the 120 days. While Policy 17.02 does not say, another policy clearly limits plans from reducing hours, unless there is a specific change in the enrollee's condition or circumstances since the original plan of care was authorized, and that fewer hours are needed because of that change. Please review MLTC Policy 16.06: *Guidance on Notices Proposing to Reduce or Discontinue Personal Care Services or Consumer Directed Personal Assistance Services.* This guidance provides explicit limitations on when plans may reduce hours, and applies to the new plan to which a member transfers when an old plan closes. If plan claims a justification for reduction, it must send Notice of Reduction at least days before the proposed effective date of the reduction, with the right to request a plan appeal (internal appeal), with Aid Continuing if the appeal is requested before the effective date. See more about the new plan appeal or exhaustion requirements here.

    - **Get Case Record from Guildnet.** Especially for consumers receiving 10+ hours/day or 24/7 care, they should request from Guildnet now, before they are transitioned, copies of their case record, including at least the last biannual Uniform Assessment System (UAS) assessments, and the last two authorizations or notices authorizing their current plan of care. If they've received the current plan of care for a longer period of time, they might request these documents going back to the first time that Guildnet authorized their current plan of care. These records may be useful if a new plan tries to reduce hours.

    - **How to request records:** The MLTC Enrollee Rights that is contained in every MLTC plan model contract states in part**, "You have the Right to get a copy of your medical records and ask that the records be amended or corrected."** See model contract Appendix L (p. 153 of PDF) This right is also in the NYS DOH Managed Long Term Care Consumer guide, available here (see p. 17), and in all plan member handbooks. We are finding out the best way to request records. Until further information is available, we suggest emailing it to gnprovrel@jgb.org or mailing it to GuildNet Member Services 250 West 57th Street 10th floor New York, NY 10107 or call Member Services at New York City: 212-769-7855 Brooklyn: 718-495-2200 Toll Free: 800-932-4703

    - If you want your records to be released to a representative or anyone other than you, include a HIPPA release - OCA Form No. 960 - Authorization for Release of Health Information Pursuant to HIPAA

- If a Guildnet member arranges to be assessed by a new plan, whether referred by NY Medicaid Choice or by the member reached out to a new plan, and the new plan says they would give fewer hours than Guildnet had authorized, the individual **should not sign anything that might be interpreted as agreeing to this reduced plan of care**. If they do sign an enrollment agreement, or even sign a reduced plan of care, we believe advocacy can be done to protect the member's rights to continuity of care under Policy 17.02. However, this will likely require advocacy once they transfer.

  Under Policy 17.02 quoted above, a Guildnet member who calls NY Medicaid Choice may ask NYMC to directly enroll them in a particular plan of their choice, without signing any enrollment agreement. If they call NYMC and NYMC refers them to contact a plan to be assessed, they can cite Poilcy 17.02 and say that they prefer to be directly enrolled into the selected plan.

- **LOCK IN - If member is unhappy with their new plan, may they change plans?** Think twice before changing plans again for two reasons.

    - **NEW LOCK IN RULES** - If hey change to the new plan on December 1st or later, new "lock-in" rules go into effect. These will allow MLTC members to change plans only in the first 90 days after enrollment. After, that they are locked in for the next nine months and may only change plans for good cause. This change has not yet been approved by CMS as of Oct. 29, 2018 so it may not go into effect on December 1st as the State has proposed. Here is the proposed notice DOH will send to all MLTC members explaining the new lock-in rule.

    - **Second, if the member changes plans again, State policy has been that changing plans a second time after a plan closing is a "voluntary" change, so the 2nd plan is not required to give the 120-day continuity rights**. The State's view is that the enrollee has agreed to the plan's plan of care and number of hours of service, so has agreed to any reduction of hours that entails. Advocates may disagree with this policy, which may be subject to challenge, but as of now this is the State's policy.

3. **FIDA CLOSINGS - Four FIDA plans are also closing in January 2019:**
    1. Guildnet GoldPlus FIDA plan - NYC only (418 members)
    2. Village Care Max Full Advantage NYC only ( 23 members)
    3. MetroPlus FIDA NYC only (205 members)
    4. AgeWell NY FIDA plan - NYC, Suffolk, Nassau, & Westchester (247 members) -- NOTE that Agewell was the SOLE FIDA plan in Suffolk county.

- **GUILDNET FIDA** - **These notices were sent by Guildnet and by New York Medicaid Choice to all Guildnet Gold Plus FIDA plan members in early October 2018, stating that if they don't select a new plan by 12/31/18, they will be auto-assigned to Healthfirst AbsoluteCare FIDA plan for January 1st**. As the notices state, consumers who are assigned to Healthfirst FIDA have transition rights to continue receiving services, including homcare, at their current levels for 90 days.

  Warning that as of now, MLTC Policy 17.02 does not specifically apply to FIDA. However, if participants in terminating FIDA plans choose to switch to another FIDA plan, they will be given a 90-day transition period per the 3-way contract (§ 2.6.6.1). It is less clear what transition rights members of a closing FIDA plan have if they switch to an MLTC plan. Stay tuned for more on that. This is especially critical for **Suffolk County residents**, where the plan that is closing - Agewell FIDA - was the ONLY FIDA plan, so they do not have the option of switching to another FIDA plan. They may switch to the sole Medicaid Advantage Plus (MAP) plan in Suffok County (VNS Choice FIDA) or to the sole PACE plan in Suffolk (Centerlight PACE).

  For plan options see the NY Medicaid Choice website:

**Long Term Care Plans in Long Island**

- MLTC Medicaid Plans - Long Island
- Medicaid Advantage Plus - Long Island
- Program of All-Inclusive Care for the Elderly (PACE) - Long Island

**Long Term Care Plans in Hudson Valley**

- MLTC Medicaid Plans - Hudson Valley
- Medicaid Advantage Plus - Hudson Valley
- Program of All-Inclusive Care for the Elderly (PACE) - Hudson Valley

**Long Term Care Plans in New York City**

- MLTC Medicaid Plans - New York City
- Medicaid Advantage Plus - New York City
- Program of All-Inclusive Care for the Elderly - New York City

**Remember Medicare Part D!** Additionally, If a member of a closing FIDA plan decides to switch to an MLTC plan instead of to another FIDA plan or another "fully capitated" plan like PACE or Medicaid Advantage Plus, they must remember to select and enroll in a Medicare Part D prescription drug plan for January 1, 2019. Before, the FIDA plan covered their drugs. Now, they need to enroll in a stand-alone plan. For more info on Medicare Part D see a training manual and other info here and see NYS plans in 2019.

4. **Exclusion of Nursing Home Residents from MLTC plans.** In late September, September 2018, NYS DOH submitted a request to CMS to amend the 1115 waiver to exclude permanent nursing home residents from MLTC enrollment after 3 months. The State's proposal and accompanying documents are posted on the State's MRT webpage here. This is a reversal of the policy in effect since 2015, described in this article.

   - See the State's proposed notice to MLTC members describing the change here.
   - See the State's proposed notice to be sent by NY Medicaid Choice before it disenrolls one of the 23,000 MLTC members who have now reportedly been in nursing homes for 3 or more months.. and members in the future.
   - The deadline to submit comments to CMS was Friday Oct. 26, 2018. Many consumer advocacy organizations submitted comments which are available on the CMS website here. Click on these links for comments by NYLAG, the Legal Aid Society and other organizations here.

     NYLAG's comments on the rule state that the "clock" should not start ticking toward three months until disenrollment if the member intends to return home. Disenrollment will make it much harder to return home. The proposed procedures do state that the period in which Medicare is covering all or part of a rehab stay will not count toward the 3 months of permanent placement. Also, NYLAG and other consumer advocates urged that plans must give notice of a decision to consider them "permanently placed," which the consumer should have the right to appeal. These decisions must be made with involvement of the consumer, not unilaterally by a managed care plan or nursing home.

     The comment period to submit comments to the State on this proposal is open until November 23, 2018. Comments can be submitted via email to mltcinfo@health.ny.gov. In the subject line please indicate *Proposed NH Benefit/Lock In 1115 Amendment Comments*.

## September 2018 Update -

**1. Upcoming Training & CLE Program on Managed Long Term Care - Nov. 14, 2018** at the New York Academy of Medicine. Click here for registration information. Conducted by NYLAG Evelyn Frank Legal Resources Program

**2. The NYS Dept. of Health has confirmed that GUILDNET will CLOSE in JANUARY 2019; UnitedHealthCare is pulling out of 4 upstate counties in February 2019:**

- **Guildnet** is terminating all of its health insurance products in New York State effective 1/1/2019, including the following plans shown with enrollment as of August 2018 (TOTAL - 8,211 members - all in NYC):
  - Guildnet Medicaid Advantage Plus - 478 members
  - Guildnet Gold Plus (FIDA) 417 members
  - Guildnet MLTC - 7,316 members
- **UnitedHealthcare** is no longer offering their partial-capitation MLTC plan in the following counties effective 2/1/2019, shown with enrollment as of AUGUST 2018:

| | |
|---|---|
| ALBANY | 103 |
| BROOME | 266 |
| ERIE | 181 |
| MONROE | 534 |
| ONEIDA | 91 |
| ONONDAGA | 288 |
| Total | 1,463 |

- In both cases, per MLTC Policy 17.02, enrollees will receive advance 60-day written notice of the change, with an opportunity to choose a new plan before the effective date. or if they do not choose a new plan, they will be auto-assigned to a new plan effective Jan. 1, 2019.
  - **Guildnet enrollees will receive notice the week of 10/15/2018**, and must choose a new plan by 12/19/2018 to avoid auto-assignment. Under MLTC Policy 17.02 they can call NY Medicaid Choice which will do a "warm transfer" to their selected plan, without the need for a Conflict Free assessment (CFEEC).
    - **WARNING:** Please note that it is not clear exactly what date NY Medicaid Choice will begin doing "warm transfers," without a CFEEC. Until clarification is received, we advise Guildnet members to remain in Guildnet until they receive the letter in mid-October explaining their options.

- UHC enrollees will receive notice in November regarding the plans closing effective Feb. 1, 2019; details to come
- DOH said that Guldnet MLTC and UHC members will be randomly auto-assigned to a different plan if they do not select one by the deadline. However, DOH indicated that NY Medicaid Choice will conduct outreach with members to try to assign the member to a plan with the same licensed home care agency (LHCSA) in its network to promote continuity of care. FIDA auto-assignments will be fully "intelligent" based on Primary Care Provider and LHCSA.

- **Transition Rights - Continuity of Care --** These transitions are covered by MLTC Policy 17.02, with the following consequences:
  - The new plan must continue to honor the same service plan with the same providers and same amount of home care and other services for 120 days after the effective date, "or until the new plan has conducted an assessment and the enrollee has agreed to the new plan of care."
  - This is true whether the enrollee chooses their own plan before 12/19 or allows themselves to be autoassigned. However, it is not clear whether members have this protection YET. We are waiting for clarification about whether members who already are switching to another plan effective October 1st are protected by these continuity protections. **Until this is confirmed, members should STAY IN THEIR CURRENT PLAN and wait for official notice before they switch plans**.
  - Those who call NYMC before 12/19 to choose their plan will be able to do a "blind enrollment" (no pre-enrollment conflict-free assessment) Again, it is not clear whether members can do this now, or must wait til after Oct. notices go out to Guildnet members. Until this is clarified, we suggest that they remain in their current plan.
- These transitions are subject to the new MLTC Lock-In policy that is effective for changes in plans 12/1/18 or later… New guidance was just issued on this. See Licensed Home Care Services Agencies (LHSCA) Contract Limitation Guidance – 08.17.2018
  - Guildnet enrollees will have 90 days from the effective date of their enrollment into a new plan, if on 12/1/18 or later, to switch plans (e.g., if they don't like the plan they were autoassigned to)
  - After the 90 days, they will be locked into their plan for 9 months unless they can establish good cause

**3. POLICY ISSUED IMPLEMENTING restriction on the number of Licensed Home Care Services Agencies that an MLTC plan may contract with, beginning Oct. 2018.**

- The budget change is described here, with links to relevant documents.
- The DOH guidance posted in August 2018 sets forth an *Exception process:*

  "An MLTC plan may request an exception targeted to specific patient needs. These include, as set forth below, continuity of service with a particular LHCSA or aide, to avoid disruption of service where geographic hardship exists or the region is otherwise hard to serve, or for the purpose of ensuring cultural or linguistic competencies." In part, if a plan stops contracting with one LHCSA to comply with the new limits, and an "enrollee wishes to be cared for by one or more home care workers employed by the current LHCSA, the MLTC plan may continue contracting with the current LHCSA for the purpose of continuing that enrollee´s care by those home care workers for **up to three months**." MLTC plans must notify DOH at LHCSAExceptions@health.ny.gov of the three–month extension of the LHCSA agreement. The guidance does not explain how an enrollee may request this extension.

- "An MLTC plan may request an exception to the maximum number of allowable contracts by demonstrating, to DOH´s satisfaction, that additional contracts are needed to ensure adequate access to services in a geographic area. Adequate access to services includes special needs services and services that are culturally or linguistically appropriate." Again, the guidance does not explain how an enrollee may request that the MLTC plan request an exception.

## August 2018 Update

- On Aug. 21, 2018, the CEO of Guildnet sent a letter to all Guildnet employees stating that its Board of Directors had decided the previous day to close Guildnet effective 12/1/18. The letter (posted here) states that the plan will be working closely with the State Dept. of Health on the transition of its members to other MLTC plans. On August 28, 2018, Crain's NY Business reported that the NYS Dept. of Health (DOH) confirmed that "GuildNet had filed a request with the state to stop offering its MLTC plan. It said the nonprofit has stopped enrolling new members. 'The department is working with GuildNet to ensure continuity of care as it finalizes particulars of this plan,' a spokeswoman said." See this article which explains member "transition rights" when an MLTC plan closes. It is very important that members do not panic and switch to other plans until there is official notice from the State. People who switch plans now will not be protected with "transition rights" under **MLTC Policy 17.02** that is described here. Read about consumer advocates' concerns about the State's transition policy here. As of August 2018, Guildnet has 7,316 MLTC Members in its MLTC plan, 478 in its Medicaid Advantage Plus plan, and 417 in its FIDA plan - all in NYC. Crain's implies that all three plans are closing but this has not been confirmed. Guildnet's enrollment has markedly decreased in the last year or two, from being the second largest MLTC plan in NYC to the 10th largest plan currently. See this chart. Read more about the Transition Policy when plans close here.

## July 2018 Update

- **NEWS OUTLETS REPORT POTENTIAL CLOSING OF INDEPENDENCE CARE SYSTEMS (ICS) MLTC PLAN later in 2018.** See this article, with advice given by ICS in a memo to its Member Council, "It is in each ICS member's best interest to stay at ICS until notification comes from DOH because the extended continuity of care will only be offered to people at ICS at the time of notification." The "continuity of care" refers to the right of members of plans that close to receive their same plan of care for 120 days after they transfer to a new plan, under NYS DOH "**MLTC Policy 17.02:** MLTC Plan Transition Process – MLTC Market Alteration."

- **NYS LEGISLATURE ENACTS CHANGES IN MLTC IN STATE BUDGET**. The NYS Dept. of Health is now preparing to implement various changes in the MLTC program that were enacted in the NYS Budget in April 2018.
  - Beginning December 2018, MLTC members will no longer be able to switch plans after a 3-month grace period after their enrollment. See this article for more about this change.
  - MLTC members who are permanently placed in a nursing home for more than 3 months will be disenrolled from the MLTC plans. .
  - Read about these and other MLTC changes in this article.

- **The new requirement to request an internal Plan Appeal** of an Initial Adverse Determination of a managed care or MLTC plan, before one may request a Fair Hearing, began May 1, 2018. See more about these changes here. Find a link to watch a recorded webinar about these changes here.

### March 27, 2018 update

- The NYS Dept. of Health now has web pages for both MLTC and Mainstream Managed Care plans about the new "exhaustion" requirement -- members must now first appeal decisions of the plans in an internal "plan appeal" before requesting a fair hearing. For links to these pages, and to learn about **webinars** sponsored by the NYS Dept. of Health and by NYLAG Evelyn Frank Legal Resources Program about the changes, click here.
- The **final NYS budget** is anxiously anticipated, with the legislature hoping to have it completed before March 30th, ahead of the weekend and Passover and Easter travel. To read about some of the proposals that affect Managed Long Term Care and Medicaid recipients generally, see this article.

## February 28, 2018 update

- On Feb. 27, 2018, the starting date for the new requirements that MLTC member request Internal Appeals with their MLTC plans before requesting a Fair Hearing has been pushed back to May 1, 2018, from April 1, 2018. See this news article for information on the changes, and also this article that explains the new rules in more detail.

### December 2017 Update

- See FIDA News Update re 5 FIDA Plans Closing in NYC and Nassau Counties in 2018, and Transition rights of the 534 members of those plans as of December 2017.
- **Heads Up about new rules for MLTC members who are appealing an adverse determination by their MLTC plan**. The changes take effect March 1, 2018. Members must first request an "internal appeal" within their MLTC plan, and wait for the plan's decision, before they may request a Fair Hearing. See this article about these changes.

## October 26, 2017 Update on Home Care Worker Pay issues

An update to the news below about the recent NYS Appellate Division decisions that allow lawsuits to go forward by home care aides challenging a 2010 NYS Dept. of Labor policy that allows live-in aides to be paid only 13 hours/day. The courts found that the 2010 policy is contrary to the state labor regulations that require that the minimum wage be paid for every hour worked, unless the worker actually resides in the consumer's home.

On Oct. 25, 2017, the NYS Dept. of Labor published an "emergency regulation" (p. 5 of link) that amends the NYS minimum wage regulations in a way that appears to attempt to undermine the recent appellate court decisions. Those decisions found that the 2010 NYS Dept. of Labor policy RO-09-0169 Live-In Companions that allowed live-in aides to be paid 13 hours for a 24-hour day, if they do not actually live with the consumer, conflicted with the actual state minimum wage regulations. Now the State amended the minimum wage regulations to state that live-in aides need not be paid for the 3 1-hour meal periods and 8 hours of sleep time (totaling 11 hours/day) that are excluded from hours worked under the federal minimum wage regulations as amended by the Obama administration. The amendments appear to be intended to adopt the 2010 policy guidance RO-09-0169 Live-In Companions and allow payment of 13 hours/day.. If the Court of Appeals accepts review of the Appellate Division cases, the impact of the regulatory amendments will no doubt be disputed. In the meantime, it is not clear what is the impact of the amendment to the regulations. See consumer advocacy tips below if consumer's 24-hour shift is not staffed adequately by an MLTC plan or managed care plan.

## August - October 2017 Update

**MLTC Plan Closings Update**

- **The NYS Department of Health has finally issued a Transition policy** that gives some protection to members of plans that close. "**MLTC Policy 17.02: MLTC Plan Transition Process – MLTC Market Alteration." issued 9/22/17**, has 2 key protections:

  1. Members of a closing plan will receive a notice from New York Medicaid Choice, the States enrollment broker for managed care, that if they do not select a new plan within sixty (60) days, they will be auto–assigned to a new MLTC plan.

  2. The new plan must continue the same services provided by the closing plan for the longer of 120 days or until the member "agrees" to a new service plan. See more about this policy and Advocacy concerns in this article.

     The new **MLTC Policy 17.02** procedures will be used for Guildnet and North Shore LIJ Closings described below.

- **Guildnet -** About **3,000** former members of Guildnet MLTC plan in Long Island and Westchester who transitioned to another plan after they heard Guildnet was closing, have received this Sept. 29, 2017 letter from the State telling them they m**ay request that their hours be restored to the amount Guildnet authorized,** if the new plan reduced their hours. To request that hours be restore, they must call New York Medicaid Choice **before Dec. 29, 2017 at 1-888-401-MLTC or 1-888-401-6582.** If they are still eligible for Medicaid, the new plan should increase their hours to the amount Guildnet authorized. **If you have called NY Medicaid Choice and cannot get your former hours restored to the amount Guildnet gave,** you can call NYLAG Special Litigation Unit at 212-613-5032 or call ICAN Ombudsprogram at 1-844-614-8800

  - **The remaining 930 Guildnet members in Nassau, Suffolk & Westchester** counties will received in mid-October that they have 60 days to select a new plan, or they will be auto-assigned to another plan The new plan must continue the same services that Guildnet provided for 120 days or until the member agrees to a change.

  - See more about the Transition Policy, status of plan closings, and SUGGESTED CONSUMER STRATEGIES to protect consumers from reductions in hours in this transition in this article.

- **North Shore LIJ MLTC -** New York Newsday publicized the closing on September 1, 2017, *Northwell to end long-term care plan that covers 6,000 elderly*, On September 22, 2017, North Shore sent this letter to all of its 5,645 members in Nassau, Suffolk, and New York City. The letter informs members that the plan is closing 12/31/17. and that unless they enroll in a different plan before **11/10/17,** they will be auto-assigned to Centers Plan for Health Living effective January 1, 2018. While the letter does not specifically say it, North Shore LIJ members should have the protections regarding keeping their same services, described above in new DOH MLTC Policy 17.02. See this article for more about the policy, advocate

concerns about the policy, and consumer strategies to ensure that services are not reduced in the transition. If hours were or are cut when they transfer to a different plan, call NYLAG Special Litigation Unit at 212-613-5032 or call ICAN Ombudsprogram at 1-844-614-8800

- See more about plan closings here, including which FIDA plans will be closing in January 2018

**Two New FIDA Plans Launched in Westchester, while 5 FIDA Plans Slated to Close in 2018**

When FIDA first expanded outside of New York City and Nassau counties to Westchester and Suffolk, only one plan -- Agewell FIDA -- was offered in those counties. **Two new FIDA plans are available in Westchester County** (since 7/1/17) -- **Healthfirst and Riverspring**. Agewell remains the only plan available in Suffolk. See complete list of FIDA plans , but note that the list will change in **2018 when these 5 FIDA plans close:** Aetna, Guildnet (in Nassau County only), Fidelis, ICS, and North Shore -LIJ,

- Lists of all MLTC, Medicaid Advantage Plus, PACE and FIDA plans by region is available on NY Medicaid Choice website. (Scroll down to Health Plan Lists)(Note that FIDA list will change in 2018).

**Home Care Aide Wages** - Court Decisions, Wage Parity and Minimum Wage increases -

- Home care workers, including CDPAP personal assistants, are entitled to increases in wages in 2017, with further increases in 2018. See
  - Minimum wage rate schedule and
  - Wage Parity which became applicable for CDPAP under 2017 amendments to Public Health Law of § 3614–c - see rates for CDPAP in NYC. and in Westchester, Nassau and Suffolk
- **Appellate Division decisions strike down state rule that allows 24-hour live-in aides to be paid only 13 hours/day.** Decisions state that 24-hour case home care workers must be paid for all 24 hours if they are "nonresidential," meaning they do not exclusively reside in the consumer's home. The decisions were based, in part, on rejecting a 2010 state Dept. of Labor policy guideline RO-09-0169 Live-In Companions as in conflict with state minimum wage regulations. *Tokhtaman v. Human Care*, LLC (1st Dept. 2017 NY Slip Op 02759); Andreyeva v. NY Home Att. Agency; Moreno v Future Care Health Serv. (2nd Dept.)

  The million (or billion?) dollar question is how State will fund the additional pay for live-in workers in MLTC, mainstream managed care, CHHA, and in fee-for-service home care authorized by local Medicaid districts as "immediate need" services or for people excluded or exempt from MLTC or managed care. Consumers are seeing ripple effects of the ruling in home care agencies refusing to accept new "live in" cases. While rulings may be appealed, the decisions are not "stayed" and are arguably the binding interpretation of the law in NYC and the entire metro area covering about 12 other counties.
  Meanwhile, it remains difficult for consumers to obtain authorizations from MLTC plans for split shift or 2-12 hour shifts/day, despite helpful clarification of the standard for split shift "continuous" care in state regulations, and despite helpful MLTC Policy 16.07. See more on standards for assessing and authorizing personal care here.
  **October 26, 2017 Update** - See above for news about change in state labor regulations published Oct. 25, 2017.
  **ADVOCACY TIPS -- Members of MLTC or other managed care plans can** file a grievance with your MLTC or managed plan and file a complaint with the NYS Dept. of Health if you are authorized for 24-hour live in care but the MLTC or managed care plan cannot find an agency to staff the case.

  - MLTC complaints can be filed at 1-866-712-7197 or email **mltctac@health.ny.gov**.
  - Mainstream managed care complaints can be filed at 1–800–206–8125 or managedcarecomplaint@health.ny.gov

  **MORE TIPS:** Also, consider whether your needs may meet the standards for 2x12 split shift care, and request the plan to increase your services. Call **ICAN** for help or guidance.

**Heads Up re Assisted Living Program (ALP) and MLTC** - The Assisted Living Program is expected to be "carved into" MLTC and Mainstream MMC, effective 1**0/1/18** for NYC, Long Island and Westchester, and effective **1/1/19** for the rest of the state. This means plans will now authorize and pay for ALP services, as they do nursing homes. Exact procedures are unknown, but we presume that current ALP residents will be "grandfathered in" as nursing home residents were grandfathered in when the nursing home benefit was carved into MLTC. See this article and MRT 1458.

**U.S. Office of Inspector General releases report, "New York State Improperly Claimed Medicaid Reimbursement for Some Managed Long-Term Care Payments"** *(A-02-15-01026)* -

*From executive summary:*

New York improperly claimed reimbursement for 36 of 100 payments made to Medicaid Managed Long-Term Care (MLTC) plans. Specifically, New York did not ensure that MLTC plans documented eligibility assessments of program applicants and reassessments of those already in the program, and conducted these assessments in a timely manner. New York also did not ensure that the plans provided services to beneficiaries according to a written care plan. Further, New York did not ensure that the plans enrolled and retained only those beneficiaries who required community-based services, and disenrolled beneficiaries who requested disenrollment in a timely manner.

In addition, CMS physicians found that for 71 beneficiaries associated with the payments we reviewed, the beneficiaries' MLTC plans did not comply with New York's contract requirements for service planning and care management.

## May 2017 UPDATE

- **HomeFirst, an MLTC plan run by ElderPlan**, announced it is also pulling out of **Suffolk County**. As reported in Crain's Health Pulse, this is "... the latest example of an insurer narrowing its geographic coverage for chronically ill and disabled members, the health plan confirmed on Friday. The decision 'was driven by the difficulties we encountered effectively staffing and serving the needs of members across such an expansive geographic area,' said a spokeswoman for the nonprofit MJHS, which runs Elderplan. The insurer will continue to cover members' services until they pick a new plan, she said.

  Crain's further reported, "The move follows the exit of another nonprofit managed long-term care plan, GuildNet, from Suffolk as well as Nassau and Westchester counties as of June 1. The two plans had covered 41% of the 5,735 managed long-term care enrollees in Suffolk County as of March. The state Department of Health is "closely tracking" the transition of members in Suffolk County following the exits of GuildNet and Elderplan, a spokeswoman told Crain's. There are still 10 plans offering coverage in the county, including Fidelis Care and North Shore-LIJ Health Plan. Earlier this month in response to GuildNet's exit, the department had said there was "ample capacity and choice" in the managed long-term care program."

- **Guildnet Withdrawal from Nassau, Suffolk and Westchester -** On May 13, 2017, NYS Dept. of Health sent over 4000 letters to members of Guildnet MLTC plan in 3 counties - Nassau, Suffolk and Westchester, clarifying information sent by Guildnet in April. (See April 2017 update below). The State Health Dept. clarified that members are not required to find a new plan by June 1st, and may remain in Guildnet after that date, and that Guildnet is required to continue providing them with MLTC services. The letter does confirm that this MLTC plan has requested to stop providing services in these 3 counties. However, the letter states Guildnet must continue providing services "until a smooth transfer can be completed to your new plan." Still not specified is what happens if the individual cannot find a plan willing to provide the same hours as Guildnet authorized. Advocates maintain that members have the right to continue the same amount of services. See letter posted here

  The letter gives contact information for ICAN - OMBUDSPROGRAM FOR FIDA & MLTC Phone: 844-614-8800 TTY Relay Service: 711 Website: icannys.org ican@cssny.org

- **From March to April 2017, 170 Guildnet members left Guildnet in the three counties** from which Guildnet is withdrawing. See this document with MLTC enrollment figures in Nassau, Suffolk and Westchester in April 2017. Data is from DOH website. May 2017 enrollment not posted as of May 23, 2017. No information is available about whether these 170 people enrolled in other MLTC plans and whether those plans are providing the same amount of care that Guildnet authorized.

**April 2017 UPDATE**

- **Guildnet notified members in Nassau, Suffolk and Westchester that its MLTC "...will no longer offer Managed Long Term Care (MLTC) services" in these counties "effective June 1, 2017."** The notice sent in late March further states, "It is important that you select a new MLTC plan before May 18, 2017 to assure a smooth transfer to your new plan." Download a copy of the notice sent to Guildnet's over 4000 members in these 3 counties. Here's more info about this change:

  - The letter further states, "You will continue to receive services from GuildNet until your transfer to your new plan is complete." Advocates are informed that **members WILL CONTINUE to receive Guildnet MLTC services even after June 1, 2017 if they do not select a new plan.**
  - Members will **not** be "auto-assigned" to a new MLTC plan if they do not enroll in one on their own.
  - Despite the letter's wording, advocates are informed that **if other MLTC plans do not authorize the same amount or type of services that the member now receives from Guildnet, they do not have to change plans**. Also, many MLTC plans are backed up and cannot schedule assessment visits until June or later. Members may stay in Guildnet after June 1, 2017. This is true regardless of what members may be told by staff of Guildnet, New York Medicaid Choice, or other organizations.
  - **Also, some members have been notified that Guildnet will no longer contract with the home care agency that employs their home care worker.** Advocates were told by the State Dept. of Health that Guildnet must do "single case" agreements with home care agencies. This means Guildnet will still pay the home care agency to continue to provide services to individual members after June 1st, even if that home care agency's contract with Guildnet ends on June 1st.
  - The Guildnet Gold Plus **FIDA** Plan continues to be offered in Nassau County and Guildnet **Medicaid Advantage Plus** (MAP) Plans continue in Nassau and Suffolk Counties
  - **Transition Policy Requested.** Advocates are asking the State to require the new plans (to which former Guildnet members are transferring) to continue the same services and same number of hours that Guildnet authorized. So far, the State has not agreed to issue this "transition policy." Transition policies require MLTC plans to continue the same services for 90 days that the consumer received before enrolling in MLTC, when the consumers are mandated to transition from fee-for-service personal care or CDPAP to MLTC. See, e.g. MLTC Policy 13.13, MLTC Policy 13.01 (revised)(period was later extended from 60 to 90 days in MLTC Policy 13.10) (All MLTC policy directives available at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm). The same protection should apply in this situation, where a plan is effectively closing down. Advocates contend that the new plan should only be allowed to reduce services below the amount Guildnet had authorized if there is a change in the member's needs or circumstances, after giving proper advance notice of hearing rights. See MLTC Policy 16.06: *Guidance on Notices Proposing to Reduce or Discontinue Personal Care Services or Consumer Directed Personal Assistance Services*
  - The Guildnet letter does not give contact information for **ICAN - the Independent Consumer Advocacy Network** that contracts with the State Dept. of Health to provide information and advocacy for consumers about MLTC, FIDA, and other managed care plans. Members with questions or who have problems keeping the same hours, or facing disruptions in their care should call ICAN. Phone: 844-614-8800 TTY Relay Service: 711 Website: icannys.org e-mail: ican@cssny.org
  - **Who IS AFFECTED – as of March 2017 - as shown in this chart comparing with Nov. 2016 enrollment, based on DOH enrollment data**
    - 35% of all 5,735 MLTC members in SUFFOLK (1,990 members)
    - 27% of 6,438 MLTC members in NASSAU (1,753 members)
    - 10% of 4,685 MLTC members in WESTCHESTER (451 members)
  - **Background** - In November 2016, as reported in the NYLAG MLTC news update article, Guildnet notified the State Dept. of Health that it "will no longer enroll members in Nassau, Suffolk and Westchester counties, according to a letter its chief sent to the state Department of Health. Alan Morse, CEO of GuildNet, told the Cuomo administration the 'calamitous state of reimbursement' made it no longer feasible to operate because the program was incurring 'substantial deficits.'" See story reported in Politico dated Nov. 23, 2016. On January 13, 2017, Crain's Health Pulse reported that Guildnet announced that it would hold off on giving the State the formal 90-day notice required before it exited from any counties. Crain's quoted Alan Morse, the CEO of Guildnet, "We said we would hold off on giving them formal notice until we figured out how well they would address our needs and how we're going to make the program work," with Mr. Morse referencing MLTC reimbursement rates.

**Please see archives for past articles:**

- MLTC updates 2014 - 2016
- MLTC Updates - 2012 - 2013
  - Home care worker wages
  - Inspector General report
  - Assisted living
  - MLTC plan closing update

## II. Medicare Update

The standard monthly premium for Medicare Part B enrollees will be $135.50 for 2019, an increase of $1.50 from $134 in 2018. Most Medicare beneficiaries will pay this amount. An estimated two million Medicare beneficiaries (about 3.5%) will pay less than the full Part B standard monthly premium amount in 2019 due to the statutory "hold harmless" provision, which limits certain beneficiaries' increase in their Part B premium to be no greater than the increase in their Social Security benefits. Due to the SSA 2.8% COLA, some beneficiaries who were held harmless against Part B premium increases in 2018 will pay the full monthly premium of $135.50 in 2019. This is because the increase in their Social Security benefits will be greater than or equal to the increase in their Part B premium.

The "hold harmless" provision does not apply to the following beneficiaries whose Part B premium will increase to $135.50 in 2019:

- beneficiaries who do not receive Social Security benefits;
- those who are directly billed for their Part B premium;
- new Medicare Part B beneficiaries;
- those who have Medicare and Medicaid, and Medicaid pays the premiums; and
- those who pay an Income-Related Monthly Adjustment Amount (IRMAA).

A chart with the 2019 Medicaid levels is attached. MBL will be programmed to use these figures when a "From" date of January 1, 2019, 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, 2019, or later, that utilize a Federal Poverty Level (FPL) must be calculated with the 2018 Social Security benefit amount and Medicare Part B premium amount until the 2019 FPLs are available on MBL. 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. In New York City, the 2019 Social Security benefit amounts and Part B premium should be used until Phase Two of Mass Re-budgeting.

# III. Veterans Benefits Update

VA Pension Final Rules - Summary

1. Veterans Pension - RIN 2900-Ao73- New Worth, Asset Transfers, And Income Exclusions for Needs- Based Benefits

    a. Initial proposed rule appeared in Federal Register on January 23, 2015.
    b. The VA Finally released draft final rule on 9/18/18.
    c. Effective Date – October 18, 2018.
    d. Not retroactive

2. Veterans Pension

    a. 36 Month Lookback period (same as proposed)
    b. Penalty Period up to 5 years
    c. Calculation:
        i. Amount transferred divided by MAPR for married veteran rate at time of application
        ii. $100,000/$2,169 = 46 months
        iii. Final Rule avoids disparate treatment of surviving spouses (with lowest pension rate)
        iv. Final Rule provides guidance on curing and reducing penalty periods.
    d. New Worth – equivalent to Medicaid CSRA ($123,600)
        i. Penalizes those with higher expenses with no adjustment upward in net worth.
        ii. Increases will track SSA COLA increase
        iii. Sum of claimant's assets plus annual income
        iv. Eliminates guesswork re: asset limit
    e. Primary Residence:
        i. Not counted even if claimant lives outside the home (i.e., nursing home or ALF – change from existing policy – although consistently applied)
        ii. If primary residence is sold, net sales proceeds not counted as an asset if used to purchase new home within same calendar year
        iii. Timing of sale is of utmost importance.
    f. Covered Assets:
        i. An asset that was part of claimant's net worth, was transferred for less than FMV, and if not transferred, would have cause or partially caused the claimant's net worth to exceed the net worth limit
    g. Spenddown:
        i. A claimant may decrease assets without penalty by spending them on an item or service for which FMV is received.

h. Trusts and Annuities:
    i. Specifically identified in the new rule as instruments the VA considers transfers for less than FMV.
    ii. However, above will not apply if claimant retains ability to liquidate entire balance of trust or annuity.
    iii. Single premium immediate annuities are now ineffective
    iv. Veterans Asset Protection Trusts are viable planning tools
i. Medical Expenses:
    i. How VA calculates Income for VA purposes remains the same
    ii. However, medical expenses only include items that are:
        1. Medically necessary
        2. Improve disabled person's functioning, or
        3. Prevent, slow or ease an individual's functional decline
    iii. Medical Expense Examples:
        1. Payments to a health care provider
        2. Prescription and non-prescription medication
        3. Payments for adaptive services (including certain payments for service animals)
j. Medicaid nursing homes VA Benefit:
    i. Beneficiary not liable for any pension payments in excess of $90 by reason of the VA failure to reduce payments, unless the beneficiary willfully conceals the overpayment from the VA.

ElderCounsel White Paper on VA Changes
*(Provided Courtesy of ElderCounsel)*

On January 23, 2015, the Department of Veterans Affairs (VA) published a comprehensive set of rules that would amend 38 CFR Part 3. Part 3 covers net worth, asset transfers and income exclusions for needs-based benefits. The stated purpose of the proposed change was to "maintain the integrity of the pension program and to implement recent statutory changes" and to "respond to recent recommendations made by the Government Accountability Office (GAO), to maintain the integrity of VA's needs-based benefit programs, and to clarify and address issues necessary for the consistent adjudication of pension and parents' dependency and indemnity compensation claims."[1]

[1] Federal Register RIN2900-A073, Summary.

On September 18, 2018, the VA published its final rules. While retaining the lookback and penalty period, the final rules addressed some inconsistencies and some unfair provisions contained in the original proposed rules.

The final rules

The stated purpose of the final rules remained the same: "maintain the integrity of the pension program and to implement recent statutory changes" and to "respond to recent recommendations made by the Government Accountability Office (GAO), to maintain the integrity of VA's needs-based benefit programs, and to clarify and address issues necessary for the consistent adjudication of pension and parents' dependency and indemnity compensation claims."

The changes are quite comprehensive and touch on a number of areas including net worth, asset transfers, medical expenses and income deductions. This paper will focus on those areas affecting eligibility for pension programs.

Net worth

Proposed rule 38 CFR §3.274(a) and (b) would impose a limit on net worth equal to the maximum community spouse resource allowance for Medicaid purposes on the effective date of the final rule.[2] In 2018 this number is $123,600. This amount would increase by the same percentage as the cost-of-living increase for Social Security benefits. The current net worth limits can be found on the VA website, www.benefits.va.gov/pension/. Net worth is defined as "the sum of a claimant's or beneficiary's assets and annual income."[3]

[2] Federal Register RIN2900-A073, 38 CFR §3.274(a)
[3] 38 CFR §3.274(b)(1)

As noted in the definition of net worth, annual income is added to a claimant's assets to come up with a total net worth number. The example provided in 3.275(b)(4) states, "For purposes of this example, presume the net worth limit is $123,600. The claimant's assets total $117,000 and annual income is $9,000.

Therefore, adding the claimant's annual income to assets produces net worth of $126,000. This amount exceeds the net worth limit."

A Veteran's assets are defined to include the assets of the Veteran as well as the assets of his or her spouse.[4] A surviving spouse's assets only include the assets of the surviving spouse.[5] The VA will not consider a child to be a dependent child of the Veteran or surviving spouse if the child's net worth exceeds the net worth limit.[6]

A child whose net worth exceeds the limit is referred to as a "potential dependent child."[7] A "dependent child" is a one for whom a Veteran or surviving spouse is entitled to an increased maximum annual pension rate.[8] However a dependent child's net worth consists of the child's income and assets, along with the income of the Veteran or surviving spouse.[9]

*When net worth is calculated*

The VA will calculate a claimant's net income as of the date of: the original pension claim; at the date of a new pension claim after a period of non-entitlement; upon a request to establish a new dependent; or after receiving information that a claimant's net worth has changed.[10]

[4] 38 CFR §3.274(c)(1)
[5] 38 CFR §3.274(c)(2)
[6] 38 CFR §3.274(d)
[7] 38 CFR §3.274(d)(1)(ii)
[8] 38 CFR §3.274(d)(1)(i)
[9] 38 CFR §3.274(d)(2)-(4)
[10] 38 CFR §3.274(e)

*Decreasing net worth*

There are three ways net worth may be decreased: the assets decrease; annual income decreases; or both decrease. Assets decrease when a Veteran, surviving spouse, child or someone acting on their behalf spends their assets on "any item or items purchase for which fair market value is received" unless the items purchased are part of their net worth.[11]. If there are allowable exclusions to income, the VA will apply those first to decrease annual income. If there are additional expenses that are appropriate to deduct from income, then those expenses may be used to reduce the assets.

Example from 3.274(f)(1)(3): Net worth limit is $123,600. MAPR is $12,000. Claimant's assets total $115,000, and annual income is $9,000. Total net worth: $124,000. However, the claimant is a patient in a nursing home and pays out of pocket fees of $29,000 per year. Claimant's unreimbursed medical expenses total $29,000, which exceeds the 5% deductible of the MAPR, or $600. The projected expenditures that exceed 5% of the MAPT (here, $28,400) are deducted from annual income, which is now zero. The claimant's net worth is now $115,000 as there is no countable income to add to it.[12]

*Effective dates of pension entitlement following a denial or reduction based on excessive net worth*

[11] 38 CFR §3.274(f)(1) This is a change from the proposed rule which allowed a decrease only for payment of basic living expenses like food, shelter, clothing or health care, or on education or vocational rehabilitation.
[12] 38 CFR §3.274(f)(3)

The effective date of pension entitlement is the day net worth ceases to exceed the limit, provided the claimant submits a certified statement that net worth has decreased, and the VA has received the statement within 1 year after its decision notice (unless an appeal was made). [13]

*Effective date for a denial, reduction or discontinuance due to excessive net worth*

The effective date of entitlement or increased entitlement is the day net worth is no longer excessive.[14] To get this effective date, the claimant has to provide a certified statement that net worth has decreased and the VA must receive it before the claim has been finally adjudicated. Otherwise the effective date is the date a new pension claim is received by the VA.

When an increase in a beneficiary's net worth results in a reduction or discontinuance of benefits, the effective date of the reduction or discontinuance is the last day of the calendar year in which net worth exceeds the limit. [15] If net worth decreases below the limit before the end of the calendar year, pension benefits will not be reduced or discontinued on the basis of excessive net worth. [16]

There are additional rules that pertain to reduction based on a dependent child's excessive net worth that are not discussed in detail here but can be found at 38 CFR §3.274(h)(2)(i)(2).

*Determining the asset amount for pension net worth*

38 CFR §3.275 contains a number of modified or new definitions. Subsection (a) contains a new definition for the term "assets." Assets are defined as "fair market value of all property than an individual owns, including all real and personal property, unless excluded under paragraph (b)

[13] 38 CFR §3.274(g)(2)
[14] 38 CFR §3.274(g)(2)
[15] 38 CFR §3.274(h)(1)
[16] 38 CFR §3.274(h)(2)

of this section, less the amount of mortgages or other encumbrances specific to the mortgaged or encumbered property. VA will consider the terms of the recorded deed or other evidence of title to be proof of ownership of a particular asset."

*New definition for "residential lot area"*

The residential lot area under the proposed rules would not exceed 2 acres unless the additional acreage is not marketable. [17]

*Exclusions from the definition of "assets"*

The primary residence remains excluded from the definition of assets, and if sold, the proceeds will not count if used to purchase another residence within the same calendar year as the sale.[18] If the claimant is not residing in the personal residence it will still be excluded.[19] Personal mortgages on the primary residence will not reduce the value of any assets. [20] If the residential lot area exceeds 2 acres, then the value of the additional land above the 2 acres is included in the asset calculation.

Personal effects "suitable to and consistent with a reasonable mode of life" will be excluded from the total asset value.[21] The rule notes appliances and family transportation vehicles as examples.

Other exclusions include Radian Exposure Compensation Act payments, Ricky Ray Hemophilia Relief Fund payments, Energy Employees Occupational Illness Compensation Program payments, payments to Aleuts and other items listed in 38 CFR §3.279.[22]

[17] 38 CFR §3.275(a)(3)
[18] 38 CFR §3.275(b)(1)
[19] 38 CFR §3.275(b)(ii)
[20] 38 CFR §3.275(b)(1)(i)
[21] 38 CFR §3.275(b)(2).
[22] 38 CFR §3.275(b)(4)-(7)

*Asset Transfers and Penalty Periods*

38 CFR §3.276 discusses the new transfer rules and penalty periods that will be imposed for transfers made prior to applying for VA pension.

*Assets subject to a transfer penalty*

Only those "covered assets" that are transferred will be subject to a penalty period. A "covered asset" is defined as an asset that "was part of the claimant's net worth, was transferred for less than fair market value, and if not transferred, would have caused or partially caused the claimant's net worth to exceed the net worth limit…"[23] Therefore, only the amount transferred in excess of the net worth provisions will be subject to a penalty.

Example in 38 CFR §3.276(a)(3)(i): The net worth limit is $123,600. A claimant has total assets of $115,900 and his annual income is zero. The claimant, prior to applying for benefits, gave $30,000 to a friend. Had the claimant not previously transferred the $30,000, his net worth would have been $145,900 and his assets would have exceeded the net worth limits. The "covered asset" amount is $22,300 (the amount subject to a penalty) as this represents that amount by which the claimant's net worth would have exceeded the limit due to the covered asset.[24]

[23] 38 CFR §3.276(a)(2)
[24] 38 CFR §3.276(a)(3)(i)

Fair market value is defined as the price a willing buyer would pay and a willing seller would sell for. The VA will use "best available information" to determine fair market value, including appraisals, public records, inspections and market value of similar property if applicable.[25]

A transfer for less than fair market value includes the sale, gift or exchange of an asset for less than fair market value, or the transfer or purchase of any financial instrument that reduces net worth and "would not be in the claimant's financial interest but for the claimant's attempt to qualify for VA pension," including the purchase of an annuity.[26]

An annuity is defined as "a financial instrument that provides income over a defined period of time for an initial payment of principal."[27] A trust is "a legal instrument by which an individual (the grantor) transfers property to an individual or an entity (the trustee), who manages the property according to the terms of the trust, whether for the grantor's own benefit or for the benefit of another individual."[28] For purposes of calculating a penalty period, "uncompensated value" means the difference between the fair market value of an asset and the amount received. With regard to transfers to a trust, annuity or other financial instrument or investment, "uncompensated value" means the amount transferred.[29] **This means any asset that is converted into an annuity will incur a transfer penalty.**

*Lookback period*

[25] 38 CFR §3.276(a)(4)
[26] 38 CFR §3.276 (a)(5)
[27] 38 CFR §3.276 (a)(5)(ii)(A) Specific reference to a trust was included here in the original rules. In the final rules it was removed and the definition of trust was kept as a separate definition.
[28] 38 CFR §3.276 (a)(5)(ii)(B)
[29] 38 CFR §3.276 (a)(6) This definition was expanded in the final rule to address trusts, annuities and other financial instruments.

The lookback period for all transfers is 36 months immediately preceding the date the VA receives an original pension claim or a new pension claim after a period of non-entitlement.[30] **This definition does not include any transfers prior to October 18, 2018.**

*General statement of policy*

38 CFR §3.276(a)(8)(b) provides a statement on the VA's policy about transferring covered assets. "VA pension is a needs-based benefit and is not intended to preserve the estates of individuals who have the means to support themselves. Accordingly, a claimant may not create pension entitlement by transferring covered assets. VA will review the terms and conditions of asset transfers made during the 36-month lookback period to determine whether the transfer constituted a transfer of a covered asset. However, VA will disregard asset transfers made before October 18, 2018. In accordance with 3.277(a), for any asset transfer, VA may require a claimant to provide evidence such as a Federal income tax return transcript, the terms of a gift, trust, or annuity, or the terms of a recorded deed or other evidence of title."

*Exceptions to transfer penalty*

The result of fraud or unfair business practice. If a claimant transferred an asset as the result of fraud, misrepresentation, or unfair business practice "related to the sale or marketing of financial products or services for purposes of establish entitlement to VA pension", it will not be considered

[30] 38 CFR §3.276 (a)(7)

a covered asset and will not be penalized. Evidence must be provided to support the assertion, which could include a complaint filed with the proper authorities.[31]

*Transfers to certain trusts*.

A Veteran, a Veteran's spouse, or the surviving spouse of a Veteran may transfer assets to a trust established on behalf of a child if the VA has rated the child incapable of self-support pursuant to 38 CFR §3.36 AND there is no circumstance where the trust assets can benefit the Veteran, the Veteran's spouse or the Veteran's surviving spouse.[32]

*Calculation of the penalty period*

There is a 5-year limit on any penalty imposed.[33] To calculate the penalty, the maximum annual pension rate for pension with an aid and attendance allowance with one dependent will be used for Veterans and surviving spouses who apply.[34] The monthly rate is figured by dividing the maximum annual amount by 12 and rounding down to the nearest whole dollar.

The penalty begins the first day of the month following the transfer.[35] If more than one transfer was made the penalty begins the first day of month following the last transfer. Entitlement to pension will begin the last day of the last penalty period month, with payment to begin the following month. [36]

*Recalculation based on error or cure.*

[31] 38 CFR §3.276(a)(8)(c)
[32] 38 CFR §3.276(a)(8)(d)
[33] The proposed rules had a 10-year limit.
[34] 38 CFR §3.276(e)(1) The proposed rules would have only allowed for the MAPR for one dependent to be used for married claimants, while surviving spouses would have had to use the MAPR for a surviving spouse with no dependent.
[35] 38 CFR §3.276 (e)(2)
[36] 38 CFR §3.276 (a)(7)(e)(3)

A penalty will only be recalculated if the original calculation was erroneous, or if the transferred assets were returned to the claimant before the date of the claim or within 60 days of the VA notifying the claimant of the penalty period.[37] This evidence must be received not later than 90 days after the notice of decision. Once the assets are returned, the penalty period will be removed. *Id.* The rules allow for a full or partial cure.

Medical Expenses That May Be Deducted From Income

The proposed and final rules undertook defining deductible medical expenses, as there was previously no statutory definitions for the purpose of VA pension. The definitions are found at 38 CFR §3.278(b).

The final rules expanded the definition of Activities of Daily Living (ADLs) to add "ambulating within the home or living area."[38] Instrumental activities of daily living (IADL) includes "independent living activities, such as shopping, food preparation, housekeeping, laundering, managing finances, handling medications, using the telephone, and transportation for non-medical purposes."[39]

Under 38 CFR §3.278(c), medical expenses for VA purposes are those that are "medically necessary; that improve a disabled individual's functioning; or that prevent, slow,

[37] 38 CFR §3.276(e)(5) The proposed rule only allowed a recalculation within 30 days of the claim, and only allowed 60 days for evidence to be received.
[38] 38 CFR §3.278(b)(2)
[39] 38 CFR §3.278(b)(3)

or ease an individual's functional decline."[40] This section continues to specifically identify medical expenses that meet the above definition.

1. Health care provider payments. Services must be performed within the scope of the provider's professional capacity.

2. Medications, medical supplies, medical equipment, medical food, vitamins and supplements. Prescriptions are recognized under this section as valid medical expenses, as are non-prescription medications obtained lawfully. Medically necessary food, vitamins and supplements are also recognized as long as prescribed by a health care provider authorized to write the prescription.

3. Adaptive equipment. Along with adaptive services, payments for service animals are included under this section, including veterinary care. However non-prescription food, boarding, grooming or other routine expenses are not recognized as a medical expense.

4. Transportation expenses. Mileage and public transportation expenses are included as long as the transportation is for medical purposes. Mileage for a privately owned vehicle is based on the reimbursement rate specified by the United States General Services Administration.

5. Health insurance premiums. Payments for long-term care insurance premiums are included, as well as health insurance and Medicare premiums for parts B and D.

[40] The language, "prevent, slow, or ease an individual's functional decline" was not in the proposed rules and was added as a result of public comments.

6. Smoking cessation products.

7. Institutional forms of care and in-home care. Hospital charges, nursing home charges, medical foster home charges and inpatient treatment centers are allowable expenses, including the cost of meals and lodging. Payment for in-home care to assist with ADLs and IADLs will be considered valid medical expenses as long as health care or custodial care is provided.[41]

*More on home care and assisted living*

In-home care for a claimant who has not been rated in need of aid and attendance or housebound must be from a licensed health care provider before it can be deducted from income as a medical expense, unless a physician, physician assistant or other qualified medical professional states in writing that the claimant requires the health care or custodial care provide by the in-home attendant. [42]

Care facilities other than nursing homes.

The final rules provided much more clarification and leniency when it comes to care in a facility other than a nursing home or assisted living facility. 38 CFR §3.278(d)(3) covers care facilities other than nursing homes, and allows a medical expense deduction for care in such a facility that is either provided by the facility, contracted by the facility, obtained by a third-party provider, or provided by family or friends. The provider does not need to

[41] The cap on hourly rates for in-home care was removed in the final rules.

[42] 38 CFR §3.278(d)(2) The final rule is more liberal than the proposed rule which would have limited care by an in-home attendant unless rated housebound or in need of aid and attendance.

be a health care provider if the disabled individual needs aid and attendance or is housebound, or if a qualified medical professional states in writing that "due to a physical, mental, development, or cognitive disorder, the individual needs to be in a protected environment."[43] Meals and lodging will be deductible medical expenses if the facility provides or contracts for health care or custodial care, or a qualified medical professional states in writing that the individual must reside in the facility to separately contract with a third-party provider to receive health or custodial care or to receive health or custodial care from family or friends, whether paid or unpaid.[44]

*Non-medical expenses*

Except as noted previously, payments for the following are not medical expenses for VA purposes: General health maintenance expenditures, cosmetic procedures, meals and lodging (except as previously noted), or assistance with IADLs (except as provided above). [45]

*Additional Statutory Exclusions From Income*

The final rules added a few additional exclusions, and corrected citations to the United States Code (USC). All of the exclusions are listed below, with a notation as to whether the income is also excluded as an asset.

[43] 38 CFR §3.278(d)(3)(iii)(A)-(B)
[44] 38 CFR §3.278(d)(3)(iv)(A)-(B)
[45] 38 CFR §3.278(e)The proposed rules also included VA fiduciary fees, but this was removed from the final rule.

38 CFR §3.279 sets out all statutory exclusions from income or assets.

(a) Compensation or Restitution Payments.

1. Relocation payments. Excluded from income, included as an asset.

2. Crime victim compensation. Excluded from income and as an asset.

3. Restitution to individuals of Japanese ancestry. Excluded from income and as an asset.

4. Victims of Nazi persecution. Excluded from income and as an asset.

5. Agent Orange settlement payments. Excluded from income and as an asset.

6. Chapter 18 benefits. Excluded from income and as an asset.

7. Flood mitigation activities. Excluded from income and as an asset.

(b) Payments to Native Americans.

1. Indian Tribal Judgment Fund distributions. Excluded from income and as an asset.

2. Interests of individual Indians in trust or restricted lands. Excluded from income and as an asset.

3. Per Capita Distributions Act. Excluded from income and as an asset.

4. Submarginal land. Excluded from income and as an asset.

5. Old Age Assistance Claims Settlement Act. Excluded from income and as an asset.

6. Alaska Native Claims Settlement Act. Excluded from income and as an asset.

7. Maine Indian Claims Settlement Act. Excluded from income and as an asset.

8. Cobell Settlement. Excluded from income for one year and as an asset for one year.

(c) Work-Related Payments

1. Workforce investment. Excluded from income and included as an asset.

2. AmeriCorps participants. Excluded from income and included as an asset.

3. Volunteer work. Excluded from income and as an asset.

(d) Miscellaneous Payments.

1. Income tax refunds. Excluded from income and for one year as an asset.

2. Food stamps. Excluded from income and as an asset.

3. Food for children. Excluded from income and as an asset.

4. Child care. Excluded from income and included as an asset.

5. Services for housing recipients. Excluded from income and included as an asset.

6. Home energy assistance. Excluded from income and as an asset.

7. Programs for older Americans. Excluded from income and included as an asset.

8. Student financial aid. Excluded from income and as an asset.

9. Retired Serviceman's Family Protection Plan annuities. Excluded from income and included as an asset.

*Waiver of Receipt of Income*

Potential income that is not otherwise excluded may not be waived, except in one circumstance. If an individual withdraws a claim for Social Security benefits after a finding of entitlement in order to maintain eligibility for unreduced Social Security benefits after reaching a particular age, this will not be treated as a waiver and income will not be counted. [46]

*Amendment to 38 CFR §3.551*

31 CFR §3.551(i) now includes a surviving child (in addition to Veterans without a spouse or child or a surviving spouse) as one whose benefits would be reduced to $90 upon entry into a nursing home and qualifying for Medicaid.

Conclusion

Time is of the essence in notifying clients, potential clients, and referral sources of these changes. The effective date of the new rules is October 18, 2018, which means

[46] 38 CFR §3.271(i)

all planning that includes transfers must be made before that date to avoid the lookback and penalty period rules.

**2019 VA Rates**

Non- Housebound

| | |
|---|---|
| Widow – Max. Benefit | $757.00 |
| Veteran- Max. Benefit | $1,128.00 |
| Married Veteran- Max. Benefit | $1,477.00 |

Housebound

| | |
|---|---|
| Widow – Max. Benefit | $925.00 |
| Veteran- Max. Benefit | $1,378.00 |
| Married Veteran- Max. Benefit | $1,728.00 |

Aide and Attendant

| | |
|---|---|
| Widow – Max. Benefit | $1,209.00 |
| Veteran- Max. Benefit | $1,881.00 |

# IV. Tax Update

1. Individual Tax Rates
   Individual income tax rates: 10, 12, 22, 24, 32, 35 and 37 percent

   10 percent: taxable income not over $9,525, single, $19,050 joint

   12 percent: taxable income not over $38,700 single, $77,400 joint

   22 percent: taxable income not over $82,500 single, $165,000 joint

   24 percent: taxable income not over $157,500 single, $315,000 joint

   32 percent: taxable income not over $200,000 single, $400,000 joint

35 percent: taxable income not over $500,000 single, $600,000 joint

37 percent: taxable income not over $500,000 single, $600,000 joint

Note: new rate structure expires after 2025. Marriage penalty only in start of top bracket

2. Capital Gains

2018: Retain 0, 15 and 20% rates

15% rate at $38,600 for single filers; $77,200 for joint filers

20% rate at $425,800 for single filers; $475,000 for joint filers

Administration proposing indexing for inflation

3. Standard Deduction and Personal Exemptions

a) Doubling standard deduction to $12,000 for singles, $18,000 for head of household, $24,000 for joint filers

-Adjusted for inflation after 2018, expires after 2025. The IRS issued revised withholding tables.

b) Elimination of personal exemptions

1. -Doubling standard deduction may not offset loss of personal exemptions for some taxpayers
2. -Less itemization may mean less incentive for home ownership, charitable giving
3. -Planning: Determine if likely to still benefit from itemizing
4.

4. Itemized Deductions

a) Mortgage Interest

5. -Mortgage interest deduction limit drops to $750,000 for new mortgage debt after December 15, 2017 ($375,000 for married filing separately). No home equity deduction after December 31, 2017.
6. - I.R. 2018-32: clarifies still deductible if used to buy, build or improve home
7. -Expires after 2025
8. -Form 1098 to include amount of outstanding mortgage, address of property, and loan origination date. Possible confusion with 1098 based on calendar year and refinancing after 12/15/17.
9. -Be careful with refinancing – no increase in debt, even for closing costs
10.

b) State and local taxes

11. -Eliminates, except preserves deduction up to $10,000 ($5,000 married filing separately)
12. -Marriage penalty in $10,000 limit; no limit if business or investment property

13. -Prepayment of 2018 property taxes in 2017 (I.R. 2017-210)
14. -State responses and IRS position (I.R. 2018-122).
15. -Charitable contribution: Proposed regulations limit charitable deduction.
16. -Payroll deduction
17.

c) Miscellaneous itemized deductions

18. -No deductions that are subject to 2% floor
19. Employee unreimbursed business expenses
20. Planning for ongoing depreciation of equipment
21. Investment expenses
22. Legal fees
23. Tax preparation fees
24. -Deductions not subject to 2% floor, like gambling expenses, survive
25.

d) Loss limitation on wagering transactions includes related gambling expenses

e) Repeal of overall limit on itemized deductions (Pease)

5. Retirement

-401(k) and IRA contribution and deduction limits remain effective

-No Roth IRA recharacterizations for Roth conversions after 12/31/17

2017 conversions can be recharacterized through 10/15/18

-Plan loans outstanding on termination or separation can be contributed to IRA by due date of tax return for that year

Guidance issued on notice requirements to employees

-Increase in length of service award exclusion for a bonafide public safety volunteer from $3,000 to $6,000 with cost of living adjustment.

6. AMT

a) Individual AMT survives through 2025 with new thresholds

26. -New exemption amounts of $109,400 for joint filers and $70,300 for single filers
27. -New exemption phase-out amounts of $1,000,000 joint filers and $500,000 single filers

b) Repeal of corporate AMT

28. -Special rules for carry forwards

7. Medical Expense Deduction

Deduction for qualified out-of-pocket medical expenses was originally slated to be eliminated entirely The new tax law preserves the deduction for taxpayer who itemize. It applies to expenses that exceed 7.5% of AGI for 2017 and 2018. 10% floor after 2018.

8. Personal and Elderly Exemptions
    a) $4,050 personal exemption eliminated under the new law
    b) Higher standard deduction – the standard deduction has been raised to $12,000 for an individual and $24, 000 for a married couple filing jointly
    c) The blind and elderly deduction ahs remained under the new law- A single filer over age 65 can claim an additional $16,00 deduction ($1,300 if married and only one deduction, $2,600 if both spouses are filing for deduction)

29.

9. Estate Gift and Tax Exemption Amounts
    a) Federal estate and gift tax exemption amount was nearly doubled to $11.8 million for an individual (effectively $22.36 million for a married couple due to portability)
    b) The exemption increase is scheduled to sunset on December 31, 2025
    c) Should individuals and couples still do planning? – gifting opportunities
    d) NYS Exemption increases on January 1, 2019 (cliff still applies, but no three-year add-back)

30.

10. State and Local Income, Sales and Property Tax Deduction

31.

    e) The deduction for all state and local income, sales and property taxes was capped at $10,000. This change in the law may prompt many people to create multiple trusts so that each trust can take advantage of the full deduction amount – but this is highly complex and clients may not have the appetite.

32.

11. 529 Plan Expansion

    A 529 Plan is a tax-advantaged method of saving for future college expenses. Previously, the IRS restricted 529 Plans to colleges and universities that were eligible to participate in federal student aid programs. Under the new tax law, parents can withdraw tax free funds from a 529 account to pay for tuition at private schools for K-12 as well. However, withdrawals are limited to $10,000 per year per student. Funds can be used for public, private or religious schools. New York limits funds to college tuition.

12. 2019 Inflation Adjustments

Each year, certain federal estate, gift and generation skipping transfer (GST) tax figures are subject to inflation adjustments:

a) For 2019, the annual exclusion amount for gifts remains at $15,000.

b) The federal estate, gift and GST tax exemption amount for gifts made in 2019 and decedents dying in 2019 increases to $11,400,000 (from $11,180,000 in 2018).
c) The annual exclusion amount for gifts made to a noncitizen spouse in 2019 increases to $155,000 (from $152,000). There are some changes to exemption amounts in our footprint states as well:
d) The New York state estate tax exemption for decedents dying in 2019 increases to $5,740,000 (from $5,250,000).
e) The contribution limit for 401(k) and similar plans increases in 2019 to $19,000 (from $18,500). The limit for catch-up contributions to such plans for people over age 50 will remain $6,000.
f) The limit on annual contributions to IRAs increases to $6,000 (from $5,500), with the IRA catch-up contribution limit remaining $1,000.

Clients may wish to make large gifts in order to take advantage of the increased federal gift and estate tax exemption ($11.4 million in 2019). The increased exemption, temporary under current law, is to be cut roughly in half for gifts made, and for decedents dying, after 2025. There were concerns the law could lead to a "clawback," charging estate tax to post-2025 estates for gifts that utilized the temporarily increased exemption while it was available. In November, proposed regulations were issued which, if finalized in their current form, will resolve the clawback issue favorably. This is good news, which removes a concern some had raised about making larger gifts now.

# V. Special Needs Update

A. The Tax Cuts and Jobs Act made several changes to ABLE accounts. ABLE accounts were created by The Achieving a Better Life Experience Act of 2014. They are authorized tax-advantaged section 529A accounts to help disabled people pay for qualified disability-related expenses.

Here are changes that will affect people who have an ABLE account:

**1. Annual Contribution limit increase**

a) The limit is $15,000 in 2018.
b) Certain employed ABLE account beneficiaries may make an additional contribution up to the lesser of these amounts:
    - The designated beneficiary's compensation for the tax year
    - The poverty line for a one-person household. For 2018, this amount is $12,140 in the continental U.S., $13,960 in Hawaii and $15,180 in Alaska

**2. Saver's Credit**

a) ABLE account designated beneficiaries may now be eligible to claim the Saver's Credit for a percentage of their contributions.
b) The credit is claimed on Form 8880, Credit for Qualified Retirement Savings Contributions. The Saver's Credit is a non-refundable credit available to individuals who meet these three requirements:
    - Are at least 18 years old at the close of the taxable year

- Are not a dependent or a full-time student
- Meet the income requirements

**3. Rollovers and transfers from section 529 plans**

a) Families may now roll over funds from a 529 plan to another family member's ABLE account.
b) The ABLE account must be for the same beneficiary as the 529 account or for a member of the same family as the 529 account holder. Rollovers from a section 529 plan count toward the annual contribution limit.
    - Here is an example: the $15,000 annual contribution limit would be met by parents contributing $10,000 to their child's ABLE account and rolling over $5,000 from a 529 plan to the same ABLE account.

States can offer ABLE accounts to help people who become disabled before age 26 and their families save and pay for disability-related expenses. These expenses include housing, education, transportation, health, prevention and wellness, employment training and support, assistive technology and personal support services. Though contributions aren't deductible for Federal tax purposes, distributions, including earnings, are tax-free to the beneficiary, as long as they are used to pay qualified disability expenses.

Income payable to the grantors as the trustee determines

Principal held in trust until the death of the grantors

Trustee could reimburse them for income tax liability

# Veteran's Benefits Update

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# NET WORTH AND TRANSFER RULES

## Net Worth

- Net worth limit is equal to the maximum CSRA amount (currently $127,061)
  - Increases per the Social Security benefit increase percentage each year
- Home is still not counted as part of net worth
- “Reasonable lot area” defined as not more than two acres unless the additional acreage is not marketable

## Net Worth

- Includes all income and assets
- Assets: FMV of all property owned by the claimant and any dependents, less mortgages or other encumbrances
  - Exclusions: Home plus two acres, personal effects (rules specifically mention family transportation vehicles)

## Lookback and Penalty Period

- 36 month lookback period
  - Triggered by the receipt of an original claim or a new claim following a period of non-entitlement
- Will not apply to transfers made prior to 10-18-18
- Only ”covered assets” that are transferred will be penalized
  - An asset that was part of the claimant’s net worth and if not transferred would have caused net worth to be over the limit

## Example of Covered Assets (From the Rules)

- Claimant has $115,900 and annual income of $0 at the time of the VA application
- Gave a friend $30,000 prior to applying for VA pension
  - If $30,000 hadn't been transferred before application, net worth would have been $145,900 and would have been excessive.
  - Covered asset amount is $17,939 ($145,900-$127,061) and will incur a penalty

## Lookback and Penalty Period

- Penalty period based on the MAPR for aid and attendance for a married Veteran
- Starts the month after the transfer is made
  - MAPR is divided by 12 to come up with the monthly amount
  - MAPR with one dependent used for a married veteran ($2,169)
- Penalty period is rounded down

## Example of Net Worth and Penalty Period

- Veteran owns one bank account with $200,000.
- Annual income is $24,000
- UMEs total $34,000 (Therefore zero out income, difference not credited toward reducing assets.)
- Total net worth: $200,000
  - Veteran transferred $80,000 on Nov. 1, 2018
  - Filed for VA pension on Dec. 1, 2018
  - Net worth=$120,000 (This is $7,061 less than the net worth limit. Difference is deducted from the transferred amount = $72,939
  - Penalty period - $72,939 divided by $2230= 32.70 rounded down to 32

## Net Worth and Penalty Period

- Penalty would start on Dec. 1, 2018 and run for 32 months (rounded down from 32.70)

## Lookback and Penalty Period

- Only amount of assets transferred that exceed the net worth limit are subject to penalty ("covered assets")
  - Includes transfers to a trust or annuity (with exceptions that would cause them to be counted as an asset)
  - Five year cap on the penalty period

## Exceptions to the Transfer Penalty

- The result of fraud or unfair business practice
- Transfer to a trust established for a child incapable of self-support prior to 18
  - No circumstances that the Veteran, Veteran's spouse or surviving spouse can benefit
- Transfer was from assets that were not over the $123,600 limit

## Curing a Gift

- Curing Gifts
  - May be a partial or total cure
  - Cure must be made before the claim was filed or within 60 days of the notice of penalty
  - Evidence of the return/cure must be received not later than 90 days after the notice of decision

## Advising Clients

- As long as transfers were made by 10-17-18, they will not be penalized, regardless of the date of application
- Net worth rules at the time of application will apply

# Advising Clients

- Adding owners to accounts won't decrease the value of the asset if done after 10-18. If done before then, will be evaluated under current rules.
- Take a proactive planning approach with those who aren't quite ready – get some assets into a properly drafted irrevocable trust now so no waiting for 36 months when they are ready

# STRATEGIES FOR PLANNING UNDER NEW VA REGS

## PRE-BENEFIT NEED PLANNING

- Transfer assets in trust or outright and wait out 36 months
- Personal Services Agreements to reduce assets over time
- Married Couples and post death planning

  Assets transferred to dying spouse who passes bequeaths them to children in death

  OR

  - Surviving spouse executes a disclaimer (Not sure how VA will treat disclaimers)

# SPEND-DOWN WHEN NEED FOR BENEFIT ARISES

- General spend down
  - Pay for care, services, a vacation, etc.
  - Buy personal property "suitable to and consistent with a reasonable mode of life." See § 3.275(b)(2).
  - Buy or upgrade vehicle(s). See § 3.275(b)(2).
  - Pay off debt
  - Buy or renovate a home

# Strategies: Crisis Planning

- Prepaid funeral services

  Uncertainty: Regs do not provide a specific exemption for this. Comment to § 3.276 said VA would regard it as a fair market value purchase, but don't know if it will be counted as assets. Even if irrevocable will it be considered an asset?

- Purchase life estate in home of another

  A life estate is countable to net worth (VAOPGCPREC 15-92), unless excluded under § 3.275(b) as the veteran's dwelling (VAOPGCPREC 9-95). This is useful for both VA and Medicaid planning purposes, but Medicaid requires applicant to live in life estate for one year.

## Strategies: Crisis Planning

- Exempt transfer to trust for child disabled before 18. See § 3.276(d).
  - Child must be disabled before 18 years of age
  - Rated as incapable of self-support under § 3.356
  - No possible benefit to veteran, veteran's spouse, or surviving spouse
- Purchase and lease out primary residence
  - Claimant can live in various other care settings and maintain exemption
  - Can lease out the home and maintain exemption
  - Rental income counts as IVAP. See § 3.275(b)(1)(ii).

## Strategies: Crisis Planning

- Transfer exempt assets such as home and cars to irrevocable trust
  - Exempt assets are not part of net worth and there are not "covered assets." See §§ 3.275(a) and 3.276(a)(2).
  - Regs do not automatically impose a penalty for transfers to trust.
  - May also transfer non-covered assets to start 5 year Medicaid clock
- Sell property on an installment contract
  - Payments will not count as income
- More options to reduce income through UME's. Can pay . . .
  - Family members
  - Independent living facilities. See § 3.278(d).

# TRAPS FOR THE UNWARY

- Multiple transfers within the 36 month look-back will be tolled to the last transfer date. See § 3.276(e)(2).

# Inclusion of Annuities and Trusts in Definition of "Transfer for Less Than Fair Market Value"

## Under new VA pension regs

DEFINITION OF ANNUITIES UNDER NEW REGS

ANNUITIES ARE SPECIFICALLY IDENTIFIED AS AN INSTRUMENT THE VA CONSIDERS AS A TRANSFER FOR LESS THAN FAIR MARKET VALUE UNDER CERTAIN CIRCUMSTANCES

§3.276 (a)(5)(ii)(A) ANNUITY MEANS A FINANCIAL INSTRUMENT THAT PROVIDES INCOME OVER A DEFINED PERIOD OF TIME FOR AN INITIAL PAYMENT OF PRINCIPAL.

# IMMEDIATE ANNUITIES

- TWO KINDS OF IMMEDIATE ANNUITIES:

- **COMMUTABLE** - THEY CAN BE CASHED IN LESS A PENALTY

THIS KIND OF ANNUITY (ASSET) IS ONE WHERE THE CLAIMANT "ESTABLISHES THAT HE OR SHE HAS THE ABILITY TO LIQUIDATE THE ENTIRE BALANCE OF THE ASSET FOR THE CLAIMANT'S OWN BENEFIT. IF THE CLAIMANT ESTABLISHES THAT THE ASSET CAN BE LIQUIDATED, THE ASSET IS INCLUDED AS NET WORTH"

A COMMUTABLE IMMEDIATE ANNUITY IS NOT A DIVESTMENT BUT TREATED AS A DEFERRED ANNUITY. NO CONSIDERATION OF WITHDRAWAL PENALTY.

## NON-TRANSFERABLE OR NON-COMMUTABLE ANNUITIES

NON-TRANSFERABLE IMMEDIATE ANNUITY

THE VOLUNTARY PURCHASE OF SUCH AN ANNUITY WITHIN THE 3-YEAR LOOK-BACK PERIOD IS SUBJECT TO A TRANSFER PENALTY. THIS APPLIES TO ANNUITIES PURCHASED AFTER OCTOBER 18, 2018.

THIS ALSO APPLIES TO A DEFERRED ANNUITY WHICH IS ANNUITIZED AFTER THE OCTOBER 18$^{TH}$ DATE. BUT ONLY WHEN THE AMOUNT DIVESTED INTO THE ANNUITY WAS IN EXCESS OF THE $127,061 ASSET LIMIT

- PENALTY WOULD ALSO APPLY IF SPOUSE PURCHASES AN IMMEDIATE ANNUITY

# EXCEPTION – DIVESTMENT FOR MANDATORY RETIREMENT ANNUITY

- ANNUITIES THAT ARE MANDATED UPON RETIREMENT
- VA ACKNOWLEDGES THAT CONVERSION OF DEFERRED RETIREMENT ACCOUNTS TO IMMEDIATE ANNUITIES IS REQUIRED UNDER SOME RETIREMENT PLANS BUT **ONLY IN THE COMMENTS** TO THE REGS. § 3.276(a)(5)(ii) ACTUALLY SAYS SUCH AN ANNUITY WILL NOT BE CONSIDERED A "COVERED ASSET" BUT INCOME WILL COUNT
- CAVEAT - THE RULE DESCRIBES ANNUITIES THAT ARE TRANSFERRED **VOLUNTARILY.** THE INFERENCE IS IT EXCEPTS THOSE THAT ARE **MANDATORY.**

# EXCEPTION FOR ANNUITY PURCHASES AS A RESULT OF FRAUD OR UNFAIR BUSINESS PRACTICES

- § 3.276(c) AN ASSET TRANSFERRED AS THE RESULT OF FRAUD, MISREPRESENTATION, OR UNFAIR BUSINESS PRACTICE RELATED TO THE SALE OR MARKETING OF FINANCIAL PRODUCTS OR SERVICES FOR PURPOSES OF ESTABLISHING ENTITLEMENT TO THE VA PENSION WILL NOT BE CONSIDERED A COVERED ASSET.
- EVIDENCE SUPPORTING THIS EXCEPTION MAY INCLUDE, BUT IS NOT LIMITED TO, A COMPLAINT CONTEMPORANEOUSLY FILED WITH STATE, LOCAL, OR FEDERAL AUTHORITIES REPORTING THE INCIDENT.

# TO RECAP

DEPENDS ON IF YOU BOUGHT IT IN THE THREE YEAR LOOK-BACK PERIOD, IF IT CAN BE LIQUIDATED, AND IF ITS VALUE KEEPS THE NET WORTH UNDER THE $127,061

IF AN ANNUITY CANNOT BE LIQUIDATED AND IT WAS PURCHASED BEFORE THE LOOK-BACK PERIOD, THEN THE ANNUITY IS NOT CONSIDERED AN ASSET; HOWEVER DISTRIBUTIONS COUNT AS INCOME AND THE TIMING OF THE PURCHASE COULD WARRANT A PENALTY PERIOD.

ANNUITIES COULD PRESENT A DOUBLE WHAMMY – NOT ONLY DOES THE VALUE COUNT BUT ALSO THE DISTRIBUTION OF THE INCOME

# TRUSTS

- §3.276 (a)(5)(ii)(B) Trust means a legal instrument by which an individual (the grantor) transfers property to an individual or an entity (the trustee), who manages the property according to the terms of the trust, whether for the grantor's own benefit or for the benefit of another individual.

## Three Types of Trusts, Revocable, Irrevocable, and Supplemental Needs Trusts

- ESTABLISHING A TRUST DOES NOT ALWAYS RESULT IN A PENALTY PERIOD.
- TRANSFERS TO ANNUITIES OR TRUSTS OVER WHICH A CLAIMANT RETAINS CONTROL AND THE ABILITY TO LIQUIDATE ARE TRANSFERS FOR FAIR MARKET VALUE AND NOT SUBJECT TO A PENALTY PERIOD.
- THEY CAN BE LIQUIDATED SO THEY ARE CONSIDERED AN ASSET.

## The VA is using a very bright line of $127,061. They call it a CSRA, but it is not because they count household income and assets.

- THEREFORE, WHETHER YOUR MONEY IS IN A TRUST OR NOT, AS LONG AS ITS CORPUS, ALONG WITH THE CLAIMANT'S INCOME AFTER UMEs ARE DEDUCTED IS UNDER $127,061, THE CLAIMANT IS ELIGIBLE.

## WHAT IF THE CORPUS EXCEEDS THE NET WORTH STANDARD?

- REVOCABLE TRUST – CORPUS GETS SPENT DOWN BEFORE ACHIEVING ELIGIBILITY
- IRREVOCABLE TRUST – FUNDING DATE IS CRITICAL. IF FUNDED BEFORE OCTOBER 18, 2018 AND CLAIMANT HAS NO CONTROL OVER THE INCOME OR PRINCIPAL NOT COUNTED. BUT…
- THE VA HAS CHALLENGED IRREVOCABLE GRANTOR TRUSTS OVER THE LAST FEW YEARS

  Citation Nr: 1529488 Board of Veterans' Appeals decision

- GRANTOR AND NON-GRANTOR TRUSTS IN VA PENSION PLANNING

The distinction of a grantor vs. non-grantor trust is significant.

1. THE VA COMPARES INCOME REPORT TO THE IRS AND SSA RECORDS WITH THEIR RECORDS. THIS IS REFERRED TO AS AN INCOME VERIFICATION MATCH. (IVM)
2. IF A VETERAN ESTABLISHES A TRUST WHICH IS TAXED AS A GRANTOR TRUST, THE INCOME WILL BE ASSUMED BY THE VA TO BE THE CLAIMANT'S INCOME AND MAY PRECLUDE PENSION BENEFITS.
3. SAFEST TO STRUCTURE TRUST AS A NON-GRANTOR TRUST
4. CAVEAT – PROBLEM WITH PERSONAL RESIDENCE AND RETENTION OF PROPERTY TAX EXEMPTIONS AND CAPITAL GAIN EXCLUSIONS.

## WHAT ABOUT SALE OF HOME DURING CLAIMANT'S LIFETIME?

- THE EFFECT OF A SALE IS TO CONVERT A NON-COUNTABLE ASSET INTO CASH, WHICH IS CONSIDERED IN CALCULATING NET WORTH.
- TO PRESERVE EXCLUSION OF GAIN ( Internal Revenue Code §121 exclusion), THE TRUST MUST BE A GRANTOR TRUST.
- IT IS MY OPINION THAT A CLAIMANT'S PERSONAL RESIDENCE SHOULD BE HELD IN A GRANTOR TRUST WITH NO PROVISION FOR ACCESS TO INCOME OR PRINCIPAL. HOWEVER, ONCE SOLD, THE PROCEEDS SHOULD BE DISTRIBUTED OUT OF THE TRUST TO THE TRUST BENEFICIARIES OR TO A NON-GRANTOR TRUST.

# POSITIVE CHANGE – SNTs ALLOWED

- THE VA WILL NOT CONSIDER AS A COVERED ASSET AN ASSET THAT A VETERAN, A VETERAN'S SPOUSE, OR A VETERAN'S SURVIVING SPOUSE TRANSFER TO A TRUST ESTABLISHED ON BEHALF OF A CHILD OF THE VETERAN IF:

- 1. THE VA RATES OR HAS RATED THE CHILD INCAPABLE OF SELF-SUPPORT UNDER § 3.356

  § 3.356 (a) – A CHILD MUST BE SHOWN TO BE PERMANENTLY INCAPABLE OF SELF-SUPPORT BY REASON OF MENTAL OR PHYSICAL DEFECT AT THE DATE OF ATTAINING THE **AGE OF 18** YEARS.

  2. THERE IS NO CIRCUMSTANCE UNDER WHICH DISTRIBUTIONS FROM THE TRUST CAN BE USED TO BENEFIT THE VETERAN, THE VETERAN'S SPOUSE, OR THE VETERAN'S SURVIVING SPOUSE.

# Medical Expense Deductions

## Why are Medical Expenses Important?

- Just like under old pension law, medical expenses are an offset of income (IVAP) to extent they exceed 5% of Maximum Base Pension Rate (based on household size)
- There are substantial changes to what was a qualifying medical expense (deduction for IVAP)

## Where to find new rules

- Deductible Medical expenses are part of 38 CFR 3.278
  - (b) defines terms
  - (c) medical expenses
    - Care, Medications, Supplements, Adaptive Equipment, Transportation expenses, Insurance premiums
  - (d) details in-home care and facility expenses
  - (e) exclusions from deductible expenses

## ADL vs IADL

Expansion of ADLs to include IADL

IADL – Instrumental activity of daily living

Activities related to Independent living, including, preparing meals, managing money, shopping, performing light or heavy housework, etc.

## VA ADDED THESE IADLs

- Ambulating to traditional list of bathing, dressing, eating, toileting and transferring
- Medication Administration- licensed caregiver unless satisfied conditions of 3.278(d)

## Licensure of Care Givers

- Important exception to licensure requirement for custodial care
  - Either assistance with 2 or more ADLS (like before)
  - Certification by health professional that due to a physical, mental, or cognitive disorder the individual requires [the custodial care]- 3.278(d)(2) and (3)(iv)(4)

## Facility Based Care

- No change for skilled nursing care (still valid expense)
- Other facilities get a specific section in 3.278(d)(3). This represents expansion.
- Family members are OK to provide care (no pay requirement)
  - Licensed caregiver required unless claimant is housebound or needs A&A and is receiving medical care or custodial care (See (d)(3)(iv))

## Previously Approved Applicants

- Comments are clear that intent was not to cause any previously approved claimant to see a reduction in benefits
- Trap is if the care provider changes, then subject to re-evaulation
  - Importance of certification letter

# Summary

- Definition of medical expenses has been expanded
- Medical professional letters are very important
- Need for licensed professionals is reduced
- No cap on payments

The Department of Veterans Affairs (VA) amended its regulations governing veterans' eligibility for VA pensions and other needs-based benefit programs effective October 18, 2018. The new regulations establish new requirements for evaluating net worth and asset transfers and more clearly identify what constitutes unreimbursed medical expenses. The VA's justification for these changes is to "ensure the integrity of VA's needs-based benefit program and the consistent adjudication of pension…claims."

**REVIEW OF PENSION PROGRAM BASIC ELIGIBILITY RULES**

1. Veterans or their surviving spouses must be at least 65 or officially disabled if younger;

2. Veteran must have served 90 days of consecutive active duty, one day of which must have been during a War-Time Period:

World War II – December 7, 1941 – December 31, 1946

Korean War – June 27, 1950 – January 31, 1955

Vietnam War – August 5, 1964 – May 7, 1975 (or February 28, 1961 – May 7, 1975 for veterans who served in Vietnam.

Gulf War – August 2, 1990 - undetermined

3. Veteran must have received a discharge other than dishonorable;

4. Disability Status – Veterans are eligible without a disability but a high benefit is available to those who are disabled.

- Aid & Attendance – the veteran must require help with the activities of daily living at home, in nursing home or assisted living.
- Housebound – the veteran needs to have a disability that prevents him or her from leaving their home.
- Basic pension – No disability requirement

5. Spousal rules: a surviving spouse must have been living with the veteran at the time of the veteran's death and must be single at time of claim.

§ 3.274 Net worth and VA pension.

The VA chose a bright-line net worth limit equal to the maximum community spouse resource allowance (CSRA) for Medicaid purposes. Important distinction: Medicaid's CSRA relates to a community spouse's resources not the entire household members' assets as the VA does.

(a) *Net worth limit*. For purposes of entitlement to VA pension, the net worth limit effective December 1, 2018 is $127,061.00. This limit will be increased by the same percentage as the Social Security increase whenever there is a cost-of-living increase in benefit amounts payable under section 215(i) of

title II of the Social Security Act (42 U.S.C. 415). VA will publish the current limit on its website at www.benefits.va.gov/pension/.

(b) *When a claimant's or beneficiary's net worth exceeds the limit.* Except as provided in paragraph (h)(2) of this section, VA will deny or discontinue pension if a claimant's or beneficiary's net worth exceeds the net worth limit in paragraph (a) of this section.

(1) *Net worth.* Net worth means the sum of a claimant's or beneficiary's assets and annual income.

(2) *Asset calculation.* VA will calculate a claimant's or beneficiary's assets under this section and § 3.275.

(3) *Annual income calculation.* VA will calculate a claimant's or beneficiary's annual income under § 3.271, and will include the annual income of dependents as required by law. *See* §§ 3.23(d)(4), 3.23(d)(5), and 3.24 for more information on annual income included when VA calculates a claimant's or beneficiary's pension entitlement rate. In calculating annual income for this purpose, VA will subtract all applicable deductible expenses, to include appropriate prospective medical expenses under § 3.272(g).

(4) *Example of net worth calculation.* For purposes of this example, presume the net worth limit is $127,061. A claimant's assets total $118,000 and annual income is $10,000. Therefore, adding the claimant's annual income to assets produces net worth of $128,000. This amount exceeds the net worth limit.

(c) *Assets of other individuals included as claimant's or beneficiary's assets—*

(1) *Claimant or beneficiary is a veteran.* A veteran's assets include the assets of the veteran as well as the assets of his or her spouse, if the veteran has a spouse.

(2) *Claimant or beneficiary is a surviving spouse.* A surviving spouse's assets include only the assets of the surviving spouse.

(3) *Claimant or beneficiary is a surviving child.*

(i) If a surviving child has no custodian or is in the custody of an institution, the child's assets include only the assets of the child.

(ii) If a surviving child has a custodian other than an institution, the child's assets include the assets of the child as well as the assets of the custodian. If the child is in the joint custody of his or her natural or adoptive parent and a stepparent, the child's assets also include the assets of the stepparent. *See* § 3.57(d) for more information on child custody for pension purposes.

(d) *How a child's net worth affects a veteran's or surviving spouse's pension entitlement.* VA will not consider a child to be a veteran's or surviving spouse's dependent child for pension purposes if the child's net worth exceeds the net worth limit in paragraph (a) of this section.

(1) *Dependent child and potential dependent child.* For the purposes of this section, (i) "Dependent child" refers to a child for whom a veteran or a surviving spouse is entitled to an increased maximum annual pension rate; (ii) "Potential dependent child" refers to a child who is excluded from a veteran's or surviving spouse's pension award solely or partly because of this paragraph (d). References in this section to "dependent child" include a potential dependent child.

(2) *Dependent child net worth*. A dependent child's net worth is the sum of his or her annual income and the value of his or her assets.

(3) *Dependent child asset calculation.* VA will calculate the value of a dependent child's assets under this section and § 3.275. A dependent child's assets include the child's assets only.

(4) *Dependent child annual income calculation.* VA will calculate a dependents child's annual income under § 3.271, and will include the annual income of the child as well as the annual income of the veteran or surviving spouse that would be included if VA were calculating a pension entitlement for the veteran or surviving spouse.

(e) *When VA calculates net worth.* VA calculates net worth only when:

(1) VA has received (i) an original pension claim; (ii) a new pension claim after a period of non-entitlement; (iii) a request to establish a new dependent; or (iv) information that a veteran's, surviving spouse's, or child's net worth has increased or decreased; and

(2) The claimant or beneficiary meets the other factors necessary for pension entitlement as provided in § 3.3(a)(3) and (b)(4).

**NOTE TO PARAGRAPH (e).**

If the evidence shows that net worth exceeds the net worth limit, VA may decide the pension claim before determining if the claimant meets other entitlement factors. VA will notify the claimant of the entitlement factors that have not been established. Caveat – Send in a complete application.

(f) *How net worth decreases.* Net worth may decrease in three ways: Assets can decrease, annual income can decrease, or both assets and annual income can decrease.

(1) *How assets decrease.* A veteran, surviving spouse, or child, or someone acting on their behalf, may decrease assets by spending them on any item or service for which fair market value is received unless the item or items purchased are themselves part of net worth. *See* § 3.276(a)(4) for the definition of "fair market value." The expenses must be those of the veteran, surviving spouse, or child, or a relative of the veteran, surviving spouse, or child. The relative must be a member or constructive member of the veteran's, surviving spouse's, or child's household.

(2) *How annual income decreases. See* §§ 3.271 through 3.273.

(3) *Example 1.* For purposes of this example, presume the net worth limit is $127,061 and the maximum annual pension rate (MAPR) is $13,535. A claimant has assets of $120,000 and annual income of $24,000. Adding annual income to assets produces a net worth of $144,000, which exceeds the net worth limit. However, the claimant is a patient in a nursing home and pays annual unreimbursed nursing home fees of $29,000. Reasonably predictable unreimbursed medical expenses are deductible from annual income under § 3.272(g) to the extent that they exceed 5 percent of the applicable MAPR (here, $28,324.25) from annual income, which decreases annual income to zero. The claimant's net worth is now $120,000; therefore, net worth is within the limit to qualify for VA pension.

(4) *Example 2.* For purposes of this example, presume the net worth limit is 127,061 and the maximum annual pension rate (MAPR) is $13,535. A claimant has assets of $126,000 and annual income of $11,500. Adding annual income to assets produces a net worth of $137,500, which exceeds the net worth limit. The claimant pays reasonably predictable annual unreimbursed medical expenses of $10,000. Unreimbursed medical expenses are deductible from annual income under § 3.272(g) to the extent that they exceed 5 percent of the applicable MAPR. VA subtracts the projected expenditures that exceed 5 percent of the applicable MAPR (here, $9,323.25) from annual income, which decreases annual income to $2,176.75. This decreases net worth to $128,176.75, which is still over the limit. VA must deny the claim for excessive net worth.

(g) *Effective dates of pension entitlement or increased entitlement after a denial, reduction, or discontinuance based on excessive net worth—*

(1) *Scope of paragraph*. This paragraph (g) applies when VA has (i) Discontinued pension or denied pension entitlement for a veteran, surviving spouse, or surviving child based on the veteran's, surviving spouse's, or surviving child's excessive net worth; or (ii) Reduced pension or denied increased pension entitlement for a veteran or surviving spouse based on a dependent child's excessive net worth.

(2) *Effective date of entitlement or increased entitlement.* The effective date of entitlement or increased entitlement is the day net worth ceases to exceed the limit. For this effective date to apply, the claimant or beneficiary must submit a certified statement that net worth has decreased and VA must receive the certified statement before the pension claim has become finally adjudicated under § 3.160. This means that VA must receive the certified statement within 1 year after its decision notice to the claimant concerning the denial, reduction, or discontinuance unless the claimant appeals VA's decision. Otherwise, the effective date is the date VA receives a new pension claim. In accordance with § 3.277(a), VA may require the claimant or beneficiary to submit additional evidence as the individual circumstances may require.

(h) *Reduction or discontinuance of beneficiary's pension entitlement based on excessive net worth—*

(1) *Effective date of reduction or discontinuance.* When an increase in a beneficiary's or dependent child's net worth results in a pension reduction or discontinuance because net worth exceeds the limit, the effective date of reduction or discontinuance is the last day of the calendar year in which net worth exceeds the limit.

(2) *Net worth decreases before the effective date.* If net worth decreases to the limit or below the limit before the effective date provided in paragraph (h)(1) of this section, VA will not reduce or discontinue the pension award on the basis of excessive net worth.

(i) *Additional effective-date provisions for dependent children*—(1) *Establishing a dependent child on veteran's or surviving spouse's pension award results in increased pension entitlement.* When establishing a dependent child on a veteran's or surviving spouse's pension award results in increased pension entitlement for the veteran or surviving spouse, VA will apply the effective-date provisions in paragraphs (g) and (h) of this section. (2) *Establishing a dependent child on veteran's or surviving spouse's pension award results in decreased pension entitlement.* (i) When a dependent child's non-excessive net worth results in decreased pension entitlement for the veteran or surviving spouse, the effective date of the decreased pension entitlement rate (i.e., VA action to add the child to the award) is the end of the year that the child's net worth decreases.

(ii) When a dependent child's excessive net worth results in increased pension entitlement for the veteran or surviving spouse, the effective date of the increased pension entitlement rate (i.e., VA action to remove the child from the award) is the date that VA receives a claim for an increased rate based on the child's net worth increase.

**§ 3.275 How VA determines the asset amount for pension net worth determinations.**

(a) *Definitions pertaining to assets*—(1) *Assets.* The term *assets* means the fair market value of all property that an individual owns, including all real and personal property, unless excluded under paragraph (b) of this section, less the amount of mortgages or other encumbrances specific to the mortgaged or encumbered property. VA will consider the terms of the recorded deed or other evidence of title to be proof of ownership of a particular asset. *See also* § 3.276(a)(4), which defines "fair market value." (2) *Claimant.* (i) Except as provided in paragraph (a)(2)(ii) of this section, for the purposes of this section and § 3.276, *claimant* means a pension beneficiary, a dependent spouse, or a dependent or potential dependent child as described in § 3.274(d), as well as a veteran, surviving spouse, or surviving child pension applicant. (ii) For the purpose of paragraph (b)(1) of this section, *claimant* means a pension beneficiary or applicant who is a veteran, a surviving spouse, or a surviving child. (3) *Residential lot area.* For purposes of this section, *residential lot area* means the lot on which a residence sits that does not exceed 2 acres (87,120 square feet), unless the additional acreage is not marketable.

(b) *Exclusions from assets*. Assets do not include the following:

(1) *Primary residence*. The value of a claimant's primary residence (single-family unit), including the residential lot area, in which the claimant has an ownership interest. VA recognizes one primary residence per claimant. If the residence is sold after pension entitlement is established, any net proceeds from the sale is an asset except to the extent the proceeds are used to purchase another residence within the same calendar year as the year in which the sale occurred.

(i) *Personal mortgage not deductible*. VA will not subtract from a claimant's assets the amount of any mortgages or encumbrances on a claimant's primary residence.

(ii) *Claimant not residing in primary residence.* Although rental income counts as annual income as provided in § 3.271(d), VA will not include a claimant's primary residence as an asset even if the claimant resides in any of the following as defined in § 3.278(b):

(A) A nursing home or medical foster home;

(B) A care facility other than a nursing home; or

(C) The home of a family member for health care or custodial care.

(2) *Personal effects.* Value of personal effects suitable to and consistent with a reasonable mode of life, such as appliances and family transportation vehicles.

(3) *Radiation Exposure Compensation Act payments.* Payments made under section 6 of the Radiation Exposure Compensation Act of 1990.

***Caveat: Assets include the following:***

Principal of an IRA that is accessible without penalty plus distributions count as income.

**§ 3.276 Asset transfers and penalty periods.**

(a) *Asset transfer definitions*. For purposes of this section—

(1) *Claimant* has the same meaning as defined in § 3.275(a)(2)(i).

(2) *Covered asset* means an asset that—(i) was part of a claimant's net worth; (ii) was transferred for less than fair market value; and (iii) if not transferred, would have caused or partially caused the claimant's net worth to exceed the net worth limit under § 3.274(a).

(3) *Covered asset amount* means the monetary amount by which a claimant's net worth would have exceeded the limit due to the covered asset alone if the uncompensated value of the covered asset had been included in net worth.

(i) *Example 1.* For purposes of this example, presume the net worth limit under § 3.274 (a) is $127,061. A claimant's assets total $115,000 and his annual income is zero. However, the claimant transferred $30,000 by giving it to a friend. If the claimant had not transferred the $30,000, his net worth would have been $145,000, which exceeds the net worth limit. The claimant's covered asset amount is $17,939, because this is the amount by which the claimant's net worth would have exceeded the limit due to the covered asset.

(4) *Fair market value* means the price at which an asset would change hands between a willing buyer and a willing seller, neither being under any compulsion to buy or to sell and both having reasonable knowledge of relevant facts. VA will use the best available information to determine fair market value, such as inspections, appraisals, public records, and the market value of similar property if applicable.

(5) *Transfer for less than fair market value* means—

(i) Selling, conveying, gifting, or exchanging an asset for an amount less than the fair market value or asset; or

(ii) A voluntary asset transfer to, or purchase of, any financial instrument or investment that reduces net worth by transferring the asset to, or purchasing, the instrument or investment unless the claimant establishes that he or she has the ability to liquidate the entire balance of the asset for the claimant's own benefit. If the claimant establishes that the asset can be liquidated, the asset is included as net worth. Examples of such instruments or investments include—

(A) *Annuities*. *Annuity* means a financial instrument that provides income over a defined period of time for an initial payment of principal.

(B) *Trusts. Trust* means a legal instrument by which an individual (the grantor) transfers property to an individual or an entity (the trustee), who manages the property according to the terms of the trust, whether for the grantor's own benefit or for the benefit of another individual.

(6) *Uncompensated value* means the difference between the fair market value of an asset and the amount of compensation an individual receives for it. In the case of a trust, annuity, or other financial instrument or investment described in paragraph (a)(5)(ii) of this section, *uncompensated value* means the amount of money or the monetary value of any other type of asset transferred to such a trust, annuity, or other financial instrument or investment.

(7) *Look-back period* means the 36-month period immediately preceding the date on which VA receives either an original pension claim or a new pension claim after a period of non-entitlement. This definition does not include any date before October 18, 2018.

(8) *Penalty period* means a period of non-entitlement, calculated under paragraph (e) of this section, due to transfer of a covered asset.

(b) *General statement of policy pertaining to pension and covered assets.* VA pension is a needs-based benefit and is not intended to preserve the estates of individuals who have the means to support themselves. Accordingly, a claimant may not create pension entitlement by transferring covered assets. VA will review the terms and conditions of asset transfers made during the 36-month look-back period to determine whether the transfer constituted transfer of a covered asset. However, VA will disregard asset transfers made before October 18, 2018. In accordance with § 3.277(a), for any asset transfer, VA may require a claimant to provide evidence such as a Federal income tax return transcript, the terms of a gift, trust, or annuity, or the terms of a recorded deed or other evidence of title.

(c) *Exception for transfers as a result of fraud or unfair business practice.* An asset transferred as the result of fraud, misrepresentation, or unfair business practice related to the sale or marketing of financial products or services for purposes of establishing entitlement to VA pension will not be considered a covered asset. Evidence supporting this exception may include, but is not limited to, a complaint contemporaneously filed with State, local, or Federal authorities reporting the incident.

(d) *Exception for transfers to certain trusts.* VA will not consider as a covered asset an asset that a veteran, a veteran's spouse, or a veteran's surviving spouse transfers to a trust established on behalf of a child of the veteran if:

(1) VA rates or has rated the child incapable of self-support under § 3.356; (Under VA regs, this is a child who before age 18 became permanently incapable of self-support) and,

(2) There is no circumstance under which distributions from the trust can be used to benefit the veteran, the veteran's spouse, or the veteran's surviving spouse.

(e) *Penalty periods and calculations.* When a claimant transfers a covered asset during the look-back period, VA will assess a penalty period not to exceed 5 years. VA will calculate the length of the penalty period by dividing the total covered asset amount by the monthly penalty rate described in paragraph (e)(1) of this section and rounding the quotient down to the nearest whole number. The result is the number of months for which the VA will not pay pension.

(1) *Monthly penalty rate.* The monthly penalty rate is the maximum annual pension rate (MAPR) under 38 U.S.C. 1521(d)(2) for a veteran in need of aid and attendance with one dependent that is in effect as of the date of the pension claim, divided by 12, and rounded down to the nearest whole dollar. The monthly penalty rate is located on VA's website at www.benefits.va.gov/pension. **THE 2019 PENALTY RATE IS $2230**

(2) *Beginning date of penalty period.* When a claimant transfers a covered asset or assets during the look-back period, the penalty period begins on the first day of the month that follows the date of the transfer. If there was more than one transfer, the penalty period will begin on the first day of the month that follows the date of the last transfer.

(3) *Entitlement upon ending of penalty period.* VA will consider that the claimant, if otherwise qualified, is entitled to benefits effective the last day of the last month of the penalty period, with a payment date as of the first day of the following month in accordance with § 3.31.

(4) *Example of penalty period calculation.* VA receives a pension claim in November 2018. The claimant's net worth is equal to the net worth limit. However, the claimant transferred covered assets totaling $10,000 on September 20, 2018, and October 23, 2018. Therefore, the total covered asset amount is $10,000, and the penalty period begins on November 1, 2018. Assume the MAPR for a veteran in need of aid and attendance with one dependent in effect in November 2018 is $24,000. The monthly penalty rate is $2,000. The penalty period is $10,000/$2,000 per month = 5 months. The fifth month of the penalty period is February 2019. The claimant may be entitled to pension effective February 28, 2019, with a payment date of March 1, 2019, if other entitlement requirements are met.

(5) *Penalty period recalculations.* VA will not recalculate a penalty period under this section unless—

(i) The original calculation is shown to be erroneous; or

(ii) VA receives evidence showing that some or all covered assets were returned to the claimant before the date of claim or within 60 days after the date of VA's notice to the claimant of VA's decision concerning the penalty period. If covered assets are returned to the claimant, VA will recalculate or eliminate the penalty period. For this exception to apply, VA must receive the evidence not later than 90 days after the date of VA's notice to the claimant of VA's decision concerning the penalty period. Once covered assets are returned, a claimant may reduce net worth at the time of transfer under the provisions of § 3.274(f).

**§ 3.278 Deductible medical expenses.**

(a) *Scope*. This section identifies medical expenses that VA may deduct from countable income for purposes of three of its needs-based programs: Pension, section 306 pension, and parents' dependency and indemnity compensation (DIC). Payments for such medical expenses must be unreimbursed to be deductible from income.

(b) *Definitions.* For the purposes of this section—

(1) *Health care provider* means: (i) an individual licensed by a State or country to provide health care in the State or country in which the individual provides the health care. The term includes, but is not limited to, a physician, physician assistant, psychologist, chiropractor, registered nurse, licensed vocational nurse, licensed practical nurse, and physical or occupational therapist; or (ii) a nursing assistant or home health aide who is supervised by a licensed health care provider as defined in paragraph (b)(1)(i) of this section.

(2) *Activities of daily living (ADLs)* mean basic self-care activities and consist of bathing or showering, dressing, eating, toileting, transferring, and ambulating within the home or living area. *Transferring* means an individual's moving himself or herself from one position to another, such as getting in and out of bed.

(3) *Instrumental activities of daily living (IADLs)* mean independent living activities, such as shopping, food preparation, housekeeping, laundering, managing finances, handling medications, using the telephone, and transportation for non-medical purposes.

(4) *Custodial care* means regular: (i) assistance with two or more ADLs; or (ii) supervision because an individual with a physical, mental, developmental, or cognitive disorder requires care or assistance on a regular basis to protect the individual from hazards or dangers incident to his or her daily environment.

(5) *Nursing home* means a facility defined in § 3.1(z)(1) or (2). If the facility is not located in a State, the facility must be licensed in the country in which it is located.

(6) *Medical foster home* means a privately-owned residence, recognized and approved by VA under 38 CFR 17.73(d), that offers a non-institutional alternative to nursing home care for veterans who are unable to live alone safely due to chronic or terminal illness.

(7) *Care facility other than a nursing home* means a facility in which a disabled individual receives health care or custodial care under the provisions of paragraph (d) of this section. A facility must be licensed if facilities of that type are required to be licensed in the State or country in which the facility is located. A facility that is residential must be staffed 24 hours per day with care providers. The providers do not have to be licensed health care providers.

(8) *Needs A&A or is housebound* refers to a disabled individual who meets the criteria in § 3.351 for needing regular aid and attendance (A&A) or being housebound and is a: (i) Veteran; (ii) Surviving spouse; (iii) Parent (for parents' DIC purposes); or (iv) Spouse of a living veteran with a service-connected disability rated at least 30 percent disabling, who is receiving pension.

(c) *Medical expenses for VA purposes.* Generally, medical expenses for VA needs-based benefit purposes are payments for items or services that are medically necessary; that improve a disabled individual's functioning; or that prevent, slow, or ease an individual's functional decline. Medical expenses may include, but are not limited to, the payments specified in paragraphs (c)(1) through (7) of this section.

(1) *Care by a health care provider.* Payments to a health care provider for services performed within the scope of the provider's professional capacity are medical expenses. Cosmetic procedures that a health care provider performs to improve a congenital or accidental deformity or related to treatment for a diagnosed medical condition are medical expenses.

(2) *Medications, medical supplies, medical equipment, and medical food, vitamins, and supplements.* Payments for prescription and non-prescription medication procured lawfully under Federal law, as well as payments for medical supplies or medical equipment, are medical expenses. Medically necessary food, vitamins, and supplements as prescribed or directed by a health care provider authorized to write prescriptions are medical expenses.

(3) *Adaptive equipment.* Payments for adaptive devices or service animals, including veterinary care, used to assist a person with an ongoing disability are medical expenses. Medical expenses do not include non-prescription food, boarding, grooming, or other routine expenses of owning an animal.

(4) *Transportation expenses*. Payments for transportation for medical purposes, such as the cost of transportation to and from a health care provider's office by taxi, bus, or other form of public transportation are medical expenses. The cost of transportation for medical purposes by privately owned vehicle (POV), including mileage, parking, and tolls, is a medical expense. For transportation in a POV, VA limits the deductible mileage rate to the current POV mileage reimbursement rate specified by the United States General Services Administration (GSA). The current amount can be obtained from www.gsa.gov. Amounts by which transportation expenses set forth in this paragraph (c)(4) exceed the amounts of other VA or non-VA reimbursements for the expense are medical expenses.

(i) *Example.* In February 2013, a veteran drives 60 miles round trip to a VA medical center and back. The veteran is reimbursed $24.90 from the Veterans Health Administration. The POV mileage reimbursement rate specified by GSA is $0.565 per mile, so the transportation expense is $0.565/mile * 60 miles = $33.90 and $24.90, is a medical expense.

(5) *Health insurance premiums.* Payments for health, medical, hospitalization, and long-term care insurance premiums are medical expenses. Premiums for Medicare Parts A, B, and D and for long-term care insurance are medical expenses.

(6) *Smoking cessation products.* Payments for items and services specifically related to smoking cessation are medical expenses.

(7) *Institutional forms of care and in-home care.* As provided in paragraph (d) of this section.

(d) *Institutional forms of care and in-home care.* This paragraph (d) applies with respect to claims for a medical expense deduction for institutional forms of care or in-home care received on or after October 18, 2018 that VA has not previously granted.

(1) *Hospitals, nursing homes, medical foster homes, and inpatient treatment centers.* Payments to hospitals, nursing homes, medical foster homes, and inpatient treatment centers (including inpatient treatment centers for drug or alcohol addiction), including the cost of meals and lodging charged by such facilities, are medical expenses.

(2) *In-home care*. Payments for assistance with ADLs and IADLs by an in-home attendant are medical expenses as long as the attendant provides the disabled individual with health care or custodial care. Payments must be commensurate with the number of hours that the provider attends to the disabled person. The attendant must be a health care provider unless—(i) the disabled individual needs A&A or is housebound; or (ii) a physician, physician assistant, certified nurse practitioner, or clinical nurse specialist states in writing that, due to a physical, mental, developmental, or cognitive disorder, the individual requires the health care or custodial care that the in-home attendant provides.

(3) *Care facilities other than nursing homes.* (i) Care in a facility may be provided by the facility, contracted by the facility, obtained from a third-party provider, or provided by family or friends; (ii) Payments for health care provided by a health care provider are medical expenses; (iii) The provider does not need to be a health provider, and payments for assistance with ADLs and IADLs are medical expenses, if the disabled individual is receiving health care or custodial care in the facility and (A) the disabled individual needs A&A or is housebound, or (B) a physician, physician assistant, certified nurse practitioner, or clinical nurse specialist states in writing that, due to a physical, mental, developmental, or cognitive disorder, the individual needs to be in a protected environment; (iv) Payments for meals and lodging (and other facility expenses not directly related to health care or custodial care) are medical expenses if (A) the facility provides or contracts for health care or custodial care for the disabled individual, or (B) a physician, physician assistant, certified nurse practitioner, or clinical nurse specialist states in writing that the individual must reside in the facility (or a similar facility) to separately contract with a third-party provider to receive health care or custodial care or to receive (paid or unpaid) health care or custodial care from family or friends.

(e) *Non-medical expenses for VA purposes.* Payments for items and services listed in paragraphs (e)(1) through (4) of this section are not medical expenses for VA needs-based benefit purposes. The list is not all-inclusive.

(1) *Maintenance of general health.* Payments for items or services that benefit or maintain general health, such as vacations and dance classes, are not medical expenses.

(2) *Cosmetic procedures.* Except as provided in paragraph (c)(1) of this section, cosmetic procedures are not medical expenses.

(3) *Meals and lodging.* Except as provided in paragraph (d) of this section, payments for meals and lodging are not medical expenses.

(4) *Assistance with IADLs.* Except as provided in paragraph (d) of this section, payments for assistance with IADLs are not medical expenses.

**§ 3.279 Statutory exclusions from income or assets (net worth or corpus of the estate).**

This section sets forth payments that Federal statutes exclude from income for the purpose of determining entitlement to any VA-administered benefit that is based on financial need. Some of the exclusions also apply to assets (pension), also known as net worth or the corpus of the estate (section 306 pension and parents as dependents for compensation). VA will exclude from income or assets any amount designated by statute as not countable as income or resources, regardless of whether or not it is listed in this section.

# Lawyer as Employer

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ATTORNEYS

# Employment Law Update for the Lawyer-Employer

**PRESENTED BY:**
**Domenique Camacho Moran, Esq.**

Tuesday, January 15, 2019

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BECAUSE SUCCESS MATTERS.

## Agenda

- **Pre-Employment Inquiries**
- **Paid Leave**
- **New Sexual Harassment Rules**

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## Pre-Employment Inquiries: Salary History Inquiries

- NYC Law prohibits **all** private employers from:
  - ❑ Asking applicants about their current or prior earnings;
  - ❑ Asking applicants' current or former employers about applicants' current or prior earnings; or
  - ❑ Searching public records (including internet searches) about applicants' current or prior earnings.

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## Pre-Employment Inquiries: Salary History Inquiries

- NYC Law permits employers to:
  - ❑ Make statements about the anticipated salary or salary range;
  - ❑ Ask applicants about their salary expectations or requirements; and
  - ❑ Verify and consider earnings information if **offered voluntarily without prompting**.

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## Pre-Employment Inquiries: Criminal Convictions in New York

- NY Law Prohibits discrimination based on a prior conviction ***unless***:
  - ❑ There is a direct relationship between the previous criminal offense and the specific job/position, or
  - ❑ Employment would involve unreasonable risk to property or to safety or welfare

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## Pre-Employment Inquiries: Criminal Convictions in New York

**REMEMBER**

It is unlawful to ask an applicant or employee whether he has been ***arrested*** or has been the ***subject of a criminal complaint***.

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## Pre-Employment Inquiries: Criminal Convictions in NYC

- Fair Chance Act (aka "Ban the Box")
  - ❑ NYC employers with 4 or more employees
  - ❑ Conditional offer of employment ***required before*** inquiries / background check re: criminal convictions.

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## Pre-Employment Inquiries: Criminal Convictions in New York

**REMEMBER**

Employers must comply with Fair Credit Reporting Act when using a third party to conduct criminal background checks.

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## Pre-Employment Inquiries: NYC: Fair Chance Act Procedure

- Before taking adverse action based on conviction(s) record:
  - ❑ Provide written copy of the inquiry to the applicant;
  - ❑ Perform analysis using 8 factor test;
  - ❑ Provide a copy of the analysis to the application; and
  - ❑ Allow applicant 3 business days to respond while holding position open.

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## Pre-Employment Inquiries: NYC: Fair Chance Act Procedure

- 8 factors:
  - ❑ Public policy encourages employment of people with criminal records;
  - ❑ The specific duties and responsibilities of the prospective job;
  - ❑ Relationship between conviction history and fitness to perform job duties;
  - ❑ Time between criminal conduct and employment application;
  - ❑ Age at the time of criminal conduct;
  - ❑ Seriousness of applicant's conviction history;
  - ❑ Information regarding rehabilitation or good conduct;
  - ❑ Employer's legitimate interest in protecting property and safety of specific individuals or the general public.

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## Paid Leave:
## NYS Paid Family Leave

- ❑ All Private Employers.
- ❑ Eligible Employees:
  - ✓ Employees who regularly work 20 or more hours per week, after 26 weeks of consecutive employment.
  - ✓ Employees who regularly work less than 20 hours per week, after 175 days of employment in a 52 week period.

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## Paid Leave:
## NYS Paid Family Leave

- ❑ Qualifying Event: Providing Care for Family Members
  - ✓ Child, Spouse, Domestic Partner, Parent, Parent-In-Law, Grandparent, Grandchild
  - ✓ Employee must be in "close and continuing proximity to the care recipient."
- ❑ Qualifying Event: Bond with Child
  - ✓ Leave permitted before placement of child;
  - ✓ Leave available for 52 weeks after birth or placement.

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## Paid Leave:
## NYS Paid Family Leave

- Qualifying Event: Military Leave
  - ✓ FMLA / Qualifying Exigency
- **EFFECTIVE 1/1/19**
  - ✓ 10 Weeks' Leave
  - ✓ 55% avg. weekly wage
- **EFFECTIVE 1/1/20**
  - ✓ 10 Weeks' Leave
  - ✓ 60% of avg. weekly wage
  - ✓ Expanded to include Bereavement Leave

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## Paid Leave:
## NYC Sick & Safe Leave

- Private employers with 5 or more employees
- 40 hours paid leave [employees accrue 1 hour paid leave for every 30 hours worked]:
  - ✓ "Sick Leave" can be used for the care and treatment of employee or a family member.
  - ✓ Effective May 5, 2018: "Safe Leave" can be used to seek assistance if employee or a family member is the victim of domestic violence, unwanted physical contact, stalking, or human trafficking.
- Leave can be used after 120 days of employment.

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## NYS Sexual Harassment Amendments Policy Requirements

- ❑ Prohibit Sexual Harassment
- ❑ Provide Examples of Inappropriate Conduct
- ❑ Refer to State and Local Laws
- ❑ List Available Remedies, as well as Administrative and Judicial Complaint Options
- ❑ Commit to Timely, [Confidential] Investigation
- ❑ Ensure Due Process
- ❑ Offer a Complaint Form

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## NYS Sexual Harassment Amendments Policy Requirements

- ❑ Prohibit Retaliation
  - ✓ Any action to alter an employee's term and condition of employment because that individual engaged in protected activity.
- ❑ "Protected Activity" includes:
  - ✓ Complaining about harassment.
  - ✓ Providing information during an investigation.
  - ✓ Testifying in connection with a complaint.

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## NYS Sexual Harassment Amendments Conduct Annual Interactive Training

- ❑ Annual Training Required
- ❑ Training Must Be Interactive
- ❑ Define Sexual Harassment
- ❑ Include Key Policy Elements
- ❑ Address Supervisor Conduct and Responsibilities

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# Thank You.

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ATTORNEYS

# Lawyer As Employer

Domenique Camacho Moran, Esq.
January 15, 2019

## Pre-Employment Inquiries

- NYC Salary History Protection [**Copy of Statute and NYCCHR FAQ**]
  - In NYC, it is unlawful for an employer to inquire about an applicants' current or prior earnings. Employers are prohibited from inquiring:
    - On a job application or during an interview
    - Ask current or former employers
    - Search public records
  - Employers can:
    - Make statements about the anticipated salary or salary range;
    - Ask applicants about their salary expectations or requirements; and
    - Verify and consider earnings information if **offered voluntarily without prompting**
  - Penalties for:
    - unintentional violations are up to $150,000
    - willful and malicious violations up to $250,000
- New York State Protection for Individuals With Criminal Convictions
  - Article 23-A of the Correction Law [**copy of statute**]
    - Employer cannot refuse to hire, terminate or take an adverse employment action against an individual because that individual has been previously convicted of one or more criminal offenses, or because of a belief that a conviction record indicates a lack of "good moral character" **unless**
      - There is a direct relationship between the previous criminal offenses and the specific employment sought or held, ***or***
      - Employment would involve unreasonable risk to property or to the safety or welfare of specific individuals or the general public
  - Human Rights Law §296(16)

- It is unlawful to ask an applicant or employee whether he has ever been arrested or has been the subject of a criminal complaint

- **Remember:** Employers must comply with the Fair Credit Reporting Act when using a third party to conduct criminal background checks

- "Ban the Box" – Fair Chance Act **[Copy of Statute]**
  - On June 29, 2015, NYC passed the Fair Chance Act to provide protections to individual's with criminal convictions
  - Applies to all employers in NYC with four or more employees
  - What does the new law prohibit and require?
    - Employers **cannot** issue any solicitation or advertisement that states any employment limitation based on person's history of arrest or criminal conviction
    - Employers must wait until ***after making a conditional offer of employment*** before:
      - Asking applicant about his/her criminal history
      - Searching public records to find any criminal background information about the applicant
    - Before taking any adverse action based on the result of the inquiry, employer **must:**
      - Provide applicant with written copy of the inquiry
      - Perform an analysis that considers the 8 factor test in Article 23-A
        - Public policy encourages employment of people with criminal records
        - The specific duties and responsibilities of the prospective job
        - Relationship between conviction history and fitness to perform job duties
        - Time between criminal conduct and employment application
        - Age at the time of the criminal conduct
        - Seriousness of applicant's conviction history
        - Information regarding rehabilitation and good conduct

- Employer's legitimate interest in protecting property and safety of specific individuals or the general public

- Provide applicant with a copy of the analysis
- Allow the applicant at least **3 business days** to respond, while holding the position open for the applicant to do so

**Paid Leave**

- New York Paid Family Leave Act **[Copy of 2019 Statement of Rights for PFL]**
  - As of the beginning of 2018, nearly all private employers are required to participate in Paid Family Leave
  - Which employees are eligible?
    - Employees who work a regular schedule of 20 or more hours per week are eligible after working 26 consecutive weeks; **or**
    - Employees who work a regular schedule of less than 20 hours per week are eligible after working 175 days, which do not need to be consecutive
  - Employees may take PFL to:
    - Bond with a newly born, adopted or fostered child
      - Permitted before placement of child
      - Available for 52 weeks after birth or placement
    - Care for a family member with a serious health condition
      - Family: child, spouse, domestic partner, parent-in-law, grandparent, grandchild
    - Assist loved ones when a family member is deployed abroad on active military service
  - **Effective January 1, 2019**, employees may take up to 10 weeks leave and receive 55% of their average weekly wage ("AWW")
  - **Effective January 1, 2020**, employees may take up to 10 weeks leave and receive 60% of their AWW
    - PFL is expanded to include "bereavement"
  - What are employees' rights and protections under PFL?
    - Employees have job protection – can return to the same or comparable job upon return from leave
    - Employees can keep their health insurance while on leave

- Employers are prohibited from discriminating or retaliating against employees for requesting or taking PFL

- NYC Mandatory Sick & Safe Leave **[Copy of Statute and Notice of Employee Rights]**
  - NYC amended the Sick Leave Law to include paid "safe leave"
  - NYC Employers with 5 or more employees must provide up to 40 hours of paid sick and safe leave
    - Employees accrue 1 hour paid leave for every 30 hours worked
  - Leave can be used after 120 of employment
  - Employees can use sick leave for the employee's:
    - mental or physical illness, injury, or health condition
    - need for medical diagnosis, care, or treatment of a mental or physical illness, injury, or health condition, or for preventative medical care
    - elective surgery, including organ donations
    - Care of a family member who needs medical diagnosis, care, or treatment of an illness, injury, or health condition, or who needs preventive medical care, or elective surgery
  - Employees can use safe leave if they or a family member may be the victim of any act or threat of domestic violence, unwanted sexual contact, stalking, or human trafficking, including to:
    - Obtain services from a domestic violence shelter, rape crisis center or other services program
    - Participate in safety planning, relocate or take other actions to protect employee or their family's safety
    - Meet with attorney or social services provider to obtain information and advice related to custody, visitation, matrimonial issues, orders of protection, immigration, housing, discrimination in employment, housing or consumer credit
    - File a domestic incident report with law enforcement
    - Attend civil or criminal court dates related to any act or threat of domestic violence, unwanted sexual contact, stalking or human trafficking

**NYS Sexual Harassment Amendments**

- Changes to the New York State Human Rights Law

- On April 12, 2018, Governor Cuomo signed into law the 2019 New York State Budget that updated the State's sexual harassment laws **[Copy of Statute]**
- What are the new changes to the law?
  - Contractors, subcontractors, vendors, consultants or others providing services in the workplace are now protected from sexual harassment
  - Beginning in October 2018, employers are required to adopt a sexual harassment prevention policy and training or use similar policy and training that meet or exceeds the law's minimum standards
  - No mandatory arbitration
  - Non-disclosure clauses in any settlement or other agreement regarding sexual harassment ***not permitted*** unless confidentiality is the complainant's preference. Further requires complainant to be given 21 days to consider the clause and 7 days to revoke it

- What must a compliant Sexual Harassment Policy contain? **[Copy of Model Policy]**
  - The policy must be provided to employees in writing
  - Harassment policy must:
    - Prohibit sexual harassment and retaliation
    - Provide examples of inappropriate conduct
    - Refer to federal and state laws and mention there may be applicable local laws
    - Include a standard complaint form **[Copy of Model Complaint Form]**
    - Commit to timely, confidential investigation
    - Include administrative and judicial complaint options
    - Ensure due process
    - List available remedies
- Mandatory Sexual Harassment Training **[Copy of Model Training]**
  - Training must provide sexual harassment prevention training to all employees on ***an annual basis***
  - Employer's sexual harassment prevention training must be interactive
    - Live trainer
    - Web-based, with questions asked of employees as part of the program
  - What are some training best practices?

- Clearly define sexual harassment – include examples
- Make clear that the policy prohibits more than unlawful sexual harassment
- Train top to bottom
- Include key policy elements
- Address supervisor conduct and responsibilities
- Enforcement must be public
- Include information concerning redress and all available forums for redress

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|---|---|---|---|
| File #: | Int 1253-2016 Version: A | Name: | Prohibiting employers from inquiring about a prospective employee's salary history. |
| Type: | Introduction | Status: | Enacted |
| | | Committee: | Committee on Civil Rights |
| On agenda: | 8/16/2016 | | |
| Enactment date: | 5/4/2017 | Law number: | 2017/067 |
| Title: | A Local Law to amend the administrative code of the city of New York, in relation to prohibiting employers from inquiring about or relying on a prospective employee's salary history | | |
| Sponsors: | The Public Advocate (Ms. James), Elizabeth S. Crowley, Laurie A. Cumbo, Helen K. Rosenthal, Rafael Salamanca, Jr., Brad S. Lander, Julissa Ferreras-Copeland, Jumaane D. Williams, Donovan J. Richards, Annabel Palma, Daniel Dromm , Deborah L. Rose, Antonio Reynoso, Vanessa L. Gibson, Rafael L. Espinal, Jr., Robert E. Cornegy, Jr., Ben Kallos, Karen Koslowitz, Ydanis A. Rodriguez, Mark Levine, Carlos Menchaca, Costa G. Constantinides, Mark Treyger, Ritchie J. Torres, I. Daneek Miller, Rosie Mendez, Alan N. Maisel, Margaret S. Chin, Inez D. Barron, Darlene Mealy, Andrew Cohen, Andy L. King, Stephen T. Levin, Mathieu Eugene, Ruben Wills, James G. Van Bramer | | |
| Council Member Sponsors: | 36 | | |
| Summary: | This bill would prohibit employers from inquiring about a prospective employee's salary history during all stages of the employment process. In the event that an employer is already aware of a prospective employee's salary history, this bill would prohibit reliance on that information in the determination of salary. When employers rely on salary histories to determine compensation, they perpetuate the gender wage gap. Adopting measures like this bill can reduce the likelihood that women will be prejudiced by prior salary levels and help break the cycle of gender pay inequity. | | |
| Indexes: | Oversight | | |
| Attachments: | 1. Legislative History Report, 2. Summary of Int. No. 1253-A, 3. Int. No. 1253 - 8/16/17, 4. August 16, 2016 - Stated Meeting Agenda with Links to Files, 5. Committee Report 12/13/16, 6. Hearing Testimony 12/13/16, 7. Hearing Transcript 12/13/16, 8. Proposed Int. No. 1253-A - 3/30/17, 9. Committee Report 4/4/17, 10. Hearing Transcript 4/4/17, 11. Committee Report - Stated Meeting, 12. April 5, 2017 - Stated Meeting Agenda with Links to Files, 13. Fiscal Impact Statement, 14. Int. No. 1253-A (FINAL), 15. Hearing Transcript - Stated Meeting 4-5-17, 16. Mayor's Letter, 17. Minutes of the Stated Meeting - April 5, 2017, 18. Local Law 67 | | |



Int. No. 1253-A

By the Public Advocate (Ms. James), Council Members Crowley, Cumbo, Rosenthal, Salamanca, Lander, Ferreras-Copeland, Williams, Richards, Palma, Dromm, Rose, Reynoso, Gibson, Espinal, Cornegy, Kallos, Koslowitz, Rodriguez, Levine, Menchaca, Constantinides, Treyger, Torres, Miller, Mendez, Maisel, Chin, Barron, Mealy, Cohen, King, Levin, Eugene, Wills and Van Bramer

A Local Law to amend the administrative code of the city of New York, in relation to prohibiting employers from inquiring about or relying on a prospective employee's salary history

Be it enacted by the Council as follows:

Section 1. Section 8-107 of the administrative code of the city of New York is amended by adding a new subdivision 25 to read as follows:

25. Employment; inquiries regarding salary history. (a) For purposes of this subdivision, "to inquire" means to communicate any question or statement to an applicant, an applicant's current or prior employer, or a current or former employee or agent of the applicant's current or prior employer, in writing or otherwise, for the purpose of obtaining an applicant's salary history, or to conduct a search of publicly available records or reports for the purpose of obtaining an applicant's salary history, but does not include informing the applicant in writing or otherwise about the position's proposed or anticipated salary or salary range. For purposes of this subdivision, "salary history" includes the applicant's current or prior wage, benefits or other compensation. "Salary history" does not include any objective measure of the applicant's productivity such as revenue, sales, or other production reports.

(b) Except as otherwise provided in this subdivision, it is an unlawful discriminatory practice for an employer, employment agency, or employee or agent thereof:

1. To inquire about the salary history of an applicant for employment; or

2. To rely on the salary history of an applicant in determining the salary, benefits or other compensation for such applicant during the hiring process, including the negotiation of a contract.

(c) Notwithstanding paragraph (b) of this subdivision, an employer, employment agency, or employee or agent thereof may, without inquiring about salary history, engage in discussion with the applicant about their expectations with respect to salary, benefits and other compensation, including but not limited to unvested equity or deferred compensation that an applicant would forfeit or have cancelled by virtue of the applicant's resignation from their current employer.

(d) Notwithstanding subparagraph 2 of paragraph (b) of this subdivision, where an applicant voluntarily and without prompting discloses salary history to an employer, employment agency, or employee or agent thereof, such employer, employment agency, or employee or agent thereof may consider salary history in determining salary, benefits and other compensation for such applicant, and may verify such applicant's salary history.

(e) This subdivision shall not apply to:

(1) Any actions taken by an employer, employment agency, or employee or agent thereof pursuant to any federal, state or local law that specifically authorizes the disclosure or verification of salary history for employment purposes, or specifically requires knowledge of salary history to determine an employee's compensation;

(2) Applicants for internal transfer or promotion with their current employer;

(3) Any attempt by an employer, employment agency, or employee or agent thereof, to verify an applicant's disclosure of non-salary related information or conduct a background check, provided that if such verification or background check discloses the applicant's salary history, such disclosure shall not be relied upon for purposes of determining the salary, benefits or other compensation of such applicant during the hiring process, including the negotiation of a contract; or

(4) Public employee positions for which salary, benefits or other compensation are determined pursuant to procedures established by collective bargaining.

§ 2. This local law takes effect 180 days after it becomes law, provided that the commission on human rights may take such actions as are necessary to implement this local law, including the promulgation of rules, before such date.

BAM/ZH
LS #7886/8042/8388/8513/8769/8775/8777
03/28/17



# ASKING ABOUT SALARY HISTORY DURING THE HIRING PROCESS IS ILLEGAL IN NYC

## EMPLOYER FACT SHEET:

### Protections Against Inquiries into Job Applicants' Salary History

**Starting October 31, 2017, employers in New York City cannot ask about or rely on salary history during the hiring process. The law is aimed at disrupting the cycle of wage inequality for women and people of color and encouraging employers to set compensation based on qualifications.**

**Q. Does this new law apply to my business?**

**A. Yes. This new law applies to all employers in New York City, regardless of size.** If you employ at least one employee in New York City, you must comply with this law.

**Q. Who is protected?**

**A. Most applicants for new jobs in New York City are protected, except:**

- Applicants for internal transfer or promotion with their current employer.
- Applicants for positions with public employers for which compensation is set pursuant to a collective bargaining agreement. However, City government agencies are prohibited from inquiring about or relying on job applicants' salary history pursuant to Mayoral Executive Order 21, signed on November 4, 2016.

**Q. What is prohibited?**

**A. Employers cannot:**

- Ask applicants questions about or solicit information about applicants' current or prior earnings or benefits, for example on job applications.
- Ask applicants' current or former employers or their employees about applicants' current or prior earnings or benefits.
- Search public records to learn about applicants' current or prior earnings or benefits.
- Rely on information about applicants' current or prior earnings or benefits to set their compensation.

**Q. What is not prohibited?**

**A. Employers can:**

- Make statements about the anticipated salary, salary range, bonus, and benefits for a position.
- Inquire about applicants' expectations or requirements for salary, benefits, bonus, or commission structure.
- Ask about objective indicators of applicants' work productivity in their current or prior jobs, such as revenue, sales, production reports, profits generated, or books of business.
- Make inquiries to applicants' current or former employers or search online to verify non-salary information, such as work history, responsibilities, or achievements. However, if this results in the accidental discovery of current or prior earnings or benefits, the employer cannot rely on this information in making salary or benefits decisions.
- Make inquiries about salary history that are authorized or required by federal, state, or local law.
- Verify and consider current or prior earnings or benefits only if offered voluntarily and without prompting by the applicant during the interview process.

**Q. What are the consequences for employers who violate the law?**

**A.** They may be required to pay damages, a fine, and/or be subject to additional affirmative relief such as mandated training and posting requirements.

**To learn more about your responsibilities as an employer in New York City under the NYC Human Rights Law, visit NYC.gov/HumanRights. You can sign up to attend a training on the Law and access materials with helpful information on how to comply.**

#SalaryIsHistoryNYC

@NYCCHR NYC.gov/SalaryHistoryNYC

NYC Commission on Human Rights

**NEW YORK CORRECTION LAW**
**ARTICLE 23-A**

**LICENSURE AND EMPLOYMENT OF PERSONS PREVIOUSLY CONVICTED OF ONE OR MORE CRIMINAL OFFENSES**



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§**750. Definitions.** For the purposes of this article, the following terms shall have the following meanings:

(1) "Public agency" means the state or any local subdivision thereof, or any state or local department, agency, board or commission.

(2) "Private employer" means any person, company, corporation, labor organization or association which employs ten or more persons.

(3) "Direct relationship" means that the nature of criminal conduct for which the person was convicted has a direct bearing on his fitness or ability to perform one or more of the duties or responsibilities necessarily related to the license, opportunity, or job in question.

(4) "License" means any certificate, license, permit or grant of permission required by the laws of this state, its political subdivisions or instrumentalities as a condition for the lawful practice of any occupation, employment, trade, vocation, business, or profession. Provided, however, that "license" shall not, for the purposes of this article, include any license or permit to own, possess, carry, or fire any explosive, pistol, handgun, rifle, shotgun, or other firearm.

(5) "Employment" means any occupation, vocation or employment, or any form of vocational or educational training. Provided, however, that "employment" shall not, for the purposes of this article, include membership in any law enforcement agency.

§751. **Applicability.** The provisions of this article shall apply to any application by any person for a license or employment at any public or private employer, who has previously been convicted of one or more criminal offenses in this state or in any other jurisdiction, and to any license or employment held by any person whose conviction of one or more criminal offenses in this state or in any other jurisdiction preceded such employment or granting of a license, except where a mandatory forfeiture, disability or bar to employment is imposed by law, and has not been removed by an executive pardon, certificate of relief from disabilities or certificate of good conduct. Nothing in this article shall be construed to affect any right an employer may have with respect to an intentional misrepresentation in connection with an application for employment made by a prospective employee or previously made by a current employee.

**§752. Unfair discrimination against persons previously convicted of one or more criminal offenses prohibited.** No application for any license or employment, and no employment or license held by an individual, to which the provisions of this article are applicable, shall be denied or acted upon adversely by reason of the individual's having been previously convicted of one or more criminal offenses, or by reason of a finding of lack of "good moral character" when such finding is based upon the fact that the individual has previously been convicted of one or more criminal offenses, unless:

(1) There is a direct relationship between one or more of the previous criminal offenses and the specific license or employment sought or held by the individual; or

(2) the issuance or continuation of the license or the granting or continuation of the employment would involve an unreasonable risk to property or to the safety or welfare of specific individuals or the general public.

**§753. Factors to be considered concerning a previous criminal conviction; presumption.** 1. In making a determination pursuant to section seven hundred fifty-two of this chapter, the public agency or private employer shall consider the following factors:

(a) The public policy of this state, as expressed in this act, to encourage the licensure and employment of persons previously convicted of one or more criminal offenses.

(b) The specific duties and responsibilities necessarily related to the license or employment sought or held by the person.

(c) The bearing, if any, the criminal offense or offenses for which the person was previously convicted will have on his fitness or ability to perform one or more such duties or responsibilities.

(d) The time which has elapsed since the occurrence of the criminal offense or offenses.

(e) The age of the person at the time of occurrence of the criminal offense or offenses.

(f) The seriousness of the offense or offenses.

(g) Any information produced by the person, or produced on his behalf, in regard to his rehabilitation and good conduct.

(h) The legitimate interest of the public agency or private employer in protecting property, and the safety and welfare of specific individuals or the general public.

2. In making a determination pursuant to section seven hundred fifty-two of this chapter, the public agency or private employer shall also give consideration to a certificate of relief from disabilities or a certificate of good conduct issued to the applicant, which certificate shall create a presumption of rehabilitation in regard to the offense or offenses specified therein.

**§754. Written statement upon denial of license or employment.** At the request of any person previously convicted of one or more criminal offenses who has been denied a license or employment, a public agency or private employer shall provide, within thirty days of a request, a written statement setting forth the reasons for such denial.

**§755. Enforcement.** 1. In relation to actions by public agencies, the provisions of this article shall be enforceable by a proceeding brought pursuant to article seventy-eight of the civil practice law and rules.

2. In relation to actions by private employers, the provisions of this article shall be enforceable by the division of human rights pursuant to the powers and procedures set forth in article fifteen of the executive law, and, concurrently, by the New York city commission on human rights.

# The New York City Council

Corey Johnson, Speaker



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|---|---|---|---|
| File #: | Int 0318-2014 Version: A | Name: | Prohibiting discrimination based on one's arrest record or criminal conviction. |
| Type: | Introduction | Status: | Enacted |
| | | Committee: | Committee on Civil Rights |
| On agenda: | 4/29/2014 | | |
| Enactment date: | 6/29/2015 | Law number: | 2015/063 |
| Title: | A Local Law to amend the administrative code of the city of New York, in relation to prohibiting discrimination based on one's arrest record or criminal conviction | | |
| Sponsors: | Jumaane D. Williams, Corey D. Johnson, Ritchie J. Torres, I. Daneek Miller, Vanessa L. Gibson, Margaret S. Chin, Annabel Palma, The Public Advocate (Ms. James), Maria Del Carmen Arroyo, Robert E. Cornegy, Jr., Daniel Dromm , Peter A. Koo, Mark Levine, Antonio Reynoso, Donovan J. Richards, Rafael L. Espinal, Jr., Stephen T. Levin, Carlos Menchaca, Inez E. Dickens, Inez D. Barron, Helen K. Rosenthal, Laurie A. Cumbo, Deborah L. Rose, Ydanis A. Rodriguez, Andy L. King, Karen Koslowitz, Ruben Wills, Rosie Mendez, Ben Kallos, Brad S. Lander, Mathieu Eugene, Fernando Cabrera , Costa G. Constantinides, Julissa Ferreras-Copeland, Alan N. Maisel, (by request of the Manhattan Borough President) | | |
| Council Member Sponsors: | 36 | | |
| Attachments: | 1. Int. No. 318 - 4/29/15, 2. Committee Report 12/3/14, 3. Hearing Testimony 12/3/14, 4. Hearing Transcript 12/3/14, 5. Committee Report 6/9/15, 6. Hearing Testimony 6/9/15, 7. Hearing Transcript 6/9/15, 8. June 10, 2015 - Stated Meeting Agenda with Links to Files, 9. Fiscal Impact Statement, 10. Mayor's Letter, 11. Hearing Transcript - Stated Meeting 6-10-15, 12. Minutes of the Stated Meeting - June 10, 2015, 13. Local Law 63 | | |



Int. No. 318-A

By Council Members Williams, Johnson, Torres, Miller, Gibson, Chin, Palma, the Public Advocate (Ms. James), Arroyo, Cornegy, Dromm, Koo, Levine, Reynoso, Richards, Espinal, Levin, Menchaca, Dickens, Barron, Rosenthal, Cumbo, Rose, Rodriguez, King, Koslowitz, Wills, Mendez, Kallos, Lander, Eugene, Cabrera, Constantinides, Ferreras-Copeland and Maisel (by the request of the Manhattan Borough President)

A Local Law to amend the administrative code of the city of New York, in relation to prohibiting discrimination based on one's arrest record or criminal conviction

Be it enacted by the Council as follows:

Section 1. Subdivision 5 of section 8-102 of tile 8 of the administrative code of the city of New York is amended to read as follows:

5. For purposes of subdivisions one, two, three, eleven-a, twenty-two, subparagraph one of paragraph a of subdivision twenty-one, and paragraph e of subdivision twenty-one of section 8-107 of this chapter, the term "employer" does not include any employer with fewer than four persons in his or her employ. For purposes of this subdivision, natural persons employed as independent contractors to carry out work in furtherance of an employer's business enterprise who are not themselves employers shall be counted as persons in the employ of such employer.

§ 2. Subdivisions 9, 10 and 11 of section 8-107 of the administrative code of the city of New York, as amended by local law 37 for the year 2015, are amended and new subdivisions 11-a and 11-b are added to read as follows:

9. Licenses, registrations and [Permits] permits. (a) It shall be an unlawful discriminatory practice:

[(a)] (1) Except as otherwise provided in paragraph (c) of this subdivision, for an agency authorized to issue a license, registration or permit or an employee thereof to discriminate against an applicant for a license, registration or permit because of the actual or perceived race, creed, color, national origin, age, gender, marital status, partnership status, disability, sexual orientation or alienage or citizenship status of such applicant.

[(b)] (2) Except as otherwise provided in paragraph (c) of this subdivision, for an agency authorized to issue a license, registration or permit or an employee thereof to declare, print or circulate or cause to be declared, printed or circulated any statement, advertisement or publication, or to use any form of application for a license, registration or permit or to make any inquiry in connection with any such application, which expresses, directly or indirectly, any limitation, specification or discrimination as to race, creed, color, national origin, age, gender, marital status, partnership status, disability, sexual orientation or alienage or citizenship status, or any intent to make any such limitation, specification or discrimination.

[(c)Nothing contained in this subdivision shall be construed to bar an agency authorized to issue a license or permit from using age or disability as a criterion for determining eligibility for a license or permit when specifically required to do so by any other provision of law.] (3) For any person to deny any license, registration or permit to any applicant, or act adversely upon any holder of a license, registration or permit by reason of his or her having been convicted of one or more criminal offenses, or by reason of a finding of a lack of "good moral character" which is based on his or her having been convicted of one or more criminal offenses,

when such denial or adverse action is in violation of the provisions of article twenty-three-a of the correction law.

(4) For any person to deny any license, registration or permit to any applicant, or act adversely upon any holder of a license, registration or permit by reason of his or her having been arrested or accused of committing a crime when such denial or adverse action is in violation of subdivision 16 of section 296 of article 15 of the New York state executive law.

(5) For any person to make any inquiry, in writing or otherwise, regarding any arrest or criminal accusation of an applicant for any license, registration or permit when such inquiry is in violation of subdivision 16 of section 296 of article 15 of the New York state executive law.

(b) (1) Except as otherwise provided in this paragraph, it shall be an unlawful discriminatory practice for an agency to request or use for licensing, registration or permitting purposes information contained in the consumer credit history of an applicant, licensee, registrant or permittee for licensing or permitting purposes.

(2) Subparagraph (1) of this paragraph shall not apply to an agency required by state or federal law or regulations to use an individual's consumer credit history for licensing, registration or permitting purposes.

(3) Subparagraph (1) of this paragraph shall not be construed to affect the ability of an agency to consider an applicant's, licensee's, registrant's or permittee's failure to pay any tax, fine, penalty, or fee for which liability has been admitted by the person liable therefor, or for which judgment has been entered by a court or administrative tribunal of competent jurisdiction, or any tax for which a government agency has issued a warrant, or a lien or levy on property.

(4) Nothing in this paragraph shall preclude a licensing agency from requesting, receiving, or using consumer credit history information obtained pursuant to a lawful subpoena, court order or law enforcement investigation.

(c) The prohibition of this subdivision relating to inquiries, denials or other adverse action related to a person's record of arrests or convictions shall not apply to licensing activities in relation to the regulation of explosives, pistols, handguns, rifles, shotguns, or other firearms and deadly weapons. Nothing contained in this subdivision shall be construed to bar an agency authorized to issue a license, registration or permit from using age, [or] disability, criminal conviction or arrest record as a criterion for determining eligibility or continuing fitness for a license, registration or permit when specifically required to do so by any other provision of law.

10. Criminal conviction; employment. (a) It shall be an unlawful discriminatory practice for any [person] employer, employment agency or agent thereof to deny [any license or permit or] employment to any person or take adverse action against any employee by reason of [his or her] such person or employee having been convicted of one or more criminal offenses, or by reason of a finding of a lack of "good moral character" which is based on [his or her] such person or employee having been convicted of one or more criminal offenses, when such denial or adverse action is in violation of the provisions of article twenty-three-a of the correction law.

(b) For purposes of this subdivision, "employment" shall not include membership in any law enforcement agency.

(c) Pursuant to section seven hundred fifty-five of the correction law, the provisions of this subdivision shall be enforceable against public agencies by a proceeding brought pursuant to article seventy-eight of the Civil Practice Law and Rules, and the provisions of this subdivision shall be enforceable against private employers by the commission through the administrative procedure provided for in this chapter or as provided in chapter five of this title. For purposes of this paragraph only, the terms "public agency" and "private employer" shall have the meaning given such terms in section seven hundred fifty of the correction law.

11. Arrest record; employment. It shall be an unlawful discriminatory practice, unless specifically required or permitted by any other law, for any person to:

(a) deny employment to any applicant or act adversely upon any employee by reason of an arrest or criminal accusation of such applicant or employee when such denial or adverse action is in violation of subdivision 16 of section 296 of article 15 of the New York state executive law; or

(b) make any inquiry [about, whether in any form of application or otherwise, or to act upon adversely to the person involved, any arrest or criminal accusation of such person not then pending against that person which was followed by a termination of that criminal action or proceeding in favor of such person, as defined in subdivision two of section 160.50 of the criminal procedure law, in connection with the licensing, employment or providing of credit to such person; provided, however, that the prohibition of such inquiries or adverse action shall not apply to licensing activities in relation to the regulation of guns firearms and other deadly weapons or in relation to an application for employment as a police officer or peace officer as those terms are defined in subdivisions thirty-three and thirty-four of section 1.20 of the Criminal Procedure Law] in writing or otherwise, regarding any arrest or criminal accusation of an applicant or employee when such inquiry is in violation of subdivision 16 of section 296 of article 15 of the New York state executive law.

11-a. Arrest and conviction records; employer inquiries. (a) In addition to the restrictions in subdivision 11 of this section, it shall be an unlawful discriminatory practice for any employer, employment agency or agent thereof to:

(1) Declare, print or circulate or cause to be declared, printed or circulated any solicitation, advertisement or publication, which expresses, directly or indirectly, any limitation, or specification in employment based on a person's arrest or criminal conviction; or

(2) Make any inquiry or statement related to the pending arrest or criminal conviction record of any person who is in the process of applying for employment with such employer or agent thereof until after such employer or agent thereof has extended a conditional offer of employment to the applicant. For purposes of this subdivision, with respect to an applicant for temporary employment at a temporary help firm as such term is defined by subdivision five of section 916 of article 31 of the New York labor law, an offer to be placed in the temporary help firm's general candidate pool shall constitute a conditional offer of employment. For purposes of this subdivision, "any inquiry" means any question communicated to an applicant in writing or otherwise, or any searches of publicly available records or consumer reports that are conducted for the purpose of obtaining an applicant's criminal background information. For purposes of this subdivision, "any statement" means a statement communicated in writing or otherwise to the applicant for purposes of obtaining an applicant's criminal background information regarding: (i) an arrest record; (ii) a conviction record; or (iii) a criminal background check.

(b) After extending an applicant a conditional offer of employment, an employer, employment agency or agent thereof may inquire about the applicant's arrest or conviction record if before taking any adverse employment action based on such inquiry, the employer, employment agency or agent thereof:

(i) provides a written copy of the inquiry to the applicant in a manner to be determined by the commission;

(ii) performs an analysis of the applicant under article twenty-three-a of the correction law and provides a written copy of such analysis to the applicant in a manner to be determined by the commission, which shall include but not be limited to supporting documents that formed the basis for an adverse action based on such analysis and the employer's or employment agency's reasons for taking any adverse action against such applicant; and

(iii) after giving the applicant the inquiry and analysis in writing pursuant to subparagraphs (i) and (ii) of this paragraph, allows the applicant a reasonable time to respond, which shall be no less than three business

days and during this time, holds the position open for the applicant.

(c) Nothing in this subdivision shall prevent an employer, employment agency or agent thereof from taking adverse action against any employee or denying employment to any applicant for reasons other than such employee or applicant's arrest or criminal conviction record.

(d) An applicant shall not be required to respond to any inquiry or statement that violates paragraph (a) of this subdivision and any refusal to respond to such inquiry or statement shall not disqualify an applicant from the prospective employment.

(e) This subdivision shall not apply to any actions taken by an employer or agent thereof pursuant to any state, federal or local law that requires criminal background checks for employment purposes or bars employment based on criminal history. For purposes of this paragraph federal law shall include rules or regulations promulgated by a self-regulatory organization as defined in section 3(a)(26) of the securities exchange act of 1934, as amended.

(f) This subdivision shall not apply to any actions taken by an employer or agent thereof with regard to an applicant for employment:

(1) as a police officer or peace officer, as those terms are defined in subdivisions thirty-three and thirty-four of section 1.20 of the criminal procedure law, respectively, or at a law enforcement agency as that term is used in article 23-a of the correction law, including but not limited to the police department, the fire department, the department of correction, the department of investigation, the department of probation, the division of youth and family services, the business integrity commission, and the district attorneys' offices; or

(2) listed in the determinations of personnel published as a commissioner's calendar item and listed on the website of the department of citywide administrative services upon a determination by the commissioner of citywide administrative services that the position involves law enforcement, is susceptible to bribery or other corruption, or entails the provision of services to or safeguarding of persons who, because of age, disability, infirmity or other condition, are vulnerable to abuse. If the department takes adverse action against any applicant based on the applicant's arrest or criminal conviction record, it shall provide a written copy of such analysis performed under article twenty-three a of the correction law to the applicant in a form and manner to be determined by the department.

(g) The provisions of this subdivision shall be enforceable against public agencies by a proceeding brought pursuant to article seventy-eight of the Civil Practice Law and Rules, and the provisions of this subdivision shall be enforceable against private employers by the commission through the administrative

procedure provided for in this chapter or as provided in chapter five of this title. For purposes of this paragraph only, the terms "public agency" and "private employer" shall have the meaning given such terms in section seven hundred fifty of the correction law.

11-b. Arrest record; credit application. For purposes of issuing credit, it shall be an unlawful discriminatory practice, unless specifically required or permitted by any other law, to:

(a) deny or act adversely upon any person seeking credit by reason of an arrest or criminal accusation of such person when such denial or adverse action is in violation of subdivision 16 of section 296 of article 15 of the New York state executive law; or

(b) make any inquiry in writing or otherwise, regarding any arrest or criminal accusation of a person seeking credit when such inquiry is in violation of subdivision 16 of section 296 of article 15 of the New York state executive law.

§ 3. The commission on human rights shall engage in outreach and education efforts regarding the rights of current and prospective employees, and the responsibilities of employers, established by this local law. Such outreach and education shall be directed at public and private employers, and the general public.

§ 4. This local law shall take effect 120 days after its enactment, provided, however, that the commissioner shall take any actions necessary prior to such effective date for the implementation of this local law including, but not limited to, the adoption of any necessary rules.

JEB/RC
Int. No. 912/2012
LS #80, #260, #755
6/2/15

NEW YORK STATE | Paid Family Leave

# 2019 STATEMENT OF RIGHTS FOR PAID FAMILY LEAVE

## IF YOU NEED TO TAKE TIME OFF FROM WORK TO CARE FOR A FAMILY MEMBER, YOU MAY BE ENTITLED TO PAID FAMILY LEAVE BENEFITS

**Paid Family Leave is employee-funded insurance that provides job-protected, paid time off to:**

- Bond with a newly born, adopted or fostered child;
- Care for a family member with a serious health condition; or
- Assist loved ones when a spouse, domestic partner, child or parent is called to active military service abroad.

**Eligibility:**

- Employees with a regular work schedule of **20 or more hours per week** are eligible after **26 consecutive weeks** of employment.
- Employees with a regular work schedule of **less than 20 hours per week** are eligible after **175 days worked**.

Citizenship or immigration status is not a factor in your eligibility.

**Benefits:** In 2019, you can take up to 10 weeks of Paid Family Leave and receive 55% of your average weekly wage, capped at 55% of the New York State average weekly wage. Generally, your average weekly wage is the average of your last eight weeks of pay prior to starting Paid Family Leave.

**Rights and Protections:**

- **Job Protection:** Return to the same or comparable job after you take leave.
- You keep your **health insurance** while on leave (you may have to continue paying your portion of the premium costs, if any).
- Your **employer is prohibited from discriminating or retaliating** against you for requesting or taking Paid Family Leave.
- You **do not have to exhaust sick leave or vacation** accruals before using Paid Family Leave.

**Paid Family Leave Request Process:**

1. Notify your employer at least 30 days in advance, if foreseeable, or as soon as possible.
2. Complete and submit the *Request for Paid Family Leave (Form PFL-1)* to your employer.
3. Complete and attach the additional forms as required and submit to the insurance carrier listed below **within 30 days of starting your leave, to avoid losing benefits**.
4. In most cases, the insurance carrier must pay or deny benefits within 18 calendar days of receiving your completed request or your first day of leave, whichever is later.

You may obtain all forms from your employer, their insurance carrier listed below or online at PaidFamilyLeave.ny.gov/Forms.

**Disputes:**

If your Paid Family Leave claim is denied, you may request to have the denial reviewed by a neutral arbitrator. The insurance carrier listed below will provide you with information about requesting arbitration.

**Discrimination Complaints:**

If your employer terminates your employment, reduces your pay and/or benefits, or disciplines you in any way as a result of you requesting or taking Paid Family Leave, you may request to be reinstated by taking these steps:

1. Complete the *Formal Request for Reinstatement Regarding Paid Family Leave (Form PFL-DC-119)*
2. Send your completed form to your employer and a copy of the completed form to: Paid Family Leave, P.O. Box 9030, Endicott, NY 13761-9030
3. If your employer does not reinstate you **or take other corrective action** within 30 days, you may file a discrimination complaint with the Workers' Compensation Board using the *Paid Family Leave Discrimination/Retaliation Complaint (Form PFL-DC-120)*, available at PaidFamilyLeave.ny.gov/Forms. The Workers' Compensation Board will assemble your case and schedule a hearing.
4. There are other state and federal laws that protect employees from discrimination. Additional information is available at PaidFamilyLeave.ny.gov.

**For more information, forms, and instructions, visit PaidFamilyLeave.ny.gov or call (844)-337-6303.**

This information is a simplified presentation of your rights as required by Section 229 of the Disability and Paid Family Leave Benefits Law. Your employer's Paid Family Leave benefits insurance carrier is:

**PRESCRIBED BY THE CHAIR, WORKERS' COMPENSATION BOARD**

**Note:** New York City businesses must comply with all relevant federal, state, and City laws and rules. All laws and rules of the City of New York, including the Consumer Protection Law and Rules, are available through the Public Access Portal, which businesses can access by visiting www.nyc.gov/dca. The Law and Rules are current as of May 2018.

Please note that businesses are responsible for knowing and complying with the most current laws, including any City Council amendments. The Department of Consumer Affairs (DCA) is not responsible for errors or omissions in this packet. The information is not legal advice. You can only obtain legal advice from a lawyer.

## NEW YORK CITY ADMINISTRATIVE CODE
## TITLE 20: CONSUMER AFFAIRS
## CHAPTER 8: EARNED SAFE AND SICK TIME ACT

### § 20-911. Short title.

This chapter shall be known and may be cited as the "Earned Safe and Sick Time Act."

### § 20-912. Definitions.

When used in this chapter, the following terms shall be defined as follows:

"Calendar year" shall mean a regular and consecutive twelve month period, as determined by an employer.

"Chain business" shall mean any employer that is part of a group of establishments that share a common owner or principal who owns at least thirty percent of each establishment where such establishments (i) engage in the same business or (ii) operate pursuant to franchise agreements with the same franchisor as defined in general business law section 681; provided that the total number of employees of all such establishments in such group is at least five.

"Child" shall mean a biological, adopted or foster child, a legal ward, or a child of an employee standing in loco parentis.

"Commissioner" shall mean the head of such office or agency as the mayor shall designate pursuant to section 20-a of the charter.

"Department" shall mean such office or agency as the mayor shall designate pursuant to section 20-a of the charter.

"Domestic partner" shall mean any person who has a registered domestic partnership pursuant to section 3-240 of the code, a domestic partnership registered in accordance with executive order number 123, dated August 7, 1989, or a domestic partnership registered in accordance with executive order number 48, dated January 7, 1993.

"Domestic worker" shall mean any "domestic worker" as defined in section 2(16) of the labor law who is employed for hire within the city of New York for more than eighty hours in a calendar year who performs work on a full-time or part-time basis.

"Employee" shall mean any "employee" as defined in subdivision 2 of section 190 of the labor law who is employed for hire within the city of New York for more than eighty hours in a calendar year who performs work on a full-time or part-time basis, including work performed in a transitional jobs program pursuant to section 336-f of the social services law, but not including work performed as a participant in a work experience program pursuant to section 336-c of the social services law, and not including those who are employed by (i) the United States government; (ii) the state of New York, including any office, department, independent agency, authority, institution, association, society or other body of the state including the legislature and the judiciary; or (iii) the city of New York or any local government, municipality or county or any entity governed by section 92 of the general municipal law or section 207 of the county law.

"Employer" shall mean any "employer" as defined in subdivision (3) of section 190 of the labor law, but not including (i) the United States government; (ii) the state of New York, including any office,

department, independent agency, authority, institution, association, society or other body of the state including the legislature and the judiciary; or (iii) the city of New York or any local government, municipality or county or any entity governed by general municipal law section 92 or county law section 207. In determining the number of employees performing work for an employer for compensation during a given week, all employees performing work for compensation on a full-time, part-time or temporary basis shall be counted, provided that where the number of employees who work for an employer for compensation per week fluctuates, business size may be determined for the current calendar year based upon the average number of employees who worked for compensation per week during the preceding calendar year, and provided further that in determining the number of employees performing work for an employer that is a chain business, the total number of employees in that group of establishments shall be counted.

"Family member" shall mean an employee's child, spouse, domestic partner, parent, sibling, grandchild or grandparent; the child or parent of an employee's spouse or domestic partner; and any other individual related by blood to the employee; and any other individual whose close association with the employee is the equivalent of a family relationship.

"Family offense matter" shall mean an act or threat of an act that may constitute disorderly conduct, harassment in the first degree, harassment in the second degree, aggravated harassment in the second degree, sexual misconduct, forcible touching, sexual abuse in the third degree, sexual abuse in the second degree as set forth in subdivision 1 of section 130.60 of the penal law, stalking in the first degree, stalking in the second degree, stalking in the third degree, stalking in the fourth degree, criminal mischief, menacing in the second degree, menacing in the third degree, reckless endangerment, strangulation in the first degree, strangulation in the second degree, criminal obstruction of breathing or blood circulation, assault in the second degree, assault in the third degree, an attempted assault, identity theft in the first degree, identity theft in the second degree, identity theft in the third degree, grand larceny in the fourth degree, grand larceny in the third degree or coercion in the second degree as set forth in subdivisions 1, 2 and 3 of section 135.60 of the penal law between spouses or former spouses, or between parent and child or between members of the same family or household.

"Grandchild" shall mean a child of an employee's child.

"Grandparent" shall mean a parent of an employee's parent. "Health care provider" shall mean any person licensed under federal or New York state law to provide medical or emergency services, including, but not limited to, doctors, nurses and emergency room personnel.

"Hourly professional employee" shall mean any individual (i) who is professionally licensed by the New York state education department, office of professions, under the direction of the New York state board of regents under education law sections 6732, 7902 or 8202, (ii) who calls in for work assignments at will determining his or her own work schedule with the ability to reject or accept any assignment referred to them and (iii) who is paid an average hourly wage which is at least four times the federal minimum wage for hours worked during the calendar year.

"Human trafficking" shall mean an act or threat of an act that may constitute sex trafficking, as defined in section 230.34 of the penal law, or labor trafficking, as defined in section 135.35 and 135.36 of the penal law.

"Member of the same family or household" shall mean (i) persons related by consanguinity or affinity; (ii) persons legally married to or in a domestic partnership with one another; (iii) persons formerly married to or in a domestic partnership with one another regardless of whether they still reside in the same household; (iv) persons who have a child in common, regardless of whether such persons have been married or domestic partners or have lived together at any time; and (v) persons who are not related by consanguinity or affinity and who are or have been in an intimate relationship regardless of whether such persons have lived together at any time.

"Paid safe/sick time" shall mean time that is provided by an employer to an employee that can be used for the purposes described in section 20-914 of this chapter and is compensated at the same rate as the employee earns from his or her employment at the time the employee uses such time, except that an employee who volunteers or agrees to work hours in addition to his or her normal schedule will not receive more in paid safe/sick time compensation than his or her regular hourly wage if such

employee is not able to work the hours for which he or she has volunteered or agreed even if the reason for such inability to work is one of the reasons in section 20-914 of this chapter. In no case shall an employer be required to pay more to an employee for paid safe/sick time than the employee's regular rate of pay at the time the employee uses such paid safe/sick time, except that in no case shall the paid safe/sick time hourly rate be less than the hourly rate provided in subdivision 1 of section 652 of the labor law.

"Parent" shall mean a biological, foster, step- or adoptive parent, or a legal guardian of an employee, or a person who stood in loco parentis when the employee was a minor child.

"Public disaster" shall mean an event such as fire, explosion, terrorist attack, severe weather conditions or other catastrophe that is declared a public emergency or disaster by the president of the United States, the governor of the state of New York or the mayor of the city of New York.

"Public health emergency" shall mean a declaration made by the commissioner of health and mental hygiene pursuant to subdivision d of section 3.01 of the New York city health code or by the mayor pursuant to section 24 of the executive law.

"Public service commission" shall mean the public service commission established by section 4 of the public service law.

"Retaliation" shall mean any threat, discipline, discharge, demotion, suspension, reduction in employee hours, or any other adverse employment action against any employee for exercising or attempting to exercise any right guaranteed under this chapter.

"Safe time" shall mean time that is provided by an employer to an employee that can be used for the purposes described in subdivision b of section 20-914 of this chapter, whether or not compensation for that time is required pursuant to this chapter.

"Sexual offense" shall mean an act or threat of an act that may constitute a violation of article 130 of the penal law.

"Sibling" shall mean an employee's brother or sister, including half-siblings, step-siblings and siblings related through adoption.

"Sick time" shall mean time that is provided by an employer to an employee that can be used for the purposes described in subdivision a of section 20-914 of this chapter, whether or not compensation for that time is required pursuant to this chapter.

"Spouse" shall mean a person to whom an employee is legally married under the laws of the state of New York.

"Stalking" shall mean an act or threat of an act that may constitute a violation of section 120.45, 120.50, 120.55, or 120.60 of the penal law.

**§ 20-913. Right to safe/sick time; accrual.**

a. All employees have the right to safe/sick time pursuant to this chapter.
   1. All employers that employ five or more employees and all employers of one or more domestic workers shall provide paid safe/sick time to their employees in accordance with the provisions of this chapter.
   2. All employees not entitled to paid safe/sick time pursuant to this chapter shall be entitled to unpaid sick time in accordance with the provisions of this chapter.

b. All employers shall provide a minimum of one hour of safe/sick time for every thirty hours worked by an employee, other than a domestic worker who shall accrue safe/sick time pursuant to paragraph 2 of subdivision d of this section. Employers shall not be required under this chapter to provide more than forty hours of safe/sick time for an employee in a calendar year. For purposes of this subdivision, any paid days of rest to which a domestic worker is entitled pursuant to subdivision 1 of section 161of the labor law shall count toward such forty hours. Nothing in this chapter shall be construed to discourage or prohibit an employer from allowing the accrual of safe/sick time at a faster rate or use of safe/sick time at an earlier date than this chapter requires.

c. An employer required to provide paid safe/sick time pursuant to this chapter who provides an employee with an amount of paid leave, including paid time off, paid vacation, paid personal days or paid days of rest required to be compensated pursuant to subdivision 1 of section 161of the labor law, sufficient to meet the requirements of this section and who allows such paid leave to be

used for the same purposes and under the same conditions as safe/sick time required pursuant to this chapter, is not required to provide additional paid safe/sick time for such employee whether or not such employee chooses to use such leave for the purposes included in subdivision a of section 20-914 of this chapter. An employer required to provide unpaid safe/sick time pursuant to this chapter who provides an employee with an amount of unpaid or paid leave, including unpaid or paid time off, unpaid or paid vacation, or unpaid or paid personal days, sufficient to meet the requirements of this section and who allows such leave to be used for the same purposes and under the same conditions as safe/sick time required pursuant to this chapter, is not required to provide additional unpaid safe/sick time for such employee whether or not such employee chooses to use such leave for the purposes set forth in subdivision a of section 20-914 of this chapter.

d. 1. For an employee other than a domestic worker, safe/sick time as provided pursuant to this chapter shall begin to accrue at the commencement of employment or on the effective date of this local law, whichever is later, and an employee shall be entitled to begin using safe/sick time on the one hundred twentieth calendar day following commencement of his or her employment or on the one hundred twentieth calendar day following the effective date of this local law, whichever is later. After the one hundred twentieth calendar day of employment or after the one hundred twentieth calendar day following the effective date of this local law, whichever is later, such employee may use safe/sick time as it is accrued.

   2. In addition to the paid day or days of rest to which a domestic worker is entitled pursuant to section 161(1) of the labor law, such domestic worker shall also be entitled to two days of paid safe/sick time as of the date that such domestic worker is entitled to such paid day or days of rest and annually thereafter, provided that notwithstanding any provision of this chapter to the contrary, such two days of paid safe/sick time shall be calculated in the same manner as the paid day or days of rest are calculated pursuant to the provisions of section 161(1) of the labor law.

e. Employees who are not covered by the overtime requirements of New York state law or regulations, including the wage orders promulgated by the New York commissioner of labor pursuant to article 19 or 19-A of the labor law, shall be assumed to work forty hours in each work week for purposes of safe/sick time accrual unless their regular work week is less than forty hours, in which case safe/sick time accrues based upon that regular work week.

f. The provisions of this chapter do not apply to (i) work study programs under 42 U.S.C. section 2753, (ii) employees for the hours worked and compensated by or through qualified scholarships as defined in 26 U.S.C. section 117, (iii) independent contractors who do not meet the definition of employee under section 190(2) of the labor law, and (iv) hourly professional employees.

g. Employees shall determine how much earned safe/sick time they need to use, provided that employers may set a reasonable minimum increment for the use of safe/sick time not to exceed four hours per day.

h. Except for domestic workers, up to forty hours of unused safe/sick time as provided pursuant to this chapter shall be carried over to the following calendar year; provided that no employer shall be required to (i) allow the use of more than forty hours of safe/sick time in a calendar year or (ii) carry over unused paid safe/sick time if the employee is paid for any unused safe/sick time at the end of the calendar year in which such time is accrued and the employer provides the employee with an amount of paid safe/sick time that meets or exceeds the requirements of this chapter for such employee for the immediately subsequent calendar year on the first day of such year.

i. Nothing in this chapter shall be construed as requiring financial or other reimbursement to an employee from an employer upon the employee's termination, resignation, retirement, or other separation from employment for accrued sick time that has not been used.

j. If an employee is transferred to a separate division, entity or location in the city of New York, but remains employed by the same employer, such employee is entitled to all safe/sick time accrued at the prior division, entity or location and is entitled to retain or use all safe/sick time as provided pursuant to the provisions of this chapter. When there is a separation from employment and the employee is rehired within six months of separation by the same employer, previously accrued safe/sick time that was not used shall be reinstated and such employee shall be entitled to use such accrued safe/sick time at any time after such employee is rehired, provided that no employer shall

be required to reinstate such safe/sick time to the extent the employee was paid for unused accrued safe/sick time prior to separation and the employee agreed to accept such pay for such unused safe/sick time.

**§ 20-914. Use of safe/sick time.**

a. Sick time.

1. An employee shall be entitled to use sick time for absence from work due to:

(a) such employee's mental or physical illness, injury or health condition or need for medical diagnosis, care or treatment of a mental or physical illness, injury or health condition or need for preventive medical care; or

(b) care of a family member who needs medical diagnosis, care or treatment of a mental or physical illness, injury or health condition or who needs preventive medical care; or

(c) closure of such employee's place of business by order of a public official due to a public health emergency or such employee's need to care for a child whose school or childcare provider has been closed by order of a public official due to a public health emergency.

2. For an absence of more than three consecutive work days for sick time, an employer may require reasonable documentation that the use of sick time was authorized by this subdivision. For sick time used pursuant to this subdivision, documentation signed by a licensed health care provider indicating the need for the amount of sick time taken shall be considered reasonable documentation and an employer shall not require that such documentation specify the nature of the employee's or the employee's family member's injury, illness or condition, except as required by law.

b. Safe time.

1. An employee shall be entitled to use safe time for absence from work due to any of the following reasons when the employee or a family member has been the victim of a family offense matter, sexual offense, stalking, or human trafficking:

(a) to obtain services from a domestic violence shelter, rape crisis center, or other shelter or services program for relief from a family offense matter, sexual offense, stalking, or human trafficking;

(b) to participate in safety planning, temporarily or permanently relocate, or take other actions to increase the safety of the employee or employee's family members from future family offense matters, sexual offenses, stalking, or human trafficking;

(c) to meet with a civil attorney or other social service provider to obtain information and advice on, and prepare for or participate in any criminal or civil proceeding, including but not limited to, matters related to a family offense matter, sexual offense, stalking, human trafficking, custody, visitation, matrimonial issues, orders of protection, immigration, housing, discrimination in employment, housing or consumer credit;

(d) to file a complaint or domestic incident report with law enforcement;

(e) to meet with a district attorney's office;

(f) to enroll children in a new school; or

(g) to take other actions necessary to maintain, improve, or restore the physical, psychological, or economic health or safety of the employee or the employee's family member or to protect those who associate or work with the employee.

2. For an absence of more than three consecutive work days for safe time, an employer may require reasonable documentation that the use of safe time was authorized by this subdivision. For safe time used pursuant to this subdivision, documentation signed by an employee, agent, or volunteer of a victim services organization, an attorney, a member of the clergy, or a medical or other professional service provider from whom the employee or that employee's family member has sought assistance in addressing family offense matters, sex offenses, stalking, or human trafficking and their effects; a police or court record; or a notarized letter from the employee explaining the need for such time shall be considered reasonable documentation and an employer shall not require that such documentation specify the details of the family offense matter, sexual offense, stalking, or human trafficking.

c. An employer may require reasonable notice of the need to use safe/sick time. Where such need is foreseeable, an employer may require reasonable advance notice of the intention to use such safe/sick

time, not to exceed seven days prior to the date such safe/sick time is to begin. Where such need is not foreseeable, an employer may require an employee to provide notice of the need for the use of safe/sick time as soon as practicable.

d. Nothing herein shall prevent an employer from requiring an employee to provide written confirmation that an employee used safe/sick time pursuant to this section.

e. An employer shall not require an employee, as a condition of taking safe/sick time, to search for or find a replacement worker to cover the hours during which such employee is utilizing time.

f. Nothing in this chapter shall be construed to prohibit an employer from taking disciplinary action, up to and including termination, against a worker who uses safe/sick time provided pursuant to this chapter for purposes other than those described in this section.

**§ 20-915. Changing schedule.**

Upon mutual consent of the employee and the employer, an employee who is absent for a reason listed in subdivision a of section 20-914 of this chapter may work additional hours during the immediately preceding seven days if the absence was foreseeable or within the immediately subsequent seven days from that absence without using safe/sick time to make up for the original hours for which such employee was absent, provided that an adjunct professor who is an employee at an institute of higher education may work such additional hours at any time during the academic term. An employer shall not require such employee to work additional hours to make up for the original hours for which such employee was absent or to search for or find a replacement employee to cover the hours during which the employee is absent pursuant to this section. If such employee works additional hours, and such hours are fewer than the number of hours such employee was originally scheduled to work, then such employee shall be able to use safe/sick time provided pursuant to this chapter for the difference. Should the employee work additional hours, the employer shall comply with any applicable federal, state or local labor laws.

**§ 20-916. Collective bargaining agreements.**

a. The provisions of this chapter shall not apply to any employee covered by a valid collective bargaining agreement if (i) such provisions are expressly waived in such collective bargaining agreement and (ii) such agreement provides for a comparable benefit for the employees covered by such agreement in the form of paid days off; such paid days off shall be in the form of leave, compensation, other employee benefits, or some combination thereof. Comparable benefits shall include, but are not limited to, vacation time, personal time, safe/sick time, and holiday and Sunday time pay at premium rates.

b. Notwithstanding subdivision a of this section, the provisions of this chapter shall not apply to any employee in the construction or grocery industry covered by a valid collective bargaining agreement if such provisions are expressly waived in such collective bargaining agreement.

**§ 20-917. Public disasters.**

In the event of a public disaster, the mayor may, for the length of such disaster, suspend the provisions of this chapter for businesses, corporations or other entities regulated by the public service commission.

**§ 20-918. Retaliation and interference prohibited.**

No employer shall engage in retaliation or threaten retaliation against an employee for exercising or attempting to exercise any right provided pursuant to this chapter, or interfere with any investigation, proceeding or hearing pursuant to this chapter. The protections of this chapter shall apply to any person who mistakenly but in good faith alleges a violation of this chapter. Rights under this chapter shall include, but not be limited to, the right to request and use sick time, file a complaint for alleged violations of this chapter with the department, communicate with any person about any violation of this chapter, participate in any administrative or judicial action regarding an alleged violation of this chapter, or inform any person of his or her potential rights under this chapter.

**§ 20-919. Notice of rights.**

a. 1. An employer shall provide an employee either at the commencement of employment or within

thirty days of the effective date of this section, whichever is later, with written notice of such employee's right to safe/sick time pursuant to this chapter, including the accrual and use of safe/sick time, the calendar year of the employer, and the right to be free from retaliation and to bring a complaint to the department. Such notice shall be in English and the primary language spoken by that employee, provided that the department has made available a translation of such notice in such language pursuant to subdivision b of this section. Such notice may also be conspicuously posted at an employer's place of business in an area accessible to employees.

2. Notices provided to employees pursuant to this section on and after the effective date of this paragraph shall in addition inform employees of their right to safe time under this chapter. Employers shall give employees who have already received notice of their right to sick time pursuant to this section notice of their right to safe time within thirty days of the effective date of this paragraph.

b. The department shall create and make available notices that contain the information required pursuant to subdivision a of this section concerning sick time and safe time and such notices shall allow for the employer to fill in applicable dates for such employer's calendar year. Such notices shall be posted in a downloadable format on the department's website in Chinese, English, French-Creole, Italian, Korean, Russian, Spanish and any other language deemed appropriate by the department.

c. Any person or entity that willfully violates the notice requirements of this section shall be subject to a civil penalty in an amount not to exceed fifty dollars for each employee who was not given appropriate notice pursuant to this section.

**§ 20-920. Employer records.**

Employers shall retain records documenting such employer's compliance with the requirements of this chapter for a period of three years unless otherwise required pursuant to any other law, rule or regulation, and shall allow the department to access such records, with appropriate notice and at a mutually agreeable time of day, in furtherance of an investigation conducted pursuant to this chapter.

**§ 20-921. Confidentiality and nondisclosure.**

An employer may not require the disclosure of details relating to an employee's or his or her family member's medical condition or require the disclosure of details relating to an employee's or his or her family member's status as a victim of family offenses, sexual offenses, stalking, or human trafficking as a condition of providing safe/sick time under this chapter. Health information about an employee or an employee's family member, and information concerning an employee's or his or her family member's status or perceived status as a victim of family offenses, sexual offenses, stalking or human trafficking obtained solely for the purposes of utilizing safe/sick time pursuant to this chapter, shall be treated as confidential and shall not be disclosed except by the affected employee, with the written permission of the affected employee or as required by law. Provided, however, that nothing in this section shall preclude an employer from considering information provided in connection with a request for safe time in connection with a request for reasonable accommodation pursuant to section 8-107.1 of the administrative code.

**§ 20-922. Encouragement of more generous policies; no effect on more generous policies.**

a. Nothing in this chapter shall be construed to discourage or prohibit the adoption or retention of a safe time or sick time policy more generous than that which is required herein.

b. Nothing in this chapter shall be construed as diminishing the obligation of an employer to comply with any contract, collective bargaining agreement, employment benefit plan or other agreement providing more generous safe time or sick time to an employee than required herein.

c. Nothing in this chapter shall be construed as diminishing the rights of public employees regarding safe time or sick time as provided pursuant to federal, state or city law.

**§ 20-923. Other legal requirements.**

a. This chapter provides minimum requirements pertaining to safe time and sick time and shall not be construed to preempt, limit or otherwise affect the applicability of any other law, regulation,

rule, requirement, policy or standard that provides for greater accrual or use by employees of safe leave or time or sick leave or time, whether paid or unpaid, or that extends other protections to employees.

b. Nothing in this chapter shall be construed as creating or imposing any requirement in conflict with any federal or state law, rule or regulation, nor shall anything in this chapter be construed to diminish or impair the rights of an employee or employer under any valid collective bargaining agreement.

**§ 20-924. Enforcement and penalties.**

a. The department shall enforce the provisions of this chapter. In effectuating such enforcement, the department shall establish a system utilizing multiple means of communication to receive complaints regarding non-compliance with this chapter and investigate complaints received by the department in a timely manner.

b. Any person alleging a violation of this chapter shall have the right to file a complaint with the department within two years of the date the person knew or should have known of the alleged violation. The department shall maintain confidential the identity of any complainant unless disclosure of such complainant's identity is necessary for resolution of the investigation or otherwise required by law. The department shall, to the extent practicable, notify such complainant that the department will be disclosing his or her identity prior to such disclosure.

c. Upon receiving a complaint alleging a violation of this chapter, the department shall investigate such complaint and attempt to resolve it through mediation. Within thirty days of written notification of a complaint by the department, the person or entity identified in the complaint shall provide the department with a written response and such other information as the department may request. The department shall keep complainants reasonably notified regarding the status of their complaint and any resultant investigation. If, as a result of an investigation of a complaint or an investigation conducted upon its own initiative, the department believes that a violation has occurred, it shall issue to the offending person or entity a notice of violation. The commissioner shall prescribe the form and wording of such notices of violation. The notice of violation shall be returnable to the administrative tribunal authorized to adjudicate violations of this chapter.

d. The department shall have the power to impose penalties provided for in this chapter and to grant an employee or former employee all appropriate relief. Such relief shall include: (i) for each instance of sick time taken by an employee but unlawfully not compensated by the employer: three times the wages that should have been paid under this chapter or two hundred fifty dollars, whichever is greater; (ii) for each instance of sick time requested by an employee but unlawfully denied by the employer and not taken by the employee or unlawfully conditioned upon searching for or finding a replacement worker, or for each instance an employer requires an employee to work additional hours without the mutual consent of such employer and employee in violation of section 20-915 of this chapter to make up for the original hours during which such employee is absent pursuant to this chapter: five hundred dollars; (iii) for each instance of unlawful retaliation not including discharge from employment: full compensation including wages and benefits lost, five hundred dollars and equitable relief as appropriate; and (iv) for each instance of unlawful discharge from employment: full compensation including wages and benefits lost, two thousand five hundred dollars and equitable relief, including reinstatement, as appropriate.

e. Any entity or person found to be in violation of the provisions of sections 20-913, 20-914, 20-915 or 20-918 of this chapter shall be liable for a civil penalty payable to the city not to exceed five hundred dollars for the first violation and, for subsequent violations that occur within two years of any previous violation, not to exceed seven hundred and fifty dollars for the second violation and not to exceed one thousand dollars for each succeeding violation.

f. The department shall annually report on its website the number and nature of the complaints received pursuant to this chapter, the results of investigations undertaken pursuant to this chapter, including the number of complaints not substantiated and the number of notices of violations issued, the number and nature of adjudications pursuant to this chapter, and the average time for a complaint to be resolved pursuant to this chapter.

**§ 20-925. Designation of agency.**
[Repealed]

**Note:** New York City businesses must comply with all relevant federal, state, and City laws and rules. All laws and rules of the City of New York, including the Consumer Protection Law and Rules, are available through the Public Access Portal, which businesses can access by visiting www.nyc.gov/dca. The Law and Rules are current as of May 2018.

Please note that businesses are responsible for knowing and complying with the most current laws, including any City Council amendments. The Department of Consumer Affairs (DCA) is not responsible for errors or omissions in this packet. The information is not legal advice. You can only obtain legal advice from a lawyer.

## RULES OF THE CITY OF NEW YORK
## TITLE 6: DEPARTMENT OF CONSUMER AFFAIRS
## CHAPTER 7: OFFICE OF LABOR POLICY AND STANDARDS

### SUBCHAPTER A: OFFICE OF LABOR POLICY AND STANDARDS

**§ 7-101. Definitions.**

(a) As used in this subchapter, the following terms have the following meanings:

"Employee" means any person who meets the definition of "employee," as defined by section 20-912 of the Code, "eligible grocery employee," as defined by section 22-507 of the Code, "fast food employee," as defined by section 20-1201 or 20-1301 of the Code, or "retail employee," as defined by section 20-1201 of the Code.

"Employer" means any person who meets the definition of "employer," as defined by section 20-912 of the Code, "successor grocery employer" or "incumbent grocery employer," as defined by section 22-507 of the Code, "fast food employer," as defined by section 20-1201 or 20-1301 of the Code, or "retail employer," as defined by section 20-1201 of the Code.

"Freelancers Law and rules" means Chapter 10 of Title 20 of the Code and subchapter E of this chapter.

"OLPS laws and rules" means chapters 8, 12, and 13 of Title 20 and section 22-507 of the Code and subchapters A, B, D, F, and G of this chapter.

"Transportation Benefits Law and rules" means Chapter 9 of Title 20 of the Code and subchapter C of this chapter.

(b) As used in the OLPS laws and rules, the following terms have the following meanings:

"Code" means the Administrative Code of the City of New York.

"Department" means the New York City Department of Consumer Affairs.

"Director" means the director of the office of labor standards established pursuant to section 20-a of the charter.

"Joint employer" means each of two or more employers who has some control over the work or working conditions of an employee or employees. Joint employers may be separate and distinct individuals or entities with separate owners, managers and facilities. A determination of whether or not a joint employment relationship exists will not often be decided by the application of any

single criterion; rather the entire relationship shall be viewed in its totality.

"Office" means the office of labor standards established pursuant to section 20-a of the New York City Charter and referred to as the Office of Labor Policy and Standards.

"Supplements" means all remuneration for employment paid in any medium other than cash, or reimbursement for expenses, or any payments which are not 'wages' within the meaning of the New York State Labor Law, including, but not limited to, health, welfare, non-occupational disability, retirement, vacation benefits, holiday pay,? life insurance, and apprenticeship training.

"Temporary help firm" means an employer that recruits and hires its own employees and assigns those employees to perform work or services for another organization to: (i) support or supplement the other organization's workforce; (ii) provide assistance in special work situations including, but not limited to, employee absences, skill shortages, or seasonal workloads; or (iii) perform special assignments or projects.

"Work week" means a fixed and regularly recurring period of 168 hours or seven consecutive 24 hour periods; it may begin on any day of the week and any hour of the day, and need not coincide with a calendar week.

"Written" or "writing" means a hand-written or machine-printed or printable communication in physical or electronic format, including a communication that is maintained or transmitted electronically, such as a text message.

**§ 7-102. Construction.**

This chapter shall be liberally construed to permit the Office to accomplish the purposes contained in section 20-a of the New York City Charter. The provisions of this subchapter shall not be construed to supersede any other provision of the OLPS laws and rules, the Freelancers Law and rules, or the Transportation Benefits Law and rules.

**§ 7-103 Severability.**

The rules contained in this chapter shall be separate and severable. If any word, clause, sentence, paragraph, subdivision, section, or portion of these rules or the application thereof to any person, employer, employee, or circumstance is contrary to a local, state or federal law or held to be invalid, it shall not affect the validity of the remainder of the rules or the validity of the application of the rules to other persons or circumstances.

**§ 7-104 Complainants and Witnesses.**

(a) All people, regardless of immigration status, may access resources provided by the Office.
(b) Any person who meets the definition of employee in section 7-101 of this subchapter is entitled to the rights and protections provided by this subchapter to employees and any applicable provision of the OLPS laws and rules, regardless of immigration status.
(c) The Office shall conduct its work without inquiring into the immigration status of complainants and witnesses.
(d) The Office shall maintain confidential the identity of a complainant or natural person providing information relevant to enforcement of the OLPS laws and rules and the Transportation Benefits Law and rules, unless disclosure is necessary for resolution of the investigation or matter, or otherwise required by law, and the Office, to the extent practicable, notifies such complainant or natural person that the Office will be disclosing such person's identity before such disclosure.
(e) For purposes of effectuating subdivision (d) of this section, the Office shall keep confidential any information that may be used to identify, contact, or locate a single person, or to identify an individual in context.

**§ 7-105 Joint Employers.**

(a) Joint employers are individually and jointly liable for violations of all applicable OLPS laws and rules and satisfaction of any penalties or restitution imposed on a joint employer for any violation thereof, regardless of any agreement among joint employers to the contrary.

(b) A joint employer must count every employee it employs for hire or permits to work, whether joint or not, in determining the number of employees employed for hire or permitted to work for the employer. For example, a joint employer who employs three workers from a temporary help firm and also has three permanent employees under its sole control has six employees for purposes of the OLPS laws and rules.

**§ 7-106 Determining Damages Based on Lost Earnings.**

(a) The following provisions apply to the extent necessary in circumstances described in paragraphs (1) and (2) below for the calculation of damages based on lost earnings in an administrative enforcement action:

(1) When an employer pays a flat rate of pay for work performed, regardless of the number of hours actually worked, an employee's hourly rate of pay shall be based on the most recent hourly rate paid to the employee for the applicable pay period, calculated by adding together the employee's total earnings, including tips, commissions, and supplements, for the most recent work week in which no sick time or other leave was taken and dividing that sum by the number of hours spent performing work during such work week or forty hours, whichever amount of hours is less.

(2) If an employee performs more than one job for the same employer or the employee's rate of pay fluctuates for a single job, the hourly rate of pay shall be the rate of pay that the employee would have been paid during the time that employee would have been performing work but for the employee's absence.

(b) If the methods for calculating the hourly rate described in subdivision (a) produce an hourly rate that is below the full hourly minimum wage, then the employee's lost earnings shall be based on the full hourly minimum wage.

**§ 7-107 Required Notices and Postings.**

(a) For any notice created by the Office that is made available on the City's website and that is then required by a provision of the OLPS laws and rules to be provided to an employee or posted in the workplace, an employer must provide and/or post such notice in English and in any language spoken as a primary language by at least five percent of employees at the employer's location, provided that the Director has made the notice available in such language. Employers covered by the Earned Safe and Sick Time Act, chapter 8 of Title 20 of the Code, are required to comply with this subdivision in addition to the requirement pursuant to section 20-919 of the Code that an employer provide the notice of rights in an employee's primary language.

(b) (1) For any notice that is not created by the Office and made available on the City's website, that is required to be provided to an employee and/or posted in the workplace by a provision of the OLPS laws and rules, an employer must provide and/or post such notice in English and in any language that the employer customarily uses to communicate with the employee.

(c) (2) For any notice that is not created by the Office and made available on the city's website, that is required to be posted in the workplace by a provision of the OLPS laws and rules, an employer must post such notice in English and in any language that the employer customarily uses to communicate with any of the employees at that location.

(d) Any notice, policy, or other writing that is required by a provision of the OLPS laws and rules to be personally provided to an employee must be provided by a method that reasonably ensures personal receipt by the employee and that is consistent with any other applicable law or rule that specifically addresses a method of delivery.

(e) Any notice, policy or, other writing that is required to be posted pursuant to a provision of the

OLPS laws and rules must be posted in a printed format in a conspicuous place accessible to employees where notices to employees are customarily posted pursuant to state and federal laws and, except for notices created by the Office, in a form customarily used by the employer to communicate with employees.

(f) An employer that places employees to perform work off-site or at dispersed job-sites, such as in private homes, building security posts, or on delivery routes, must comply with any applicable requirement to post a notice, policy or other writing contained in the OLPS laws and rules by providing employees with the required notice personally upon commencement of employment, within fourteen (14) days of the effective date of any changes to the required posting, and upon request by the employee, in addition to the requirements in subdivision (c) of this section.

**§ 7-108 Retaliation.**

(a) No person shall take any adverse action against an employee that penalizes an employee for, or is reasonably likely to deter an employee from, exercising or attempting to exercise rights under the OLPS laws and rules or interfere with an employee's exercise of rights under the OLPS laws and rules.

(b) Taking an adverse action includes, but is not limited to threatening, intimidating, disciplining, discharging, demoting, suspending, or harassing an employee, reducing the hours of pay of an employee, informing another employer than an employee has engaged in activities protected by the OLPS laws and rules, discriminating against the employee, including actions related to perceived immigration status or work authorization, and maintenance or application of. an absence control policy that counts protected leave as an absence that may lead to or result in an adverse action.

(c) An employee need not explicitly refer to a provision of the OLPS laws and rules to be protected from an adverse action.

(d) The Office may establish a causal connection between the exercise, attempted exercise, or anticipated exercise of rights protected by the OLPS laws and rules and an employer's adverse action against an employee or a group of employees by indirect or direct evidence.

(e) For purposes of this section, retaliation is established when the Office shows that a protected activity was a motivating factor for an adverse action, whether or not other factors motivated the adverse action.

**§ 7-109 Enforcement and Penalties.**

(a) The Office may open an investigation to determine compliance with laws enforced by the Office on its own initiative or based on a complaint, except as otherwise provided by section 20-1309 of Chapter 13 of Title 20 of the Code.

(b) Whether it was issued in person, via mail, or, on written consent of the employer, email, an employer must respond to a written request for information or records by providing the Office with true, accurate, and contemporaneously-made records or information within the following timeframes, except as provided in subdivision (c) of this section, subdivision (c) of section 20-924 of the Code, section 7-213 of this title or other applicable law:

(1) For an initial request for information or records, the employer shall

i. Within ten (10) days of the date that the request for information was received by the employer provide the following information, if applicable:

A. the employer's correct legal name and business form;
B. the employer's trade name or DBA;
C. the names and addresses of other businesses associated with the employer;
D. the employer's Federal Employer Identification Number;
E. the employer's addresses where business is conducted;
F. the employer's headquarters and principal place of business addresses;
G. the name, phone number, email address, and mailing address of the owners, officers, directors, principals, members, partners and/or stockholders of more than 10 percent of the outstanding stock of the

employer business and their titles;

H. the name, phone number, email address, and mailing address of the individuals who have operational control over the business;

I. the name, phone number, email address, and mailing address of the individuals who supervise employees;

J. the name and contact information of the individual who the office should contact regarding an investigation of the business and an affirmation granting authority to act; and

ii. Within fourteen (14) days of the date of that the initial request for information or records was received, provide the remaining information or records requested in that initial request.

(2) For all requests for information or records after the initial request, an employer must respond within the timeframe prescribed by the Office in the request, which shall not exceed fourteen (14) days from the date that the request was received by the employer, unless a longer timeframe has been agreed to by the Office.

(3) Upon good cause shown, the Director may extend response timeframes required pursuant to this subdivision.

(c) An employer shall respond to a written request for information or records by providing the Office with true, accurate, and contemporaneously-made records or information in a lesser amount of time than provided in paragraphs 2 and 3 of subdivision b of this section if agreed to by the parties or the Office has reason to believe that:

(1) The employer will destroy or falsify records;

(2) The employer is closing, selling, or transferring its business, disposing of assets or is about to declare bankruptcy;

(3) The employer is the subject of a government investigation or enforcement action or proceeding related to wages and hours, unemployment insurance, workers' compensation, discrimination, OLPS laws and rules, the Freelancers Law and rules, or the Transportation Benefits Law and rules; or

(4) More immediate access to records is necessary to prevent or remedy retaliation against employees.

(d) In accordance with applicable law, the Office may resolve or attempt to resolve an investigation at any point through settlement upon terms that are satisfactory to the Office.

(e) The Office may issue a notice of violation to an employer who fails to provide true and accurate information or records requested by the Office in connection with an investigation.

(f) An employer who fails to timely and fully respond to the request for information or records that is the subject of a notice of violation issued under subdivision (e) of this section on or before the first scheduled appearance date is subject to a penalty of five hundred dollars, in addition to any penalties or remedies imposed as a result of the Office's investigation.

(g) The employer may cure a notice of violation issued in accordance with subdivision (e) of this section without the penalty imposed in connection with subdivision (f) by:

(1) producing the requested information or records on or before the first scheduled appearance date; or

(2) resolving, to the satisfaction of the Office on or before the first scheduled appearance date, the investigation that is the basis for the request for information or records.

(h) A finding that an employer has an official or unofficial policy or practice that denies a right established or protected by the OLPS laws and rules shall constitute a violation of the applicable provision of the OLPS laws and rules for each and every employee subject to such policy or practice.

**§ 7-110 Service.**

Service of documents issued by the Office to employers, including written requests for information or records and notices of violation, shall be made in a manner reasonably calculated to achieve actual notice

to the employer. The following are presumed to be reasonably calculated to achieve actual notice: (i) personal service on the employer; (ii) personal service on the employer by regular first-class mail, certified mail, return receipt requested, or private mail delivery services, such as UPS, to an employer's last known business address; or (iii) if an employer has so consented, facsimile, email, including an attachment to an email.

**§ 7-111 Recordkeeping.**

(a) An employer's failure to maintain, retain, or produce a record that is required to be maintained under the OLPS laws and rules that is relevant to a material fact alleged by the Office in a notice of violation issued pursuant to a provision of the OLPS laws and rules creates a reasonable inference that such fact is true, unless a rebuttable presumption or other adverse inference is provided by applicable law.

(b) An employer that produces records to the department or Office in response to a request for information affirms that the records produced are true and accurate.

## SUBCHAPTER B: EARNED SAFE AND SICK TIME ACT

**§ 7-201 Definitions.**

(a) As used in this chapter, the terms "calendar year", "employee," "employer," "health care provider," "paid safe/sick time," "safe time," and "sick time" shall have the same meanings as set forth in section 20-912 of the Administrative Code.

(b) As used in the Earned Safe and Sick Time Act and in this subchapter, the term "domestic worker" means a person who provides care for a child, companionship for a sick, convalescing or elderly person, housekeeping, or any other domestic service in a home or residence whenever such person is directly and solely employed to provide such service by an individual or private household. The term "domestic worker" does not include any person who is employed by an agency whenever such person provides services as an employee of such agency, regardless of whether such person is jointly employed by an individual or private household in the provision of such services. Such person may be considered an employee under the Earned Safe and Sick Time Act and this subchapter.

**§ 7-202 Business Size.**

(a) Business size for an employer that has operated for less than one year shall be determined by counting the number of employees performing work for an employer for compensation per week, provided that if the number of employees fluctuates between less than five employees and five or more employees per week, business size may be determined for the current calendar year based on the average number of employees per week who worked for compensation for each week during the 80 days immediately preceding the date the employee used safe time or sick time.

(b) Business size for an employer that has operated for one year or more is determined by counting the number of employees working for the employer per week at the time the employee uses safe time or sick time, unless the number of employees fluctuates, in which case business size may be determined for the current calendar year based on the average number of employees per week during the previous calendar year. For purposes of this section, "fluctuates" means that at least three times in the most recent calendar quarter the number of employees working for an employer fluctuated between less than five employees and five or more employees.

**§ 7-203 Employees.**

(a) An individual is "employed for hire within the city of New York for more than eighty hours in a calendar year" for purposes of section 20-912(f) of the Administrative Code if the individual performs work, including work performed by telecommuting, for more than eighty hours while the individual is physically located in New York City, regardless of where the employer is

located.

i. Example: An individual who only performs work while physically located outside of New York City, even if the employer is based in New York City, is not "employed for hire within the city of New York" for purposes of section 20-912(f) for hours worked outside New York City.

ii. Example: An individual performs twenty hours of work in New Jersey and sixty hours of work in New York City in a calendar year. The twenty hours of work performed by the employee in New Jersey do not count towards the employee's eighty hours of work for purposes of section 20-912(f).

**§ 7-204 Minimum increments and fixed intervals for the use of safe time and sick time.**

(a) Unless otherwise in conflict with state or federal law or regulations, an employee may decide how much earned safe time or sick time to use, provided however, that an employer may set a minimum increment for the use of safe time and sick time, not to exceed four hours per day, provided such minimum increment is reasonable under the circumstances.

(i) Example: An employee has worked eighty hours and more than one hundred twenty calendar days have passed since the employee's first day of work for the employer. The employer has set a minimum increment of four hours per day for use of safe time and sick time. The employee has not yet accrued four hours of time, but is entitled to use the time he or she has already accrued. Under these circumstances, it would not be "reasonable under the circumstances" for the employer to require the employee to use a minimum of four hours of safe time or sick time as the minimum increment.

(ii) Example: An employee is scheduled to work from 8:00 am to 4:00 pm Mondays. She schedules a doctor's appointment for 9:00 am on a Monday and notifies her employer of her intent to use sick time and return to work the same day. The employer's written sick time policies require a four hour minimum increment of sick time used per day. If she does not go to work before her appointment, she should appear for work by 12:00 pm.

(b) An employer may set fixed periods of thirty minutes or any smaller amount of time for the use of accrued safe time or sick time beyond the minimum increment described in subdivision (a) of this section and may require fixed start times for such intervals.

Example: The employee in Example (ii) of subdivision (a) of this section arrives to work at 12:17pm. Under her employer's written sick time policies, employees must use sick time in half-hour intervals that start on the hour or half-hour. The employer can require the employee to use four-and-a-half hours of her accrued sick time and require her to begin work at 12:30 pm. Similarly, if the employee wanted to leave work at 8:40 am to go to her 9:00 am doctor's appointment, the employer could require the employee to stop work at 8:30 am.

**§ 7-205 Employee notification of use of safe time or sick time.**

(a) An employer may require an employee to provide reasonable notice of the need to use safe time or sick time.

(b) An employer that requires notice of the need to use safe time or sick time where the need is not foreseeable shall provide a written policy that contains procedures for the employee to provide notice as soon as practicable. Examples of such procedures may include, but are not limited to, instructing the employee to: (1) call a designated phone number at which an employee can leave a message; (2) follow a uniform call-in procedure; or (3) use another reasonable and accessible means of communication identified by the employer. Such procedures for employees to give notice of the need to use safe time or sick time when the need is not foreseeable may not include any requirement that an employee appear in person at a worksite or deliver any document to the employer prior to using safe time or sick time.

(c) In determining when notice is practicable in a given situation, an employer must consider the

individual facts and circumstances of the situation.

(d) An employer that requires notice of the need to use safe time or sick time where the need is foreseeable shall have a written policy for the employee to provide reasonable notice. Such policy shall not require more than seven days' notice prior to the date such safe time or sick time is to begin. The employer may require that such notice be in writing.

**§ 7-206 Documentation from licensed health care provider.**

(a) When an employee's use of sick time results in an absence of more than three consecutive work days, an employer may require reasonable written documentation that the use of sick time was for a purpose authorized under section 20-914(a) of the Administrative Code. Written documentation signed by a licensed health care provider indicating the need for the amount of sick time taken shall be considered reasonable documentation. "Work days" as used in this subdivision and in section 20-914(a)(2) of the Administrative Code means the days or parts of days the employee would have worked had the employee not used sick time.

(b) If an employer requires an employee to provide written documentation from a licensed health care provider when the employee's use of sick time resulted in an absence of more than three consecutive work days, the employee shall be allowed a minimum of seven days from the date he or she returns to work to obtain such documentation. The employee is responsible for the cost of such documentation not covered by insurance or any other benefit plan.

(c) If an employee provides written documentation from a licensed health care provider in accordance with subdivision (a) of this section, an employer may not require an employee to obtain documentation from a second licensed health care provider indicating the need for sick time in the amount used by the employee.

**§ 7-207 Domestic workers.**

(a) Domestic workers who have worked for the same employer for at least one year and who work more than 80 hours in a calendar year will be entitled to two days of paid safe/sick time per year, as provided in this section.

(b) The two days of paid safe/sick time must be calculated in the manner that paid days of rest for domestic workers are calculated pursuant to New York State Labor Law section 161(1).

(c) A domestic worker described in subdivision (a) of this section is entitled to two days of paid safe/sick time on the next date that such domestic worker is entitled to a paid day or days of rest under New York State Labor Law section 161(1), and annually thereafter.

(d) Safe time and sick time accrued by a domestic worker will carry over to the next calendar year.

**§ 7-208 Rate of pay for Safe Time and Sick Time.**

(a) Except as provided in subdivision (b) of this section, when using paid safe/sick time, an employee shall be compensated at the same hourly rate that the employee would have earned at the time the paid safe/sick time is taken.

(b) If the employee uses paid safe/sick time during hours that would have been designated as overtime, the employer is not required to pay the overtime rate of pay.

(c) An employee is not entitled to compensation for lost tips or gratuities, provided, however, that an employer must pay an employee whose hourly rate of pay or salary is based in whole or in part on tips or gratuities at least the full minimum wage.

(d) For employees who are paid on a commission (whether base wage plus commission or commission only), the hourly rate of pay shall be the base wage or minimum wage, whichever is greater. When an employer pays a flat rate of pay for work performed, regardless of the number of hours actually worked, an employee's hourly rate of pay shall be based on the most recent hourly rate paid to the employee for the applicable pay period, calculated by adding together the employee's total earnings, including tips, commissions, and supplements, for the most recent work week in which no safe time or sick time or other leave was taken and dividing that sum by the number of hours spent performing work during such work week or forty hours, whichever amount of hours is less.

(e) If an employee performs more than one job for the same employer or the employee's rate of pay fluctuates for a single job, the rate of pay shall be the rate of pay that the employee would have been paid during the time the employee used the safe time or sick time.
(f) An employer is not required to pay cash in lieu of supplements for safe time or sick time used if remuneration for employment includes supplements. The fact that an employer pays cash in lieu of supplements to an employee does not relieve the employer of the requirements of the Earned Safe and Sick Time Act.
(g) Under no circumstance can the employer pay the employee less than the minimum wage for paid safe/sick time.

**§ 7-209 Payment of safe/sick time.**

(a) Safe time and [Sick] sick time must be paid no later than the payday for the next regular payroll period beginning after the safe time or sick time was used by the employee.
(b) If the employer has asked for written documentation or verification of use of safe time or sick time pursuant to section 20-914(a), 20-914(b) or 20-914(d) of the Administrative Code, the employer is not required to pay safe time or sick time until the employee has provided such documentation or verification.

**§ 7-210 Employer's sale of business.**

(a) If an employer sells its business or the business is otherwise acquired by another business, an employee will retain and may use all accrued safe time and sick time if the employee continues to perform work within the City of New York for the successor employer.
(b) If the successor employer has fewer than five employees, and the former employer had more than five employees, the employee is entitled to use and be compensated for unused safe time and sick time accrued while working for the former employer, until such safe time and sick time is exhausted.
(c) A successor employer must provide employees with its written safe time and sick time policies at the time of sale or acquisition, or as soon as practicable thereafter, which shall include a policy that complies with this section.

**§ 7-211 Employer's Written safe time and sick time policies.**

(a) Every employer shall maintain written safe time and sick time policies in a single writing and follow such written safe time and sick time policies except as allowed in subdivision (d) of this section.
(b) Every employer must distribute [or post] its written safe time and sick time policies personally upon commencement of employment, within 14 days of the effective date of any changes to the policy, and upon request by the employee.
(c) An employer's written safe time and sick time policies must meet or exceed all of the requirements of the Earned Safe and Sick Time Act and this chapter and state at a minimum:
  (1) The employer's method of calculating safe time and sick time as follows:
    (i) If an employer provides employees with an amount of safe time and sick time that meets or exceeds the requirements of the Earned Safe and Sick Time Act on or before the employee's 120th day of employment and on the first day of each new calendar year, which for the purposes of this section is defined as "frontloaded safe time and sick time," then the employer's written safe time and sick time policy must specify the amount of frontloaded safe time and sick time to be provided;
    (ii) If the employer does not apply frontloaded safe time and sick time, then the employer's written safe time and sick time policy must specify when accrual of safe time and sick time starts, the rate at which an employee accrues safe time and sick time and the maximum number of hours an employee may accrue in a calendar year;
  (2) The employer's policies regarding the use of safe time and sick time, including any limitations or conditions the employer places on the use of safe time and sick time, such as:
    (i) Any requirement that an employee provide notice of a need to use safe time and sick time

and the procedures for doing so in accordance with section 7-205 of this chapter;

(ii) Any requirement for written documentation or verification of the use of safe time and sick time in accordance with Sections 20-914(a)(2), 20-914(b)(2), or 20-914(d) of the Administrative Code, and the employer's policy regarding any consequences of an employee's failure or delay in providing such documentation or verification;

(iii) Any reasonable minimum increment or fixed period for the use of accrued safe time and sick time;

(iv) Any policy on discipline for employee misuse of safe time and sick time under Section 7-215 of this Title; and

(v) A description of the confidentiality requirements of Section 20-921 of the Administrative Code.

(3) The employer's policy regarding carry-over of unused safe time and sick time at the end of an employer's calendar year in accordance with Section 20-913(h) of the Administrative Code; and,

(4) If an employer uses a term other than "safe/sick time" or "safe and sick time" to describe leave provided by the employer to meet the requirements of the Earned Safe and Sick Time Act, the employer's policy must state that such leave may be used by an employee for any of the purposes set forth in the Earned Safe and Sick Time Act without any condition prohibited by the Earned Safe and Sick Time Act. Terms used to describe such leave may include, but are not necessarily limited to, "paid time off" ("PTO"), vacation time, personal days, or days of rest.

(d) Nothing in this chapter shall prevent an employer from making exceptions to its written safe time and sick time policy for individual employees that are more generous to the employee than the terms of the employer's written policy.

(e) Requirements relating to an employer's additional and separate obligation to provide employees with a Notice of Rights under the Earned Safe and Sick Time Act are set forth in section 20-919 of the Administrative Code. An employer may not distribute the Notice of Rights required by Section 20-919 of the Administrative Code or any other department writing in lieu of distributing or posting its own written safe time and sick time policies as required by this section.

(f) An employer that has not provided to the employee a copy of its written safe time and sick time policies along with any forms or procedures required by the employer related to the use of safe time and sick time shall not deny safe time or sick time or payment of safe time or sick time to the employee based on non-compliance with such a policy.

**§ 7-212 Employer records.**

(a) Employers must retain records demonstrating compliance with the requirements of the Earned Safe and Sick Time Act, including records of any policies required pursuant to this Chapter, for a period of three years unless otherwise required by any other law, rule or regulation.

(b) An employer must maintain, in an accessible format, contemporaneous, true, and accurate records that show, for each employee:

(1) The employee's name, address, phone number, date(s) of start of employment, date(s) of end of employment (if any), rate of pay, and whether the employee is exempt from the overtime requirements of New York State labor laws and regulations;

(2) The hours worked each week by the employee, unless the employee is exempt from the overtime requirements of New York State labor laws and regulations and has a regular work week of forty hours or more;

(3) The date and time of each instance of safe time or sick time used by the employee and the amount paid for each instance;

(4) Any change in the material terms of employment specific to the employee; and

(5) The date that the Notice of Rights as set forth in section 20-919 of the Administrative Code was provided to the employee and proof that the Notice of Rights was received by the employee.

(c) If the office issues a written request for information or records, an employer shall provide the

office with such information or records, upon appropriate notice, at the department's office. Alternately, an employer shall provide the office with access to such information or records upon appropriate notice and at a mutually agreeable time of day at the employer's place of business.

(d) "Appropriate notice" shall mean 30 days' written notice, unless the employer agrees to a lesser amount of time, the office's request for the information or records is a second or subsequent request made to the same employer during the same investigation or case as the first request, or the office has reason to believe that:
(1) the employer will destroy or falsify records;
(2) the employer is closing, selling or transferring its business, disposing of assets or is about to declare bankruptcy;
(3) the employer is the subject of a government investigation or enforcement action or proceeding related to wages and hours, unemployment insurance, workers' compensation, discrimination, or an OLPS law or rule; or
(4) more immediate access to records is necessary to prevent retaliation against employees.

(e) The office will make two attempts by letter, email or telephone to arrange a mutually agreeable time of day for the employer to provide access to its records in accordance with subdivision (d) of this section. If these attempts are not successful, the office may set a time to access records at the employer's place of business during regular business hours, upon two days' notice.

**§ 7-213 Enforcement and Penalties.**

(a) A finding that an employer has an official or unofficial policy or practice of not providing or refusing to allow the use of safe time or sick time as required under the Earned Safe and Sick Time Act constitutes a violation of Section 20-913 of the Administrative Code for each and every employee affected by the policy and will be subject to penalties as provided in Section 20-924(e) of the Code.

(b) For purposes of Section 20-924(e) of the Administrative Code, penalties shall be imposed on a per employee basis.

(c) If an employer, as a matter of policy or practice, does not allow accrual of safe time and sick time as required under the Earned Safe and Sick Time Act, the relief granted to each and every employee affected by the policy or practice must include either application of 40 hours of safe time and sick time to the employee's safe time and sick time balance or, where such information is known, application of the number of hours of safe time and sick time the employee should have accrued to the employee's safe time and sick time balance, provided that such balance does not exceed 80 hours.

**§ 7-214 Accrual, Hours Worked and Carry Over.**

(a) If an employee is scheduled and available to work for an on-call shift and is compensated for the scheduled time regardless of whether the employee works, the scheduled time constitutes hours worked for the purposes of accrual under the Earned Safe and Sick Time Act.

(b) For employees who are paid on a piecework basis, accrual of safe time and sick time is measured by the actual length of time spent performing work.

(c) For employees who are paid on a commission basis, accrual of safe time and sick time is measured by the actual length of time spent performing work.

(d) For employees with indeterminate shift lengths (e.g. a shift defined by business needs), an employer shall base the hours of safe time or sick time used upon the hours worked by the replacement employee for the same shift. If this method is not possible, the hours of safe time or sick time must be based on the hours worked by the employee when the employee most recently worked the same shift in the past.

(e) If an employee is rehired within six months of separation from employment and had not reached the required 120 days to begin using accrued safe time and sick time under section 20-913(d)(1) of the Administrative Code at the time the employee separated from employment, upon resumption of employment, the employee shall be credited at least his or her previous calendar days towards the 120 day waiting period. For the purposes of this subdivision, "waiting period"

shall mean the time period described in section 20-913(d)(1) of the Administrative Code between the start of employment and the 120th calendar day following the start of employment or July 30, 2014, whichever is later, except for that an employer is not required to allow an employee to begin to use safe time before May 5, 2018.

(f) An employee may carry over up to 40 hours of unused safe and sick time from one calendar year to the next, unless the employer has a policy of paying employees for unused safe time and sick time at the end of the calendar year in which such time is accrued and providing the employee with an amount of paid safe time and sick time that meets or exceeds the requirements of the Earned Safe and Sick Time Act for such employee for the immediately subsequent calendar year on the first day of such year in accordance with Section 20-913(h) of the Administrative Code. Regardless of the number of hours an employee carried over from the previous calendar year, an employer is only required to allow employees to accrue up to 40 hours of safe time and sick time in a calendar year. If an employee's safe time and sick time balance exceeds 40 hours in a single calendar year, an employer is only required to allow the employee to use up to 40 hours in such calendar year.

Example: An employee accrues 40 hours of safe time and sick time in calendar year one and uses 20 hours of safe time and sick time in calendar year one. She carries over 20 hours from calendar year one to calendar year two, accrues 40 hours in calendar year two, and does not use any hours in calendar year two. Her safe time and sick leave balance at the end of calendar year two is 60 hours (20 hours from calendar year two plus 40 hours from calendar year two). She may carry over 40 of those 60 hours into calendar year three and accrue another 40 hours in calendar year three.

**§ 7-215 Employee Abuse of Safe Time and Sick Time.**

An employer may take disciplinary action, up to and including termination, against an employee who uses safe time or sick time provided under the Earned Safe and Sick Time Act for purposes other than those described in sections 20-914(a) and section 20-914(b) of the Administrative Code. Indications of abuse of safe time and sick time may include, but are not limited to a pattern of: (1) use of unscheduled safe time and sick time on or adjacent to weekends, regularly scheduled days off, holidays, vacation or pay day, (2) taking scheduled safe time and sick time on days when other leave has been denied, and (3) taking safe time and sick time on days when the employee is scheduled to work a shift or perform duties perceived as undesirable.

Consumer Affairs

Bill de Blasio
Mayor

Lorelei Salas
Commissioner

# NOTICE OF EMPLOYEE RIGHTS

Under New York City's Earned Safe and Sick Time Act (Paid Safe and Sick Leave Law), certain employees have a right to safe and sick leave. Go to nyc.gov/PaidSickLeave to learn which employees are covered by the law.

Employees who work for employers with five or more employees who work more than 80 hours a calendar year in New York City have a right to *paid* safe and sick leave. Employees who work for employers with fewer than five employees have a right to *unpaid* safe and sick leave.

**Employees who work for employers who must provide safe and sick leave must receive this written notice from their employer when they begin employment or by June 4, 2018, whichever is later.**

## YOU HAVE A RIGHT TO SAFE LEAVE, which you can use to seek assistance or take other safety measures if you or a family member may be the victim of any act or threat of domestic violence or unwanted sexual contact, stalking, or human trafficking.

## YOU HAVE A RIGHT TO SICK LEAVE, which you can use for the care and treatment of yourself or a family member.

### AMOUNT OF SAFE AND SICK LEAVE:

- Your employer must provide up to a total of 40 hours of safe and sick leave every calendar year. You may use any earned leave for either safe or sick leave purposes. Your employer's calendar year is:

  Start of Calendar Year: _____ End of Calendar Year: _____

### RATE OF ACCRUAL:

- You accrue safe and sick leave at the rate of one hour for every 30 hours worked, up to a maximum of 40 hours of safe and sick leave per calendar year.

### DATE ACCRUAL BEGINS:

You begin to accrue safe and sick leave on April 1, 2014 or on your first day of employment, whichever is later.

*Exception*: If you are covered by a collective bargaining agreement that was in effect on April 1, 2014, you begin to accrue safe and sick leave under City law beginning on the date that the agreement expires.

### DATE SAFE AND SICK LEAVE IS AVAILABLE FOR USE:

- You could begin using sick leave on July 30, 2014 or 120 days after you begin employment, whichever is later.
- You could begin using safe leave on May 5, 2018 or 120 days after you begin employment, whichever is later.

### ACCEPTABLE REASONS TO USE SAFE AND SICK LEAVE:

You can use safe and sick leave to take time off from work when:

- You have a mental or physical illness, injury, or health condition; you need to get a medical diagnosis, care, or treatment of your mental or physical illness, injury, or condition; you need to get preventive medical care.
- You must care for a family member who needs medical diagnosis, care, or treatment of a mental or physical illness, injury, or health condition, or who needs preventive medical care.

### FAMILY MEMBERS:

The law recognizes the following individuals as "family members:"

- Any individual whose close association with the employee is the equivalent of family
- Child (biological, adopted, or foster child; legal ward; child of an employee standing *in loco parentis*)
- Grandchild
- Spouse
- Domestic Partner
- Parent
- Grandparent
- Child or Parent of an employee's spouse or domestic partner
- Sibling (including a half, adopted, or step sibling)
- Any other individual related by blood to the employee

### ADVANCE NOTICE:

If the need is foreseeable, your employer can require up to seven days advance notice of your intention to use safe or sick leave. If the need is unforeseeable, your employer may require you to give notice as soon as practicable.

### DOCUMENTATION:

Your employer can require documentation if you use more than three consecutive workdays as safe or sick leave. The Paid Safe and Sick Leave Law prohibits employers from requiring the health care provider to specify the medical reason for sick leave or requiring safe leave documentation to specify the details of any act or threat of domestic violence or unwanted sexual contact, stalking, or human trafficking. Disclosure may be required by other laws.

### UNUSED SAFE AND SICK LEAVE:

Up to 40 hours of unused safe and sick leave can be carried over to the next calendar year. However, your employer is only required to let you use up to 40 hours of safe and sick leave per calendar year.

## YOU HAVE A RIGHT TO BE FREE FROM RETALIATION FROM YOUR EMPLOYER FOR USING SAFE AND SICK LEAVE.

Your employer cannot retaliate against you for:

- Requesting and using safe and sick leave.
- Filing a complaint for alleged violations of the law with DCA.
- Communicating with any person, including coworkers, about any violation of the law.
- Participating in a court proceeding regarding an alleged violation of the law.
- Informing another person of that person's potential rights.

Retaliation includes any threat, discipline, discharge, demotion, suspension, or reduction in your hours, or any other adverse employment action against you for exercising or attempting to exercise any right guaranteed under the law.

## YOU HAVE A RIGHT TO FILE A COMPLAINT.

You can file a complaint with DCA. To get the complaint form, go online to nyc.gov/PaidSickLeave or contact 311 (212-NEW-YORK outside NYC).

DCA will conduct an investigation and try to resolve your complaint. DCA will keep your identity confidential unless disclosure is necessary to conduct the investigation, resolve the complaint, or is required by law.

**Keep a copy of this notice and all documents that show your amount of safe and sick leave accrual and use.**

**Note: The Earned Safe and Sick Time Act sets the minimum requirements for safe and sick leave. Your employer's leave policies may already meet or exceed the requirements of the law.**

the use of reverse auctions through electronic means and make recommendations regarding future use of this procurement method. Such reports shall be published on the website of the office of general services. Except where otherwise provided by law, procurements shall be competitive, and state agencies shall conduct formal competitive procurements to the maximum extent practicable. State agencies shall document the determination of the method of procurement and the basis of award in the procurement record. Where the basis for award is the best value offer, the state agency shall document, in the procurement record and in advance of the initial receipt of offers, the determination of the evaluation criteria, which whenever possible, shall be quantifiable, and the process to be used in the determination of best value and the manner in which the evaluation process and selection shall be conducted.

§ 3. This act shall take effect on the first of January next succeeding the date on which it shall have become a law; provided, however, that the amendments to subdivision 7 of section 163 of the state finance law made by section one of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

SUBPART B

Section 1. The civil practice law and rules are amended by adding a new section 7515 to read as follows:

§ 7515. Mandatory arbitration clauses; prohibited. (a) Definitions. As used in this section:

1. The term "employer" shall have the same meaning as provided in subdivision five of section two hundred ninety-two of the executive law.

2. The term "prohibited clause" shall mean any clause or provision in any contract which requires as a condition of the enforcement of the contract or obtaining remedies under the contract that the parties submit to mandatory arbitration to resolve any allegation or claim of an unlawful discriminatory practice of sexual harassment.

3. The term "mandatory arbitration clause" shall mean a term or provision contained in a written contract which requires the parties to such contract to submit any matter thereafter arising under such contract to arbitration prior to the commencement of any legal action to enforce the provisions of such contract and which also further provides language to the effect that the facts found or determination made by the arbitrator or panel of arbitrators in its application to a party alleging an unlawful discriminatory practice based on sexual harassment shall be final and not subject to independent court review.

4. The term "arbitration" shall mean the use of a decision making forum conducted by an arbitrator or panel of arbitrators within the meaning and subject to the provisions of article seventy-five of the civil practice law and rules.

(b) (i) Prohibition. Except where inconsistent with federal law, no written contract, entered into on or after the effective date of this section shall contain a prohibited clause as defined in paragraph two of subdivision (a) of this section.

(ii) Exceptions. Nothing contained in this section shall be construed to impair or prohibit an employer from incorporating a non-prohibited clause or other mandatory arbitration provision within such contract, that the parties agree upon.

(iii) Mandatory arbitration clause null and void. Except where inconsistent with federal law, the provisions of such prohibited clause as defined in paragraph two of subdivision (a) of this section shall be

null and void. The inclusion of such clause in a written contract shall not serve to impair the enforceability of any other provision of such contract.

(c) Where there is a conflict between any collective bargaining agreement and this section, such agreement shall be controlling.

§ 2. This act shall take effect on the ninetieth day after it shall have become a law.

SUBPART C

Section 1. The public officers law is amended by adding a new section 17-a to read as follows:

§ 17-a. Reimbursement of funds paid by state agencies and state entities for the payment of awards adjudicated in sexual **harassment** claims. 1. As used in this section, the term "employee" shall mean any person holding a position by election, appointment, or employment in the service of the state of New York, whether or not compensated. The term "employee" shall include a former employee or judicially appointed personal representative.

2. Notwithstanding any law to the contrary, any employee who has been subject to a final judgment of personal liability for intentional wrongdoing related to a claim of sexual **harassment**, shall reimburse any state agency or entity that makes a payment to a plaintiff for an adjudicated award based on a claim of sexual **harassment** resulting in a judgment, for his or her proportionate share of such judgment. Such employee shall personally reimburse such state agency or entity within ninety days of the state agency or entity's payment of such award.

3. If such employee fails to reimburse such state agency or entity pursuant to subdivision two of this section within ninety days from the date such state agency or entity makes a payment for the financial award, the comptroller shall, upon obtaining a money judgment, withhold from such employee's compensation the amounts allowable pursuant to section fifty-two hundred thirty-one of the civil practice law and rules.

4. If such employee is no longer employed by such state agency or entity such state agency or entity shall have the right to receive reimbursement through the enforcement of a money judgment pursuant to article fifty-two of the civil practice law and rules.

§ 2. The public officers law is amended by adding a new section 18-a to read as follows:

§ 18-a. Reimbursement of funds paid by a public entity for the payment of awards adjudicated in sexual **harassment** claims. 1. As used in this section:

(a) The term "public entity" shall mean (i) a county, city, town, village or any other political subdivision or civil division of the state; (ii) a school district, board of cooperative educational services, or any other governmental entity or combination or association of governmental entities operating a public school, college, community college or university; (iii) a public improvement or special district; (iv) a public authority, commission, agency or public benefit corporation; or (v) any other separate corporate instrumentality or unit of government; but shall not include the state of New York or any other public entity the employees of which are covered by section seventeen-a of this article.

(b) The term "employee" shall mean any commissioner, member of a public board or commission, trustee, director, officer, employee, or any

other person holding a position by election, appointment or employment in the service of a public entity, whether or not compensated. The term "employee" shall include a former employee or judicially appointed personal representative.

2. Notwithstanding any law to the contrary, any employee who has been subject to a final judgment of personal liability for intentional wrongdoing related to a claim of sexual harassment, shall reimburse any public entity that makes a payment to a plaintiff for an adjudicated award based on a claim of sexual harassment resulting in a judgment, for his or her proportionate share of such judgment. Such employee shall personally reimburse such public entity within ninety days of the public entity's payment of such award.

3. If such employee fails to reimburse such public entity pursuant to subdivision two of this section within ninety days from the date such public entity makes a payment for the financial award, the chief fiscal officer of such public entity shall, upon obtaining a money judgment, withhold from such employee's compensation the amounts allowable pursuant to section fifty-two hundred thirty-one of the civil practice law and rules.

4. If such employee is no longer employed by such public entity, such public entity shall have the right to receive reimbursement through the enforcement of a money judgment pursuant to article fifty-two of the civil practice law and rules.

§ 3. This act shall take effect immediately.

SUBPART D

Section 1. The general obligations law is amended by adding a new section 5-336 to read as follows:

§ 5-336. Nondisclosure agreements. Notwithstanding any other law to the contrary, no employer, its officers or employees shall have the authority to include or agree to include in any settlement, agreement or other resolution of any claim, the factual foundation for which involves sexual harassment, any term or condition that would prevent the disclosure of the underlying facts and circumstances to the claim or action unless the condition of confidentiality is the complainant's preference. Any such term or condition must be provided to all parties, and the complainant shall have twenty-one days to consider such term or condition. If after twenty-one days such term or condition is the complainant's preference, such preference shall be memorialized in an agreement signed by all parties. For a period of at least seven days following the execution of such agreement, the complainant may revoke the agreement, and the agreement shall not become effective or be enforceable until such revocation period has expired.

§ 2. The civil practice law and rules is amended by adding a new section 5003-b to read as follows:

§ 5003-b. Nondisclosure agreements. Notwithstanding any other law to the contrary, for any claim or cause of action, whether arising under common law, equity, or any provision of law, the factual foundation for which involves sexual harassment, in resolving, by agreed judgment, stipulation, decree, agreement to settle, assurance of discontinuance or otherwise, no employer, its officer or employee shall have the authority to include or agree to include in such resolution any term or condition that would prevent the disclosure of the underlying facts and circumstances to the claim or action unless the condition of confidentiality is the plaintiff's preference. Any such term or condition must be

provided to all parties, and the plaintiff shall have twenty-one days to consider such term or condition. If after twenty-one days such term or condition is the plaintiff's preference, such preference shall be memorialized in an agreement signed by all parties. For a period of at least seven days following the execution of such agreement, the plaintiff may revoke the agreement, and the agreement shall not become effective or be enforceable until such revocation period has expired.

§ 3. This act shall take effect on the ninetieth day after it shall have become a law.

SUBPART E

Section 1. The labor law is amended by adding a new section 201-g to read as follows:

§ 201-g. Prevention of sexual harassment. 1. The department shall consult with the division of human rights to create and publish a model sexual harassment prevention guidance document and sexual harassment prevention policy that employers may utilize in their adoption of a sexual harassment prevention policy required by this section.

a. Such model sexual harassment prevention policy shall: (i) prohibit sexual harassment consistent with guidance issued by the department in consultation with the division of human rights and provide examples of prohibited conduct that would constitute unlawful sexual harassment; (ii) include but not be limited to information concerning the federal and state statutory provisions concerning sexual harassment and remedies available to victims of sexual harassment and a statement that there may be applicable local laws; (iii) include a standard complaint form; (iv) include a procedure for the timely and confidential investigation of complaints and ensure due process for all parties; (v) inform employees of their rights of redress and all available forums for adjudicating sexual harassment complaints administratively and judicially; (vi) clearly state that sexual harassment is considered a form of employee misconduct and that sanctions will be enforced against individuals engaging in sexual harassment and against supervisory and managerial personnel who knowingly allow such behavior to continue; and (vii) clearly state that retaliation against individuals who complain of sexual harassment or who testify or assist in any proceeding under the law is unlawful.

b. Every employer shall adopt the model sexual harassment prevention policy promulgated pursuant to this subdivision or establish a sexual harassment prevention policy to prevent sexual harassment that equals or exceeds the minimum standards provided by such model sexual harassment prevention policy. Such sexual harassment prevention policy shall be provided to all employees in writing. Such model sexual harassment prevention policy shall be publicly available and posted on the websites of both the department and the division of human rights.

2. The department shall consult with the division of human rights and produce a model sexual harassment prevention training program to prevent sexual harassment in the workplace.

a. Such model sexual harassment prevention training program shall be interactive and include: (i) an explanation of sexual harassment consistent with guidance issued by the department in consultation with the division of human rights; (ii) examples of conduct that would constitute unlawful sexual harassment; (iii) information concerning the federal and state statutory provisions concerning sexual harassment and remedies available to victims of sexual harassment; and (iv) information

concerning employees' rights of redress and all available forums for adjudicating complaints.

b. The department shall include information in such model sexual harassment prevention training program addressing conduct by supervisors and any additional responsibilities for such supervisors.

c. Every employer shall utilize the model sexual harassment prevention training program pursuant to this subdivision or establish a training program for employees to prevent sexual harassment that equals or exceeds the minimum standards provided by such model training. Such sexual harassment prevention training shall be provided to all employees on an annual basis.

3. The commissioner may promulgate regulations as he or she deems necessary for the purposes of carrying out the provisions of this section.

§ 2. This act shall take effect on the one hundred eightieth day after it shall have become a law. Effective immediately, the department of labor, in consultation with the division of human rights, is authorized to create the model sexual harassment prevention policy and the model sexual harassment prevention training program required to be created and published pursuant to section 201-g of the labor law as added by section one of this act.

SUBPART F

Section 1. The executive law is amended by adding a new section 296-d to read as follows:

§ 296-d. Sexual harassment relating to non-employees. It shall be an unlawful discriminatory practice for an employer to permit sexual harassment of non-employees in its workplace. An employer may be held liable to a non-employee who is a contractor, subcontractor, vendor, consultant or other person providing services pursuant to a contract in the workplace or who is an employee of such contractor, subcontractor, vendor, consultant or other person providing services pursuant to a contract in the workplace, with respect to sexual harassment, when the employer, its agents or supervisors knew or should have known that such non-employee was subjected to sexual harassment in the employer's workplace, and the employer failed to take immediate and appropriate corrective action. In reviewing such cases involving non-employees, the extent of the employer's control and any other legal responsibility which the employer may have with respect to the conduct of the harasser shall be considered.

§ 2. Subdivision 4 of section 292 of the executive law, as amended by chapter 97 of the laws of 2014, is amended to read as follows:

4. The term "unlawful discriminatory practice" includes only those practices specified in sections two hundred ninety-six, two hundred ninety-six-a [~~and~~], two hundred ninety-six-c and two hundred ninety-six-d of this article.

§ 3. This act shall take effect immediately.

§ 2. Severability clause. If any clause, sentence, paragraph, subdivision, section or subpart of this act shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section or subject thereof directly involved in the controversy in which such judgment shall have been rendered. It is hereby declared to be the

intent of the legislature that this act would have been enacted even if such invalid provisions had not been included herein.

§ 3. This act shall take effect immediately; provided, however, that the applicable effective dates of Subparts A through F of this Part shall be as specifically set forth in the last section of such Subparts.

PART LL

Section 1. The public health law is amended by adding a new section 1114-a to read as follows:

§ 1114-a. Voluntary public water system consolidation study. 1. There shall be established in the department, by the commissioner, a voluntary public water system consolidation study designed to evaluate the feasibility of the joining of public water systems in order to improve water quality. Such study shall include:

(a) the feasibility of joining of two or more public water systems to form one water system;

(b) the feasibility of the consolidation of one or more public water systems into a larger public water system;

(c) the appropriate technical, managerial and financial capacity necessary for consolidation, including state funding mechanisms and incentives that could be utilized;

(d) potential public health impacts of consolidation, including ability to meet legally required water quality standards and the impact on monitoring, reporting and enforcement of drinking water standards;

(e) appropriate and sufficient guidance from the department necessary for those public water systems interested in consolidation; and

(f) recommendations for public water systems interested in voluntary consolidation.

2. The department shall prepare and submit a report and supporting materials to the governor, the temporary president of the senate and the speaker of the assembly setting forth the information gathered and recommendations to the legislature by January first of the following year.

§ 2. This act shall take effect immediately.

PART MM

Section 1. The public health law is amended by adding a new section 280-c to read as follows:

§ 280-c. Pharmacy audits by pharmacy benefit managers. 1. Definitions. As used in this section, the following terms shall have the following meanings:

(a) "Pharmacy benefit manager" shall have the same meaning as in section two hundred eighty-a of this article.

(b) "Pharmacy" shall mean a pharmacy that has contracted with a pharmacy benefit manager for the provision of pharmacy services.

2. When conducting an audit of a pharmacy's records, a pharmacy benefit manager shall:

(a) not conduct an on-site audit of a pharmacy at any time during the first three calendar days of a month;

(b) notify the pharmacy or its contracting agent no later than fifteen days before the date of initial on-site audit. Such notification to the pharmacy or its contracting agent shall be in writing delivered either (i) by mail or common carrier, return receipt requested, or (ii) electronically with electronic receipt confirmation, addressed to the super-

# Sexual Harassment Policy for All Employers in New York State

NEW YORK STATE | Combating Sexual Harassment

## Introduction

[*Employer Name*] is committed to maintaining a workplace free from sexual harassment. Sexual harassment is a form of workplace discrimination. All employees are required to work in a manner that prevents sexual harassment in the workplace. This Policy is one component of [*Employer Name's*] commitment to a discrimination-free work environment. Sexual harassment is against the law[1] and all employees have a legal right to a workplace free from sexual harassment and employees are urged to report sexual harassment by filing a complaint internally with [*Employer Name*]. Employees can also file a complaint with a government agency or in court under federal, state or local antidiscrimination laws.

## Policy:

1. [*Employer Name's*] policy applies to all employees, applicants for employment, interns, whether paid or unpaid, contractors and persons conducting business, regardless of immigration status, with [*Employer Name*]. In the remainder of this document, the term "employees" refers to this collective group.

2. Sexual harassment will not be tolerated. Any employee or individual covered by this policy who engages in sexual harassment or retaliation will be subject to remedial and/or disciplinary action (e.g., counseling, suspension, termination).

3. Retaliation Prohibition: No person covered by this Policy shall be subject to adverse action because the employee reports an incident of sexual harassment, provides information, or otherwise assists in any investigation of a sexual harassment complaint. [*Employer Name*] will not tolerate such retaliation against anyone who, in good faith, reports or provides information about suspected sexual harassment. Any employee of [*Employer Name*] who retaliates against anyone involved in a sexual harassment investigation will be subjected to disciplinary action, up to and including termination. All employees, paid or unpaid interns, or non-employees[2] working in the workplace who believe they have been subject to such retaliation should inform a supervisor, manager, or [*name of appropriate person*]. All employees, paid or unpaid interns or non-employees who believe they have been a target of such retaliation may also seek relief in other available forums, as explained below in the section on Legal Protections.

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[1] While this policy specifically addresses sexual harassment, harassment because of and discrimination against persons of all protected classes is prohibited. In New York State, such classes includeage, race, creed, color, national origin, sexual orientation, military status, sex, disability, marital status, domestic violence victim status, gender identity and criminal history.

[2] A non-employee is someone who is (or is employed by) a contractor, subcontractor, vendor, consultant, or anyone providing services in the workplace. Protected non-employees include persons commonly referred to as independent contractors, "gig" workers and temporary workers. Also included are persons providing equipment repair, cleaning services or any other services provided pursuant to a contract with the employer.

*Adoption of this policy does not constitute a conclusive defense to charges of unlawful sexual harassment. Each claim of sexual harassment will be determined in accordance with existing legal standards, with due consideration of the particular facts and circumstances of the claim, including but not limited to the existence of an effective anti-harassment policy and procedure.*

4. Sexual harassment is offensive, is a violation of our policies, is unlawful, and may subject [*Employer Name*] to liability for harm to targets of sexual harassment. Harassers may also be individually subject to liability. Employees of every level who engage in sexual harassment, including managers and supervisors who engage in sexual harassment or who allow such behavior to continue, will be penalized for such misconduct.

5. [*Employer Name*] will conduct a prompt and thorough investigation that ensures due process for all parties, whenever management receives a complaint about sexual harassment, or otherwise knows of possible sexual harassment occurring. [*Employer Name*] will keep the investigation confidential to the extent possible. Effective corrective action will be taken whenever sexual harassment is found to have occurred. All employees, including managers and supervisors, are required to cooperate with any internal investigation of sexual harassment.

6. All employees are encouraged to report any harassment or behaviors that violate this policy. [*Employer Name*] will provide all employees a complaint form for employees to report harassment and file complaints.

7. Managers and supervisors are **required** to report any complaint that they receive, or any harassment that they observe or become aware of, to [*person or office designated*].

8. This policy applies to all employees, paid or unpaid interns, and non-employees and all must follow and uphold this policy. This policy must be provided to all employees and should be posted prominently in all work locations to the extent practicable (for example, in a main office, not an offsite work location) and be provided to employees upon hiring.

## What Is "Sexual Harassment"?

Sexual harassment is a form of sex discrimination and is unlawful under federal, state, and (where applicable) local law. Sexual harassment includes harassment on the basis of sex, sexual orientation, self-identified or perceived sex, gender expression, gender identity and the status of being transgender.

Sexual harassment includes unwelcome conduct which is either of a sexual nature, or which is directed at an individual because of that individual's sex when:

- Such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive work environment, even if the reporting individual is not the intended target of the sexual harassment;

- Such conduct is made either explicitly or implicitly a term or condition of employment; or

- Submission to or rejection of such conduct is used as the basis for employment decisions affecting an individual's employment.

A sexually harassing hostile work environment includes, but is not limited to, words, signs, jokes, pranks, intimidation or physical violence which are of a sexual nature, or which are directed at an

individual because of that individual's sex. Sexual harassment also consists of any unwanted verbal or physical advances, sexually explicit derogatory statements or sexually discriminatory remarks made by someone which are offensive or objectionable to the recipient, which cause the recipient discomfort or humiliation, which interfere with the recipient's job performance.

Sexual harassment also occurs when a person in authority tries to trade job benefits for sexual favors. This can include hiring, promotion, continued employment or any other terms, conditions or privileges of employment. This is also called "quid pro quo" harassment.

Any employee who feels harassed should report so that any violation of this policy can be corrected promptly. Any harassing conduct, even a single incident, can be addressed under this policy.

**Examples of sexual harassment**

The following describes some of the types of acts that may be unlawful sexual harassment and that are strictly prohibited:

- Physical acts of a sexual nature, such as:
  - Touching, pinching, patting, kissing, hugging, grabbing, brushing against another employee's body or poking another employee's body;
  - Rape, sexual battery, molestation or attempts to commit these assaults.

- Unwanted sexual advances or propositions, such as:
  - Requests for sexual favors accompanied by implied or overt threats concerning the target's job performance evaluation, a promotion or other job benefits or detriments;
  - Subtle or obvious pressure for unwelcome sexual activities.

- Sexually oriented gestures, noises, remarks or jokes, or comments about a person's sexuality or sexual experience, which create a hostile work environment.

- Sex stereotyping occurs when conduct or personality traits are considered inappropriate simply because they may not conform to other people's ideas or perceptions about how individuals of a particular sex should act or look.

- Sexual or discriminatory displays or publications anywhere in the workplace, such as:
  - Displaying pictures, posters, calendars, graffiti, objects, promotional material, reading materials or other materials that are sexually demeaning or pornographic. This includes such sexual displays on workplace computers or cell phones and sharing such displays while in the workplace.

- Hostile actions taken against an individual because of that individual's sex, sexual orientation, gender identity and the status of being transgender, such as:
  - Interfering with, destroying or damaging a person's workstation, tools or equipment, or otherwise interfering with the individual's ability to perform the job;
  - Sabotaging an individual's work;
  - Bullying, yelling, name-calling.

**Who can be a target of sexual harassment?**

Sexual harassment can occur between any individuals, regardless of their sex or gender. New York Law protects employees, paid or unpaid interns, and non-employees, including independent contractors, and those employed by companies contracting to provide services in the workplace. Harassers can be a superior, a subordinate, a coworker or anyone in the workplace including an independent contractor, contract worker, vendor, client, customer or visitor.

**Where can sexual harassment occur?**

Unlawful sexual harassment is not limited to the physical workplace itself. It can occur while employees are traveling for business or at employer sponsored events or parties. Calls, texts, emails, and social media usage by employees can constitute unlawful workplace harassment, even if they occur away from the workplace premises, on personal devices or during non-work hours.

## Retaliation

Unlawful retaliation can be any action that could discourage a worker from coming forward to make or support a sexual harassment claim. Adverse action need not be job-related or occur in the workplace to constitute unlawful retaliation (e.g., threats of physical violence outside of work hours).

Such retaliation is unlawful under federal, state, and (where applicable) local law. The New York State Human Rights Law protects any individual who has engaged in "protected activity." Protected activity occurs when a person has:

- made a complaint of sexual harassment, either internally or with any anti-discrimination agency;
- testified or assisted in a proceeding involving sexual harassment under the Human Rights Law or other anti-discrimination law;
- opposed sexual harassment by making a verbal or informal complaint to management, or by simply informing a supervisor or manager of harassment;
- reported that another employee has been sexually harassed; or
- encouraged a fellow employee to report harassment.

Even if the alleged harassment does not turn out to rise to the level of a violation of law, the individual is protected from retaliation if the person had a good faith belief that the practices were unlawful. However, the retaliation provision is not intended to protect persons making intentionally false charges of harassment.

## Reporting Sexual Harassment

**Preventing sexual harassment is everyone's responsibility.** [*Employer Name*] cannot prevent or remedy sexual harassment unless it knows about it. Any employee, paid or unpaid intern or non-employee who has been subjected to behavior that may constitute sexual harassment is encouraged to report such behavior to a supervisor, manager or [*person or office designated*]. Anyone who witnesses or becomes aware of potential instances of sexual harassment should report such behavior to a supervisor, manager or [*person or office designated*].

Reports of sexual harassment may be made verbally or in writing. A form for submission of a written complaint is attached to this Policy, and all employees are encouraged to use this complaint form. Employees who are reporting sexual harassment on behalf of other employees should use the complaint form and note that it is on another employee's behalf.

Employees, paid or unpaid interns or non-employees who believe they have been a target of sexual harassment may also seek assistance in other available forums, as explained below in the section on Legal Protections.

## Supervisory Responsibilities

All supervisors and managers who receive a complaint or information about suspected sexual harassment, observe what may be sexually harassing behavior or for any reason suspect that sexual harassment is occurring, **are required** to report such suspected sexual harassment to [*person or office designated*].

In addition to being subject to discipline if they engaged in sexually harassing conduct themselves, supervisors and managers will be subject to discipline for failing to report suspected sexual harassment or otherwise knowingly allowing sexual harassment to continue.

Supervisors and managers will also be subject to discipline for engaging in any retaliation.

## Complaint and Investigation of Sexual Harassment

***All*** complaints or information about sexual harassment will be investigated, whether that information was reported in verbal or written form. Investigations will be conducted in a timely manner, and will be confidential to the extent possible.

An investigation of any complaint, information or knowledge of suspected sexual harassment will be prompt and thorough, commenced immediately and completed as soon as possible. The investigation will be kept confidential to the extent possible. All persons involved, including complainants, witnesses and alleged harassers will be accorded due process, as outlined below, to protect their rights to a fair and impartial investigation.

Any employee may be required to cooperate as needed in an investigation of suspected sexual harassment. [*Employer Name*] will not tolerate retaliation against employees who file complaints, support another's complaint or participate in an investigation regarding a violation of this policy.

While the process may vary from case to case, investigations should be done in accordance with the following steps:

- Upon receipt of complaint, [*person or office designated*] will conduct an immediate review of the allegations, and take any interim actions (e.g., instructing the respondent to refrain from communications with the complainant), as appropriate. If complaint is verbal, encourage the individual to complete the "Complaint Form" in writing. If he or she refuses, prepare a Complaint Form based on the verbal reporting.

- If documents, emails or phone records are relevant to the investigation, take steps to obtain and preserve them.

- Request and review all relevant documents, including all electronic communications.

- Interview all parties involved, including any relevant witnesses;

- Create a written documentation of the investigation (such as a letter, memo or email), which contains the following:
    - A list of all documents reviewed, along with a detailed summary of relevant documents;
    - A list of names of those interviewed, along with a detailed summary of their statements;
    - A timeline of events;
    - A summary of prior relevant incidents, reported or unreported; and
    - The basis for the decision and final resolution of the complaint, together with any corrective action(s).

- Keep the written documentation and associated documents in a secure and confidential location.

- Promptly notify the individual who reported and the individual(s) about whom the complaint was made of the final determination and implement any corrective actions identified in the written document.

- Inform the individual who reported of the right to file a complaint or charge externally as outlined in the next section.

## Legal Protections And External Remedies

Sexual harassment is not only prohibited by [*Employer Name*] but is also prohibited by state, federal, and, where applicable, local law.

Aside from the internal process at [*Employer Name*], employees may also choose to pursue legal remedies with the following governmental entities. While a private attorney is not required to file a complaint with a governmental agency, you may seek the legal advice of an attorney.

In addition to those outlined below, employees in certain industries may have additional legal protections.

### State Human Rights Law (HRL)

The Human Rights Law (HRL), codified as N.Y. Executive Law, art. 15, § 290 et seq., applies to all employers in New York State with regard to sexual harassment, and protects employees, paid or unpaid interns and non-employees, regardless of immigration status. A complaint alleging violation of the Human Rights Law may be filed either with the Division of Human Rights (DHR) or in New York State Supreme Court.

Complaints with DHR may be filed any time **within one year** of the harassment. If an individual did not file at DHR, they can sue directly in state court under the HRL, **within three years** of the alleged sexual harassment. An individual may not file with DHR if they have already filed a HRL complaint in state court.

Complaining internally to [*Employer Name*] does not extend your time to file with DHR or in court. The one year or three years is counted from date of the most recent incident of harassment.

You do not need an attorney to file a complaint with DHR, and there is no cost to file with DHR.

DHR will investigate your complaint and determine whether there is probable cause to believe that sexual harassment has occurred. Probable cause cases are forwarded to a public hearing before an administrative law judge. If sexual harassment is found after a hearing, DHR has the power to award relief, which varies but may include requiring your employer to take action to stop the harassment, or redress the damage caused, including paying of monetary damages, attorney's fees and civil fines.

DHR's main office contact information is: NYS Division of Human Rights, One Fordham Plaza, Fourth Floor, Bronx, New York 10458. You may call (718) 741-8400 or visit: www.dhr.ny.gov.

Contact DHR at (888) 392-3644 or visit dhr.ny.gov/complaint for more information about filing a complaint. The website has a complaint form that can be downloaded, filled out, notarized and mailed to DHR. The website also contains contact information for DHR's regional offices across New York State.

## Civil Rights Act of 1964

The United States Equal Employment Opportunity Commission (EEOC) enforces federal anti-discrimination laws, including Title VII of the 1964 federal Civil Rights Act (codified as 42 U.S.C. § 2000e et seq.). An individual can file a complaint with the EEOC anytime within 300 days from the harassment. There is no cost to file a complaint with the EEOC. The EEOC will investigate the complaint, and determine whether there is reasonable cause to believe that discrimination has occurred, at which point the EEOC will issue a Right to Sue letter permitting the individual to file a complaint in federal court.

The EEOC does not hold hearings or award relief, but may take other action including pursuing cases in federal court on behalf of complaining parties. Federal courts may award remedies if discrimination is found to have occurred. In general, private employers must have at least 15 employees to come within the jurisdiction of the EEOC.

An employee alleging discrimination at work can file a "Charge of Discrimination." The EEOC has district, area, and field offices where complaints can be filed. Contact the EEOC by calling 1-800-669-4000 (TTY: 1-800-669-6820), visiting their website at www.eeoc.gov or via email at info@eeoc.gov.

If an individual filed an administrative complaint with DHR, DHR will file the complaint with the EEOC to preserve the right to proceed in federal court.

## Local Protections

Many localities enforce laws protecting individuals from sexual harassment and discrimination. An individual should contact the county, city or town in which they live to find out if such a law exists. For example, employees who work in New York City may file complaints of sexual harassment with the New York City Commission on Human Rights. Contact their main office at Law Enforcement Bureau of the NYC Commission on Human Rights, 40 Rector Street, 10th Floor, New York, New York; call 311 or (212) 306-7450; or visit www.nyc.gov/html/cchr/html/home/home.shtml.

## Contact the Local Police Department

If the harassment involves unwanted physical touching, coerced physical confinement or coerced sex acts, the conduct may constitute a crime. Contact the local police department.

# Model Complaint Form for Reporting Sexual Harassment

NEW YORK STATE | Combating Sexual Harassment

*[Name of employer]*

New York State Labor Law requires all employers to adopt a sexual harassment prevention policy that includes a complaint form to report alleged incidents of sexual harassment.

If you believe that you have been subjected to sexual harassment, you are encouraged to complete this form and submit it to [*person or office designated; contact information for designee or office; how the form can be submitted*]. You will not be retaliated against for filing a complaint.

If you are more comfortable reporting verbally or in another manner, your employer should complete this form, provide you with a copy and follow its sexual harassment prevention policy by investigating the claims as outlined at the end of this form.

**For additional resources, visit: ny.gov/programs/combating-sexual-harassment-workplace**

## COMPLAINANT INFORMATION

Name:

Work Address: Work Phone:

Job Title: Email:

Select Preferred Communication Method: ☐Email ☐Phone ☐In person

## SUPERVISORY INFORMATION

Immediate Supervisor's Name:

Title:

Work Phone: Work Address:

*Adoption of this form does not constitute a conclusive defense to charges of unlawful sexual harassment. Each claim of sexual harassment will be determined in accordance with existing legal standards, with due consideration of the particular facts and circumstances of the claim, including but not limited to the existence of an effective anti-harassment policy and procedure.*

**COMPLAINT INFORMATION**

1. Your complaint of Sexual Harassment is made about:

   Name: Title:

   Work Address: Work Phone:

   Relationship to you: ☐Supervisor ☐Subordinate ☐Co-Worker ☐Other

2. Please describe what happened and how it is affecting you and your work. Please use additional sheets of paper if necessary and attach any relevant documents or evidence.

3. Date(s) sexual harassment occurred:

   Is the sexual harassment continuing? ☐Yes ☐No

4. Please list the name and contact information of any witnesses or individuals who may have information related to your complaint:

*The last question is optional, but may help the investigation.*

5. Have you previously complained or provided information (verbal or written) about related incidents? If yes, when and to whom did you complain or provide information?

If you have retained legal counsel and would like us to work with them, please provide their contact information.

*Signature:* _____ *Date:* _____

**Instructions for Employers**

If you receive a complaint about alleged sexual harassment, follow your sexual harassment prevention policy.

An investigation involves:

- Speaking with the employee
- Speaking with the alleged harasser
- Interviewing witnesses
- Collecting and reviewing any related documents

While the process may vary from case to case, all allegations should be investigated promptly and resolved as quickly as possible. The investigation should be kept confidential to the extent possible.

Document the findings of the investigation and basis for your decision along with any corrective actions taken and notify the employee and the individual(s) against whom the complaint was made. This may be done via email.

# Model Sexual Harassment Prevention Training

OCTOBER 2018 EDITION

NEW YORK STATE | Combating Sexual Harassment

## Purpose of this Model Training

New York State is a national leader in the fight against sexual harassment in the workplace and the 2019 Budget includes legislation to further combat it.

Under the new law, every employer in New York State is **now required to establish a sexual harassment prevention policy** pursuant to Section 201-g of the Labor Law. The Department of Labor in consultation with the Division of Human Rights has established a model sexual harassment prevention policy for employers to adopt, available at www.ny.gov/programs/combating-sexual-harassment-workplace. Or, employers may adopt a similar policy that meets or exceeds the minimum standards of the model policy.

In addition, every employer in New York State is **now required to provide employees with sexual harassment prevention training** pursuant to Section 201-g of the Labor Law. The Department of Labor in consultation with the Division of Human Rights has established this model training for employers to use. Or, employers may use a training program that meets or exceeds the minimum standards of the model training.

An employer's sexual harassment prevention training **must be interactive**, meaning it requires some level of feedback by those being trained.

**The training, which may be presented to employees individually or in groups; in person, via phone or online; via webinar or recorded presentation, should include as many of the following elements as possible:**

- Ask questions of employees as part of the program;
- Accommodate questions asked by employees, with answers provided in a timely manner;
- Require feedback from employees about the training and the materials presented.

## How to Use This Training

This model training is presented in a variety of formats, giving employers maximum flexibility to deliver the training across a variety of worksite settings, while still maintaining a core curriculum.

Available training elements include:

1. **Script** for in-person group training, available in PDF and editable Word formats
2. **PowerPoint** to accompany the script, available online and for download, also in PDF
3. **Video** presentation, viewable online and for download
4. **FAQs**, available online to accompany the training, answering additional questions that arise

## Instructions for Employers

- This training is meant to be a model that can be used as is, or adapted to meet the specific needs of each organization.

- Training may include additional interactive activities, including an opening activity, role playing or group discussion.

- If specific employer policies or practices differ from the content in this training, the training should be modified to reflect those nuances, while still including all of the minimum elements required by New York State law (shown on Page 4).

- The training should detail any internal process employees are encouraged to use to complain and include the contact information for the specific name(s) and office(s) with which employees alleging harassment should file their complaints.

- It should also be modified to reflect the work of the organization by including, for example, industry specific scenarios.

- To every extent possible, this training should be given consistently (using the same delivery method) across each organization's workforce to ensure understanding at every level and at every location.

- It is every employer's responsibility to ensure all employees are trained to employer's standards and familiar with the organization's practices.

- All employees must complete initial sexual harassment prevention training before Oct. 9, 2019.

- All employees must complete an additional training at least once per year. This may be based on calendar year, anniversary of each employee's start date or any other date the employer chooses.

- All new employees should complete sexual harassment prevention training as quickly as possible.

- Employers should provide employees with training in the language spoken by their employees. When an employee identifies as a primary language one for which a template training is not available from the State, the employer may provide that employee an English-language version. However, as employers may be held liable for the conduct of all of their employees, employers are strongly encouraged to provide a the policy and training in the language spoken by the employee.

- On occasion, a participant may share a personal or confidential experience during the training. If this happens, the trainer should interrupt and recommend the story be discussed privately and with the appropriate office contact. After the training, follow up with this individual to ensure they are aware of the proper reporting steps. Managers and supervisors must report all incidents of harassment.

## Minimum Training Standards Checklist

An employer that does not use this model training -- developed by the State Department of Labor and State Division of Human Rights -- must ensure their training meets or exceeds the following minimum standards.

The training **must**:

- ☐ Be interactive;
- ☐ Include an explanation of sexual harassment consistent with guidance issued by the Department of Labor in consultation with the Division of Human Rights;
- ☐ Include examples of unlawful sexual harassment;
- ☐ Include information concerning the federal and state statutory provisions concerning sexual harassment and remedies available to targets of sexual harassment;
- ☐ Include information concerning employees' rights of redress and all available forums for adjudicating complaints; and
- ☐ Include information addressing conduct by supervisors and additional responsibilities for supervisors.

NEW YORK STATE

# Sexual Harassment Prevention Training

## ELEMENT 1: TRAINING SCRIPT

**OCTOBER 2018 EDITION**

NEW YORK STATE | Combating Sexual Harassment

# Table of Contents

## Trainer Introduction

- Welcome to our annual training on sexual harassment prevention.
- My name is _____[*name*]_____ and I am the _____[*title*]_____ at _____[*organization*]_____.
- In recent years, the topic of sexual harassment in the workplace has been brought into the national spotlight, bringing with it renewed awareness about the serious and unacceptable nature of these actions and the severe consequences that follow.
- The term "sexual harassment" may mean different things to different people, depending on your life experience.
- Certain conduct may seem acceptable or have seemed acceptable in the past. That does not mean it is acceptable to the people we work with.
- The purpose of this training is to set forth a common understanding about what is and what is not acceptable in our workplace.

## Sexual Harassment in the Workplace

- New York State has long been committed to ensuring that all individuals have an equal opportunity to enjoy a fair, safe and productive work environment.
- Laws and policies help ensure that diversity is respected and that everyone can enjoy the privileges of working in New York State.
- Preventing sexual harassment is critical to our continued success. Sexual harassment will not be tolerated.
- This means any harassing behavior will be investigated and the perpetrator or perpetrators will be told to stop.
- It also means that disciplinary action may be taken, if appropriate. If the behavior is sufficiently serious, disciplinary action may include termination.
- Repeated behavior, especially after an employee has been told to stop, is particularly serious and will be dealt with accordingly.
- This interactive training will help you better understand what is considered sexual harassment.
- It will also show you how to report sexual harassment in our workplace, as well as your options for reporting workplace sexual harassment to external state and federal agencies that enforce anti-discrimination laws.
- These reports will be taken seriously and promptly investigated, with effective remedial action taken where appropriate.

## What is Sexual Harassment?

- Sexual harassment is a form of sex discrimination and is unlawful under federal, state, and (where applicable) local law.

- Sexual harassment includes harassment on the basis of sex, sexual orientation, self-identified or perceived sex, gender expression, gender identity and the status of being transgender.

- Sexual harassment includes unwelcome conduct which is either of a sexual nature, or which is directed at an individual because of that individual's sex when:

    1. Such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive work environment, even if the reporting individual is not the intended target of the sexual harassment;

    2. Such conduct is made either explicitly or implicitly a term or condition of employment; or

    3. Submission to or rejection of such conduct is used as the basis for employment decisions affecting an individual's employment.

- There are two main types of sexual harassment.

### Hostile Environment

- A hostile environment on the basis of sex may be created by any action previously described, in addition to unwanted words, signs, jokes, pranks, intimidation, physical actions or violence, either of a sexual nature or not of a sexual nature, directed at an individual because of that individual's sex.

- Hostile environment sexual harassment includes:

    - Sexual or discriminatory displays or publications anywhere in the workplace, such as displaying pictures, posters, calendars, graffiti, objects, promotional material, reading materials or other materials that are sexually demeaning or pornographic.

        - This includes such sexual displays on workplace computers or cell phones and sharing such displays while in the workplace.

        - This also includes sexually oriented gestures, noises, remarks, jokes or comments about a person's sexuality or sexual experience.

    - Hostile actions taken against an individual because of that individual's sex, such as:

        - Rape, sexual battery, molestation or attempts to commit these assaults.

        - Physical acts of a sexual nature (including, but not limited to, touching, pinching, patting, grabbing, kissing, hugging, brushing against another employee's body or poking another employee's body)

- Interfering with, destroying or damaging a person's workstation, tools or equipment, or otherwise interfering with the individual's ability to perform the job;
- Sabotaging an individual's work;
- Bullying, yelling, name-calling.

**Quid Pro Quo Sexual Harassment**

- Quid pro quo sexual harassment occurs when a person in authority trades, or tries to trade, job benefits for sexual favors.
- Quid pro quo is a legal term meaning a trade.
- This type of harassment occurs between an employee and someone with authority, like a supervisor, who has the ability to grant or withhold job benefits.
- Quid pro quo sexual harassment includes:
    - Offering or granting better working conditions or opportunities in exchange for a sexual relationship
    - Threatening adverse working conditions (like demotions, shift alterations or work location changes) or denial of opportunities if a sexual relationship is refused
    - Using pressure, threats or physical acts to force a sexual relationship
    - Retaliating for refusing to engage in a sexual relationship

## Who can be the Target of Sexual Harassment?

- Sexual harassment can occur between any individuals, regardless of their sex or gender.
- New York Law protects employees, paid or unpaid interns, and non-employees, including independent contractors, and those employed by companies contracting to provide services in the workplace.

## Who can be the Perpetrator of Sexual Harassment?

- The perpetrator of sexual harassment can be anyone in the workplace:
- The harasser can be a **coworker** of the recipient
- The harasser can be a **supervisor** or **manager**
- The harasser can be any third-party, including: a **non-employee**, **intern**, **vendor**, **building security**, **client**, **customer** or **visitor**.

## Where Can Workplace Sexual Harassment Occur?

- Harassment can occur **whenever and wherever** employees are fulfilling their work responsibilities, including in the field, at any employer-sponsored event, trainings, conferences open to the public and office parties.
- Employee interactions during non-work hours, such as at a hotel while traveling or at events after work can have an impact in the workplace.
- Locations off site and off-hour activities can be considered extensions of the work environment.
- Employees can be the target of sexual harassment through calls, texts, email and social media.
- Harassing behavior that in any way affects the work environment is rightly the concern of management.

## Sex Stereotyping

- Sex stereotyping occurs when conduct or personality traits are considered inappropriate simply because they may not conform to other people's ideas or perceptions about how individuals of either sex should act or look.
- Harassing a person because that person does not conform to gender stereotypes as to "appropriate" looks, speech, personality, or lifestyle is sexual harassment.
- Harassment because someone is performing a job that is usually performed, or was performed in the past, mostly by persons of a different sex, is sex discrimination.

# Retaliation

- Any employee who has engaged in "protected activity" is protected by law from being retaliated against because of that "protected activity."
- "Protected activities" with regard to harassment include:
    - Making a complaint to a supervisor, manager or another person designated by your employer to receive complaints about harassment
    - Making a report of suspected harassment, even if you are not the target of the harassment
    - Filing a formal complaint about harassment
    - Opposing discrimination
    - Assisting another employee who is complaining of harassment
    - Providing information during a workplace investigation of harassment, or testifying in connection with a complaint of harassment filed with a government agency or in court

## What is Retaliation?

- Retaliation is any action taken to alter an employee's terms and conditions of employment (such as a demotion or harmful work schedule or location change) because that individual engaged in any of the above protected activities. Such individuals should expect to be free from any negative actions by supervisors, managers or the employer motivated by these protected activities.
- Retaliation can be any such adverse action taken by the employer against the employee, that could have the effect of discouraging a reasonable worker from making a complaint about harassment or discrimination.
- The negative action need not be job-related or occur in the workplace, and may occur after the end of employment, such as an unwarranted negative reference.

## What is Not Retaliation

- A negative employment action is not retaliatory merely because it occurs after the employee engages in protected activity.
- Employees continue to be subject to all job requirements and disciplinary rules after having engaged in such activity.

## The Supervisor's Responsibility

- Supervisors and managers are held to a high standard of behavior. This is because:
    - They are placed in a position of authority by the employer and must not abuse that authority.
    - Their actions can create liability for the employer without the employer having any opportunity to correct the harassment.
    - They are required to report any harassment that is reported to them or which they observe.
    - They are responsible for any harassment or discrimination that they should have known of with reasonable care and attention to the workplace for which they are responsible.
    - They are expected to model appropriate workplace behavior.

### Mandatory Reporting

- Supervisors **must report any harassment** that they observe or know of, even if no one is objecting to the harassment.
- If a supervisor or manager receives a report of harassment, or is otherwise aware of harassment, it must be promptly reported to the employer, without exception,
    - Even if the supervisor or manager thinks the conduct is trivial
    - Even if the harassed individual asks that it not be reported
- Supervisors and managers will be subject to discipline for failing to report suspected sexual harassment or otherwise knowingly allowing sexual harassment to continue.
- Supervisors and managers will also be subject to discipline for engaging in any retaliation.

## What Should I Do If I Am Harassed?

- We cannot stop harassment in the workplace unless management knows about the harassment. It is everyone's responsibility.
- You are encouraged to report harassment to a supervisor, manager or other another person designated by your employer to receive complaints (as outlined in the sexual harassment prevention policy) so the employer can take action.
- Behavior does not need to be a violation of law in order to be in violation of the policy.

- We will provide you with a complaint form to report harassment and file complaints, but if you are more comfortable reporting verbally or in another manner, we are still required to follow the sexual harassment prevention policy by investigating the claims.

- If you believe that you have been subjected to sexual harassment, you are encouraged to complete the Complaint Form and submit it to:

    - [*Person or office designated*]

    - [*Contact information for designee or office*]

    - [*How the Complaint Form can be submitted*]

- You may also make reports verbally.

- Once you submit this form or otherwise report harassment, our organization must follow its sexual harassment prevention policy and investigate any claims.

- You should report any behavior you experience or know about that is inappropriate, as described in this training, without worrying about whether or not if it is unlawful harassment.

- Individuals who report or experience harassment should cooperate with management so a full and fair investigation can be conducted and any necessary corrective action can be taken.

- If you report harassment to a manager or supervisor and receive an inappropriate response, such as being told to "just ignore it," you may take your complaint to the next level as outlined in our policy under "Legal Protections And External Remedies."

- Finally, if you are not sure you want to pursue a complaint at the time of potential harassment, document the incident to ensure it stays fresh in your mind.

## What Should I Do If I Witness Sexual Harassment?

- Anyone who witnesses or becomes aware of potential instances of sexual harassment should report it to a supervisor, manager or designee.

- It can be uncomfortable and scary, but it is important to tell coworkers "that's not okay" when you are uncomfortable about harassment happening in front of you.

- It is unlawful for an employer to retaliate against you for reporting suspected sexual harassment or assisting in any investigation.

## Investigation and Corrective Action

- Anyone who engages in sexual harassment or retaliation will be subject to remedial and/or disciplinary action, up to and including termination.
- [*Name of Company*] will investigate all reports of harassment, whether information was reported in verbal or written form.
- An investigation of any complaint should be commenced immediately and completed as soon as possible.
- The investigation will be kept confidential to the extent possible.
- Any employee may be required to cooperate as needed in an investigation of suspected sexual harassment.
    - It is illegal for employees who participate in any investigation to be retaliated against.

### Investigation Process

- Our organization also has a duty to take appropriate steps to ensure that harassment will not occur in the future. Here is how we will investigate claims.
- [*Person or office designated*] will conduct an immediate review of the allegations, and take any interim actions, as appropriate
- Relevant documents, emails or phone records will be requested, preserved and obtained.
- Interviews will be conducted with parties involved and witnesses
- Investigation is documented as outlined in the sexual harassment policy
- The individual who complained and the individual(s) accused of sexual harassment are notified of final determination and that appropriate administrative action has been taken.

## Additional Protections and Remedies

- In addition to what we've already outlined, employees may also choose to pursue outside legal remedies as suggested below.

### New York State Division of Human Rights (DHR)

- A complaint alleging violation of the Human Rights Law may be filed either with DHR or in New York State Supreme Court.
- Complaints may be filed with DHR any time **within one year** of the alleged sexual harassment. You do not need to have an attorney to file.
- If an individual did not file at DHR, they can sue directly in state court under the Human Rights Law, **within three years** of the alleged sexual harassment.
- An individual may not file with DHR if they have already filed a Human Rights Law complaint in state court.
- For more information, visit: **www.dhr.ny.gov**.

### United States Equal Employment Opportunity Commission (EEOC)

- An individual can file a complaint with the EEOC anytime **within 300 days** from the alleged sexual harassment. You do not need to have an attorney to file.
- A complaint must be filed with the EEOC before you can file in federal court.
- For more information, visit: **www.eeoc.gov**.
- *NOTE: If an individual files an administrative complaint with DHR, DHR will automatically file the complaint with the EEOC to preserve the right to proceed in federal court.*

### Local Protections

- Many localities enforce laws protecting individuals from sexual harassment and discrimination.
- You should contact the county, city or town in which you live to find out if such a law exists.
- Harassment may constitute a crime if it involves things like physical touching, coerced physical confinement or coerced sex acts. **You should also contact the local police department**.

## Other Types of Workplace Harassment

- Workplace harassment can be based on other things and is not just about gender or inappropriate sexual behavior in the workplace.
- Any harassment or discrimination based on a protected characteristic is prohibited in the workplace and may lead to disciplinary action against the perpetrator.
    - Protected characteristics include age, race, creed, color, national origin, sexual orientation, military status, sex, disability, marital status, domestic violence victim status, gender identity and criminal history.
- Much of the information presented in this training applies to all types of workplace harassment.

## Summary

- After this training, all employees are should understand what we have discussed, including:
    - How to recognize harassment as inappropriate workplace behavior
    - The nature of sexual harassment
    - That harassment because of any protected characteristic is prohibited
    - The reasons why workplace harassment is employment discrimination
    - That all harassment should be reported
    - That supervisors and managers have a special responsibility to report harassment.
- With this knowledge, all employees can achieve appropriate workplace behavior, avoid disciplinary action, know their rights and feel secure that they are entitled to and can work in an atmosphere of respect for all people.
- Find the Complaint Form [*insert information here*].
- For additional information, visit: **ny.gov/programs/combating-sexual-harassment-workplace**

## Sexual Harassment Case Studies

- Let's take a look at a few scenarios that help explain the kind of behaviors that can constitute sexual harassment.
- These examples describe inappropriate behavior in the workplace that will be dealt with by corrective action, including disciplinary action.
- Remember, it is up to **all employees** to report inappropriate behavior in the workplace.

### Example 1: Not Taking "No" for an Answer

Li Yan's coworker Ralph has just been through a divorce. He drops comments on a few occasions that he is lonely and needs to find a new girlfriend. Li Yan and Ralph have been friendly in the past and have had lunch together in local restaurants on many occasions. Ralph asks Li Yan to go on a date with him—dinner and a movie. Li Yan likes Ralph and agrees to go out with him. She enjoys her date with Ralph but decides that a relationship is not a good idea. She thanks Ralph for a nice time, but explains that she does not want to have a relationship with him. Ralph waits two weeks and then starts pressuring Li Yan for more dates. She refuses, but Ralph does not stop. He keeps asking her to go out with him.

**Question 1.** When Ralph first asked Li Yan for a date, this was sexual harassment. True or False?

FALSE: Ralph's initial comments about looking for a girlfriend and asking Li Yan, a coworker, for a date are not sexual harassment. Even if Li Yan had turned Ralph down for the first date, Ralph had done nothing wrong by asking for a date and by making occasional comments that are not sexually explicit about his personal life.

**Question 2.** Li Yan cannot complain of sexual harassment because she went on a date with Ralph. True or False?

FALSE: Being friendly, going on a date, or even having a prior relationship with a coworker does not mean that a coworker has a right to behave as Ralph did toward Li Yan. She has to continue working with Ralph, and he must respect her wishes and not engage in behavior that has now become inappropriate for the workplace.

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Li Yan complains to her supervisor, and the supervisor (as required) reports her complaint to the person designated by her employer to receive complaints. Ralph is questioned about his behavior and he apologizes. He is instructed by the designated person to stop. Ralph stops for a while but then starts leaving little gifts for Li Yan on her desk with accompanying love notes. The love notes are not overtly offensive, but Ralph's behavior is starting to make Li Yan nervous, as she is afraid he may start stalking her.

**Question 3.** Ralph's subsequent behavior with gifts and love notes is not sexual harassment because he has stopped asking Li Yan for dates as instructed. He is just being nice to Li Yan because he likes her. True or False?

FALSE: Li Yan should report Ralph's behavior. She was entitled to have effective assistance in getting Ralph to stop his inappropriate workplace behavior. Because Ralph has returned to pestering Li Yan after being told to stop, he could be subject to serious disciplinary action for his behavior.

**Example 2: The Boss with a Bad Attitude**

Sharon transfers to a new location with her employer. Her new supervisor, Paul, is friendly and helps her get familiar with her new job duties. After a few days, when no one else is around, Paul comes over to Sharon's work area to chat. Paul talks about what he did last night, which was to go to a strip club. Sharon is shocked that Paul would bring up such a topic in the workplace and says nothing in response. Paul continues talking and says that all the women in the office are so unattractive that he needs to get out and "see some hot chicks" once in a while. He tells Sharon he is glad she joined the staff because, unlike the others, she is "easy on the eyes." Sharon feels very offended and demeaned that she and the other women in her workplace are being evaluated on their looks by their supervisor.

**Question 1.** Because Paul did not tell Sharon that she is unattractive, he has not harassed her. True or False?

FALSE: Paul has made sexually explicit statements to Sharon, which are derogatory and demeaning to Sharon and her female coworkers. It does not matter that Paul supposedly paid Sharon a "compliment." The discussion is still highly offensive to Sharon, as it would be to most reasonable persons in her situation.

**Question 2.** By bringing up his visit to the strip club, Paul is engaging in inappropriate workplace behavior. True or False?

TRUE: Simply bringing up the visit to the strip club is inappropriate in the workplace, especially by a supervisor, and it would be appropriate for Sharon to report this conduct. A one-time comment about going to a strip club is behavior that Paul would be told to stop, even though it probably would not rise to the level of unlawful harassment, unless it was repeated on multiple occasions.

**Question 3.** Paul should be instructed to stop making these types of comments, but this is not a serious matter. True or False?

FALSE: Paul's comments about the female employees are a serious matter and show his contempt for women in the workplace. Paul is required to model appropriate behavior, and must not exhibit contempt for employees on the basis of sex or any protected characteristic. Sharon should not have to continue to work for someone she knows harbors such contempt for women, nor should the other employees have to work for such a supervisor. Management should be aware of this, even if the other employees are not, and Paul should be disciplined and, most likely, removed from his current position.

**Example 3: No Job for a Woman?**

Carla works as a licensed heavy equipment operator. Some of her male coworkers think it is fun to tease her. Carla often hears comments like "Watch out, here she comes–that crazy woman driver!" in a joking manner. Also, someone keeps putting a handmade sign on the only port-a-potty at the worksite that says, "Men only."

**Question 1.** Women in traditionally male jobs should expect teasing and should not take the joking comments too seriously. True or False?

FALSE: Whether Carla is being harassed depends in part on Carla's opinion of the situation; that is, whether she finds the behavior offensive. However, if at any point Carla does feel harassed, she is entitled to complain of the behavior and have it stopped, regardless of whether and for how long she has endured the behavior without complaint. Carla can always say when enough is enough.

**Question 2.** Carla cannot complain, because the site supervisor sometimes joins in with the joking behavior, so she has nowhere to go. True or False?

FALSE: Carla can still complain to the supervisor who is then on notice that the behavior bothers Carla and must be stopped. The supervisor's failure to take Carla's complaint seriously, constitutes serious misconduct on his or her part. Carla can also complain directly to the person designated by her employer to receive complaints, either instead of going to the supervisor, or after doing so. The employer is responsible for assuring that all employees are aware of its anti-harassment policies and procedures.

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Some of Carla's other coworkers are strongly opposed to her presence in the traditionally all-male profession. These coworkers have sometimes said things to her like, "You're taking a job away from a man who deserves it," "You should be home with your kids," and "What kind of a mother are you?" Also, someone scratched the word "bitch" on Carla's toolbox.

**Question 3.** These behaviors, while rude, are not sexual harassment because they are not sexual in nature. True or False?

FALSE: The behaviors are directed at her because she is a woman and appear to be intended to intimidate her and cause her to quit her job. While not sexual in nature, this harassment is because of her sex and will create a hostile work environment if it is sufficiently severe or frequent.

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Carla complains about the jokes and other behaviors, and an investigation is conducted. It cannot be determined who defaced Carla's toolbox. Her coworkers are told to stop their behavior or face disciplinary charges. The supervisor speaks with Carla and tells her to come to him immediately if she has any further problems. Carla then finds that someone has urinated in her toolbox.

**Question 4.** There is nothing Carla can do because she can't prove who vandalized her toolbox. True or False?

FALSE: Carla should speak to her supervisor immediately, or contact any other person designated by her employer to receive complaints directly. Although the situation has become very difficult, it is the employer's responsibility to support Carla and seek a solution. An appropriate investigation must be promptly undertaken and appropriate remedial action must follow.

**Example 4: Too Close for Comfort**

Keisha has noticed that her new boss, Sarah, leans extremely close to her when they are going over the reports that she prepares. She touches her hand or shoulder frequently as they discuss work. Keisha tries to move away from her in these situations, but she doesn't seem to get the message.

**Question 1.** Keisha should just ignore Sarah's behavior. True or False?

FALSE: If Keisha is uncomfortable with Sarah's behavior, she has options. If she feels comfortable doing so, she should tell Sarah to please back off because her closeness and touching make her uncomfortable. Another option is to complain directly to a person designated by her employer to receive complaints, who will speak with Sarah. Although this may not be sufficiently severe or pervasive to create an unlawful harassment situation (unless it was repeated by Sarah after she was told to stop), there is no reason for Keisha to be uncomfortable in the workplace. There is no valid reason for Sarah to engage in this behavior.

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Before Keisha gets around to complaining, Sarah brushes up against her back in the conference room before a meeting. She is now getting really annoyed but still puts off doing anything about it. Later Sarah "traps" Keisha in her office after they finish discussing work by standing between her and the door of the small office. Keisha doesn't know what to do, so she moves past her to get out. As she does so, Sarah runs her hand over Keisha's breast.

**Question 2.** Sarah's brushing up against Keisha in the conference room could just be inadvertent and does not give Keisha any additional grounds to complain about Sarah. True or False?

FALSE: Sarah is now engaging in a pattern of escalating behavior. Given the pattern of her "too close" and "touching" behavior, it is unlikely that this was inadvertent. Even before being "trapped" in Sarah's office, Keisha should have reported all of the behaviors she had experienced that had made her uncomfortable.

**Question 3.** Sarah touching Keisha's breast is inappropriate but is probably not unlawful harassment because it only happened once. True or False?

FALSE: Any type of sexual touching is very serious and does not need to be repeated to constitute sexual harassment. Keisha should immediately report it without waiting for it to be repeated. Sarah can expect to receive formal discipline, including possible firing.

**Example 5: A Distasteful Trade**

The following scenario will explain many aspects of quid pro quo sexual harassment.

Tatiana is hoping for a promotion to a position that she knows will become vacant soon. She knows that her boss, David, will be involved in deciding who will be promoted. She tells David that she will be applying for the position, and that she is very interested in receiving the promotion. David says, "We'll see. There will be a lot of others interested in the position."

A week later, Tatiana and David travel together on state business, including an overnight hotel stay. Over dinner, David tells Tatiana that he hopes he will be able to promote her, because he has always really enjoyed working with her. He tells her that some other candidates "look better on paper" but that she is the one he wants. He tells her that he can "pull some strings" to get her into the job and Tatiana thanks David. Later David suggests that they go to his hotel room for "drinks and some relaxation." Tatiana declines his "offer."

**Question 1.** David's behavior could be harassment of Tatiana. True or False?

TRUE: David's behavior as Tatiana's boss is inappropriate, and Tatiana should feel free to report the behavior if it made her uncomfortable. It is irrelevant that this behavior occurs away from the workplace. Their relationship is that of supervisor and supervisee, and all their interactions will tend to impact the workplace.

David's behavior, at this point, may or may not constitute quid pro quo harassment; David has made no threat that if Tatiana refuses his advance he will handle her promotion any differently. However, his offer to "pull some strings" followed by a request that they go to his hotel room for drinks and relaxation might be considered potentially coercive. Certainly, if David persists in his advances—even if he never makes or carries out any threat or promise about job benefits—then this could create a hostile environment for Tatiana, for which the employer could be strictly liable because David is a management employee.

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After they return from the trip, Tatiana asks David if he knows when the job will be posted so that she can apply. He says that he is not sure, but there is still time for her to "make it worth his while" to pull strings for her. He then asks, "How about going out to dinner this Friday and then coming over to my place?"

**Question 2.** David engaged in sexual harassment. True or False?

TRUE: It is now evident that David has offered to help Tatiana with her promotion in exchange for sexual favors.

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Tatiana, who really wants the position, decides to go out with David. Almost every Friday they go out at David's insistence and engage in sexual activity. Tatiana does not want to be in a relationship with David and is only going out with him because she believes that he will otherwise block her promotion.

**Question 3.** Tatiana cannot complain of harassment because she voluntarily engaged in sexual activity with David. True or False?

FALSE: Because the sexual activity is unwelcome to Tatiana, she is a target of sexual harassment. Equally, if she had refused David's advances, she would still be a target of sexual harassment. The offer to Tatiana to trade job benefits for sexual favors by someone with authority over her in the workplace is quid pro quo sexual harassment, and the employer is exposed to liability because of its supervisor's actions.

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Tatiana receives the promotion.

**Question 4.** Tatiana cannot complain of harassment because she got the job, so there is no discrimination against her. True or False?

FALSE: Tatiana can be the recipient of sexual harassment whether or not she receives the benefit that was used as an inducement.

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Tatiana breaks off the sexual activities with David. He then gives her a bad evaluation, and she is removed from her new position at the end of the probationary period and returns to her old job.

**Question 5.** It is now "too late" for Tatiana to complain. Losing a place of favor due to the break up of the voluntary relationship does not create a claim for sexual harassment. True or False?

FALSE: It is true that the breakup of a relationship, if truly consensual and welcomed at the time, usually does not create a claim for sexual harassment. However, the "relationship" in this case was never welcomed by Tatiana. David's behavior has at all times been inappropriate and a serious violation of the employer's policy. As the person who abused the power and authority of a management position, David has engaged in sexual harassment.

**Example 6: An Issue about Appearances**

Leonard works as a clerk typist for a large employer. He likes to wear jewelry, and his attire frequently includes earrings and necklaces. His boss, Margaret, thinks it's "weird" that, as a man, Leonard wears jewelry and wants to be a clerical worker. She frequently makes sarcastic comments to him about his appearance and refers to him "jokingly" as her office boy. Leonard, who hopes to develop his career in the area of customer relations, applies for an open promotional position that would involve working in a "front desk" area, where he would interact with the public. Margaret tells Leonard that if he wants that job, he had better look "more normal" or else wait for a promotion to mailroom supervisor.

**Question 1.** Leonard's boss is correct to tell him wearing jewelry is inappropriate for customer service positions. True or False?

FALSE: Leonard's jewelry is only an issue because Margaret considers it unusual for a man to wear such jewelry. Therefore, her comments to Leonard constitute sex stereotyping.

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Margaret also is "suspicious" that Leonard is gay, which she says she "doesn't mind," but she thinks Leonard is "secretive." She starts asking him questions about his private life, such as "Are you married?" "Do you have a partner?" "Do you have kids?" Leonard tries to respond politely "No" to all her questions but is becoming annoyed. Margaret starts gossiping with Leonard's coworkers about his supposed sexual orientation.

**Question 2.** Leonard is the recipient of harassment on the basis of sex and sexual orientation. True or False?

TRUE: Leonard is harassed on the basis of sex because he is being harassed for failure to adhere to Margaret's sex stereotypes.

Leonard is also harassed on the basis of his perceived sexual orientation. It does not matter whether or not Leonard is a gay man in order for him to have a claim for sexual orientation harassment.

Leonard might also be considered a target of harassment on the basis of gender identity, which is a form of sex and/or disability discrimination prohibited by the Human Rights Law. Leonard should report Margaret's conduct, which is clearly a violation of the sexual harassment policy, to a person designated by his employer to receive complaints (i.e. his employer's "designee").

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Leonard decides that he is not going to get a fair chance at the promotion under these circumstances, and he complains to the employer's designee about Margaret's behavior. The designee does an investigation and tells Margaret that Leonard's jewelry is not in violation of any workplace rule, that she is to consider him for the position without regard for his gender, and that she must stop making harassing comments, asking Leonard intrusive questions, and gossiping about his personal life. Margaret stops her comments, questions, and gossiping, but she then recommends a woman be promoted to the open position. The woman promoted has much less experience than Leonard and lacks his two-year degree in customer relations from a community college.

**Question 3.** Leonard has likely been the target of discrimination on the basis of sex, sexual orientation and/or retaliation. True or False?

TRUE: We don't know Margaret's reason for not recommending Leonard for the promotion, but it is not looking good for Margaret. It appears that she is either biased against Leonard for the same reasons she harassed him, or she is retaliating because he complained, or both.

Leonard should speak further with the employer's designee, and the circumstances of the promotion should be investigated. If it is found that Margaret had abused her supervisory authority by failing to fairly consider Leonard for the promotion, she should be subject to disciplinary action. This scenario shows that sometimes more severe action is needed in response to harassment complaints, in order to prevent discrimination in the future.

# Judicial Panel - Article 81 Judges

**Moderator**

**Ira Salzman, Esq.**

Goldfarb, Abrandt, Salzman & Kutzin, LLC | New York, NY

**Hon. Arthur M. Diamond**

New York State Supreme Court | Mineola, NY

**Hon. David H. Guy**

Broome County Surrogate's Court | Binghamton, NY

**Hon. Tanya R. Kennedy**

New York State Surpeme Court | New York, NY

**Hon. Bernice D. Siegal**

Supremem Court, Queens County | Jamaica, NY

----------X

TO THE SUPREME COURT, ---COUNTY:

---, an attorney at law licensed to practice in the State of New York, affirms subject to the penalties of perjury pursuant to the CPLR:

**FIRST:** That she is an attorney at law licensed to practice in the State of New York maintaining offices at ---and represents "GUARDIAN" as Guardian of IP, and BANK as Trustee of the IP SUPPLEMENTAL NEEDS TRUST.

**SECOND:** That she makes this Affirmation in Support of a Motion Allowing Social Security Funds to Remain Separate from Guardianship and Trust Assets.

## RELIEF REQUESTED

**THIRD:** Your Affirmant respectfully requests that this Court authorize the Social Security funds of IP to remain outside of the Guardianship. "GUARDIAN" is Representative Payee for the SSI funds of IP. If this relief is granted, "GUARDIAN" will include the Annual Report of the Representative Payee filed with the Social Security Administration with her Annual Guardianship Report.

**LEGAL ARGUMENT:**

### POINT I: THE SOCIAL SECURITY ADMINISTRATION HAS BLANKETED THE FIELD IN THE MANAGEMENT OF SSI BENEFITS FOR A PERSON WITH A DISABILITY BY THE APPOINTMENT, INVESTIGATION, ACCOUNT REVIEW AND DISCIPLINARY AUTHORITY OVER A REPRESENTATIVE PAYEE

#### A. SSA Need Not Appoint the Guardian as Representative Payee

**FOURTH:** The Social Security Administration determines who will be appointed the Representative Payee for Social Security payments. The Social Security Administration will not necessarily appoint the legal guardian of the beneficiary. If the beneficiary is a legally incompetent individual, SSA may appoint the legal guardian or some other person as a representative payee. 20 CFR 416.601(b)(2). If a Representative Payee has been appointed prior to the appointment of a Guardian, the SSA will appoint the Guardian only if the Guardian can better serve the person's interests than the appointed Representative Payee. See POMS GN00502.139(B)(1)(2),

**FIFTH: "1. Legal Guardian/Conservator**

If you learn that the beneficiary has a court-appointed legal guardian:

- obtain proof of appointment, and
- advise the guardian of the beneficiary's entitlement to benefits and of a guardian's right to file to be appointed payee.

**REMINDER: You are not required to appoint the legal guardian as payee.** Appoint the person who will best serve the beneficiary." Emphasis in original. Id.

#### B. SSA Has Remedies if the Representative Payee Misuses Funds

**SIXTH:** The Representative Payee is subject to a federal accounting requirement to the Social Security Administration at least annually. POMS GN 00605.001; 20 C.F.R. 416.635 and 20 C.F.R. 416.665. If, after having reviewed the accountings, the SSA

finds misuse of funds, the remedies available to SSA include removing the Representative Payee, requiring restitution to the beneficiary or reporting the conversion of Social Security funds for criminal prosecution. See 20 C.F.R. 404.2050 for SSDI, the same as for SSI.

**C. Conflicts Exist between New York State Guardianship Laws and Federal Law in the Management and Control over SSI Benefits**

**SEVENTH:** If SSI is brought into the Guardianship estate, the Court could assert the authority to direct how SSI is to be spent, pursuant to MHL 81.21. However, the Social Security Act gives sole authority to SSA to decide how Social Security benefits are to be spent. "A payee must use benefits to provide for the beneficiary's current needs such as food, clothing, housing, medical care and personal comfort items, or for reasonably foreseeable needs. If not needed for these purposes . . . the payee must conserve or invest benefits on behalf of the beneficiary." POMS GN 00602.001(A)(2), annexed hereto as **Exhibit B**. As per POMS GN 00602.120(B)(2), annexed hereto as **Exhibit C**, "[i]f at any time the field office (FO) learns that a court has initiated an action or issued an order requiring a payee to resign, turn benefits over to another, or use the benefits in a specific manner, the FO will notify the regional office (RO) for consultation with the regional chief counsel (RCC). On a case-by-case basis, the RO may determine the need to seek RCC assistance in drafting a letter to the payee explaining that social security law governs a payee's use of benefits. The payee may use that letter to pursue the matter further with the court. **Do not contact the court directly.**" Id.

**EIGHTH:** Discretion given the Guardian is often different from that given the Representative Payee. Pursuant to Ruppert Acquiescence Ruling, annexed hereto as **Exhibit D**, when SSI payments are used to pay room and board to a family/landlord, there will not be a reduction in SSI benefits even if the beneficiary does not pay for his per capita share of household expenses, as a business relationship is presumed. The Guardianship court, however, may exercise discretion and not allow the SSI to be used to pay rent to a parent/landlord.

**D. Removal of Guardian**

**NINTH:** The Guardianship Court has the right to remove a Guardian for reasons that may have nothing to do with the Guardian's use of SSI. For example, the Guardian may not have accounted to the Guardianship Part but may have filed annual Representative Payee reports with the Social Security Administration. If the SSI is in the Guardianship account, the Guardian would no longer have the right to access the SSI. As only the Social Security Administration has the right to remove the Representative Payee, 20 C.F.R. 404.2050, the Court's removal of a Guardian would be a de facto removal of a Representative Payee, in contravention of the Social Security Act.

**WHEREFORE**, Your Affirmant respectfully prays that the Social Security Income remain outside the Guardianship and/or Trust account.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

**SMD# 17-002**

**RE: Implications of the ABLE Act for State Medicaid Programs**

September 7, 2017

Dear State Medicaid Director:

The Stephen Beck, Jr., Achieving a Better Life Experience Act of 2014 (the ABLE Act), enacted as Division B of Pub. L. No. 113-295, and as amended by the Protecting America from Tax Hikes Act of 2015 (Pub. L. No. 114-113), enables individuals with disabilities to save money in tax-advantaged accounts which they can later use for meeting their disability-related needs, with limited impact on their eligibility for certain means-tested benefits.[1] The purpose of this letter is to provide guidance to states on the implications of the ABLE Act for state Medicaid programs.

## Background

The ABLE Act amended the Internal Revenue Code of 1986 to create section 529A ("Qualified ABLE Programs"), permitting states to establish ABLE programs within which people with disabilities can open accounts that will generally be exempt from taxation. The purpose of the ABLE Act is to permit people with disabilities to save money in and withdraw funds from their ABLE accounts to pay for disability-related expenses, in support of their efforts to maintain health, independence and quality of life. The law states that ABLE accounts should "supplement, but not supplant" benefits available to ABLE account beneficiaries under Medicaid, the Supplemental Security Income program (SSI), and other programs.[2]

Section 103 of the ABLE Act (hereinafter referred to as "section 103") provides that, for the purpose of determining an individual's eligibility to receive, or the amount of, any assistance provided by a needs-based federal program (such as Medicaid), amounts in, contributions to, and certain distributions from, ABLE accounts shall be disregarded. This letter provides guidance to states on the treatment of funds in, contributions to, and distributions from an ABLE account, under section 103, for purposes of Medicaid eligibility. We also address the treatment of funds in an ABLE account for purposes of the post-eligibility treatment of income, and the disposition of amounts remaining in a Medicaid beneficiary's ABLE account upon the death of the beneficiary.

## Eligibility to Participate in a Qualified ABLE Program

[1] State agencies should apply the guidance set forth in this letter to the Children's Health Insurance Program (CHIP) where applicable to determine the income of the family unit to which the applicant belongs.
[2] ABLE Act, section 101(2)

Section 103 applies to individuals who have an ABLE account in a *qualified* ABLE program. Eligibility for an ABLE account is open to an individual of any age who has blindness or a disability, provided, however, that the individual's blindness or disability occurred before the age of 26. An individual is permitted to have only one ABLE account. The individual may open the account in the program of the state of which the individual is a resident, or in another state's ABLE program. The determination of eligibility for an ABLE account is the responsibility of the ABLE program in which an individual seeks to establish the account.

Under section 102(a) of the ABLE Act (codified at 26 U.S.C. §529A(e)), an individual is eligible for an ABLE account if the individual is receiving SSI or Social Security Disability Insurance (SSDI) benefits based on a disability or blindness that occurred before age 26. Alternatively, an individual (or a parent or guardian acting on the individual's behalf) may establish eligibility by filing a disability certification (and obtaining a signed physician's diagnosis) with the qualified ABLE program indicating that the individual has a medically determinable impairment meeting certain criteria that occurred before age 26. However, while sufficient to establish eligibility to participate in an ABLE program, section 102(a) of the ABLE Act provides that "no inference" may be drawn from a disability certification for purposes of establishing eligibility for Medicaid.

Although the statute refers to "qualified" ABLE programs, the ABLE Act does not provide for formal federal certification of a state ABLE program as a "qualified" program. Moreover, the Department of Treasury and Internal Revenue Service (IRS) have not proposed to establish a formal certification process in a proposed rule that is designed to implement the ABLE act.[3] We have concluded that state Medicaid agencies should presume that an ABLE program established by a state is a qualified program in the absence of evidence to the contrary (CMS will issue additional guidance if a formal certification process for ABLE programs is established).

**Treatment of Funds in an ABLE Account**

Generally, an account containing funds that a Medicaid applicant or beneficiary can access is considered a resource in determining Medicaid eligibility if a resource test is applied, as is generally the case in determining eligibility for individuals excepted from application of Modified Adjusted Gross Income (MAGI)-based methodologies. Section 103 requires that funds in an ABLE account, including earnings on the account (*e.g.*, interest), be disregarded in determining eligibility for Medicaid and other federal need-based programs.[4] We interpret section 103 to mean that state Medicaid agencies must disregard all funds in an ABLE account in determining the resource eligibility of Medicaid applicants and beneficiaries who are subject to a resource test.[5] Additionally, although earnings generated by funds in an account generally will

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[3] "Guidance Under Section 529A: Qualified ABLE Programs," 80 F.R. 35602 (June 22, 2015). We note that a proposed rule does not have the force of law and is not legally effective. Moreover, an agency may make changes from a proposed rule based on the timely public comments and other factors. The Department of Treasury and IRS have not issued a final rule at this time.

[4] We interpret section 103 to apply to an individual's ABLE account, regardless of whether the individual opens his or her ABLE account in the state of which the individual is a resident or in another state's ABLE program.

[5] Section 103(a)(1) and (2) state that, "in the case of the supplemental security income program . . . , a distribution for housing expenses . . . shall not be so disregarded," and "any amount . . . in [an] ABLE account shall be considered a resource to the designated beneficiary to the extent that such amount exceeds $100,000." However, while SSI methodologies are typically applied for non-MAGI eligibility determinations, these limitations on the

be countable income in determining eligibility for both MAGI and non-MAGI based eligibility groups, the disregard required under the ABLE Act applies "notwithstanding any other provision of Federal law," which we interpret as including the general prohibition on application of disregards in determining income eligibility using MAGI-based methods under section 1902(e)(14)(B) of the Social Security Act ("the Act"). Accordingly, under section 103, earnings on the account should be excluded from income for both individuals subject to and those excepted from application of MAGI-based methodologies.[6]

**Contributions to ABLE Accounts**

Contributions by a Third Party

For MAGI and SSI-based eligibility determinations, under section 103, third party contributions to an ABLE account are disregarded in determining Medicaid eligibility. This is different than the treatment of such contributions in determining financial eligibility using SSI-based methodologies and, in narrow circumstances, different than the treatment of such contributions under MAGI-based methodologies.

Under SSI-based methodologies, applied to most non-MAGI eligibility groups, money contributed by a third party to an account which an individual can access generally is considered countable income in the month in which the contribution is received and, if not spent, a resource in the month following. Per section 103, however, third party contributions to an ABLE account are not counted either as income or included in total resources of the account beneficiary.

For MAGI-based individuals, a third-party contribution to an account that is accessible to the individual would generally qualify as a gift which usually is not taxable to the gift recipient. Even in the rare circumstance in which a gift could be subject to a gift tax lien against the recipient (e.g., where the donor does not pay a tax due on gifts), section 103 directs that its disregards apply "notwithstanding any other provision of Federal law," which means the third party contribution must be disregarded in a MAGI-based income determination.[7]

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disregard of distributions from or funds in an ABLE account are expressly described as applying exclusively "in the case of the [SSI] program." In fact, section 103(b)(2), entitled "No Impact on Medicaid Eligibility," requires that SSI beneficiaries whose benefits are suspended on the basis of resources exceeding the $100,000 limit shall be considered to be receiving SSI for purposes of Medicaid eligibility. Therefore, we interpret section 103 to require that states, in determining Medicaid eligibility of ABLE account beneficiaries, disregard distributions used for housing expenses (provided the expense is a qualified disability expense, as discussed below), and all funds in an ABLE account, regardless of the amount in the account.

[6] For SSI-based individuals, we also interpret the disregard to apply to the ABLE accounts of individuals whose income or resources are deemed available to a Medicaid applicant. Under the SSI program's rules, which apply in most states to individuals who seek Medicaid on the basis of being 65 years old or older, or having blindness or a disability, the income and resources of a spouse or parent (a "deemor") are generally disregarded in the applicant's SSI eligibility determination where such income or resources would be disregarded if received or owned exclusively by the SSI applicant. We consider this to be the most reasonable approach, as we believe it would be inconsistent with the ABLE Act's goals to count as available to a Medicaid applicant the ABLE account of the applicant's deemor.

[7] Section 529A(b)(2)(B) of the Internal Revenue Code generally limits aggregate annual contributions to an individual's ABLE account to the annual gift tax exclusion, which means a third-party's accepted contribution to an ABLE account, when it is the third party's only gift during the taxable year, will not be taxable to either the donor or ABLE account beneficiary.

Some ABLE account beneficiaries may also be a beneficiary of a special needs trust (SNT) or pooled trust, as described in section 1917(d)(4) of the Act. Distributions from such trusts made on behalf of the trust beneficiary to the beneficiary's ABLE account should be treated the same as contributions to ABLE accounts from any other third party. Thus, while disbursements from an SNT or pooled trust can be considered in some circumstances income to the trust beneficiary,[8] disbursements from an SNT or pooled trust to the ABLE account of the trust beneficiary are not counted as income under section 103. Therefore, states should disregard as income a distribution from an SNT or pooled trust that is deposited into the ABLE account of the SNT or pooled trust beneficiary.

Contributions by the ABLE Account Beneficiary

Designated beneficiaries of an ABLE account can contribute their own income or resources to their ABLE account. If an ABLE account beneficiary transfers some of his or her own (otherwise countable) resources to his or her ABLE account, the effect would be a corresponding reduction in total countable resources. By contrast, if a beneficiary of an ABLE account transfers some of his or her income in the month received to his or her ABLE account, the effect would *not* be a reduction in countable income. This is because how an individual uses income generally does not change its designation as income at the point of its receipt, and there is nothing in the ABLE Act which supersedes this general rule. Consistent with this interpretation, the Treasury's and IRS's NPRM does not propose that income contributed to an ABLE account by the designated beneficiary reduces the individual's taxable income. Similarly, SSA's Program Operations Manual System (POMS) directs that income contributed to an ABLE account by the account beneficiary is counted as available income.[9] Therefore, income contributed to an ABLE account by the applicant or beneficiary him- or herself is not disregarded from income, unless the state utilizes its authority under section 1902(r)(2) of the Act and 42 CFR §435.601(d) (regarding less restrictive methodologies), if available.[10]

Contributions by Third Parties who Apply for Medicaid

It is possible that a third party who has made a contribution to an ABLE account of someone else may apply for Medicaid and seek coverage of long-term services and supports (LTSS). Section 103 of the ABLE Act does not provide for any special treatment of contributions made to an ABLE account benefiting another person. Thus, for example, a contribution from a grandfather to the ABLE account of his grandchild, whether from the grandfather's income or resources, would constitute a transfer of assets from the grandfather to his grandchild's account which may need to be evaluated under the requirements in section 1917(c)(1) of the Act (depending on when the transfer occurred), if the grandfather subsequently seeks Medicaid coverage of LTSS. The

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[8] This determination is generally made under the rules of SI 01120.200 of the Social Security Administration's Program Operations Manual System (POMS) ("Trusts, General – Including Trusts Established Prior to 1/1/00, Trusts Established with the Asset of Third Parties and Trusts Not Subject to Section 1613(e) of the Social Security Act," available at https://secure.ssa.gov/apps10/poms.nsf/lnx/0501120200 )).

[9] *See* "Achieving a Better Life Experience (ABLE) Accounts, Program Operations Manual Systems, SI 01130.740 available at https://secure.ssa.gov/apps10/poms.nsf/lnx/0501130740

[10] Per section 1902(e)(14)(B) of the Act, states cannot disregard in MAGI-based eligibility determinations income as a less restrictive methodology under the authority of section 1902(r)(2) of the Act and 42 CFR §435.601(d).

amount transferred by the grandfather to his grandchild's ABLE account would not be an exempt transfer by virtue of section 103 in the determination of the grandfather's eligibility for Medicaid coverage of LTSS.[11]

**Distributions from ABLE Accounts**

Like *funds in* and *contributions to* ABLE accounts, *distributions from* ABLE accounts are not included in the beneficiary's taxable income or counted as income in eligibility determinations for federal programs such as Medicaid as long as they are used for "qualified disability expenses" (QDEs). Section 529A(e)(5) of the Internal Revenue Code broadly defines QDEs as any expenses related to the eligible individual's blindness or disability which may include, but are not limited to, expenses incurred for education, housing, transportation, employment training and support, and assistive technology. The Treasury's and IRS's NPRM explains that QDEs can include ones not identified in the statute, and that the term should be broadly construed "in order to implement the legislative purpose" of the ABLE Act.[12] As long as distributions from an ABLE account are used for QDEs of the designated beneficiary, they are not included as income for purposes of determining Medicaid eligibility for MAGI-based and non-MAGI eligibility categories.

In some cases, however, ABLE account beneficiaries may receive distributions that exceed their QDEs in a taxable year or are paid toward expenses that do not qualify as QDEs. Distributions from an ABLE account that are not for QDEs do not fall within the scope of the protection afforded by section 103, and may be countable as income under both MAGI-based and non-MAGI financial methodologies. The extent to which distributions exceeding total QDEs are countable as income for Medicaid eligibility purposes depends on whether the individual is being evaluated for eligibility under a MAGI-based or non-MAGI category.

Treatment of Distributions Exceeding QDEs for Non-MAGI Determinations

For individuals whose financial eligibility is determined using SSI-based methodologies, receipt of cash from a resource, whether the resource itself is counted or excluded, generally is not considered to be income, but rather the conversion of a resource from one form to another. The protection afforded under section 103, however, does not require that distributions from an ABLE account be used within the month the distribution is made, or within any particular time frame. Accordingly, a distribution from an ABLE account may be countable as a resource only if (1) it is retained beyond the month in which the distribution is made and (2) it is used for something other than a QDE in that or a subsequent month. Thus, we interpret section 103 to mean that states should continue to disregard ABLE account distributions retained after the month of receipt unless used for a non-qualifying expense.

For example, if an SSI-based individual receives an ABLE account distribution in August, but does not spend the distribution until December (and uses the distribution for a QDE in that month), the amount of the distribution is not counted in any month. If the individual uses the

[11] Section 1917(c) would not apply to a Medicaid applicant's contribution of income or resources to his or her own ABLE account, as the individual retains the ability to use the funds for his or her own needs.
[12] 80 F.R. at 35608.

distribution in December for a non-QDE, the distribution would be counted as a resource in the month of December.

Treatment of Distributions Exceeding QDEs for MAGI-Based Eligibility

A portion of ABLE account distributions which exceed the QDEs incurred by the account beneficiary in a taxable year is taxable and therefore, per section 1902(e)(14)(A) of the Act and 42 CFR §435.603(e), included in determining MAGI-based income eligibility. The taxable portion will be determined based upon Department of Treasury and IRS rulemaking. Based on the formula proposed and preamble discussion in Treasury's and IRS's NPRM, we expect that, in nearly all circumstances, the taxable portion of such distributions will be *de minimus;*[13] nonetheless, however small, the taxable portion is included in an individual's MAGI-based income. Under 42 CFR §435.945(a), states may accept self-attestation of income for which no electronic data for verification purposes is available. Because the amount of taxable income from ABLE account distributions exceeding QDEs is likely to be negligible, a state may want to consider exercising the option to take self-attestation. If additional verification is necessary, documentation should only be required in accordance with 42 CFR §435.952. Pursuant to 42 CFR §435.945(j), a state must update its verification plan to reflect its procedure for verifying taxable income from ABLE account distributions.

**Post-Eligibility Treatment of Income**

Under regulations at 42 CFR §435.700 et. seq. and §435.832, the extent of medical assistance provided to certain individuals receiving LTSS in institutions or through home and community-based services (HCBS) waivers under sections 1915(c) or (d) of the Act is reduced by the amount of the individual's available income. Under these regulations, the Medicaid agency determines the beneficiary's total income. After making certain deductions, the individual is required to apply the remaining income toward the cost of LTSS received. The requirement that affected individuals apply most of their total available income to the cost of LTSS before federal financial participation for medical assistance is available is referred to as post-eligibility treatment of income (PETI).

Under long-standing CMS policy, reflected in section 3701.2 of the State Medicaid Manual, all income is taken into account for purposes of PETI, including types or amounts of income that are not counted in making an initial eligibility determination. Consistent with this policy, distributions from an ABLE account, including earnings, typically would be counted. However, section 103 of the ABLE Act provides that its provisions apply "notwithstanding any other provision of Federal law." Accordingly, for purposes of PETI, states should disregard from an individual's total income any ABLE account distributions that are used for a QDE. To the extent that a distribution is counted as income in determining the individual's eligibility for other Medicaid benefits, discussed above, the distribution also would be counted for purposes of PETI.

**Transfers of ABLE Account Funds to States and Estate Recovery**

[13] See 80 Fed. Reg. at 35607.

Section 529A(f) requires that certain amounts remaining in an ABLE account upon the death of the account beneficiary, subject to any outstanding payments due for QDEs, shall be distributed to a state that provided medical assistance to the beneficiary after the establishment of the ABLE account upon the filing of a claim for payment by such state ("section 529A claim"). The amount that may be so distributed is limited to the excess of the total medical assistance paid for the account beneficiary after the establishment of the ABLE account over the amount of premiums paid from the ABLE account or paid by or on behalf of the beneficiary to a Medicaid "Buy-In program" under the state's Medicaid plan.[14]

The Treasury's and IRS's NPRM does not propose mandating that states file section 529A claims. However, even in the absence of a Treasury and IRS mandate regarding claims against ABLE accounts, pursuant to section 1917(b) of the Act, states are required to seek recovery against the estates of certain deceased Medicaid beneficiaries.[15] Thus, consistent with section 1917(b) of the Act, states are required to seek recovery of funds in an ABLE account that have become part of an estate subject to recovery under the statute. If the estate of an ABLE account beneficiary is not subject to Medicaid estate recovery, states have discretion whether to file a section 529A claim against the ABLE account of a deceased individual who had been enrolled in a Medicaid Buy In program.

CMS is committed to realizing the goals of the ABLE program and facilitating the program's implementation. If you have questions about this guidance, please contact Gene Coffey at 410-786-2234, or gene.coffey@cms.hhs.gov, or contact your SOTA team lead.

Sincerely,

/s/

Brian Neale
Director

cc:
National Association of Medicaid Directors
National Academy for State Health Policy
National Governors Association
American Public Human Services Association
Association of State Territorial Health Officials
Council of State Governments
National Conference of State Legislatures
Academy Health

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[14] Neither the ABLE Act nor the Treasury's and IRS's NPRM define a Medicaid "buy in" program. We are working with the Treasury and IRS to provide clarification to stakeholders on the scope of this language.

[15] The specific individuals whose estates state Medicaid agencies must seek recovery from are those who received Medicaid at the age of 55 or older, or who received coverage for certain LTSS and were subject to PETI rules.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU

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In the Matter of the Appointment of

ATTORNEY , as Guardian for Property Management of

IP,

An Incapacitated Person

----------X

**EX PARTEAPPLICATION FOR APPROVAL OF SECONDARY APPOINTMENT**

Index No.:

APPROVAL of the following SECONDARY APPOINTEE is respectfully requested (attach one page resume)

Name :
Address:
Phone:

The secondary appointee will serve as REAL ESTATE BROKER

The secondary appointee IS ON THE LIST ESTABLISHED BY THE CHIEF ADMINISTRATOR OF THE Courts for the Category of appointment requested.

The reasons for the request are as follows:

The IP is a owner of REALTY , which owns commercial real property located at --- New York. This property was appraised at $---in 2018 pursuant to appraisal by---, made upon order of the court. Subsequent to the appraisal, the Guardian received an unsolicited offer to purchase this real property in the amount of $---,000. After this offer was made, the Guardian obtained authority to retain ---as counsel in this matter. After the appointment of---, the Guardian received additional offers in amounts significantly greater than $-000,000. Because all of these offers had been made without any marketing of the property, the co-owner, and a potential heir of the IP, agreed that marketing the property was in the best financial interest of the IP.

The Guardian and her counsel, interviewed prospective brokers. Only brokers on Part 36 were interviewed. Based upon the reputation of---, the energy with which they will proceed and their proposed listing price the Guardian respectfully requests authority to enter into the annexed listing agreement with---. The listing agreement recognizes that the commission is subject to court approval, as would the sale of the property. The broker commission is equivalent to the others

Title of Action

The sale of this property will be beneficial to the Guardianship because there has been a loss in maintaining this property, given the repairs and extremely high fuel costs not covered by the rent.

Although a real property proceeding is customarily brought in the county in which the real property is located, in this case, this Court has retained jurisdiction over any possible sale. ---is on the Part 36 list in both Queens and Nassau.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU
----------X
In the Matter of the Appointment of
**attorney**
, as Guardian for Property

Management of

IP,

An Incapacitated Person
----------X

**APPROVING EX PARTE APPLICATION FOR SECONDARY APPOINTMENT (Pursuant to 22 NYCRR 36.1(a)(10)**

Index No.:

*Name of Judge*:

Upon ex parte application of---, as GUARDIAN dated July 11, 2014 for approval of a Secondary Appointment, it is determined that

1. A Secondary Appointment is necessary and

Name:

Address:

Phone:

Is appropriate for appointment as REAL ESTATE BROKER

2. The Appointee is on the list established by the Chief Administrator of the Courts for the category of appointment requested;

ACCORDINGLY it is

ORDERED that this application for approval of a secondary appointment as REAL ESTATE BROKER is GRANTED.

ORDERED that _____ the secondary appointee shall immediately file form UCS 872;

ORDERED that compensation for the secondary appointee is subject to PRIOR court approval upon submission of an application showing experience/expertise, services rendered,

time expended, prevailing rate in the community, rate charged, challenges presented and results achieved;

ORDERED that the applicant shall serve a copy of this order upon the secondary appointee and all persons entitled to notice in this action/proceeding by certified mail.

DATED: _____ Signature:

File copy of this order with the Fiduciary Clerk.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF QUEENS

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In the Matter of the Final Account of

**NOTICE OF MOTION TO SETTLE FINAL ACCOUNT**

As Co-Guardians for Personal Needs for

and As Co-Guardians for Property/Co-Trustee of **Index No.:**

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GENTLEPERSONS:

PLEASE TAKE NOTICE that upon the Order of this Court dated and filed herein the ____ day of _____, 200__, a copy of which is annexed hereto, the Final Accounting of GUARDIAN., as Guardian for the Property of I.P.NAME, the above named Incapacitated Person which was duly filed in the Office of the Clerk of the County of Queens on the _____ day of _____, 2018, a copy of which is annexed hereto, and upon the affidavit of ---sworn to the 4th day of August, 2018, a copy of which is annexed hereto, the undersigned will move this Court at the Supreme Court Building, at an IAS Part---, before the Honorable Justice of the Supreme Court to be held at the Supreme Court Building, 88-11 Sutphin Boulevard, Jamaica, New York 11534, on the 29th day of August, 2017, at 9:30 o'clock in the forenoon of that day, or as soon thereafter as counsel can be heard, for an order judicially settling the final account, determining and allowing the account as filed, for the fixing of compensation of the parties attorneys, and granting such other and further relief as to the Court may seem just and proper.

PRESENT:

HON.

Justice.

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|---|---|
| In the Matter of the Application of | **ORDER PURSUANT TO MENTAL HYGIENE** |
| IP | **LAW SECTION 81.36 AND DIRECTING FINAL** |
| An Incapacitated Person | **ACCOUNT** |
| For Leave to Terminate the Guardianship | |
| | Index No.: 25930-I-99 |

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A PROCEEDING HAVING BEEN COMMENCED PURSUANT TO Article 81 of the Mental Hygiene Law for the appointment of a Guardian for the Person and Property of IP, an Incapacitated Person; and the Court having found IP to be an Incapacitated Person and having appointed GUARDIANS, as the Co-Guardians of the Person and Property by Order and Judgment dated the---, 1999; and the Co-Guardians having been required to file a bond in the sum of $--- which bond was approved by the Court on _____ and an additional bond in the sum of _____ which bond was approved by the Court on _____; and each such bond having been issued by, and remaining in full force and effect, and

The Incapacitated Person, by her counsel, ---having thereafter moved this Court by Petition to Discontinue the Guardianship, duly verified the---, 2018, with exhibits annexed, to terminate the within Guardianship on the grounds that the said Incapacitated Person has become fully able to care for her person and property;

By Order dated the--- 2018, the Court having directed that a hearing be conducted pursuant to Section 81.36 of the Mental Hygiene Law to consider the modification and/or termination of the within guardianship; and such hearing having been held on the 2nd day of December, 2018 and attended by IP, ---counsel for the Petitioner and the Co-Guardians,---; and the Court having heard from the parties and upon the consent of the Co-Guardians, the Court having issued a Bench decision directing that the Guardianship of IP be terminated based upon the ability of IP to care for own personal needs and property; and upon all of the pleadings and proccedings heretofore had herein; and after due deliberation,

NOW on motion of ---Counsel for the Petitioner, it is

ORDERED, that pursuant to Mental Hygiene Law Section 81.36(a)(1), IP be and she hereby is declared now fully able to care for her own property; and it is further

ORDERED, that within THIRTY (30) DAYS of the date hereof, the Co-Guardians, shall deliver to IP, a former Incapacitated Person, all of her property in the hands

of the Co-Guardians, and shall execute and deliver any instrument(s) necessary to effectuate such transfer of assets and/or property or IP individually; and it is further

ORDERED, that within NINETY (90) DAYS from the date hereof, ---as Co-Guardians of the Property of IP a former Incapacitated Person are hereby directed to file a Final Account of their proceedings as such from January 1, 201-, the day following the last annual accounting period approved by the Court, through the date of filing of the said Final Account, with a schedule containing year-end balances (as previously approved by the Court) of all categories from the date of their appointment on--, 1999 through the date of filing of the said Final Account; and it is further

ORDERED, that the Co-Guardians shall cause said Final Account to be settled and that a notice of motion for the settlement thereof, together with a copy of this Order, shall be served either personally or by certified mail by such Co-Guardians at least THIRTEEN (13) DAYS prior to return fate of said motion, upon the Court Examiner, ----, who is hereby appointed Referee and who shall review the Final Account and to report to the Court with his/her recommendations concerning the settlement thereof within FORTY-FIVE (45) DAYS following the return date of such motion, and upon all other persons entitled to notice pursuant to Mental Hygiene Law Section 81.33(c), including the former Incapacitated Person; her counsel,--; and, the surety on the bonds of the Co-Guardians, and it is further

ORDERED, that all fees to be awarded hereafter by the Court shall be paid by the former Incapacitated Person, from her individual funds; and it is further

ORDERED, that pursuant to Mental Hygiene Law Section 81.14(b), the Clerk of this Court shall seal the within Court record and all papers which have been and which may hereafter be filed under index number---, except to appropriate Court personnel; the Referee; the former Incapacitated Person; her counsel; the Co-Guardians; and their counsel, on the grounds that this proceeding involves confidential and privileged information (including personal and medical information) as defined pursuant to 22 N.Y.C.R.R. Part 216.

ENTER:

_____

J.S.C.

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PRESENT: HON.,

Justice

----------X

In the Matter of the Final Account
of the Proceedings of

ORDER TO SHOW CAUSE
TO SETTLE
FINAL ACCOUNT

,

As Guardian for the Person Needs
and Property Management of

,

Index No. 91848/05

And

As Co-Trustees of the

IP SUPPLEMENTAL NEEDS TRUST.

----------X

Upon reading and filing the annexed Final Account of---, as Co-Trustee of the IP SUPPLEMENTAL NEEDS TRUST, verified on the---, and the Order of this Court dated --- directing GUARDIAN, the Guardian for Personal Needs and Property Management of IP and GUARDIAN and TRUSTEE, to file said Final Account,

LET

SHOW CAUSE before the ---the justice presiding at IA---, Room ____, of this court to be held in the County of Bronx at the Courthouse thereof, 851 Grand Concourse, Bronx, New York, on the _____ day of October, 2018, at _____ a.m., or as soon thereafter as counsel can be heard,

WHY AN ORDER SHOULD NOT BE ENTERED

(1) Judicially settling the Final Account of TRUSTEE, , as Co-Trustee of the IP SUPPLEMENTAL NEEDS TRUST;
(2) Discharging TRUSTEE, as Co-Trustee of the IP SUPPLEMENTAL NEEDS TRUST, from any further liability and accountability for all matters contained within the Final Account;
(3) Granting legal fees to ATTORNEYS for their work on this matter upon submission of an Affirmation of Services;
(4) Granting such other and further relief as the Court may deem proper and just.

SUFFICIENT REASON APPEARING THEREFORE, IT IS

ORDERED, that the Court Examiner/Referee shall review the final accounting and report to the Court by the return date, and it is further

ORDERED, that the petitioner's attorney shall provide the Court Examiner/Referee with all pertinent financial records not previously provided, and it is further

ORDERED that service of a copy of this Order to Show Cause, and the Final Account and all other papers attached hereto, via personal delivery, regular mail, certified mail, RRR or overnight delivery upon the Incapacitated Person; by _____ , 2015 shall be deemed good and sufficient service.

ENTER:

_____

**TN 74 (03-18)**

# SI 01130.740 Achieving a Better Life Experience (ABLE) Accounts

**Citations:** Public Law 113–295 The Stephen Beck, Jr., Achieving a Better Life Experience Act (ABLE Act) – Enacted December 19, 2014

## A. What Is An ABLE Account?

An Achieving a Better Life Experience (ABLE) account is a type of tax-advantaged savings account that an eligible individual can use to pay for qualified disability expenses. The eligible individual is the owner and designated beneficiary of the ABLE account. An eligible individual may establish an ABLE account provided that the individual is blind or disabled by a condition that began before the individual's 26th birthday.

An ABLE program can be established by a State (or State agency or instrumentality of a State). An eligible individual can open an ABLE account through the ABLE program in any State, if the State permits it.

Some States formed partnerships to improve access for eligible individuals to enroll in ABLE programs. You may see different types of arrangements between States administering ABLE programs.

Some States have formed a consortium where the States have their own ABLE program, but join together to provide lower administrative costs and better investment options than they could on their own.

Some States established their own ABLE program, but contracted with private companies to manage their ABLE program for them.

Some States established their own ABLE program, but contracted with other States to manage their ABLE program for them.

Some States do not operate their own ABLE program, but partnered with another State to offer the other State's ABLE program to their residents.

### 1. One ABLE account

A designated beneficiary is limited to one ABLE account, which a qualified ABLE program administers. Except in the case of a rollover or program-to-program transfer, if a designated beneficiary has an additional account, it generally will not be treated as an ABLE account, and will be subject to normal resource counting rules.

**EXCEPTION:** If an additional account is closed within 90 days from the account open date, the account will not be a countable resource for any period the additional account was open.

### 2. Medicaid reimbursement

Upon the death of the designated beneficiary, funds remaining in the ABLE account, after payment of all outstanding qualified disability expenses, must be used to reimburse the State(s) for Medical Assistance (Medicaid) benefits that the designated beneficiary received, if the State(s) files(s) a claim for reimbursement.

## B. Definition Of ABLE Terms

### 1. ABLE program

An ABLE program is the program established and maintained by a State (or agency or instrumentality thereof) through which eligible individuals can open ABLE accounts.

### 2. Contributions

A contribution is the payment of funds into an ABLE account. Contributions must be in cash and may be made in the form of cash or a check, money order, credit card, electronic transfer, or a similar method. Any person can contribute to an ABLE account. ("Person," as defined by the Internal Revenue Code, includes an individual, trust, estate, partnership, association, company, or corporation.) However, the total annual contributions that an ABLE account can receive from all sources is limited to the amount of the per-donee gift-tax exclusion in effect for a given calendar year. For 2018, that limit is $15,000.

### 3. Designated beneficiary

The designated beneficiary is the individual who owns the ABLE account and who was an eligible individual when the account was established or who succeeded the former designated beneficiary in that capacity.

To be an eligible individual, he or she must:

1. a.

Be eligible for Supplemental Security Income (SSI) based on disability or blindness that began before age 26;

2. b.

Be entitled to disability insurance benefits (DIB), childhood disability benefits (CDB), or disabled widow's or widower's benefits (DWB) based on disability or blindness that began before age 26; or

3. c.

Certify (or an agent under a power of attorney or, if none, a parent or guardian must certify) that the individual:

has a medically determinable impairment meeting statutorily specified criteria or is blind; and,

the disability or blindness occurred before age 26.

**NOTE:** Do not draw an inference regarding disability under the Social Security Act from a disability certification.

## 4. Distributions

A distribution is any payment from an ABLE account. (A program-to-program transfer is not a distribution.) The designated beneficiary or person with signature authority determines when a distribution is made. Distributions (other than rollovers and returns of contributions) may be made only to or for the benefit of the designated beneficiary.

## 5. Member of the family

A member of the designated beneficiary's family means a sibling whether by blood or adoption, and includes a brother, sister, stepbrother, stepsister, half-brother, and half-sister.

## 6. Person with signature authority

A person with signature authority can establish and administer an ABLE account for a designated beneficiary who is a minor child or is otherwise incapable of managing the account. Signature authority is not the equivalent of ownership. The person with signature authority must be the designated beneficiary's agent acting under power of

attorney, or if none, a parent or legal guardian of the designated beneficiary. For SSI purposes, always consider the designated beneficiary to be the owner of the ABLE account, regardless of whether someone else has signature authority over it.

### 7. Program-to-program transfer

A program-to-program transfer means the direct transfer of:

- The entire balance of an ABLE account into an ABLE account of the same designated beneficiary in which the first ABLE account is closed upon the transfer of the funds; or
- Part or all of the balance to an ABLE account of an eligible individual who is a member of the family of the designated beneficiary.

### 8. Qualified disability expenses

Qualified disability expenses (QDEs) are expenses related to the blindness or disability of the designated beneficiary and for the benefit of the designated beneficiary. In general, a QDE includes, but is not limited to, an expense for:

Education;

Housing;

Transportation;

Employment training and support;

Assistive technology and related services;

Personal support services;

Health;

Prevention and wellness;

Financial management and administrative services;

Legal fees;

Expenses for ABLE account oversight and monitoring;

Funeral and burial; and,

Basic living expenses.

### 9. Housing expenses

Housing expenses for purposes of an ABLE account are similar to household costs for in-kind support and maintenance purposes, with the exception of food. Housing expenses include expenses for:

Mortgage (including property insurance required by the mortgage holder);

Real property taxes;

Rent;

Heating fuel;

Gas;

Electricity;

Water;

Sewer; and

Garbage removal.

### 10. Rollover

A rollover is the contribution to an ABLE account of a designated beneficiary (or a family member of the designated beneficiary), of all or a portion of an amount withdrawn from the designated beneficiary's ABLE account, provided that the contribution is made within 60 days of the date of the withdrawal. In the case of a rollover to the designated beneficiary's ABLE account, no rollover should have been made to an ABLE account of the designated beneficiary within the prior 12 months.

## C. When To Exclude ABLE Account Contributions, Balances, Earnings, And Distributions

### 1. Exclude contributions as income

A payment made into an ABLE account constitutes a contribution. Consider the contribution made by the person to whom the funds belong or are due. Exclude contributions to an ABLE account from the income of the designated beneficiary. Excluded contributions include rollovers from a member of the family's ABLE account to an SSI applicant, recipient, or deemor's ABLE account.

**NOTE:** The fact that a person uses his or her income to contribute to an ABLE account does not mean that his or her income is not countable for SSI purposes as it normally would be. Income received by the designated beneficiary and then deposited into his or her ABLE account is income to the designated beneficiary. For example, an applicant, recipient, or deemor can have contributions automatically deducted from his or her paycheck and deposited into an ABLE account. In this case, include the income used to make the ABLE account contribution in the applicant, recipient or deemor's gross wages.

**a. First party contributions**

A contribution made by the designated beneficiary into his or her ABLE account is not income to the designated beneficiary. However, income received by the designated beneficiary and deposited into his or her ABLE account is income to the designated beneficiary. That is, the income is income in the first instance, but the contribution is not income.

An individual cannot use direct deposit to avoid income counting.

So, when a payment that belongs or is due to the designated beneficiary is direct-deposited into his or her ABLE account, the payment is considered to be received by the designated beneficiary, it is counted as income to the designated beneficiary as it otherwise would be, the designated beneficiary is considered the contributor for ABLE purposes, and the ABLE contribution is not considered income to the designated beneficiary.

Examples of payments that might be direct-deposited into an ABLE account, but still are counted as income as they otherwise would be, include:

- Wages;
- Benefit payments (Title II, Veterans Administration, pensions, etc.); and
- Mandatory Support payments (child support or alimony).

### b. Third party contributions

Third party contributions are contributions made by persons other than the designated beneficiary. Further, third party contributions are made with funds that do not otherwise belong, or are not otherwise due, to the designated beneficiary; that is, they are made with the third party's funds. Accordingly, an ABLE contribution by a person other than the designated beneficiary is treated as a completed gift.

**NOTE:** A transfer of funds from a trust, of which the designated beneficiary is the beneficiary and which is not considered a resource to him or her, to the designated beneficiary's ABLE account generally will be considered a third party contribution for ABLE purposes because the contribution is made by a person or entity other than the designated beneficiary (namely, the trustee) and because the designated beneficiary does not legally own the trust. You may seek guidance from your regional trust lead if you have questions regarding the trust transfer to an ABLE account.

## 2. Exclude ABLE account earnings

The funds in an ABLE account can accrue interest, earn dividends, and otherwise appreciate in value. Earnings increase the account's balance. Exclude earnings an ABLE account receives from the income of the designated beneficiary.

## 3. Exclude up to and including $100,000 of balance

Exclude up to and including $100,000 of the balance of funds in an ABLE account from the resources of the designated beneficiary.

## 4. Do not count ABLE account distributions as income

A distribution from an ABLE account is not income but is a conversion of a resource from one form to another. See SI 01110.600B.4.

Do not count distributions from an ABLE account as income of the designated beneficiary, regardless of whether the distributions are for a QDE not related to housing, for a housing expense, or for a non-qualified expense.

## 5. Exclude retained distributions for a QDE not related to housing

### a. Distribution for a QDE not related to housing

Exclude a distribution for a QDE not related to housing from the designated beneficiary's countable resources if he or she retains it beyond the month received.

This exclusion applies while:

The designated beneficiary maintains, makes contributions to, or receives distributions from the ABLE account;

The distribution is unspent;

The distribution is identifiable. (**NOTE**: Identify excludable funds commingled with non-excludable funds. See SI 01130.700A); and

The individual intends to use the distribution for a QDE not related to housing.

**NOTE:** Apply normal SSI resource counting rules and exclusions to assets or other items purchased with funds from an ABLE account.

### b. Previously excluded distribution used for non-qualified expenses or housing expenses

If a designated beneficiary uses a distribution previously excluded per SI 01130.740C.5.a. in this section, for a non-qualified expense or a housing expense, or the individual's intent to use it for a qualified disability expense (not related to housing) changes, see SI 01130.740D.3. in this section.

### c. Example of an excluded distribution

Eric takes a distribution of $500 from his ABLE account in June 2016 to pay for a health-related QDE. His health-related expense is not due until September, and Eric deposits the distribution into his checking account in June. The distribution is not income in June. Eric's distribution is both unspent and identifiable until Eric pays his health-related expense in September. Exclude the $500 from Eric's countable resources in July, August, and September. For instructions to identify commingled, excluded, and non-excluded funds, see SI 01130.700.

### d. Example of an excluded QDE purchase

Fred takes a distribution of $1,500 from his ABLE account in September 2016 to buy a health-related item that is a QDE. The item is an excluded resource in October and continuing, because it is the individual's personal property required for a medical condition. For instructions on household goods, personal effects, and other personal property, see SI 01130.430.

# D. When To Count ABLE Account Balances And Distributions

## 1. Count ABLE account balance amounts over $100,000

Count the amount by which an ABLE account balance exceeds $100,000 as a resource of the designated beneficiary.

### a. Rule for indefinite benefit suspension and continuing eligibility for Medicaid during periods of excess resources attributable to an ABLE account

A special rule applies when the balance of an SSI recipient's ABLE account exceeds $100,000 by an amount that causes the recipient to exceed the SSI resource limit--whether alone or with other resources. When this situation happens, we will place the recipient into a special SSI suspension during which:

- We suspend the recipient's SSI benefits without time limit (as long as he or she remains otherwise eligible);
- The recipient is SSI eligible for Medical Assistance (Medicaid) purposes; and
- The individual's eligibility does not terminate after 12 continuous months of suspension.

Reinstate the recipient's regular SSI eligibility for all months in which the individual's ABLE account balance no longer causes the recipient to exceed the resource limit and he or she is otherwise eligible.

**NOTE:** "SSI-eligible for Medicaid purposes" means that the individual is eligible for Medicaid in States where Medicaid eligibility is based on SSI eligibility (For SSA determinations of Medicaid Eligibility in 1634 States see SI 01730.000). No SSI recipients will reach this suspension status for several years (that is, until it is possible for an ABLE account balance to exceed $100,000; that is not yet possible due to the limitation on contributions described in SI 01130.740B.2. in this section).

**EXAMPLE: Excess resources — recipient is suspended but retains eligibility for Medicaid**

Paul is the designated beneficiary of an ABLE account with a balance of $101,000 on the first of the month. Paul's only other countable resource is a checking account with a

balance of $1,500. Paul’s countable resources are $2,500 and therefore exceed the SSI resource limit. However, since Paul's ABLE account balance causes him to exceed the resource limit (i.e., his countable resources other than the ABLE account are less than $2,000), suspend Paul’s SSI eligibility and stop his cash benefits, but he retains eligibility for Medicaid in his State.

**b. Ineligibility due to excess resources other than an ABLE account**

The special suspension rule does not apply when:

- The balance of an SSI recipient's ABLE account exceeds $100,000 by an amount that causes the recipient to exceed the SSI resource limit; but
- The resources other than the ABLE account alone make the individual ineligible for SSI due to excess resources.

When this situation happens, suspend the recipient's SSI benefits using the payment status code N04. While in N04, the recipient loses eligibility for Medical Assistance (Medicaid) and the individual’s SSI eligibility terminates 12 months later if the suspension continues throughout this period. Reinstate the recipient's regular SSI eligibility and Medicaid benefits for all months in which the individual’s resources, including the ABLE account, no longer cause the recipient to exceed the resource limit.

**EXAMPLE: Combination of resources — recipient loses SSI eligibility**

Christine is the designated beneficiary of an ABLE account with a first of the month balance of $101,000. Christine's only other countable resource is a checking account with a balance of $3,000. Christine's countable resources are $4,000 and therefore exceed the SSI resource limit.

However, because her ABLE account balance is not the cause of her excess resources (i.e., her countable resources other than the ABLE account are more than $2,000), the special rule does not apply, and Christine is not eligible for SSI because of excess resources. Suspend Christine’s SSI benefits using payment status N04. Her Medicaid benefits stop.

**c. Ineligibility for other reasons**

If an individual is ineligible for any reason other than excess resources in an ABLE account, the special suspension status does not apply. Suspend the individual’s SSI eligibility using normal procedures.

**EXAMPLE: Ineligibility for a reason other than excess resources in an ABLE account**

In April, Sam's ABLE account balance is $102,500 as of the first of the month. However, Sam also has excess deemed income in April and is N01 despite the excess funds in his ABLE account. Before the end of April, Sam leaves the U.S. and does not return until July 1. Sam is N03 for May June, and July. If Sam still has excess resources in his ABLE account effective August 1 and is otherwise SSI eligible, place him in the special ABLE resource suspension status. He is eligible for Medicaid.

## 2. Count retained distributions for housing expenses or expenses that are not QDEs as a resource

A distribution from an ABLE account is not income, but is a conversion of a resource from one form to another. For more information see SI 01110.600B.4.

Count a distribution for a housing expense or for an expense that is not a QDE as a resource, if the designated beneficiary retains the distribution into the month following the month of receipt. If the designated beneficiary spends the distribution within the month of receipt, there is no effect on eligibility. However, apply normal SSI resource counting rules and exclusions to items purchased with funds from an ABLE account.

**EXAMPLE: Retained distribution intended for housing expenses is a resource**

Amy takes a distribution of $500 from her ABLE account in May to pay a housing expense for June. She deposits the $500 into her checking account in May, withdraws $500 in cash on June 3, and pays her landlord. This distribution is a housing expense and part of her checking account balance as of June 1, which makes it a countable resource for the month of June.

## 3. Count previously excluded distributions used for a non-qualified purpose or housing expense

Count the amount of funds used for a non-qualified expense or housing expense as a resource as of the first moment of the month in which the funds were spent if the designated beneficiary uses the distribution (that was previously excluded per SI 01130.740C.5.a. in this section) for a non-qualified purpose or a housing expense.

If an individual's intent to use the funds for a QDE changes at any other time, but he or she has not spent the funds, count the retained funds as a resource as of the first of the following month.

**a. Example of a previously excluded distribution used for a non-QDE**

Sam takes a distribution of $25,000 from his ABLE account in May for an assistive technology and related service. He pays a $10,000 deposit. While waiting for the service to be completed, Sam takes a trip to a local casino in July where he loses $1,000 of his ABLE distribution gambling. The $1,000 he lost gambling is a countable resource in July. The other $14,000 Sam retains is an excluded resource while it meets the requirements of SI 01130.740C.5.a. in this section.

**b. Example of a previously excluded distribution used for a housing expense**

In June, Jennifer takes a $7,000 distribution from her ABLE account to pay an educational expense that is a QDE. Her educational expense is due in September. However, she has to make a $750 advance rent payment to her landlord for her college apartment in August. She uses some of the distribution she took in June to make the rent payment – a housing expense. The $750 is a countable resource in August. Exclude the remaining $6,250 of the retained distribution while it continues to meet the requirements of SI 01130.740C.5.a. in this section.

**c. Example of a change of intent on the use of a distribution**

In June, Jennifer takes a $7,000 distribution from her ABLE account to pay an educational expense that is a QDE. Her educational expense is due in September. In August, Jennifer gets a job offer and decides not to return to school. The $7,000 becomes a countable resource in September because she no longer intends to use it for an educational expense that is a QDE, unless Jennifer re-designates it for another QDE or returns the funds to her ABLE account prior to September.

## E. How To Verify, Document, And Record ABLE Account Balances

You may become aware of an individual's ownership of an ABLE account if he or she tells you during an initial claim or redetermination or contacts the office to report it.

### 1. Obtain evidence of the ABLE account

When an applicant, recipient, or deemor alleges being the designated beneficiary of an ABLE account, obtain evidence and enter the following information:

Select yes to the ABLE account question;

Select the program State where the ABLE account was established or indicate unknown;

Enter the unique account number assigned by the State or indicate Unknown;

Enter the account opened date or indicate unknown;

If the account is closed, input the account closed date or indicate unknown, or leave the field blank;

Enter the name of the person with signature authority (if different from the designated beneficiary); and

Enter the account balance information in the values field.

If the available evidence does not provide the necessary information, contact the appropriate ABLE program to obtain it.

Beginning October 1, 2017, States report the first-of-the-month account balances and the prior month's distribution information for all ABLE accounts in their program to us. Not all States began reporting in October 2017, but eventually all State ABLE programs will report. If you become aware of a new ABLE account via the monthly data exchange, see SI 01130.740E.4. in this section.

## 2. Document the evidence

Fax the evidence into the certified electronic folder (CEF) or Non-disability Repository for Evidentiary Documents (NDRED). If you contact the ABLE program directly, document the information you received on a Report of Contact (DROC) in the Supplemental Security Income (SSI) claims system or on an SSA-5002 (Report of Contact) in paper claims.

## 3. Record the account on the SSI claim system "Achieving a Better Life Experience (RABL)" page

Record the account information and balance on the SSI claim system Achieving a Better Life Experience (RABL) page. For instructions to complete RABL, see MS INTRANETSSI 013.038.

**NOTE:** The designated beneficiary of an ABLE account is always the owner of the account for SSI purposes. Review ABLE account balances during redeterminations and when potential ineligibility exists due to the ABLE account balance.

## 4. Determine status of mismatched account data

State ABLE programs notify us through a monthly data exchange when individuals establish new accounts. The pending Achieving a Better Life Experience (RAPN) page displays new account information. The following information will be included:

Account Owner Name;

Account Owner SSN;

Account Owner Birth date;

Program State;

Account Number;

Account Opened Date;

Account Closed Date;

Name of Signature Authority;

Balance Month/Year; and

Balance Amount.

If the data on the RAPN page does not match an existing ABLE account on the RABL page, determine whether the ABLE data received applies to the person for whom it was received. Select one of the options in the SSI claim system:

update an existing ABLE page;

add this ABLE account;

reject this ABLE account; or

decide later.

If you chose “decide later,” address the pending RAPN page before closing an initial claim, redetermination, or appeal event.

**NOTE:** Once you document the ABLE account information in the SSI claim system, subsequent reports received from the State that have matching data automatically update the account balance information. However, distribution data will not be available until a future systems release.

# F. How To Verify, Document, And Record ABLE Account Distributions

## 1. When to develop

Verify a distribution only when an applicant, recipient, or deemor alleges retaining, or other evidence indicates that he or she retained, all or part of the distribution into months following the month of receipt. The distribution is material only to determine whether the applicant, recipient, or deemor's countable resources exceed the resource limit, since distributions do not count as income.

## 2. Verify the distribution

Obtain evidence that shows distribution amount(s), distribution date(s), and the distribution recipient(s) (for example, the designated beneficiary paid the distribution directly to a vendor). Obtain and accept the applicant, recipient, or deemor's allegation that he or she used or intends to use the distribution for:

a QDE not related to housing;•

a housing expense; or

an expense that is not a QDE.

## 3. Exclude retained distributions for QDEs not related to housing

Exclude any retained distribution, or part of a distribution, for a QDE not related to housing, from the designated beneficiary's countable resources per SI 01130.740C.5. in this section.

### Example of a retained QDE not related to housing

Elizabeth takes a distribution of $500 from her ABLE account in May to pay for a health-related QDE that she expects to pay in September. She deposits the distribution into her checking account in May and withdraws it in September to pay the health-related QDE. Exclude the $500 from Elizabeth's countable resources from June through September. Starting in June, document the deposit on the Financial Institution Account (RFIA) page. Input $500 as the "excluded amount." Select "Other" as the exclusion reason and input "ABLE QDE distribution" as the "other reason."

## 4. Count retained distributions for housing expenses and expenses that are not QDEs

Count as a resource any distribution or part of a distribution for a housing expense or an expense that is not a QDE if it is retained into the month following the month of receipt.

**Example of a retained distribution for a housing expense**

Amy takes a distribution of $500 from her ABLE account in May to pay a housing expense for June. She deposits the $500 into her checking account in May, withdraws $500 in cash on June 3, and pays her landlord. This distribution is a housing expense and is part of her checking account balance as of the first of the month in June, which makes it a countable resource for the month of June.

## 5. Count previously excluded distributions used for a non-qualified purpose or housing expense

Count the amount of funds used for a non-qualified expense or housing expense as a resource as of the first moment of the month in which the funds were spent if the designated beneficiary uses the distribution (that was previously excluded per SI 01130.740C.5.a. in this section) for a non-qualified purpose or a housing expense.

If an individual's intent to use the funds for a QDE changes at any other time, but he or she has not spent the funds, count the retained funds as a resource as of the first of the month following the month of change of intent. Document the individual's change of intent on a Report of Contact (DROC) in the SSI claim system or on an SSA-5002 (Report of Contact) in paper claims. For examples, see SI 01130.740D.3. in this section.

## 6. Record the amount excluded on the appropriate resource page

ABLE account distributions are the conversion of a resource from one form to another. Accordingly, they continue to be a resource if retained into the month following the month of receipt. Exclude from resources a distribution retained for a QDE not related to housing, per SI 01130.740C.5.a. in this section. Document ABLE account distributions on the appropriate SSI claim system resources page (e.g., cash, financial institution account).

**NOTE:** Distribution information obtained from the State by data exchange is in the SSI claim system, but you cannot access it until additional system enhancements are completed.

# G. Handling And Recording ABLE Prepaid Debit Card Information

## 1. Handling ABLE prepaid debit cards

Some ABLE programs provide designated beneficiaries with a prepaid debit card, which may be used to control the issuance of distributions and provide designated beneficiaries with convenient access to their ABLE funds.

## 2. Handling ABLE debit cards in the SSI claim system

If a designated beneficiary has an ABLE prepaid debit card, record the ABLE prepaid debit card on the Other Resource (ROTH) page in SSI claim system. You need the program State and account number. Monies distributed onto an ABLE prepaid debit card are considered a qualified distribution unless we determine otherwise. Enter the intended use of the funds in the Description field. Enter the alleged Value of the ABLE prepaid debit card. Enter the entire alleged value as an excluded amount and as qualified distributions when funds are added onto the debit card. Use the new exclusion reason of "Qualified Disability Expenses" on the ROTH page to exclude monies on a prepaid ABLE debit card.

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- Regulations.gov
- USA.gov
- Other Government Sites

This website is produced and published at U.S. taxpayer expense.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF
---
In the Matter of the Application of

GUARDIAN

**REPORT & ACCOUNT OF SPECIAL GUARDIAN**

for her discharge as Special Guardian for

Index No.:

IP
An Incapacitated Person
---
**STATE OF NEW YORK)**
**COUNTY OF ) ss.:**

GUARDIAN, being duly sworn, deposes and says:

1. Your deponent resides at ---and was appointed Special Guardian in behalf of IP, an incapacitated person by order of the Court on---.

2. That said order authorized your deponent to exercise the following powers in behalf of the incapacitated person:

3. That all of the aforesaid powers have been duly exercised and your deponent is now seeking her discharge as Special Guardian.

4. That annexed hereto, in support of those duties which your deponent was required to complete as Special Guardian, are the following schedules:

Exhibit A, showing the Compromise Order authorizing GUARDIAN to settle and compromise the lawsuit.

Exhibit B, showing checks for the settlement amount received of $---

Wherefore, based upon the foregoing and all proceedings heretofore had herein, your deponent prays that she be discharged as Special Guardian herein.

_____
GUARDIAN, Special Guardia

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF
---
In the Matter of the Application of

GUARDIAN

**REPORT & ACCOUNT OF SPECIAL GUARDIAN**

for her discharge as Special Guardian for

Index No.:

IP
An Incapacitated Person
---
**STATE OF NEW YORK)**
**COUNTY OF ) ss.:**

GUARDIAN, being duly sworn, deposes and says:

1. Your deponent resides at ---and was appointed Special Guardian in behalf of IP, an incapacitated person by order of the Court on---.

2. That said order authorized your deponent to exercise the following powers in behalf of the incapacitated person:

3. That all of the aforesaid powers have been duly exercised and your deponent is now seeking her discharge as Special Guardian.

4. That annexed hereto, in support of those duties which your deponent was required to complete as Special Guardian, are the following schedules:

Exhibit A, showing the Compromise Order authorizing GUARDIAN to settle and compromise the lawsuit.

Exhibit B, showing checks for the settlement amount received of $---

Wherefore, based upon the foregoing and all proceedings heretofore had herein, your deponent prays that she be discharged as Special Guardian herein.

_____
GUARDIAN, Special Guardia

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF
----------X
In the Matter of _____

Index No.:

An Incapacitated Person.
----------X

**TO THE JUSTICE PRESIDING:**

Guardian respectfully requests permission to expend a sum not to exceed $_____ for the following:

_____
_____
_____
_____.

2. The current value of Guardianship estate (Excluding the value of real property) $_____.

3. The Guardian believes that the aforesaid expenditures are for the direct benefit of the Incapacitated Person in that (explain briefly)

_____
_____
_____
_____.

4. The Guardian annexes supporting documentation (e.g., expense estimates; estimates of professional performing services; appraisals; etc.) and other necessary information establishing that this sum is fair and reasonable.

5. _____, (insert the name(s) of the interested parties requiring notice, if any) was/were notified of the pending application by mail/email/fax on the ___ day of _____, 201__.

Dated: _____ _____

Signature of Guardian

Sworn to before me this
___day of

_____

Notary Public

---------- To be submitted by the Court Examiner for consideration ----------

I respectfully recommend _____ (do not recommend) _____ the above expenditures.

Comments: _____

_____
_____.

Dated: _____ _____
Signature of Court Examiner

---------- To be submitted to assigned Judge for decision ----------

Upon reading and filing the foregoing, the expenditure(s) is/are

_____ APPROVED ____ NOT APPROVED/DENIED

_____ NOT APPROVED/DENIED WITHOUT PREJUDICE

Additional Comments
_____
_____.

So ordered:
_____
_____
_____
_____.

Dated: _____ _____
J. S. C.

Trust Agreement

This TRUST AGREEMENT made this ____ day of _____, 2017, by and between GUARDIAN, as Guardian of PERSON, pursuant to Order of the Supreme Court ---- County, as Grantor and GUARDIAN as Trustee. The Guardian resides at --- The Beneficiary resides at---.

## TRUST PURPOSE

**1.0 TRUST NAME:**

The Trust shall be known as the PERSON Special Needs Trust.

**1.1 PURPOSE OF TRUST:**

The Beneficiary of the Trust is PERSON. The purpose of the Trust is that the Trust's assets be used to supplement, not supplant, impair or diminish any benefits or assistance of any Federal, State, County, City, or other governmental entity for which the Beneficiary may otherwise be eligible or which the Beneficiary may be receiving. The Trust is intended to conform with New York State EPTL § 7-1.12, N.Y. Soc. Serv. Law §366, and 42 U.S.C. § 1396p(d)(4)(A) and 42 U.S.C. § 1382b(e).

**1.2 DECLARATION OF IRREVOCABILITY:**

The Trust shall be irrevocable and may not at any time be altered, amended or revoked.

**1.3 EPTL § 7-1.6:**

EPTL 7-1.6 or any successor statute, or any similar statute of any other jurisdiction, shall not be applied by any court having jurisdiction of an inter-vivos or testamentary trust to compel, against the Trustee's discretion, the payment or application of the trust principal to or for the benefit of PERSON, or any beneficiary for any reason whatsoever.

## SECTION 2 - USE OF TRUST INCOME AND PRINCIPAL

**2.0 ADMINISTRATION OF TRUST DURING LIFETIME OF BENEFICIARY:**

The property shall be held in trust for the Beneficiary, and the Trustee shall collect income and, after deducting all charges and expenses attributed thereto, shall apply for the benefit of the Beneficiary, in-kind, so much of the income and principal (even to the extent of the whole) as the Trustee deem advisable in its sole and absolute discretion as set forth in the Order and Judgment Appointing Guardian. The Trustee shall add the balance of net income not paid or applied to the principal of the Trust.

**2.1 AVAILABILITY OF OTHER BENEFITS:**

Consistent with the Trust's purpose, before expending any amounts from the net income and/or principal of this Trust, the Trustee shall consider the availability of all benefits from government or private assistance programs for which the Beneficiary may be eligible. The Trustee, where appropriate and to the extent possible, shall endeavor to maximize the collection and facilitate the distribution of these benefits for the benefit of the Beneficiary.

**2.2 USE OF INCOME OR PRINCIPAL:**

None of the income or principal of this Trust shall be applied in such a manner as to supplant, impair or diminish any governmental benefits or assistance for which the beneficiary may be eligible or which the beneficiary may be receiving, unless the Trustee, in her sole and absolute discretion determines that such use of trust assets is beneficial to the beneficiary.

**2.3 POWER TO EXECUTE OR ASSIGN DISTRIBUTIONS:**

The Beneficiary does not have the power to assign, encumber, direct, distribute or authorize distributions from this Trust.

**2.4 FOOD AND SHELTER:**

Notwithstanding the above provisions, the Trustee may make distributions to meet the Beneficiary's need for food, shelter, health care, or other personal needs, even if those distributions will impair or diminish the Beneficiary's receipt or eligibility for government benefits or assistance if the Trustee determines that the distributions will better meet the Beneficiary's needs, and it is in the Beneficiary's best interests, notwithstanding the consequent effect on the Beneficiary's eligibility for, or receipt of benefits.

**2.5 NULLIFICATION OF § 2.4:**

However, if the mere existence of this authority to make distributions will result in a reduction or loss of the Beneficiary's entitlement program benefits, regardless of whether the Trustee actually exercises this discretion, the preceding paragraph (2.4) shall be null and void and the Trustee's authority to make these distributions shall terminate and the Trustee authority to make distributions shall be limited to purchasing supplemental goods and services in a manner that will not adversely affect the Beneficiary's government benefits.

**2.6 ADDITIONS TO INCOME AND PRINCIPAL:**

With the Trustee's consent, any person may, at any time, from time to time, by Court order, assignment gift, transfer, Deed or Will, provide income or add to the principal of the Trust created herein, and any property so added shall be held, administered and distributed under the terms of this Trust. The Trustee shall execute documents necessary to accept additional contributions to the trust and shall designate the additions on an amended Schedule A of this trust.

## SECTION 3 - DISTRIBUTION UPON DEATH OF BENEFICIARY

**3.0 DISPOSITION OF TRUST ON DEATH OF BENEFICIARY:**

The Trust shall terminate upon the death of PERSON. The Trustee shall distribute any principal and accumulated interest that then remain in the Trust pursuant to paragraphs 3.1 and 3.2 of this Trust.

**3.1 REIMBURSEMENT TO THE STATE:**

The New York State Department of Health, or other appropriate Medicaid entity within New York State, and any other state in which the beneficiary received Medicaid shall receive all amounts remaining in the trust, up to an amount equal to the total amount of medical assistance paid on behalf ot he beneficiary under the State Medicaid plans(s). The States shall have priority over payment of other debts and administrative expenses except as listed in SI 01120.203B.10. If the amount remaining in the Trust is not sufficient to completely repay all states, and if the beneficiary received Medicaid in more than one state, then the amount distributed to each state shall be based on each state's proportionate share of the total amount of Medicaid benefits paid by all states on behalf of the Beneficiary.

**3.2 DISTRIBUTION AFTER REIMBURSEMENT TO STATE:**

All remaining principal and accumulated income shall be paid to the legal representative of the Estate of the Beneficiary.

## SECTION 4 - TRUSTEE

**4.0 TRUSTEE:**

GUARDIAN is appointed Trustee of this Trust.

**4.1 CONSENT OF TRUSTEE:**

The Trustee shall file with the Clerk of the Supreme Court, Kings County, a "Consent to Act" as Trustee, Oath and Designation, duly acknowledged.

**4.2 BOND:**

The Trustee shall execute and file a bond pursuant to the Order of the Supreme Court, Kings County, Guardianship Part authorizing this Trust, to be approved by the Court, and shall submit a copy of such bond to DSS, OPA, IREA, Supplemental Needs Trust Program, 250 Church Street, New York, N.Y. 10013-2429, Attn: Director, by regular mail, and shall also include any additional or subsequent replacement bonds required by Order of the Court in the annual accountings to be sent to the New York City Human Resources Administration at the above address.

**4.3 RESIGNATION:**

A Trustee may resign by giving written notice, a signed and acknowledged instrument, delivered to (i) the Supreme Court, Kings County; (ii) the Guardian of the beneficiary, if any; (iii) the beneficiary; (iv) the Successor Trustees; (v) DSS, OPA, IREA, Supplemental Needs Trust Program, 250 Church Street, New York, N.Y. 10013-2429, Attn: Director, and by Registered or Certified Mail, Return Receipt Requested to New York City Department of Social Services, Attn: General Counsel, 150 Greenwich Street, New York, New York 10007. The resignation is subject to the approval of the Supreme Court, Kings County.

**4.4 DISCHARGE AND FINAL ACCOUNTING OF TRUSTEE:**

No Trustee shall be discharged and released from office and bond, except upon filing a Final Accounting in the form and in the manner required by §81.33 of the Mental Hygiene Law, and obtaining judicial approval of same. The Final Accounting shall be delivered to DSS, OPA, IREA, Supplemental Needs Trust Program, 250 Church Street, New York, NY 10013, Attn: Director, and by Registered or Certified Mail, return receipt requested to NYC Human Resources Administration/Department of Social Services, Office of Legal Affairs, 150 Greenwich Street, 38th Floor, New York, NY 10007, and obtaining approval of the final accounting with the New York City Human Resources Administration.

**4.5 ANNUAL ACCOUNTING:**

The Trustee shall file during the month of May in the Office of the Clerk of the County of Kings, an annual report in the form and manner required by §81.31 of the Mental Hygiene Law, and such annual accountings shall be examined in the manner required by §81.32 of the Mental Hygiene Law. Such annual accounting shall also be sent to DSS, OPA, IREA, Supplemental Needs Trust Program 250 Church Street, New York, NY 10013, Attn: Director, and by Registered or Certified Mail, return receipt requested to NYC Human Resources Administration/Department of Social Services, Office of Legal Affairs, 150 Greenwich Street,

38th Floor, New York, NY 10007, and to the Court Examiner appointed in the Order and Judgment Appointing Guardian.

**4.6 CONTINUING JURISDICTION:**

The Supreme Court, Kings County, shall have continuing jurisdiction over the interpretation, administration and operation of this Trust, and all other related matters.

**4.7 POWERS OF TRUSTEE:**

In addition to any powers which may be conferred upon the Trustee under the law of the State of New York in effect during the life of this Trust, the Trustee shall have all those discretionary powers mentioned in EPTL §11.1.1 et. seq., or any successor statute or statutes governing the discretion of a Trustee, so as to confer upon the Trustee the broadest possible powers available for the management of the Trust assets. In the event that the Trustee wishes to exercise powers beyond the express and implied powers of EPTL Article 11, the Trustee therefor shall seek and must obtain judicial approval.

**4.8 APPOINTMENT OF A SUCCESSOR TRUSTEE:**

Appointment of a successor Trustee not named in this Trust shall be upon application to the Supreme Court, Kings County, with notice to the NYC Human Resources Administration/Department of Social Services.

**4.9 COMMISSIONS OF TRUSTEE:**

The Trustee shall receive compensation and/or commissions as determined by the Supreme Court, Kings County.

## SECTION 5 - MISCELLANEOUS PROVISIONS

**5.0 GOVERNING LAW:**

This Trust Agreement shall be interpreted and the administration of the Trust shall be governed by the laws of the State of New York; provided, however, that Federal law shall govern any matter alluded to herein which shall relate to or involve government entitlements such as SSI, Medicaid, and or other federal benefit programs.

**5.1 NOTIFICATIONS AND NOTICE TO SOCIAL SERVICES DISTRICT:**

The Trustee shall provide the required notification to the Social Services District in accordance with the requirements of Section 360-4.5 of Title 18 of the Official Regulations of the State Department of Social Services, and any other applicable statutes or regulations, as they may be amended. These regulations currently require notification of the creation or funding of the trust, proof of bond, if required, the death of the beneficiary, and in the case of trusts exceeding $100,000, in advance of transactions that tend to substantially deplete the trust principal (as defined in that section), and in advance of transactions for less than fair market value. In addition, the Trustee shall give the Department of Social Services proper notice of any court application for any matter relating to the interpretation, administration and operation of the Trust. All notifications and notices hereunder shall be made as follows: (1) by registered or certified mail with return receipt requested to NYC Human Resources Administration/Department of Social Services, Office of Legal Affairs, 150 Greenwich Street, 38th Floor, New York, NY 10007; and (2) by regular mail to DSS OPA IREA, Supplemental Needs Trust Monitoring Unit, 250 Church Street, New York, N.Y. 10013-3429, Att: , Director,

**5.2 SAVINGS CLAUSE:**

If it is determined that any provision hereof shall in any way violate any applicable law, such determination shall not impair the validity of the remaining provisions of the Trust.

**5.3 USAGE:**

In construing this Trust, feminine or neuter pronouns shall be substituted for those of the masculine form and vice versa, and the plural for the singular and vice versa in any case in which the context may require.

**5.4 HEADINGS:**

Any headings or captions in the Trust are for reference only, and shall not expand, limit, change, or affect the meaning of any provision of the Trust.

**5.5 BINDING EFFECT:**

This Trust shall be binding upon the estate, executors, administrators and assigns of the Grantor and any individual Trustee, and upon any Successor Trustee.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

----------x Index No:

IN THE MATTER OF THE PROCEEDINGS OF

_____

VERIFIED PETITION TO
GUARDIAN OF THE PERSON AND PROPERTY OF SETTLE FINAL ACCOUNTING

_____

An Alleged Incapacitated Person.

----------x

The Petitioner alleges the following:

1. _____ Petitioner is the Guardian ofthe Person and Property of _____ . an incapacitated deceased person.

2. _____Petitioner resides at

3. Petitioner was appointed Guardian to provide for the personal needs and to manage the financial affairs and property of _____on _____, by Order of the Honorable _____ . Justice of the Supreme Court of the State of New York in and for County ofNew York. A copy of the Order of Appointment is annexed hereto.

4. The petitioner filed a bond with the County Clerk of New York County pursuant to the Order and Judgment in the sum of _____ . [The filing of a bond was waived by the Order and Judgment] and a commission was issued to me by the Clerk of this court on _____

5. Petitioner has fulfilled his/her duties as set forth in the Order.

6. _____ Petitioner has filed his/her annual reports for the years

7. _____ Examinations of the following annual reports were confirmed by orders dated respectively _____ copies of which are annexed hereto.

Petitioner respectfully requests that copies of the following annual reports , annexed hereto, be deemed part of the final herein.

Judicial settlement of the following annual reports_____
were approved by orders dated respectively_ copies_____
of which are annexed hereto.

8. _ _____ . the incapacitated person died onA copy of the death certificate is annexed hereto.

9. Petitioner filed a Statement of Death on _____ , a copy of which is annexed hereto.

10. Petitioner filed a Statement of Assets and Notice of Claim on, copies of which are annexed hereto.

11.. Petitioner respectfully requests that the Court approve the final accounting for the period _____submitted herewith.

Petitioner respectfully presents the following annual reports _____
, copies of which
are annexed hereto, and the examinations of which were confirmed by the court, be made confirmed

12. _____ Pet
itioner respectfully requests that commissions in the sum of _____ be approved. A schedule of commissions due is annexed hereto.

13. _____Petitioner respectfully requests that legal fees payable to

in the sum of _____be approved. An affirmation of legal services is annexed hereto.

14. Petitioner respectfully requests that any money remaining after payment of claims, if any, guardian's commissions and legal fees if due, be turned over to the personal representative of the estate of the deceased incapacitated person.

15. Petitioner has submitted an Order Settling Final Account herewith.

16. As provided in section 81.16 © (3) of the Mental Hygiene Law , the names and addresses of all persons entitled to receive notice are:

17. Petitioner has annexed an affidavit of service.

18. Accordingly, Petitioner hereby requests that the relief requested be granted.

19. There has been no previous application for the relief requested herein.

# Ethical Considerations in the Special Needs Practice: Uniquie Challenges in Representing the Trustee and Beneficiary

**Edward V. Wilcenski, Esq.**
Wilcenski & Pleat PLLC | Clifton Park, NY

# NAVIGATING THE RULES OF PROFESSIONAL RESPONSIBILTY WHEN REPRESENTING TRUSTEES OF SUPPLEMENTAL NEEDS TRUSTS

**Edward V. Wilcenski, Esq.**
**Wilcenski & Pleat PLLC**

## Introduction

Estate planning and elder law attorneys have long recognized that many of the rules of professional responsibility for lawyers are difficult to apply in our practice, which is typically collaborative and non-adversarial.

Consider the statement in Preamble to the New York Rules of Professional Conduct for attorneys in New York:

"The touchstone of the client-lawyer relationship is the lawyer's obligation to assert the client's position *under the rules of the adversary system*, to maintain the client's confidential information except in limited circumstances, and to act with loyalty during the period of the representation." (emphasis added).

The New York Rules of Professional Conduct provide little practical guidance for attorneys wrestling with issues of declining capacity and the involvement of family caregivers and other advocates in important financial and medical decisions. These challenges can be compounded in cases involving supplemental needs trusts, where counsel must consider how to manage communications with and decisions by a trustee who has independent fiduciary responsibilities of its own.

This article will focus on one fact pattern which is common to the special needs planning practice. It will introduce some of the rules that are implicated when undertaking representation, and will suggest some sources of commentary and analysis which may help the practitioner navigate this complicated area. While the fact pattern involves a first party supplemental needs trust, the analysis should also be helpful in cases involving third party supplemental needs trusts.

## Sources of authority

1. New York Rules of Professional Conduct

The New York Rules of Professional Conduct are found at 22 NYCRR 1200 et seq. Throughout this article they will be referred to as the "NY Rule(s)." The New York Rules were developed using the ABA Model Rules of Professional Conduct ("MRPC") as a guide. The NY Rules with commentaries can be found at: https://www.nysba.org/DownloadAsset.aspx?id=50671 (last visited November 10, 2018) and are reproduced at the end of this article (without commentaries) for ease of reference.

The NY Rules highlighted in this article are:

1.2 Scope of Representation and Allocation of Authority Between Client and Lawyer

1.4 Communication

1.6 Confidentiality of Information

1.7 Conflict of Interest: Current Clients

1.16 Declining or Terminating Representation

1.18 Duties to Prospective Clients

4.1 Truthfulness in Statements to Others

4.3 Communicating with Unrepresented Persons

The NY Rules and accompanying commentaries serve as the governing authority in any disciplinary action in New York. However, the NAELA Aspirational Standards and the ACTEC Commentaries (discussed below) were written with elder law and estate planning attorneys in mind, and they address the same concepts found in the NY Rules with a focus on fiduciary representation and collaborative engagement. The NAELA Aspirational Standards and the ACTEC Commentaries will serve as the primary sources for analyses in this article, but practitioners are encouraged to refer back to the Commentaries to the NY Rules to compare how the insights and recommendations of the other two entities have been applied and interpreted in our State.

2. NAELA Aspirational Standards (Second Edition) with Commentaries

These are not "rules." Rather, they are what one would expect given the title: non-binding guidance developed by and for elder law attorneys who regularly provide representation in situations involving individuals with diminished capacity. Throughout this article they will be referred to as "Standards." The Standards with commentaries can be found on the NAELA website ( www.naela.org ).

NAELA's explanation of the challenges faced by elder and special needs planning attorneys and the difficulties faced by practitioners trying to reconcile the traditional rules of attorney conduct with this area of the law is insightful:

"The client-attorney relationship in elder law and special needs planning is not always as clear-cut and unambiguous as in other areas of law. Questions relating to end-of-life planning, self-determination, exploitation, abuse, long-term care planning, best interests, substituted judgment, and, fundamentally, "who is the client?" present issues not regularly faced by attorneys in other areas of law." https://www.naela.org/Web/About_Tab/History_and_Standards/History_and_Standards_Sub_landing/Aspirational_Standards.aspx (last visited November 10, 2018).

Nonetheless, the Standards introduce and reinforce some key concepts which are important to the special needs planning practitioner, including:

a. A "protected individual," which "refers to the individual whose personal and property interests are the subject of the representation." Comment to Standard B.1. The protected individual is not necessarily the client. See further discussion on this concept below.

b. The holistic approach to representation, including the use of non-legal professionals who are employed by an attorney or by a firm owned by the attorney and who help the attorney accomplish the objectives of the engagement with a client or protected individual. Comment to Standard A.1 and A.2.

c. The collaborative, non-judicial approach to conflict resolution among family members and others involved in the life of the 'protected individual.' Standard A.5.

The Standards acknowledge the broad and collaborative nature of the elder law and special needs practice, and practitioners can look to the Standards for significant discussion on issues relating to diminished capacity. However, the Standards may be less helpful than the ACTEC Commentaries in developing practical approaches in those cases where the trustee is the client and the "protected individual" is the beneficiary.

3. ACTEC Commentaries to the ABA Model Rules of Professional Conduct.

The ACTEC Commentaries are heavily focused on representation of fiduciaries (executors, administrators and trustees). While this article analyzes the ACTEC Commentaries from the perspective of the supplemental needs trustee, in most situations the discussion and analysis presented here would apply to any one of these fiduciary appointments. References will be to the ACTEC Commentaries, Fifth Edition

2016 located at https://www.actec.org/assets/1/6/ACTEC_Commentaries_5th_rev_06_29.pdf (last visited November 10, 2018).

The spirit and approach of the ACTEC Commentaries is reflected in the Reporter's Note to the First Edition:

"The main themes of the Commentaries are: (1) the relative freedom that lawyers and clients have to write their own charter with respect to a representation in the trusts and estates field; (2) the generally non adversarial nature of the trusts and estates practice; (3) the utility and propriety, in this area of law, of representing multiple clients, whose interests may differ but are not necessarily adversarial; and (4) the opportunity, with full disclosure, to moderate or eliminate many problems that might otherwise arise under the [Model Rules of Professional Conduct]. The Commentaries additionally reflect the role that the trusts and estates lawyer has traditionally played as the lawyer for members of a family. In that role a trusts and estates lawyer frequently represents the fiduciary of a trust or estate and one or more of the beneficiaries. In drafting the Commentaries, we have attempted to express views that are consistent with the spirit of the MRPC as evidenced in the following passage: "The Rules of Professional Conduct are rules of reason. They should be interpreted with reference to the purposes of legal representation and of the law itself." ACTEC Commentaries at p. 1.

The ACTEC Commentaries highlight positions taken by courts and state bar associations in analyzing the roles and responsibilities of lawyers who represent fiduciaries. According to the ACTEC Commentaries, the majority view is "that a distinction should be drawn between the duties of a lawyer who represents a fiduciary in the fiduciary's representative capacity (a "general" representation") and the duties of a lawyer who represents the fiduciary individually (ie., not in a representative capacity)." ACTEC Commentaries at p. 1. This distinction is critically important in the area of special needs planning, where the trust beneficiary often lacks cognitive capacity to review the trustee's actions and consent to the trustee's decisions.

The Editor's Note to the First Edition goes on to acknowledge the continuing challenges which arise in fiduciary representation, and the lack of a single and well established approach to guide practitioners in this area: "Unfortunately, the duties that the lawyer for a fiduciary owes to the beneficiaries of the fiduciary estate have not been adequately identified, defined, or discussed." ACTEC Commentaries at p. 2.

Yet the Commentaries are clear on one point. Lawyers who provide general representation to trustees have certain responsibilities to the beneficiaries: the requirement that the lawyer act in good faith and with fairness toward the beneficiaries, and to take affirmative steps to protect a beneficiary if the lawyer becomes aware that the fiduciary is engaged in acts of wrongdoing that would harm the beneficiaries. Here in New York, the general rule is that the lawyer for a fiduciary has the same level of responsibility to the beneficiaries as the trustee, and would be held liable to the beneficiaries if the lawyer places her own interests above the fiduciary responsibilities of the trustee. *In re Bond & Mortgage Guarantee Company,* 303 N.Y. 423 (1952).

While the ACTEC Commentaries provide a more practical analysis than the NAELA Aspirational Standards, both the Standards and the Commentaries – read together – provide an excellent framework for analyzing ethical questions that arise in this area of practice.

**Fact pattern**

Adrian is a seven-year old boy who sustained significant physical and cognitive injuries after being hit by a car while crossing the street. His parents hired an attorney to file a lawsuit on behalf of the boy, and the lawsuit includes a derivative claim by the boy's parents. The parents are not court appointed guardians.

As a result of his injuries, Adrian has been approved for the New York State Office of People With Developmental Disabilities (OPWDD) waiver, a Medicaid funded program which provides services and supports to children living with developmental and other cognitive disabilities.

The litigating attorney notifies you that the matter has settled for a significant sum, and he wants you to prepare a supplemental needs trust to protect the boy's eligibility for government benefits. The litigating attorney has a long-standing relationship with a trust company and has already discussed the appointment of that institution as trustee with the parents. The attorney asks you to attend a meeting to include him, the parents, and a trust officer from the trust company.

Prior to the meeting, and in order to provide credible and informed recommendations, you ask the litigating attorney for a copy of the Life Care Plan prepared for the litigation, and you ask the parents to complete a worksheet which provides information on the parents' financial assets and on any other household members who may be receiving government benefits.

**Answering *the* question**

"Whom do you represent?"

The answer is typically: "I represent the disabled plaintiff." But do you? As you consider the question, keep in mind the comments to the NAELA Aspirational Standards on this very question: "*different attorneys with the same set of facts may identify different individuals as the client, and each result is equally appropriate.*" Comment to Standard B.1.

The Standards suggest that an attorney should – at the very first meeting – identify the client and make that identification known to all in attendance. This is easier said than done. Consider the issues that the special needs planning attorney may be called upon to address in an engagement of this nature, and consider who benefits from that advice.

1. You will discuss different options for management of settlement proceeds, and you will explain how first party supplemental needs trusts are used to protect government benefits. Who benefits? Clearly, the disabled plaintiff.

2. You will draft a first partly supplemental needs trust document. Once the trust is drafted and funded, most practitioners will submit the document to the Medicaid program representatives with proof of funding as required under 18 NYCRR 360-4.5. Who benefits? Clearly the disabled plaintiff benefits, but isn't the proposed trustee of the trust relying on you to prepare a document which is compliant with federal and New York law, and when you submit the trust, aren't you taking a step which the regulations state is the trustee's responsibility?

3. The litigating attorney will append a copy of your trust to the compromise petition and represent to the Court that the establishment and funding of the trust is both consistent with the law and in the disabled plaintiff's best interest. Filing the application for court approval of the settlement is clearly the attorney's responsibility under his engagement agreement with the plaintiffs, and absent some written agreement to the contrary the plaintiff attorney would be liable to the disabled plaintiff if the trust he submitted to the court turned out to be defective and government benefits were lost. Isn't the attorney relying on your advice to protect him as well as the disabled minor?

4. Assume the child is an SSI recipient because the parents have limited resources and income of their own. The litigating attorney asks for your opinion on whether the derivative payment to the parents will have an impact on the child's benefits, and if so, what options exist to minimize this impact. Who benefits? Clearly the disabled minor will benefit if your advice is designed to protect his benefits, but aren't you also making recommendations to the parents and to the litigating attorney regarding the allocation of settlement proceeds between the young boy and his parents? You might recommend allocating more to the parents so that they can purchase a home where the family can live, understanding that ownership of a home by the parents will not have an impact on the SSI entitlement. Who is benefitting from this advice?

5. The litigating attorney may ask you to review a claim by the Medicaid program for payment of its lien under section 104-b of New York's Social Services Law. In doing so, you see that the claim includes charges for school-based services, charges which must be backed out of the lien. In pointing this out to the attorney and, possibly, helping the attorney identify incorrect charges, who benefits from your advice? Clearly the disabled minor and the parents benefit because there will be more money left over for the plaintiffs, but aren't you also providing a service which directly benefits the professional who brought you into the engagement in the first place, possibly avoiding the possibility of a malpractice claim against the litigating attorney if the parents later learn that Medicaid was paid more than it was owed?

6. During the initial consultation with the plaintiff attorney and parents, you learn that the mother had to leave her job in order to provide care and oversight to her disabled son, and you discuss the possibility of using funds in the trust to compensate her on an ongoing basis for the extraordinary support she provides. After the trust is funded, can you prepare and file this petition with the Court, and if so, whom will you represent? The parent? The trustee? The disabled minor? All of them?

**Preliminary concepts**:

In considering your answer to *the* question, some important concepts introduced and reinforced by the NY Rules, the Standards and the ACTEC Commentaries warrant attention:

1. "Protected Individual": someone who may not be your client, but someone whose interests you are engaged to protect and to whom you have an affirmative responsibility. Comment to Standard B.1.

2. "Prospective client": someone with whom you have communicated, with whom you have met, and/or from whom you have received information. You have not yet established an attorney-client relationship with this person, but you may have certain responsibilities to that individual under the Rules. NY Rule 1.18; ACTEC Commentaries at p. 178; Comment to Standard B.1.

3. Representation of a trustee in an "individual capacity" versus in a "representative (general) capacity". When representing a trustee in a representative (general) capacity, the attorney is also bound by the trustee's fiduciary responsibility to make decisions in the best interest of the beneficiary. This is contrasted with representing a trustee in an individual capacity, where the attorney is retained to advance the trustee's separate and individual interests. NY Rule 1.2; ACTEC Commentaries at p. 35.

4. Joint representation versus concurrent representation. Both involve representing two or more separate clients simultaneously, with the primary difference being the approach to the rules of confidentiality. Both models of representation presume that the interests of both (or all) clients are not adverse. NY Rule 1.7; Standard D.1; ACTEC Commentaries at p. 101.

**Seeking guidance in answering *the* question: "Who is the client?"**

<u>New York Rules of Professional Conduct</u>

Interestingly, the NY Rules do not define the term "client." NY Rule 1.0 ("Terminology") contains a number of definitions, but "client" is not one of them. They leave it up to the attorney to figure out the answer to the question. Once identified, the rules begin to ferret out the attorney's responsibilities.

*Conclusion: New York's Rules do not provide a definitive answer to the question.*

<u>NAELA Aspirational Standards</u>

The Standards say that "usually, the client is the individual whose property and interests are to be protected," but they then go on to state that "alternatively, a family member, fiduciary, or other person seeking to protect or assist another person can be the client." Comment to Standard B.1.

The Comment introduces the idea of providing legal advice to a client in the client's representative capacity, similar to the concept of "general representation" discussed in the ACTEC Commentaries. The

Standards' discussion of fiduciary representation seems much more focused on agents appointed under Powers of Attorney, and less on trustees with independent responsibilities as defined under the terms of varying trust instruments. Nonetheless, the Standards reinforce a concept which applies across all fiduciary appointments: the advice and counsel provided by the attorney derives from and must be consistent with the fiduciary's affirmative obligation to make decisions in the best interest of the "protected individual."

Does this concept provide any credible guidance in the scenario presented here, where the attorney is providing information and recommendations to the litigating attorney, the injured minor, the parents of the injured minor, and the proposed trustee of the supplemental needs trust? The Standards ask, " 'Who is seeking legal advice and services?' or 'For whom or for whose interests are legal services requested?' " Comment to Standard B.1.

In this scenario, all of the individuals at the initial meeting are "seeking legal advice" from the special needs planning attorney, and that advice may benefit more than one or all of them in differing degrees.

*Conclusion: NAELA's Aspirational Standards do not provide a definitive answer to the question.*

ACTEC Commentaries

The ACTEC Commentaries focus on fiduciary representation and typically presume that the fiduciary is already a client. The Commentaries concentrate their analysis on how lawyers navigate conflicts between a fiduciary and a beneficiary, manage representation of more than one trustee, or manage simultaneous representation of both a trustee and a beneficiary. The Model Rules of Professional Conduct (which served as the basis for New York's Rule of Professional Conduct) do not define the term "client," and the ACTEC Commentaries are similarly silent.

*Conclusion: the ACTEC Commentaries to the MRPC do not provide a definitive answer to the question.*

**Considering alternative answers to *the* question**

1. You represent the disabled minor.

The intuitive reaction of most attorneys is that the special needs planning attorney represents the disabled minor. Interestingly, while the NY Rules do not define the term "client," they do define the term "prospective client." "A person becomes a prospective client by consulting with a lawyer about the possibility of forming client-lawyer relationship with respect to a matter." NY Rule 1.18, Comment 2. Certain obligations - such as confidentiality of information provided during the consultation and preclusion from later representation in an adverse matter without written consent - will automatically apply. NY Rule 1.18(c). Clearly the disabled minor would be a prospective client.

The Standards' definition of a "protected individual" would also apply to the disabled minor, an "individual whose personal and property interests are the subject of the representation." Comment to Standard B.1. If the parents were the plaintiffs in an accident which didn't involve their disabled son, you wouldn't have been called in to the matter. You are consulted because the minor plaintiff is disabled.

The ACTEC Commentaries follow the analysis of NY Rule 1.18, Comment 2: "A person becomes a prospective client by consulting with a lawyer about the possibility of forming a client-lawyer relationship with respect to a matter." ACTEC Commentaries at p. 179.

Do these authorities conclusively determine that the disabled minor is your client? Not really. The Standards explain that the protected individual may not be the actual client: "Usually, the client is the individual whose property and interests are to be protected. *Alternatively, a family member, fiduciary, or other person seeking to protect or assist another person can be the client*." Standards Comment to B.1 (emphasis added).

There may also be some practical challenges in identifying the disabled minor as your client in this scenario. Under New York's Civil Practice Law and Rules ("CPLR"), an infant can appear by a parent unless a guardian ad litem has been appointed or unless there is a guardian of the property. This allows the parent to retain an attorney to represent the minor in an action. CPLR 1201, 1207.

Do these provisions authorize the parents to retain you to consult on how the proceeds of the litigation should be distributed for the minor's behalf? The parents in the fact pattern presented here are not court appointed property guardians, and as such they have no legal authority to direct the disposition of the minor's proceeds (in trust or otherwise). Nonetheless, these CPLR provisions are understood to allow you to appear in the underlying matter (perhaps at a settlement conference, or by reference in the moving papers to settle the suit) and recommend the establishment and funding of a supplemental need trust.

But what if the court appointed a guardian ad litem to represent the interests of the disabled minor? The court can do so if there is a conflict of interest, and many courts do so as a matter of practice. CPLR 1201. If the parents are also plaintiffs in the action and the proceeds will be divided between the parents and child, isn't there a prima facie conflict? If the plaintiff is a minor and you are recommending the use of a trust to hold litigation proceeds, aren't the parents considered intestate heirs with a potentially conflicting interest in the trust that you will draft (as contingent remainder beneficiaries whose interests are adverse to the lifetime beneficiary)? Finally, if there is a conflict of interest and a guardian ad litem is appointed to appear for the disabled minor, then wouldn't the guardian ad litem have to hire you?

2. <u>You represent the parents.</u>

The personal injury attorney and the parents understand that you will be providing advice and recommendations for the benefit of the disabled minor. In order to make informed recommendations, you will ask the parents for information on household composition, financial condition, and household benefit eligibility. All will be relevant in determining how the settlement should be structured to protect the ongoing benefit eligibility for the disabled minor and to ensure that trust funds will be available to enhance the minor's quality of life. Once you receive this information from the parents, the parents will fit squarely into the definition of "prospective clients" under the provisions of the Standards and ACTEC Commentaries cited above. But are they also clients?

These consultations are typically wide ranging, and special needs planning attorneys often provide information and advice that would be considered specific to the parents: discussion of the tax implications of the parents' settlement, consideration of the impact of the settlement on means tested benefits being paid to the parents or family members other than the disabled minor, or recommendations for transfers by the parents to protect their windfall (which might be recommended when a parent's settlement will have an impact on the disabled minor's SSI payment, as the parent is considered a "deemor" under the SSI program rules) See POMS SI 01330.280 Examples - Parent-to-Child Deeming.

Recognizing that these discussions could be viewed as providing legal advice to the parents in addition to providing legal advice for the benefit of the disabled minor, you could refuse to answer any questions relating to parents' settlement, and insist they retain their own lawyer. Your recommendation may not be well received given that the family will now be paying another lawyer for her time, and the litigating attorney involved you because of your expertise in this area. Like it or not, the interests of the parents and the disabled minor are often inextricably linked in this type of representation.

You might relent and take the position that you represent both the disabled minor and the parents. This would be consistent with the broader objectives outlined in the ACTEC Commentaries which emphasize that estate and elder law planning is inherently non-adversarial and representation of multiple clients is often a cost-effective means of accomplishing a mutually beneficial result. Combined representation of parents and child with a disability is specifically addressed in the Comment to Standard E.4. discussing client confidentiality. The Standards also discuss a "holistic approach to legal problems" and the importance of recommending "harmony-enhancing measures consistent with the client's estate planning

goals to minimize [potential] conflicts." Standards A.1 and A.4. Advice which is designed to help parents and child alike would be consistent with the spirit of both the ACTEC Commentaries and the Standards.

If you take the position that you represent the parents and the disabled minor, your engagement will be governed by the rules of joint or concurrent representation, and you will need to address issues relating to conflicts of interest and confidentiality of communication.

*Potential conflicts are different than actual, irreconcilable conflicts*

The Preamble to the NY Rules state that "the touchstone of the client-lawyer relationship is the lawyer's obligation to assert the client's position *under the rules of the adversary system…"* In other words, the NY Rules presume that separate individuals involved in a single matter are necessarily in opposition and an infrastructure must be constructed to protect each of them.

As a result of this presumption, "conflict" is a term that is often used in a knee jerk manner when one perceives the possibility of disagreement between two parties. The term works nicely for the litigation practice, but it is often overused and misapplied in estate planning, elder law and special needs planning.

Much of the special needs planning practice (like traditional estate planning) is inherently non-adversarial, and multiple clients will have common objectives. They may have disagreements on how to achieve those objectives and counsel may be called upon to help them resolve those disagreements, but the potential for disagreement (potential conflicts) should not preclude the engagement, and the rules governing clients in actual, irreconcilable conflict should not (yet) apply.

In the scenario presented here - where the special needs planning attorney takes the position that she represents both the disabled minor and the parents - NY Rule 1.7 governing conflicts of interest stands front and center:

RULE 1.7:

CONFLICT OF INTEREST: CURRENT CLIENTS

(a) Except as provided in paragraph (b), a lawyer shall not represent a client if a reasonable lawyer would conclude that either:

(1) the representation will involve the lawyer in representing differing interests; or

(2) there is a significant risk that the lawyer's professional judgment on behalf of a client will be adversely affected by the lawyer's own financial, business, property or other personal interests.

(b) Notwithstanding the existence of a concurrent conflict of interest under paragraph (a), a lawyer may represent a client if:

(1) the lawyer reasonably believes that the lawyer will be able to provide competent and diligent representation to each affected client;

(2) the representation is not prohibited by law;

(3) the representation does not involve the assertion of a claim by one client against another client represented by the lawyer in the same litigation or other proceeding before a tribunal; and

(4) each affected client gives informed consent, confirmed in writing.

*Is there a conflict which implicates 1.7?*

In the scenario presented here - an attorney consulting with both a disabled minor and the minor's parents in a personal injury settlement - NY Rule 1.7 may not even apply. After all, 1.7(a) precludes representation only if "(1) the representation will involve the lawyer in representing differing interests; or

(2) there is a significant risk that the lawyer's professional judgment on behalf of a client will be adversely affected by the lawyer's own financial, business, property or other personal interests."

One may argue that there are no differing interests - protection of the settlement for both the parents and the disabled minor benefits them equally. The fact that there may be some disagreement on the allocation of the settlement between the parents and the minor doesn't mean that their interests differ - they simply have differing opinions on how to achieve a common result - protection of the entire settlement without adverse impact on the household. Presuming that the lawyer has no personal interest in the matter under section (a)(2), one never gets to paragraph (b), and the attorney need not worry about a written consent for representation despite the conflict.

If one concedes a "differing interest" under (a)(1), then the clients would have to give informed consent in writing as outlined in 1.7(b). Substantively speaking, nothing in paragraph (b) would preclude the representation here: the attorney can provide competent advice, it would not be prohibited by law, and there will be no claim asserted against either client.

Rather, the challenge is a practical one. Who signs the informed written consent on behalf of the minor? There may not be a substantive conflict of interest to preclude the attorney's representation of both the parents and the disabled minor, but the parents may not have the right to waive the conflict on behalf of their minor child. You may be able to represent all of them under the NY Rules, but there may be a practical barrier to your accepting the engagement. At least one Ethics opinion in New York suggests that joint representation may be impossible if one client cannot consent in writing. NYS Bar Association Committee on Professional Ethics Opinion #836 (02/25/2010) (discussing the ability of an attorney to represent an AIP and a guardian in a petition to terminate the guardianship).

In sum, simultaneous representation of the parents and their minor child is an easy concept to grasp, but may be difficult to effectuate in a manner that is consistent with the NY Rules of Professional Conduct and the mechanics of representation under the CPLR. You would also need to determine whether you represent the parents and child jointly or concurrently, discussed below.

3. <u>You represent the attorney.</u>

Recall the NAELA Aspirational Standard's comment on client identification: "Alternatively, a family member, fiduciary, *or other person seeking to protect or assist another person can be the client."* (emphasis added).

Isn't the personal injury attorney "seeking to protect" the disabled minor, and asking for your assistance in doing so? Would that make the attorney your client, with the understanding that the advice you provide is "to assist another person" (the disabled minor)?

The Standards also say that when drafting a supplemental needs trust for an individual whose disability would preclude him from hiring the drafting attorney directly, the attorney "should only draft such a trust at the request of a fiduciary who has the authority to engage the attorney." Comment to Standard C.4.c.

The term 'fiduciary' as used in the Standards refers primarily to an agent under power of attorney or a court appointed guardian – someone who steps into the shoes of the individual with diminished capacity. Is the plaintiff attorney a "fiduciary" as that term is used in the Standards, such that he is hiring you to provide advice for the benefit of his client? He certainly has an obligation to act in the plaintiff's best interest, and hiring you is consistent with that obligation.

There may also be some support for this position in the ACTEC Commentaries to MRPC 1.18 where one lawyer (the consulting lawyer) contacts another lawyer to provide advice. ACTEC Commentaries at 180. The Commentaries approach the issue from the perspective of whether the lawyer being consulted has an obligation to the consulting lawyer's client, and whether the lawyer being consulted would be

precluded from representing another client in an adverse action against the consulting lawyer's client at some future point in time.

While the ACTEC Commentaries do not directly address the relationship between the two attorneys, consider the nature and purpose of the consultation when considering whether an attorney-client relationship exists between them. The litigating attorney expects the special needs planning attorney to offer advice and recommendations in a number of different areas, including:

a. charges which should be removed from a Medicaid lien;

b. the need for a Medicare set aside trust;

c. an allocation between lump sum and structure;

d. tax impact of the settlement on both the disabled minor and the parents; and

e. possible uses of funds in the supplemental needs trust once funded.

Clearly the disabled minor benefits from this advice. But in practice the litigating attorney seeks out the special needs planning attorney precisely because she will be able to offer advice and recommendations which cover a wide range of areas and which impact everyone at the table during the consultation, including the litigating attorney. Lawyers hire other lawyers all the time.

Finally, if you represent the litigating attorney in this scenario, consider whether your fee should be paid by the litigating attorney and not from the proceeds of settlement. ACTEC Commentaries at p. 79.

4. <u>You represent the proposed trustee.</u>

In this scenario, a trust officer from a local financial institution is invited to the meeting with the litigating attorney and the family to discuss the supplemental needs trust. The discussion with the proposed trustee may focus on the benefit programs in which the beneficiary participates, permissible uses of funds once the trust is funded, and the need to secure court approval for large expenditures. Once appointed, the trustee will be relying on the advice you provide when later conferring with the family. Does that reliance make you the trustee's attorney?

In practice, the trust will not be established until a court order so directs, and so it would be difficult to take the position that the future trustee is your client at this early stage. Rather, the trustee would likely be considered a "prospective client" to whom you owe those limited responsibilities under NY Rule 1.18 (maintaining confidentiality and precluding later adverse representation). ACTEC Commentaries at p. 83.

5. <u>You represent all of them.</u>

You have provided information and advice to or for the benefit of everyone at the table, albeit in differing degrees: the disabled minor, the parents, the litigating attorney and the proposed trustee. They rely or they will rely on the information and advice you provide. Perhaps you represent all of them.

If you come to this conclusion, then the analysis earlier in this article involving potential conflicts between parent and child would similarly apply here.

In addition, your representation agreement would need to address the confidentiality of information consistent with NY Rule 1.6, and you would need to decide whether you represent them *jointly* or *concurrently*. Both models of representation acknowledge that "a lawyer may represent more than one client with related, but not necessarily identical, interests... The fact that the goals of the clients are not entirely consistent does not necessarily constitute a conflict of interest that precludes the same lawyer from representing them." ACTEC Commentaries at p. 83.

Both the ACTEC Commentaries and the NAELA Aspirational Standards discuss the representation of multiple parties, but the ACTEC Commentaries beginning at page 83 provide a much more comprehensive and practical analysis of the topic when one of the clients is a trustee with its own independent fiduciary obligations.

In *joint representation*, an attorney can continue to represent multiple clients so long as their interests and objectives remain consistent, and information that one joint client provides cannot be withheld from another joint client. ACTEC Commentaries at p. 102; Comment to Standard D.1. The most common example of joint representation in an estate planning practice is the representation of a husband and wife, where the engagement agreement makes clear that information shared by one spouse cannot be kept from the other. ACTEC Commentaries at p. 83; Comment to Standard E.2. Other examples include representing both trustee and beneficiary in an estate administration and business owners developing a partnership agreement. So long as their objectives are consistent, and despite the fact that disagreements on how to achieve those objectives may arise during the course of the engagement, a lawyer may represent multiple clients jointly.

In *concurrent representation,* an attorney represents two or more clients simultaneously, but communications between each client and the attorney remain confidential and do not need to be shared with the other clients represented in the concurrent representation. Comment to Standard D.1. The ACTEC Commentaries provide the example of an attorney who is working with a father and son on separate estate plans which have certain common objectives. If the attorney believes that she can maintain client confidentiality for each of them and still accomplish the common objectives of both, then concurrent representation is possible. ACTEC Commentaries at p. 103. Both the and ACTEC Commentaries and the Standards acknowledge that concurrent representation can be difficult to carry out in practice.

In the scenario presented here, all involved – the disabled minor, the parents, the litigating attorney and the proposed trustee – arguably share a common objective, and to the extent they have what NY Rule 1.7 calls "differing interests," all of them could consent to *joint representation* in writing. Information which is necessary for the special needs planning attorney to provide advice and counsel – information about the settlement, the injury and resulting disability, individual and household benefits, planning options, uses of trust funds – would be shared between and among all of them. That sharing arrangement would be clearly spelled out in the engagement agreement.

*Concurrent representation* would be difficult to carry out in this scenario, as the expertise that the special needs planning attorney brings to the engagement is her ability to synthesize information received from one client and advise on how that information may impact another. For example, if the special needs planning attorney learned that the parents were in the process of getting a divorce, that may impact the relative financial positions of the parents and the advice that the attorney might provide in the allocation of settlement proceeds between the parents and disabled minor. It would be difficult to provide competent representation to all clients while preserving this confidence at the request of the parents.

A special needs planning attorney may find comfort in the joint representation model in that it seems to dovetail nicely with the NY Rules given the non-adversarial nature of the engagement and the common objectives of the clients. In practice it may be difficult to pull off. For example, the litigating attorney may disagree with this reading of the NY Rules and refuse to acknowledge an attorney-client relationship as between the two attorneys. The proposed trustee might resist signing an engagement agreement when the trust document has not been executed and the institution has not yet been formally appointed as trustee.

Finally, the problem of who has the right to waive potential conflicts and consent to the sharing of confidential information on behalf of the minor (also discussed in paragraph 2 above) still exists.

6. You represent none of them – they are all "prospective clients" – but you have an affirmative obligation to the 'protected individual' (the disabled minor).

This position is the most closely aligned with what actually occurs in engagements of this nature, and it allows for continuity throughout the initial engagement and into any subsequent representation. Adopting this position may require a more expansive interpretation of the NY Rules and the ideas expressed in the ACTEC Commentaries and NAELA Aspirational Standards. It would also require clear, written explanation at the outset of the engagement.

In the author's opinion, this model best represents the purposes for which the special needs planning attorney was first engaged. Litigation attorneys who work with experienced special needs planning counsel understand that the ability to draft a supplemental needs trust is one small part of the skill set. Special needs planning attorneys provide advice and guidance in a number of different areas: government benefits, guardianship issues, waiver program eligibility, Medicare and Medicaid lien resolution, Medicare set aside trusts, income and gift tax issues, just to name a few.

In many cases, the litigating attorney, the family of the disabled minor, and the trustee (once appointed) expect to draw on the special needs planning attorney's expertise after the trust is funded. Subsequent services might include Medicaid applications and recertifications, advocacy with service providers, preparation of detailed accountings of trust activity, petitions for court approval for significant trust expenditures, and preparation of fiduciary or personal income tax returns. A well drafted trust sets the stage for effective administration, but arguably the greater value is in the advice and assistance that will be needed after the case has settled and the trust is funded.

*Developing the written agreement for the initial engagement*

This analysis – that the special needs planning attorney does not have a specifically identifiable client - would be based on the following:

a. all involved would be "prospective clients" pursuant to NY Rule 1.18; and

b. the disabled minor would be a "protected individual" as defined in the Comment to Standard B.1., and advice provided throughout the engagement would be for the primary benefit of the disabled minor and not others involved in engagement;

This information would be included in an explanatory letter prepared at the outset of the engagement, directed to the litigating attorney, to be signed by parents of the minor, explaining that:

a. the litigating attorney has requested that you consult on issues arising from the settlement, and you expect to prepare a trust document for consideration by the court as part of your engagement;

b. the advice you provide and the document you draft will be based on your professional opinion of what is in the best interest of the disabled minor, a "protected individual," in a manner consistent with the law, rules and practice governing supplemental needs trust in New York;

c. information shared with you cannot be kept confidential from others involved in the settlement on behalf of the disabled minor (the plaintiff attorney, the parents, and any guardian ad litem appointed on behalf of the minor);

d. the parents waive the right to later argue that the existence of a potential conflict of interest – during the initial engagement or at some point in the future - precluded the representation (see the discussion of "prospective waivers" in the ACTEC Commentaries at p. 105);

e. you may later be retained by the trustee of the supplemental needs trust, but your obligation to render advice for the primary benefit of the disabled minor/beneficiary will continue; and

f. if during the course of the representation "differing interests" emerge (as that term is defined in NY Rule 1.18 regarding duties to prospective clients), you would inform the individual with the differing interest of the need for independent counsel, and you would need to secure the informed written consent of the prospective clients to continued representation. If the differing interest becomes an irreconcilable conflict, you would need to withdraw from representation in a manner consistent with NY Rule 1.16. This might occur if the parents argued for an allocation of the settlement proceeds in favor of their derivative claim which far exceeded any reasonable allocation under existing New York law and practice.

*Developing the written agreement with the trustee for ongoing representation*

If after the trust is funded the trustee chooses to retain you to provide ongoing representation in a manner consistent with the discussions during the settlement process, your engagement agreement with the trustee would identify the trustee as your client, but would also explain that you are being retained to provide general representation in a manner which is consistent with the trustee's affirmative obligation to the primary beneficiary of the trust (the "protected individual"). You will not offer advice or take steps which you believe to be adverse to the primary beneficiary's interests, even if those steps would be beneficial to the trustee (individually). In such a case, you would need to withdraw from representation and direct the trustee to retain counsel to provide representation in an individual (versus a general) capacity.

Your engagement agreement with the trustee should also address how you will handle ongoing communication between counsel, trustee and the family. The ACTEC Commentaries suggest that counsel for the fiduciary can maintain confidentiality of communication with its client (in this scenario, the trustee), but in communicating with individuals who are not actual clients (in this scenario, the disabled minor and the parents) the attorney has an obligation to speak candidly and in a forthright manner on issues which involve the administration of the trust. ACTEC Commentaries at pages 36-39 and 190-191:

"If a fiduciary is not subject to court supervision and is therefore not required to render an accounting to the court but renders an accounting to the beneficiaries, the lawyer for the fiduciary must exercise at least the same candor in statements made to the beneficiaries that the lawyer would be required to exercise toward any court having jurisdiction over the fiduciary accounting." ACTEC Commentaries at p. 191.

For example, if you consult with the trustee about whether payment of a utility bill for the household is appropriately made from the trust, your email communications with the trustee discussing the risks and benefits of doing so would be confidential and would not be shared with the parents of the beneficiary without the trustee's consent. If the trustee ultimately refuses to pay the utility bill because the payment of the bill would impact SSI benefits and the parents later call you to discuss the matter, you (as attorney for the trustee) would be obligated to explain the basis for the trustee's decision in an honest and forthright manner.

This communication protocol should be explained in writing to the trustee and to the parents at the time you undertake the representation of the trustee, and should make clear that:

a. you represent the trustee and not the primary beneficiary of the trust or the parents;

b. you represent the trustee for the purpose of assisting the trustee in carrying out its fiduciary obligations to the primary beneficiary, and your advice and services must be consistent with that responsibility to the primary beneficiary;

c. your communications with the trustee are confidential and protected, while your communications with the parents are not;

d. notwithstanding the confidentiality of communication between the attorney and trustee, the primary beneficiary and the primary beneficiary's legal representatives (here, the parents) are entitled to

information on how trust funds are being used for the primary beneficiary's benefit, and you will communicate openly and honestly with them for that purpose; and

[if you were involved in the initial representation during the course of the settlement such that the disabled minor and his parents are all "prospective clients" under NY Rule 1.18]:

e. you would be precluded under the rules of professional conduct from representing the trustee in an adversarial proceeding against the primary beneficiary or his parents, and you would be precluded under the rules of professional conduct from representing the primary beneficiary or his parents in an adversarial proceeding against the trustee.

**Conclusion:**

Every ethics presentation and publication seems to begin with *the* question: "Who is the client?" After reviewing the New York Rules of Professional Conduct and associated Commentaries, the NAELA Aspirational Standards, the ACTEC Commentaries, and select ethics opinions from the New York State Bar Association, one is left with a different question: "In the scenario presented in this article, must one identify a specific client in order to provide effective representation?" Or is it more important to determine how you will accomplish the broader objectives and protections which serve as the foundation of the Rules of Professional Conduct: the obligations of loyalty, confidentiality, and effective communication?

In considering the answer to this question, the passage from the Preamble to the Model Rules of Professional Conduct bears repeating: "The Rules of Professional Conduct are rules of reason. They should be interpreted with reference to the purposes of the legal representation and of the law itself."

If the individual who will be the focus of the special needs planning attorney's efforts is clearly identified (the protected individual" in the language of the Standards), and if the rules of communication and confidentiality are clearly explained, understood, and consented to by all involved, wouldn't the engagement accomplish the objectives that the NY Rules are designed to promote?

NEW YORK STATE UNIFIED COURT SYSTEM

# PART 1200

## RULES OF PROFESSIONAL CONDUCT

Dated: January 1, 2017

These Rules of Professional Conduct were promulgated as Joint Rules of the Appellate Divisions of the Supreme Court, effective April 1, 2009, and amended on several occasions thereafter. They supersede the former part 1200 (Disciplinary Rules of the Code of Professional Responsibility).

The New York State Bar Association has issued a Preamble, Scope and Comments to accompany these Rules. They are not enacted with this Part, and where a conflict exists between a Rule and the Preamble, Scope or a Comment, the Rule controls.

**This unofficial compilation of the Rules provided for informational purposes only. The official version of Part 1200 is published by the New York State Department of State. An unofficial on-line version is available at www.dos.ny.gov/info/nycrr.html (Title 22 [Judiciary]; Subtitle B Courts; Chapter IV Supreme Court; Subchapter E All Departments; Part 1200 Rules of Professional Conduct; § 1200.0 Rules of Professional Conduct).**

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**PART 1200 - RULES OF PROFESSIONAL CONDUCT**

# RULE 1.0.

*Terminology*

**(a) "Advertisement"** means any public or private communication made by or on behalf of a lawyer or law firm about that lawyer or law firm's services, the primary purpose of which is for the retention of the lawyer or law firm. It does not include communications to existing clients or other lawyers.

**(b) "Belief" or "believes"** denotes that the person involved actually believes the fact in question to be true. A person's belief may be inferred from circumstances.

**(c) "Computer-accessed communication"** means any communication made by or on behalf of a lawyer or law firm that is disseminated through the use of a computer or related electronic device, including, but not limited to, web sites, weblogs, search engines, electronic mail, banner advertisements, pop-up and pop-under advertisements, chat rooms, list servers, instant messaging, or other internet presences, and any attachments or links related thereto.

**(d) "Confidential information"** is defined in Rule 1.6.

**(e) "Confirmed in writing"** denotes (i) a writing from the person to the lawyer confirming that the person has given consent, (ii) a writing that the lawyer promptly transmits to the person confirming the person's oral consent, or (iii) a statement by the person made on the record of any proceeding before a tribunal. If it is not feasible to obtain or transmit the writing at the time the person gives oral consent, then the lawyer must obtain or transmit it within a reasonable time thereafter.

**(f) "Differing interests"** include every interest that will adversely affect either the judgment or the loyalty of a lawyer to a client, whether it be a conflicting, inconsistent, diverse, or other interest.

**(g) "Domestic relations matter"** denotes representation of a client in a claim, action or proceeding, or preliminary to the filing of a claim, action or proceeding, in either Supreme Court or Family Court, or in any court of appellate jurisdiction, for divorce, separation, annulment, custody, visitation, maintenance, child support or alimony, or to enforce or modify a judgment or order in connection with any such claim, action or proceeding.

**(h) "Firm" or "law firm"** includes, but is not limited to, a lawyer or lawyers in a law partnership, professional corporation, sole proprietorship or other

association authorized to practice law; or lawyers employed in a qualified legal assistance organization, a government law office, or the legal department of a corporation or other organization.

**(l) "Fraud" or "fraudulent"** denotes conduct that is fraudulent under the substantive or procedural law of the applicable jurisdiction or has a purpose to deceive, provided that it does not include conduct that, although characterized as fraudulent by statute or administrative rule, lacks an element of scienter, deceit, intent to mislead, or knowing failure to correct misrepresentations that can be reasonably expected to induce detrimental reliance by another.

**(j) "Informed consent"** denotes the agreement by a person to a proposed course of conduct after the lawyer has communicated information adequate for the person to make an informed decision, and after the lawyer has adequately explained to the person the material risks of the proposed course of conduct and reasonably available alternatives.

**(k) "Knowingly," "known," "know," or "knows"** denotes actual knowledge of the fact in question. A person's knowledge may be inferred from circumstances.

**(l) "Matter"** includes any litigation, judicial or administrative proceeding, case, claim, application, request for a ruling or other determination, contract, controversy, investigation, charge, accusation, arrest, negotiation, arbitration, mediation or any other representation involving a specific party or parties.

**(m) "Partner"** denotes a member of a partnership, a shareholder in a law firm organized as a professional legal corporation or a member of an association authorized to practice law.

**(n) "Person"** includes an individual, a corporation, an association, a trust, a partnership, and any other organization or entity.

**(o) "Professional legal corporation"** means a corporation, or an association treated as a corporation, authorized by law to practice law for profit.

**(p) "Qualified legal assistance organization"** means an office or organization of one of the four types listed in Rule 7.2(b)(1)-(4) that meets all of the requirements thereof.

**(q) "Reasonable" or "reasonably,"** when used in relation to conduct by a lawyer, denotes the conduct of a reasonably prudent and competent lawyer. When used in the context of conflict of interest determinations, "reasonable lawyer" denotes a lawyer acting from the perspective of a reasonably prudent and

competent lawyer who is personally disinterested in commencing or continuing the representation.

**(r) "Reasonable belief" or "reasonably believes,"** when used in reference to a lawyer, denotes that the lawyer believes the matter in question and that the circumstances are such that the belief is reasonable.

**(s) "Reasonably should know,"** when used in reference to a lawyer, denotes that a lawyer of reasonable prudence and competence would ascertain the matter in question.

**(t) "Screened" or "screening"** denotes the isolation of a lawyer from any participation in a matter through the timely imposition of procedures within a firm that are reasonably adequate under the circumstances to protect information that the isolated lawyer or the firm is obligated to protect under these Rules or other law.

**(u) "Sexual relations"** denotes sexual intercourse or the touching of an intimate part of the lawyer or another person for the purpose of sexual arousal, sexual gratification or sexual abuse.

**(v) "State"** includes the District of Columbia, Puerto Rico, and other federal territories and possessions.

**(w) "Tribunal"** denotes a court, an arbitrator in an arbitration proceeding or a legislative body, administrative agency or other body acting in an adjudicative capacity. A legislative body, administrative agency or other body acts in an adjudicative capacity when a neutral official, after the presentation of evidence or legal argument by a party or parties, will render a legal judgment directly affecting a party's interests in a particular matter.

**(x) "Writing" or "written"** denotes a tangible or electronic record of a communication or representation, including handwriting, typewriting, printing, photocopying, photography, audio or video recording, e-mail or other electronic communication or any other form of recorded communication or recorded representation. A "signed" writing includes an electric sound, symbol or process attached to or logically associated with a writing and executed or adopted by a person with the intent to sign the writing.

## RULE 1.1.

*Competence*

**(a)** A lawyer should provide competent representation to a client. Competent representation requires the legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation.

**(b)** A lawyer shall not handle a legal matter that the lawyer knows or should know that the lawyer is not competent to handle, without associating with a lawyer who is competent to handle it.

**(c)** lawyer shall not intentionally:

*(1)* fail to seek the objectives of the client through reasonably available means permitted by law and these Rules; or

*(2)* prejudice or damage the client during the course of the representation except as permitted or required by these Rules.

## RULE 1.2.

*Scope of Representation and Allocation of Authority Between Client and Lawyer*

**(a)** Subject to the provisions herein, a lawyer shall abide by a client's decisions concerning the objectives of representation and, as required by Rule 1.4, shall consult with the client as to the means by which they are to be pursued. A lawyer shall abide by a client's decision whether to settle a matter. In a criminal case, the lawyer shall abide by the client's decision, after consultation with the lawyer, as to a plea to be entered, whether to waive jury trial and whether the client will testify.

**(b)** A lawyer's representation of a client, including representation by appointment, does not constitute an endorsement of the client's political, economic, social or moral views or activities.

**(c)** A lawyer may limit the scope of the representation if the limitation is reasonable under the circumstances, the client gives informed consent and where necessary notice is provided to the tribunal and/or opposing counsel.

**(d)** A lawyer shall not counsel a client to engage, or assist a client, in conduct that the lawyer knows is illegal or fraudulent, except that the lawyer may discuss the legal consequences of any proposed course of conduct with a client.

**(e)** A lawyer may exercise professional judgment to waive or fail to assert a right or position of the client, or accede to reasonable requests of opposing counsel, when doing so does not prejudice the rights of the client.

**(f)** A lawyer may refuse to aid or participate in conduct that the lawyer believes to be unlawful, even though there is some support for an argument that the conduct is legal.

**(g)** A lawyer does not violate these Rules by being punctual in fulfilling all professional commitments, by avoiding offensive tactics, and by treating with courtesy and consideration all persons involved in the legal process.

## RULE 1.3.

*Diligence*

**(a)** A lawyer shall act with reasonable diligence and promptness in representing a client.

**(b)** A lawyer shall not neglect a legal matter entrusted to the lawyer.

**(c)** A lawyer shall not intentionally fail to carry out a contract of employment entered into with a client for professional services, but the lawyer may withdraw as permitted under these Rules.

## RULE 1.4.

*Communication*

**(a)** A lawyer shall:

*(1)* promptly inform the client of:

(i) any decision or circumstance with respect to which the client's informed consent, as defined in Rule 1.0(j), is required by these Rules;

(ii) any information required by court rule or other law to be communicated to a client; and

(iii) material developments in the matter including settlement or plea offers.

*(2)* reasonably consult with the client about the means by which the client's objectives are to be accomplished;

*(3)* keep the client reasonably informed about the status of the matter;

*(4)* promptly comply with a client's reasonable requests for information; and

*(5)* consult with the client about any relevant limitation on the lawyer's conduct when the lawyer knows that the client expects assistance not permitted by these Rules or other law.

**(b)** A lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation.

## RULE 1.5.

*Fees and Division of Fees*

**(a)** A lawyer shall not make an agreement for, charge, or collect an excessive or illegal fee or expense. A fee is excessive when, after a review of the facts, a reasonable lawyer would be left with a definite and firm conviction that the fee is excessive. The factors to be considered in determining whether a fee is excessive may include the following:

*(1)* the time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly;

*(2)* the likelihood, if apparent or made known to the client, that the acceptance of the particular employment will preclude other employment by the lawyer;

*(3)* the fee customarily charged in the locality for similar legal services;

*(4)* the amount involved and the results obtained;

*(5)* the time limitations imposed by the client or by circumstances;

*(6)* the nature and length of the professional relationship with the client;

*(7)* the experience, reputation and ability of the lawyer or lawyers performing the services; and

*(8)* whether the fee is fixed or contingent.

**(b)** A lawyer shall communicate to a client the scope of the representation and the basis or rate of the fee and expenses for which the client will be responsible. This information shall be communicated to the client before or within a reasonable time after commencement of the representation and shall be in writing where required by statute or court rule. This provision shall not apply when the lawyer will charge a regularly represented client on the same basis or rate and perform services that are of the same general kind as previously rendered to and paid for by the client. Any changes in the scope of the representation or the basis or rate of the fee or expenses shall also be communicated to the client.

**(c)** A fee may be contingent on the outcome of the matter for which the service is rendered, except in a matter in which a contingent fee is prohibited by paragraph (d) or other law. Promptly after a lawyer has been employed in a contingent fee matter, the lawyer shall provide the client with a writing stating the method by which the fee is to be determined, including the percentage or percentages that shall accrue to the lawyer in the event of settlement, trial or appeal; litigation and other expenses to be deducted from the recovery; and whether such expenses are to be deducted before or, if not prohibited by statute or court rule, after the contingent fee is calculated. The writing must clearly notify the client of any expenses for which the client will be liable regardless of whether the client is the prevailing party. Upon conclusion of a contingent fee matter, the lawyer shall provide the client with a writing stating the outcome of the matter and, if there is a recovery, showing the remittance to the client and the method of its determination.

**(d)** A lawyer shall not enter into an arrangement for, charge or collect:

*(1)* a contingent fee for representing a defendant in a criminal matter;

*(2)* a fee prohibited by law or rule of court;

*(3)* fee based on fraudulent billing;

*(4)* a nonrefundable retainer fee; provided that a lawyer may enter into a retainer agreement with a client containing a reasonable minimum fee clause if it defines in plain language and sets forth the circumstances under which such fee may be incurred and how it will be calculated; or

*(5)* any fee in a domestic relations matter if:

(i) the payment or amount of the fee is contingent upon the securing of a divorce or of obtaining child custody or visitation or is in any way determined by reference to the amount of maintenance, support, equitable distribution, or property settlement;

(ii) a written retainer agreement has not been signed by the lawyer and client setting forth in plain language the nature of the relationship and the details of the fee arrangement; or

(iii) the written retainer agreement includes a security interest, confession of judgment or other lien without prior notice being provided to the client in a signed retainer agreement and approval from a tribunal after notice to the adversary. A lawyer shall not foreclose on a mortgage placed on the marital residence while the spouse who consents to the mortgage remains the titleholder and the residence remains the spouse's primary residence.

**(e)** In domestic relations matters, a lawyer shall provide a prospective client with a statement of client's rights and responsibilities at the initial conference and prior to the signing of a written retainer agreement.

**(f)** Where applicable, a lawyer shall resolve fee disputes by arbitration at the election of the client pursuant to a fee arbitration program established by the Chief Administrator of the Courts and approved by the Administrative Board of the Courts.

**(g)** A lawyer shall not divide a fee for legal services with another lawyer who is not associated in the same law firm unless:

*(1)* the division is in proportion to the services performed by each lawyer or, by a writing given to the client, each lawyer assumes joint responsibility for the representation;

*(2)* the client agrees to employment of the other lawyer after a full disclosure that a division of fees will be made, including the share each lawyer will receive, and the client's agreement is confirmed in writing; and

*(3)* the total fee is not excessive.

**(h)** Rule 1.5(g) does not prohibit payment to a lawyer formerly associated in a law firm pursuant to a separation or retirement agreement.

## RULE 1.6.

*Confidentiality of Information*

**(a)** A lawyer shall not knowingly reveal confidential information, as defined in this Rule, or use such information to the disadvantage of a client or for the advantage of the lawyer or a third person, unless:

*(1)* the client gives informed consent, as defined in Rule 1.0(j);

*(2)* the disclosure is impliedly authorized to advance the best interests of the client and is either reasonable under the circumstances or customary in the professional community; or

*(3)* the disclosure is permitted by paragraph (b).

"Confidential information" consists of information gained during or relating to the representation of a client, whatever its source, that is (a) protected by the attorney-client privilege, (b) likely to be embarrassing or detrimental to the client if disclosed, or (c) information that the client has requested be kept confidential. "Confidential information" does not ordinarily include (i) a lawyer's legal knowledge or legal research or (ii) information that is generally known in the local community or in the trade, field or profession to which the information relates.

**(b)** A lawyer may reveal or use confidential information to the extent that the lawyer reasonably believes necessary:

*(1)* to prevent reasonably certain death or substantial bodily harm;

*(2)* to prevent the client from committing a crime;

*(3)* to withdraw a written or oral opinion or representation previously given by the lawyer and reasonably believed by the lawyer still to be relied upon by a third person, where the lawyer has discovered that the opinion or representation was based on materially inaccurate information or is being used to further a crime or fraud;

*(4)* to secure legal advice about compliance with these Rules or other law by the lawyer, another lawyer associated with the lawyer's firm or the law firm;

*(5)* (i) to defend the lawyer or the lawyer's employees and associates against an accusation of wrongful conduct; or

(ii) to establish or collect a fee; or

*(6)* when permitted or required under these Rules or to comply with other law or court order.

**(c)** A lawyer shall make reasonable efforts to prevent the inadvertent or unauthorized disclosure or use of, or unauthorized access to, information protected by Rules 1.6, 1.9(c), or 1.18(b).

## RULE 1.7.

*Conflict of Interest: Current Clients*

**(a)** Except as provided in paragraph (b), a lawyer shall not represent a client if a reasonable lawyer would conclude that either:

*(1)* the representation will involve the lawyer in representing differing interests; or

*(2)* there is a significant risk that the lawyer's professional judgment on behalf of a client will be adversely affected by the lawyer's own financial, business, property or other personal interests.

**(b)** Notwithstanding the existence of a concurrent conflict of interest under paragraph (a), a lawyer may represent a client if:

*(1)* the lawyer reasonably believes that the lawyer will be able to provide competent and diligent representation to each affected client;

*(2)* the representation is not prohibited by law;

*(3)* the representation does not involve the assertion of a claim by one client against another client represented by the lawyer in the same litigation or other proceeding before a tribunal; and

*(4)* each affected client gives informed consent, confirmed in writing.

## RULE 1.8.

*Current Clients: Specific Conflict of Interest Rules*

**(a)** A lawyer shall not enter into a business transaction with a client if they have differing interests therein and if the client expects the lawyer to exercise professional judgment therein for the protection of the client, unless:

*(1)* the transaction is fair and reasonable to the client and the terms of the transaction are fully disclosed and transmitted in writing in a manner that can be reasonably understood by the client;

*(2)* the client is advised in writing of the desirability of seeking, and is given a reasonable opportunity to seek, the advice of independent legal counsel on the transaction; and

*(3)* the client gives informed consent, in a writing signed by the client, to the essential terms of the transaction and the lawyer's role in the transaction, including

whether the lawyer is representing the client in the transaction.

**(b)** A lawyer shall not use information relating to representation of a client to the disadvantage of the client unless the client gives informed consent, except as permitted or required by these Rules.

**(c)** A lawyer shall not:

*(1)* solicit any gift from a client, including a testamentary gift, for the benefit of the lawyer or a person related to the lawyer; or

*(2)* prepare on behalf of a client an instrument giving the lawyer or a person related to the lawyer any gift, unless the lawyer or other recipient of the gift is related to the client and a reasonable lawyer would conclude that the transaction is fair and reasonable.

For purposes of this paragraph, related persons include a spouse, child, grandchild, parent, grandparent or other relative or individual with whom the lawyer or the client maintains a close, familial relationship.

**(d)** Prior to conclusion of all aspects of the matter giving rise to the representation or proposed representation of the client or prospective client, a lawyer shall not negotiate or enter into any arrangement or understanding with:

*(1)* a client or a prospective client by which the lawyer acquires an interest in literary or media rights with respect to the subject matter of the representation or proposed representation; or

*(2)* any person by which the lawyer transfers or assigns any interest in literary or media rights with respect to the subject matter of the representation of a client or prospective client.

**(e)** While representing a client in connection with contemplated or pending litigation, a lawyer shall not advance or guarantee financial assistance to the client, except that:

*(1)* a lawyer may advance court costs and expenses of litigation, the repayment of which may be contingent on the outcome of the matter;

*(2)* a lawyer representing an indigent or pro bono client may pay court costs and expenses of litigation on behalf of the client; and

*(3)* a lawyer, in an action in which an attorney's fee is payable in whole or in part as a percentage of the recovery in the action, may pay on the lawyer's own account court costs and expenses of litigation. In such case, the fee paid to the lawyer from the proceeds of the action may include an amount equal to such costs and expenses incurred.

**(f)** A lawyer shall not accept compensation for representing a client, or anything of value related to the lawyer's representation of the client, from one other than the client unless:

*(1)* the client gives informed consent;

*(2)* there is no interference with the lawyer's independent professional judgment or with the client-lawyer relationship; and

*(3)* the client's confidential information is protected as required by Rule 1.6.

**(g)** A lawyer who represents two or more clients shall not participate in making an aggregate settlement of the claims of or against the clients, absent court approval, unless each client gives informed consent in a writing signed by the client. The lawyer's disclosure shall include the existence and nature of all the claims involved and of the participation of each person in the settlement.

**(h)** A lawyer shall not:

*(1)* make an agreement prospectively limiting the lawyer's liability to a client for malpractice; or

*(2)* settle a claim or potential claim for such liability with an unrepresented client or former client unless that person is advised in writing of the desirability of seeking, and is given a reasonable opportunity to seek, the advice of independent legal counsel in connection therewith.

**(i)** A lawyer shall not acquire a proprietary interest in the cause of action or subject matter of litigation the lawyer is conducting for a client, except that the lawyer may:

*(1)* acquire a lien authorized by law to secure the lawyer's fee or expenses; and

*(2)* contract with a client for a reasonable contingent fee in a civil matter subject to Rule 1.5(d) or other law or court rule.

**(j)** *(1)* A lawyer shall not:

(i) as a condition of entering into or continuing any professional representation by the lawyer or the lawyer's firm, require or demand sexual relations with any person;

(ii) employ coercion, intimidation or undue influence in entering into sexual relations incident to any professional representation by the lawyer or the lawyer's firm; or

(iii) in domestic relations matters, enter into sexual relations with a client during the course of the lawyer's representation of the client.

*(2)* Rule 1.8(j)(1) shall not apply to sexual relations between lawyers and their spouses or to ongoing consensual sexual relationships that predate the initiation of the client-lawyer relationship.

**(k)** Where a lawyer in a firm has sexual relations with a client but does not participate in the representation of that client, the lawyers in the firm shall not be subject to discipline under this Rule solely because of the occurrence of such sexual relations.

## RULE 1.9.

*Duties to Former Clients*

**(a)** A lawyer who has formerly represented a client in a matter shall not thereafter represent another person in the same or a substantially related matter in

which that person's interests are materially adverse to the interests of the former client unless the former client gives informed consent, confirmed in writing.

**(b)** Unless the former client gives informed consent, confirmed in writing, a lawyer shall not knowingly represent a person in the same or a substantially related matter in which a firm with which the lawyer formerly was associated had previously represented a client:

*(1)* whose interests are materially adverse to that person; and

*(2)* about whom the lawyer had acquired information protected by Rules 1.6 or paragraph (c) of this Rule that is material to the matter.

**(c)** A lawyer who has formerly represented a client in a matter or whose present or former firm has formerly represented a client in a matter shall not thereafter:

*(1)* use confidential information of the former client protected by Rule 1.6 to the disadvantage of the former client, except as these Rules would permit or require with respect to a current client or when the information has become generally known; or

*(2)* reveal confidential information of the former client protected by Rule 1.6 except as these Rules would permit or require with respect to a current client.

## RULE 1.10.

*Imputation of Conflicts of Interest*

**(a)** While lawyers are associated in a firm, none of them shall knowingly represent a client when any one of them practicing alone would be prohibited from doing so by Rule 1.7, 1.8 or 1.9, except as otherwise provided therein.

**(b)** When a lawyer has terminated an association with a firm, the firm is prohibited from thereafter representing a person with interests that the firm knows or reasonably should know are materially adverse to those of a client represented by the formerly associated lawyer and not currently represented by the firm if the firm or any lawyer remaining in the firm has information protected by Rule 1.6 or Rule 1.9(c) that is material to the matter.

**(c)** When a lawyer becomes associated with a firm, the firm may not knowingly represent a client in a matter that is the same as or substantially related to a matter in which the newly associated lawyer, or a firm with which that lawyer was associated, formerly represented a client whose interests are materially adverse to the prospective or current client unless the newly associated lawyer did not acquire any information protected by Rule 1.6 or Rule 1.9(c) that is material to the current matter.

**(d)** A disqualification prescribed by this Rule may be waived by the affected client or former client under the conditions stated in Rule 1.7.

**(e)** A law firm shall make a written record of its engagements, at or near the time of each new engagement, and shall implement and maintain a system by which proposed engagements are checked against current and previous engagements when:

*(1)* the firm agrees to represent a new client;

*(2)* the firm agrees to represent an existing client in a new matter;

*(3)* the firm hires or associates with another lawyer; or

*(4)* an additional party is named or appears in a pending matter.

**(f)** Substantial failure to keep records or to implement or maintain a conflict-checking system that complies with paragraph (e) shall be a violation thereof regardless of whether there is another violation of these Rules.

**(g)** Where a violation of paragraph (e) by a law firm is a substantial factor in causing a violation of paragraph (a) by a lawyer, the law firm, as well as the individual lawyer, shall be responsible for the violation of paragraph (a).

**(h)** A lawyer related to another lawyer as parent, child, sibling or spouse shall not represent in any matter a client whose interests differ from those of another party to the matter who the lawyer knows is represented by the other lawyer unless the client consents to the representation after full disclosure and the lawyer concludes that the lawyer can adequately represent the interests of the client.

## RULE 1.11.

*Special Conflicts of Interest for Former and Current Government Officers and Employees*

**(a)** Except as law may otherwise expressly provide, a lawyer who has formerly served as a public officer or employee of the government:

*(1)* shall comply with Rule 1.9(c); and

*(2)* shall not represent a client in connection with a matter in which the lawyer participated personally and substantially as a public officer or employee, unless the appropriate government agency gives its informed consent, confirmed in writing, to the representation. This provision shall not apply to matters governed by Rule 1.12(a).

**(b)** When a lawyer is disqualified from representation under paragraph (a), no lawyer in a firm with which that lawyer is associated may knowingly undertake or continue representation in such a matter unless:

*(1)* the firm acts promptly and reasonably to:

(i) notify, as appropriate, lawyers and nonlawyer personnel within the firm that the personally disqualified lawyer is prohibited from participating in the representation of the current client;

(ii) implement effective screening procedures to prevent the flow of information about the matter between the personally disqualified lawyer and the others in the firm;

(iii) ensure that the disqualified lawyer is apportioned no part of the fee therefrom; and

(iv) give written notice to the appropriate government agency to enable it to ascertain compliance with the provisions of this Rule; and

*(2)* there are no other circumstances in the particular representation that create an appearance of impropriety.

**(c)** Except as law may otherwise expressly provide, a lawyer having information that the lawyer knows is confidential government information about a person, acquired when the lawyer was a public officer or employee, may not represent a private client whose interests are adverse to that person in a matter in which the information could be used to the material disadvantage of that person. As used in this Rule, the term "confidential government information" means information that has been obtained under governmental authority and that, at the time this Rule is applied, the government is prohibited by law from disclosing to the public or has a legal privilege not to disclose, and that is not otherwise available to the public. A firm with which that lawyer is associated may undertake or continue representation in the matter only if the disqualified lawyer is timely and effectively screened from any participation in the matter in accordance with the provisions of paragraph (b).

**(d)** Except as law may otherwise expressly provide, a lawyer currently serving as a public officer or employee shall not:

*(1)* participate in a matter in which the lawyer participated personally and substantially while in private practice or nongovernmental employment, unless under applicable law no one is, or by lawful delegation may be, authorized to act in the lawyer's stead in the matter; or

*(2)* negotiate for private employment with any person who is involved as a party or as lawyer for a party in a matter in which the lawyer is participating personally and substantially.

**(e)** As used in this Rule, the term "matter" as defined in Rule 1.0(l) does not include or apply to agency rulemaking functions.

**(f)** A lawyer who holds public office shall not:

*(1)* use the public position to obtain, or attempt to obtain, a special advantage in legislative matters for the lawyer or for a client under circumstances where the lawyer knows or it is obvious that such action is not in the public interest;

*(2)* use the public position to influence, or attempt to influence, a tribunal to act in favor of the lawyer or of a client; or

*(3)* accept anything of value from any person when the lawyer knows or it is obvious that the offer is for the purpose of influencing the lawyer's action as a public official.

## RULE 1.12.

*Specific Conflicts of Interest for Former Judges, Arbitrators, Mediators or Other Third-Party Neutrals*

**(a)** A lawyer shall not accept private employment in a matter upon the merits of which the lawyer has acted in a judicial capacity.

**(b)** Except as stated in paragraph (e), and unless all parties to the proceeding give informed consent, confirmed in writing, a lawyer shall not represent anyone in connection with a matter in which the lawyer participated personally and substantially as:

*(1)* an arbitrator, mediator or other third-party neutral; or

*(2)* a law clerk to a judge or other adjudicative officer or an arbitrator, mediator or other third-party neutral.

**(c)** A lawyer shall not negotiate for employment with any person who is involved as a party or as lawyer for a party in a matter in which the lawyer is participating personally and substantially as a judge or other adjudicative officer or as an arbitrator, mediator or other third-party neutral.

**(d)** When a lawyer is disqualified from representation under this Rule, no lawyer in a firm with which that lawyer is associated may knowingly undertake or continue representation in such a matter unless:

*(1)* the firm acts promptly and reasonably to:

(i) notify, as appropriate, lawyers and nonlawyer personnel within the firm that the personally disqualified lawyer is prohibited from participating in the representation of the current client;

(ii) implement effective screening procedures to prevent the flow of information about the matter between the personally disqualified lawyer and the others in the firm;

(iii) ensure that the disqualified lawyer is apportioned no part of the fee therefrom; and

(iv) give written notice to the parties and any appropriate tribunal to enable it to ascertain compliance with the provisions of this Rule; and

*(2)* there are no other circumstances in the particular representation that create an appearance of impropriety.

**(e)** An arbitrator selected as a partisan of a party in a multimember arbitration panel is not prohibited from subsequently representing that party.

## RULE 1.13.

*Organization As Client*

**(a)** When a lawyer employed or retained by an organization is dealing with the organization's directors, officers, employees, members, shareholders or other constituents, and it appears that the organization's interests may differ from those of the constituents with whom the lawyer is dealing, the lawyer shall explain that the lawyer is the lawyer for the organization and not for any of the constituents.

**(b)** If a lawyer for an organization knows that an officer, employee or other person associated with the organization is engaged in action or intends to act or refuses to act in a matter related to the representation that (i) is a violation of a legal obligation to the organization or a violation of law that reasonably might be imputed to the organization, and (ii) is likely to result in substantial injury to the organization, then the lawyer shall proceed as is reasonably necessary in the best interest of the organization. In determining how to proceed, the lawyer shall give due consideration to the seriousness of the violation and its consequences, the scope and nature of the lawyer's representation, the responsibility in the organization and the apparent motivation of the person involved, the policies of the organization concerning such matters and any other relevant considerations. Any measures taken shall be designed to minimize disruption of the organization and

the risk of revealing information relating to the representation to persons outside the organization. Such measures may include, among others:

*(1)* asking reconsideration of the matter;

*(2)* advising that a separate legal opinion on the matter be sought for presentation to an appropriate authority in the organization; and

*(3)* referring the matter to higher authority in the organization, including, if warranted by the seriousness of the matter, referral to the highest authority that can act in behalf of the organization as determined by applicable law.

**(c)** If, despite the lawyer's efforts in accordance with paragraph (b), the highest authority that can act on behalf of the organization insists upon action, or a refusal to act, that is clearly in violation of law and is likely to result in a substantial injury to the organization, the lawyer may reveal confidential information only if permitted by Rule 1.6, and may resign in accordance with Rule 1.16.

**(d)** A lawyer representing an organization may also represent any of its directors, officers, employees, members, shareholders or other constituents, subject to the provisions of Rule 1.7. If the organization's consent to the concurrent representation is required by Rule 1.7, the consent shall be given by an appropriate official of the organization other than the individual who is to be represented, or by the shareholders.

## RULE 1.14.

*Client With Diminished Capacity*

**(a)** When a client's capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental impairment or for some other reason, the lawyer shall, as far as reasonably possible, maintain a conventional relationship with the client.

**(b)** When the lawyer reasonably believes that the client has diminished capacity, is at risk of substantial physical, financial or other harm unless action is taken and cannot adequately act in the client's own interest, the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian ad litem, conservator or guardian.

**(c)** Information relating to the representation of a client with diminished capacity is protected by Rule 1.6. When taking protective action pursuant to paragraph (b), the lawyer is impliedly authorized under Rule 1.6(a) to reveal information about the client, but only to the extent reasonably necessary to protect the client's interests.

## RULE 1.15.

*Preserving Identity of Funds and Property of Others; Fiduciary Responsibility; Commingling and Misappropriation of Client Funds or Property; Maintenance of Bank Accounts; Record Keeping; Examination of Records*

**(a)** Prohibition Against Commingling and Misappropriation of Client Funds or Property.

> A lawyer in possession of any funds or other property belonging to another person, where such possession is incident to his or her practice of law, is a fiduciary, and must not misappropriate such funds or property or commingle such funds or property with his or her own.

**(b)** Separate Accounts.

> *(1)* A lawyer who is in possession of funds belonging to another person incident to the lawyer's practice of law shall maintain such funds in a banking institution within New York State that agrees to provide dishonored check reports in accordance with the provisions of 22 N.Y.C.R.R. Part 1300. "Banking institution" means a state or national bank, trust company, savings bank, savings and loan association or credit union. Such funds shall be maintained, in the lawyer's own name, or in the name of a firm of lawyers of which the lawyer is a member, or in the name of the lawyer or firm of lawyers by whom the lawyer is employed, in a special account or accounts, separate from any business or personal accounts of the lawyer or lawyer's firm, and separate from any accounts that the lawyer may maintain as executor, guardian, trustee or receiver, or in any other fiduciary capacity; into such special account or accounts all funds held in escrow or otherwise entrusted to the lawyer or firm shall be deposited; provided, however, that such funds may be maintained in a banking institution located outside New York State if such

banking institution complies with 22 N.Y.C.R.R. Part 1300 and the lawyer has obtained the prior written approval of the person to whom such funds belong specifying the name and address of the office or branch of the banking institution where such funds are to be maintained.

*(2)* A lawyer or the lawyer's firm shall identify the special bank account or accounts required by Rule 1.15(b)(1) as an "Attorney Special Account," "Attorney Trust Account," or "Attorney Escrow Account," and shall obtain checks and deposit slips that bear such title. Such title may be accompanied by such other descriptive language as the lawyer may deem appropriate, provided that such additional language distinguishes such special account or accounts from other bank accounts that are maintained by the lawyer or the lawyer's firm.

*(3)* Funds reasonably sufficient to maintain the account or to pay account charges may be deposited therein.

*(4)* Funds belonging in part to a client or third person and in part currently or potentially to the lawyer or law firm shall be kept in such special account or accounts, but the portion belonging to the lawyer or law firm may be withdrawn when due unless the right of the lawyer or law firm to receive it is disputed by the client or third person, in which event the disputed portion shall not be withdrawn until the dispute is finally resolved.

**(c)** Notification of Receipt of Property; Safekeeping; Rendering Accounts; Payment or Delivery of Property.

A lawyer shall:

*(1)* promptly notify a client or third person of the receipt of funds, securities, or other properties in which the client or third person has an interest;

*(2)* identify and label securities and properties of a client or third person promptly upon receipt and place them

in a safe deposit box or other place of safekeeping as soon as practicable;

*(3)* maintain complete records of all funds, securities, and other properties of a client or third person coming into the possession of the lawyer and render appropriate accounts to the client or third person regarding them; and

*(4)* promptly pay or deliver to the client or third person as requested by the client or third person the funds, securities, or other properties in the possession of the lawyer that the client or third person is entitled to receive.

**(d)** Required Bookkeeping Records.

*(1)* A lawyer shall maintain for seven years after the events that they record:

(i) the records of all deposits in and withdrawals from the accounts specified in Rule 1.15(b) and of any other bank account that concerns or affects the lawyer's practice of law; these records shall specifically identify the date, source and description of each item deposited, as well as the date, payee and purpose of each withdrawal or disbursement;

(ii) a record for special accounts, showing the source of all funds deposited in such accounts, the names of all persons for whom the funds are or were held, the amount of such funds, the description and amounts, and the names of all persons to whom such funds were disbursed;

(iii) copies of all retainer and compensation agreements with clients;

(iv) copies of all statements to clients or other persons showing the disbursement of funds to them or on their behalf;

(v) copies of all bills rendered to clients;

(vi) copies of all records showing payments to lawyers, investigators or other persons, not in the lawyer's regular employ, for services rendered or performed;

(vii) copies of all retainer and closing statements filed with the Office of Court Administration; and

(viii) all checkbooks and check stubs, bank statements, prenumbered canceled checks and duplicate deposit slips.

*(2)* Lawyers shall make accurate entries of all financial transactions in their records of receipts and disbursements, in their special accounts, in their ledger books or similar records, and in any other books of account kept by them in the regular course of their practice, which entries shall be made at or near the time of the act, condition or event recorded.

*(3)* For purposes of Rule 1.15(d), a lawyer may satisfy the requirements of maintaining "copies" by maintaining any of the following items: original records, photocopies, microfilm, optical imaging, and any other medium that preserves an image of the document that cannot be altered without detection.

**(e)** Authorized Signatories.

All special account withdrawals shall be made only to a named payee and not to cash. Such withdrawals shall be made by check or, with the prior written approval of the party entitled to the proceeds, by bank transfer. Only a lawyer admitted to practice law in New York State shall be an authorized signatory of a special account.

**(f)** Missing Clients.

Whenever any sum of money is payable to a client and the lawyer is unable to locate the client, the lawyer shall apply to the court in which the action was brought if in the unified court system, or, if no action was commenced in the unified court system, to the Supreme Court in the county in which the lawyer maintains an

office for the practice of law, for an order directing payment to the lawyer of any fees and disbursements that are owed by the client and the balance, if any, to the Lawyers' Fund for Client Protection for safeguarding and disbursement to persons who are entitled thereto.

**(g)** Designation of Successor Signatories.

*(1)* Upon the death of a lawyer who was the sole signatory on an attorney trust, escrow or special account, an application may be made to the Supreme Court for an order designating a successor signatory for such trust, escrow or special account, who shall be a member of the bar in good standing and admitted to the practice of law in New York State.

*(2)* An application to designate a successor signatory shall be made to the Supreme Court in the judicial district in which the deceased lawyer maintained an office for the practice of law. The application may be made by the legal representative of the deceased lawyer's estate; a lawyer who was affiliated with the deceased lawyer in the practice of law; any person who has a beneficial interest in such trust, escrow or special account; an officer of a city or county bar association; or counsel for an attorney disciplinary committee. No lawyer may charge a legal fee for assisting with an application to designate a successor signatory pursuant to this Rule.

*(3)* The Supreme Court may designate a successor signatory and may direct the safeguarding of funds from such trust, escrow or special account, and the disbursement of such funds to persons who are entitled thereto, and may order that funds in such account be deposited with the Lawyers' Fund for Client Protection for safeguarding and disbursement to persons who are entitled thereto.

**(h)** Dissolution of a Firm.

Upon the dissolution of any firm of lawyers, the former partners or members shall make appropriate arrangements for the maintenance, by one of them or by a successor firm, of the records specified in Rule 1.15(d).

**(i)** Availability of Bookkeeping Records: Records Subject to Production in Disciplinary Investigations and Proceedings.

The financial records required by this Rule shall be located, or made available, at the principal New York State office of the lawyers subject hereto, and any such records shall be produced in response to a notice or subpoena duces tecum issued in connection with a complaint before or any investigation by the appropriate grievance or departmental disciplinary committee, or shall be produced at the direction of the appropriate Appellate Division before any person designated by it. All books and records produced pursuant to this Rule shall be kept confidential, except for the purpose of the particular proceeding, and their contents shall not be disclosed by anyone in violation of the attorney-client privilege.

**(j)** Disciplinary Action.

A lawyer who does not maintain and keep the accounts and records as specified and required by this Rule, or who does not produce any such records pursuant to this Rule, shall be deemed in violation of these Rules and shall be subject to disciplinary proceedings.

## RULE 1.16.

*Declining or Terminating Representation*

**(a)** A lawyer shall not accept employment on behalf of a person if the lawyer knows or reasonably should know that such person wishes to:

*(1)* bring a legal action, conduct a defense, or assert a position in a matter, or otherwise have steps taken for such person, merely for the purpose of harassing or maliciously injuring any person; or

*(2)* present a claim or defense in a matter that is not warranted under existing law, unless it can be supported by a good faith argument for an extension, modification, or reversal of existing law.

**(b)** Except as stated in paragraph (d), a lawyer shall withdraw from the representation of a client when:

*(1)* the lawyer knows or reasonably should know that the representation will result in a violation of these Rules or of law;

*(2)* the lawyer's physical or mental condition materially impairs the lawyer's ability to represent the client;

*(3)* the lawyer is discharged; or

*(4)* the lawyer knows or reasonably should know that the client is bringing the legal action, conducting the defense, or asserting a position in the matter, or is otherwise having steps taken, merely for the purpose of harassing or maliciously injuring any person.

**(c)** Except as stated in paragraph (d), a lawyer may withdraw from representing a client when:

*(1)* withdrawal can be accomplished without material adverse effect on the interests of the client;

*(2)* the client persists in a course of action involving the lawyer's services that the lawyer reasonably believes is criminal or fraudulent;

*(3)* the client has used the lawyer's services to perpetrate a crime or fraud;

*(4)* the client insists upon taking action with which the lawyer has a fundamental disagreement;

*(5)* the client deliberately disregards an agreement or obligation to the lawyer as to expenses or fees;

*(6)* the client insists upon presenting a claim or defense that is not warranted under existing law and cannot be supported by good faith argument for an extension, modification, or reversal of existing law;

*(7)* the client fails to cooperate in the representation or otherwise renders the representation unreasonably difficult for the lawyer to carry out employment effectively;

*(8)* the lawyer's inability to work with co-counsel indicates that the best interest of the client likely will be served by withdrawal;

*(9)* the lawyer's mental or physical condition renders it difficult for the lawyer to carry out the representation effectively;

*(10)* the client knowingly and freely assents to termination of the employment;

*(11)* withdrawal is permitted under Rule 1.13(c) or other law;

*(12)* the lawyer believes in good faith, in a matter pending before a tribunal, that the tribunal will find the existence of other good cause for withdrawal; or

*(13)* the client insists that the lawyer pursue a course of conduct which is illegal or prohibited under these Rules.

**(d)** If permission for withdrawal from employment is required by the rules of a tribunal, a lawyer shall not withdraw from employment in a matter before that tribunal without its permission. When ordered to do so by a tribunal, a lawyer shall continue representation notwithstanding good cause for terminating the representation.

**(e)** Even when withdrawal is otherwise permitted or required, upon termination of representation, a lawyer shall take steps, to the extent reasonably practicable, to avoid foreseeable prejudice to the rights of the client, including giving reasonable notice to the client, allowing time for employment of other counsel, delivering to the client all papers and property to which the client is entitled, promptly refunding any part of a fee paid in advance that has not been earned and complying with applicable laws and rules.

## RULE 1.17.

*Sale of Law Practice*

**(a)** A lawyer retiring from a private practice of law; a law firm, one or more members of which are retiring from the private practice of law with the firm; or the personal representative of a deceased, disabled or missing lawyer, may sell a law practice, including goodwill, to one or more lawyers or law firms, who may purchase the practice. The seller and the buyer may agree on reasonable restrictions on the seller's private practice of law, notwithstanding any other provision of these Rules. Retirement shall include the cessation of the private

practice of law in the geographic area, that is, the county and city and any county or city contiguous thereto, in which the practice to be sold has been conducted.

**(b)** Confidential information.

*(1)* With respect to each matter subject to the contemplated sale, the seller may provide prospective buyers with any information not protected as confidential information under Rule 1.6.

*(2)* Notwithstanding Rule 1.6, the seller may provide the prospective buyer with information as to individual clients:

(i) concerning the identity of the client, except as provided in paragraph (b)(6);

(ii) concerning the status and general nature of the matter;

(iii) available in public court files; and

(iv) concerning the financial terms of the client-lawyer relationship and the payment status of the client's account.

*(3)* Prior to making any disclosure of confidential information that may be permitted under paragraph (b)(2), the seller shall provide the prospective buyer with information regarding the matters involved in the proposed sale sufficient to enable the prospective buyer to determine whether any conflicts of interest exist. Where sufficient information cannot be disclosed without revealing client confidential information, the seller may make the disclosures necessary for the prospective buyer to determine whether any conflict of interest exists, subject to paragraph (b)(6). If the prospective buyer determines that conflicts of interest exist prior to reviewing the information, or determines during the course of review that a conflict of interest exists, the prospective buyer shall not review or continue to review the information unless the seller shall have

obtained the consent of the client in accordance with Rule 1.6(a)(1).

*(4)* Prospective buyers shall maintain the confidentiality of and shall not use any client information received in connection with the proposed sale in the same manner and to the same extent as if the prospective buyers represented the client.

*(5)* Absent the consent of the client after full disclosure, a seller shall not provide a prospective buyer with information if doing so would cause a violation of the attorney-client privilege.

*(6)* If the seller has reason to believe that the identity of the client or the fact of the representation itself constitutes confidential information in the circumstances, the seller may not provide such information to a prospective buyer without first advising the client of the identity of the prospective buyer and obtaining the client's consent to the proposed disclosure.

**(c)** Written notice of the sale shall be given jointly by the seller and the buyer to each of the seller's clients and shall include information regarding:

*(1)* the client's right to retain other counsel or to take possession of the file;

*(2)* the fact that the client's consent to the transfer of the client's file or matter to the buyer will be presumed if the client does not take any action or otherwise object within 90 days of the sending of the notice, subject to any court rule or statute requiring express approval by the client or a court;

*(3)* the fact that agreements between the seller and the seller's clients as to fees will be honored by the buyer;

*(4)* proposed fee increases, if any, permitted under paragraph (e); and

*(5)* the identity and background of the buyer or buyers, including principal office address, bar admissions,

number of years in practice in New York State, whether the buyer has ever been disciplined for professional misconduct or convicted of a crime, and whether the buyer currently intends to resell the practice.

**(d)** When the buyer's representation of a client of the seller would give rise to a waivable conflict of interest, the buyer shall not undertake such representation unless the necessary waiver or waivers have been obtained in writing.

**(e)** The fee charged a client by the buyer shall not be increased by reason of the sale, unless permitted by a retainer agreement with the client or otherwise specifically agreed to by the client.

## RULE 1.18.

*Duties to Prospective Clients*

**(a)** Except as provided in Rule l.18(e), a person who consults with a lawyer about the possibility of forming a client-lawyer relationship with respect to a matter is a prospective client.

**(b)** Even when no client-lawyer relationship ensues, a lawyer who has learned information from a prospective client shall not use or reveal that information, except as Rule 1.9 would permit with respect to information of a former client.

**(c)** A lawyer subject to paragraph (b) shall not represent a client with interests materially adverse to those of a prospective client in the same or a substantially related matter if the lawyer received information from the prospective client that could be significantly harmful to that person in the matter, except as provided in paragraph (d). If a lawyer is disqualified from representation under this paragraph, no lawyer in a firm with which that lawyer is associated may knowingly undertake or continue representation in such a matter, except as provided in paragraph (d).

**(d)** When the lawyer has received disqualifying information as defined in paragraph (c), representation is permissible if:

*(1)* both the affected client and the prospective client have given informed consent, confirmed in writing; or

*(2)* the lawyer who received the information took reasonable measures to avoid exposure to more

disqualifying information than was reasonably necessary to determine whether to represent the prospective client; and

(i) the firm acts promptly and reasonably to notify, as appropriate, lawyers and nonlawyer personnel within the firm that the personally disqualified lawyer is prohibited from participating in the representation of the current client;

(ii) the firm implements effective screening procedures to prevent the flow of information about the matter between the disqualified lawyer and the others in the firm;

(iii) the disqualified lawyer is apportioned no part of the fee therefrom; and

(iv) written notice is promptly given to the prospective client; and

*(3)* a reasonable lawyer would conclude that the law firm will be able to provide competent and diligent representation in the matter.

**(e)** A person is not a prospective client within the meaning of paragraph (a) if the person:

*(1)* communicates information unilaterally to a lawyer, without any reasonable expectation that the lawyer is willing to discuss the possibility of forming a client-lawyer relationship; or

*(2)* communicates with a lawyer for the purpose of disqualifying the lawyer from handling a materially adverse representation on the same or a substantially related matter.

## RULE 2.1.

*Advisor*

In representing a client, a lawyer shall exercise independent professional judgment and render candid advice. In rendering advice, a lawyer may refer not only to law but to other considerations such as moral, economic, social, psychological, and political factors that may be relevant to the client's situation.

## RULE 2.2.

***[Reserved]***

## RULE 2.3.

*Evaluation for Use by Third Persons*

**(a)** A lawyer may provide an evaluation of a matter affecting a client for the use of someone other than the client if the lawyer reasonably believes that making the evaluation is compatible with other aspects of the lawyer's relationship with the client.

**(b)** When the lawyer knows or reasonably should know that the evaluation is likely to affect the client's interests materially and adversely, the lawyer shall not provide the evaluation unless the client gives informed consent.

**(c)** Unless disclosure is authorized in connection with a report of an evaluation, information relating to the evaluation is protected by Rule 1.6.

## RULE 2.4.

*Lawyer Serving as Third-Party Neutral*

**(a)** A lawyer serves as a "third-party neutral" when the lawyer assists two or more persons who are not clients of the lawyer to reach a resolution of a dispute or other matter that has arisen between them. Service as a third-party neutral may include service as an arbitrator, a mediator or in such other capacity as will enable the lawyer to assist the parties to resolve the matter.

**(b)** A lawyer serving as a third-party neutral shall inform unrepresented parties that the lawyer is not representing them. When the lawyer knows or

reasonably should know that a party does not understand the lawyer's role in the matter, the lawyer shall explain the difference between the lawyer's role as a third-party neutral and a lawyer's role as one who represents a client.

## RULE 3.1.

*Non-Meritorious Claims and Contentions*

**(a)** A lawyer shall not bring or defend a proceeding, or assert or controvert an issue therein, unless there is a basis in law and fact for doing so that is not frivolous. A lawyer for the defendant in a criminal proceeding or for the respondent in a proceeding that could result in incarceration may nevertheless so defend the proceeding as to require that every element of the case be established.

**(b)** A lawyer's conduct is "frivolous" for purposes of this Rule if:

*(1)* the lawyer knowingly advances a claim or defense that is unwarranted under existing law, except that the lawyer may advance such claim or defense if it can be supported by good faith argument for an extension, modification, or reversal of existing law;

*(2)* the conduct has no reasonable purpose other than to delay or prolong the resolution of litigation, in violation of Rule 3.2, or serves merely to harass or maliciously injure another; or

*(3)* the lawyer knowingly asserts material factual statements that are false.

## RULE 3.2.

*Delay of Litigation*

In representing a client, a lawyer shall not use means that have no substantial purpose other than to delay or prolong the proceeding or to cause needless expense.

## RULE 3.3.

*Conduct Before a Tribunal*

**(a)** A lawyer shall not knowingly:

*(1)* make a false statement of fact or law to a tribunal or fail to correct a false statement of material fact or law previously made to the tribunal by the lawyer;

*(2)* fail to disclose to the tribunal controlling legal authority known to the lawyer to be directly adverse to the position of the client and not disclosed by opposing counsel; or

*(3)* offer or use evidence that the lawyer knows to be false. If a lawyer, the lawyer's client, or a witness called by the lawyer has offered material evidence and the lawyer comes to know of its falsity, the lawyer shall take reasonable remedial measures, including, if necessary, disclosure to the tribunal. A lawyer may refuse to offer evidence, other than the testimony of a defendant in a criminal matter, that the lawyer reasonably believes is false.

**(b)** A lawyer who represents a client before a tribunal and who knows that a person intends to engage, is engaging or has engaged in criminal or fraudulent conduct related to the proceeding shall take reasonable remedial measures, including, if necessary, disclosure to the tribunal.

**(c)** The duties stated in paragraphs (a) and (b) apply even if compliance requires disclosure of information otherwise protected by Rule 1.6.

**(d)** In an ex parte proceeding, a lawyer shall inform the tribunal of all material facts known to the lawyer that will enable the tribunal to make an informed decision, whether or not the facts are adverse.

**(e)** In presenting a matter to a tribunal, a lawyer shall disclose, unless privileged or irrelevant, the identities of the clients the lawyer represents and of the persons who employed the lawyer.

**(f)** In appearing as a lawyer before a tribunal, a lawyer shall not:

*(1)* fail to comply with known local customs of courtesy or practice of the bar or a particular tribunal without giving to opposing counsel timely notice of the intent not to comply;

*(2)* engage in undignified or discourteous conduct;

*(3)* intentionally or habitually violate any established rule of procedure or of evidence; or

*(4)* engage in conduct intended to disrupt the tribunal.

## RULE 3.4.

*Fairness to Opposing Party and Counsel*

A lawyer shall not:

**(a)** *(1)* suppress any evidence that the lawyer or the client has a legal obligation to reveal or produce;

*(2)* advise or cause a person to hide or leave the jurisdiction of a tribunal for the purpose of making the person unavailable as a witness therein;

*(3)* conceal or knowingly fail to disclose that which the lawyer is required by law to reveal;

*(4)* knowingly use perjured testimony or false evidence;

*(5)* participate in the creation or preservation of evidence when the lawyer knows or it is obvious that the evidence is false; or

*(6)* knowingly engage in other illegal conduct or conduct contrary to these Rules;

**(b)** offer an inducement to a witness that is prohibited by law or pay, offer to pay or acquiesce in the payment of compensation to a witness contingent upon the content of the witness's testimony or the outcome of the matter. A lawyer may advance, guarantee or acquiesce in the payment of:

*(1)* reasonable compensation to a witness for the loss of time in attending, testifying, preparing to testify or otherwise assisting counsel, and reasonable related expenses; or

*(2)* a reasonable fee for the professional services of an expert witness and reasonable related expenses;

**(c)** disregard or advise the client to disregard a standing rule of a tribunal or a ruling of a tribunal made in the course of a proceeding, but the lawyer may take appropriate steps in good faith to test the validity of such rule or ruling;

**(d)** in appearing before a tribunal on behalf of a client:

*(1)* state or allude to any matter that the lawyer does not reasonably believe is relevant or that will not be supported by admissible evidence;

*(2)* assert personal knowledge of facts in issue except when testifying as a witness;

*(3)* assert a personal opinion as to the justness of a cause, the credibility of a witness, the culpability of a civil litigant or the guilt or innocence of an accused but the lawyer may argue, upon analysis of the evidence, for any position or conclusion with respect to the matters stated herein; or

*(4)* ask any question that the lawyer has no reasonable basis to believe is relevant to the case and that is intended to degrade a witness or other person; or

**(e)** present, participate in presenting, or threaten to present criminal charges solely to obtain an advantage in a civil matter.

## RULE 3.5.

*Maintaining and Preserving the Impartiality of Tribunals and Jurors*

**(a)** A lawyer shall not:

*(1)* seek to or cause another person to influence a judge, official or employee of a tribunal by means prohibited by law or give or lend anything of value to such judge, official, or employee of a tribunal when the recipient is prohibited from accepting the gift or loan but a lawyer may make a contribution to the campaign fund of a candidate for judicial office in conformity with Part 100 of the Rules of the Chief Administrator of the Courts;

*(2)* in an adversarial proceeding communicate or cause another person to do so on the lawyer's behalf, as to the merits of the matter with a judge or official of a tribunal or an employee thereof before whom the matter is pending, except:

(i) in the course of official proceedings in the matter;

(ii) in writing, if the lawyer promptly delivers a copy of the writing to counsel for other parties and to a party who is not represented by a lawyer;

(iii) orally, upon adequate notice to counsel for the other parties and to any party who is not represented by a lawyer; or

(iv) as otherwise authorized by law, or by Part 100 of the Rules of the Chief Administrator of the Courts;

*(3)* seek to or cause another person to influence a juror or prospective juror by means prohibited by law;

*(4)* communicate or cause another to communicate with a member of the jury venire from which the jury will be selected for the trial of a case or, during the trial of a case, with any member of the jury unless authorized to do so by law or court order;

*(5)* communicate with a juror or prospective juror after discharge of the jury if:

(i) the communication is prohibited by law or court order;

(ii) the juror has made known to the lawyer a desire not to communicate;

(iii) the communication involves misrepresentation, coercion, duress or harassment; or

(iv) the communication is an attempt to influence the juror's actions in future jury service; or

*(6)* conduct a vexatious or harassing investigation of either a member of the venire or a juror or, by financial support or otherwise, cause another to do so.

**(b)** During the trial of a case a lawyer who is not connected therewith shall not communicate with or cause another to communicate with a juror concerning the case.

**(c)** All restrictions imposed by this Rule also apply to communications with or investigations of members of a family of a member of the venire or a juror.

**(d)** A lawyer shall reveal promptly to the court improper conduct by a member of the venire or a juror, or by another toward a member of the venire or a juror or a member of his or her family of which the lawyer has knowledge.

## RULE 3.6.

*Trial Publicity*

**(a)** A lawyer who is participating in or has participated in a criminal or civil matter shall not make an extrajudicial statement that the lawyer knows or reasonably should know will be disseminated by means of public communication and will have a substantial likelihood of materially prejudicing an adjudicative proceeding in the matter.

**(b)** A statement ordinarily is likely to prejudice materially an adjudicative proceeding when it refers to a civil matter triable to a jury, a criminal matter or any other proceeding that could result in incarceration, and the statement relates to:

*(1)* the character, credibility, reputation or criminal record of a party, suspect in a criminal investigation or witness, or the identity of a witness or the expected testimony of a party or witness;

*(2)* in a criminal matter that could result in incarceration, the possibility of a plea of guilty to the offense or the existence or contents of any confession, admission or statement given by a defendant or suspect, or that person's refusal or failure to make a statement;

*(3)* the performance or results of any examination or test, or the refusal or failure of a person to submit to an examination or test, or the identity or nature of physical evidence expected to be presented;

*(4)* any opinion as to the guilt or innocence of a defendant or suspect in a criminal matter that could result in incarceration;

*(5)* information the lawyer knows or reasonably should know is likely to be inadmissible as evidence in a trial and would, if disclosed, create a substantial risk of prejudicing an impartial trial; or

*(6)* the fact that a defendant has been charged with a crime, unless there is included therein a statement explaining that the charge is merely an accusation and that the defendant is presumed innocent until and unless proven guilty.

**(c)** Provided that the statement complies with paragraph (a), a lawyer may state the following without elaboration:

*(1)* the claim, offense or defense and, except when prohibited by law, the identity of the persons involved;

*(2)* information contained in a public record;

*(3)* that an investigation of a matter is in progress;

*(4)* the scheduling or result of any step in litigation;

*(5)* a request for assistance in obtaining evidence and information necessary thereto;

*(6)* a warning of danger concerning the behavior of a person involved, when there is reason to believe that there exists the likelihood of substantial harm to an individual or to the public interest; and

*(7)* in a criminal matter:

(i) the identity, age, residence, occupation and family status of the accused;

(ii) if the accused has not been apprehended, information necessary to aid in apprehension of that person;

(iii) the identity of investigating and arresting officers or agencies and the length of the investigation; and

(iv) the fact, time and place of arrest, resistance, pursuit and use of weapons, and a description of physical evidence seized, other than as contained only in a confession, admission or statement.

**(d)** Notwithstanding paragraph (a), a lawyer may make a statement that a reasonable lawyer would believe is required to protect a client from the substantial prejudicial effect of recent publicity not initiated by the lawyer or the lawyer's client. A statement made pursuant to this paragraph shall be limited to such information as is necessary to mitigate the recent adverse publicity.

**(e)** No lawyer associated in a firm or government agency with a lawyer subject to paragraph (a) shall make a statement prohibited by paragraph (a).

## RULE 3.7.

*Lawyer As Witness*

**(a)** A lawyer shall not act as advocate before a tribunal in a matter in which the lawyer is likely to be a witness on a significant issue of fact unless:

*(1)* the testimony relates solely to an uncontested issue;

*(2)* the testimony relates solely to the nature and value of legal services rendered in the matter;

*(3)* disqualification of the lawyer would work substantial hardship on the client;

*(4)* the testimony will relate solely to a matter of formality, and there is no reason to believe that substantial evidence will be offered in opposition to the testimony; or

*(5)* the testimony is authorized by the tribunal.

**(b)** A lawyer may not act as advocate before a tribunal in a matter if:

*(1)* another lawyer in the lawyer's firm is likely to be called as a witness on a significant issue other than on behalf of the client, and it is apparent that the testimony may be prejudicial to the client; or

*(2)* the lawyer is precluded from doing so by Rule 1.7 or Rule 1.9.

## RULE 3.8.

*Special Responsibilities of Prosecutors and Other Government Lawyers*

**(a)** A prosecutor or other government lawyer shall not institute, cause to be instituted or maintain a criminal charge when the prosecutor or other government lawyer knows or it is obvious that the charge is not supported by probable cause.

**(b)** A prosecutor or other government lawyer in criminal litigation shall make timely disclosure to counsel for the defendant or to a defendant who has no counsel of the existence of evidence or information known to the prosecutor or other government lawyer that tends to negate the guilt of the accused, mitigate the degree of the offense, or reduce the sentence, except when relieved of this responsibility by a protective order of a tribunal.

**(c)** When a prosecutor knows of new, credible and material evidence creating a reasonable likelihood that a convicted defendant did not commit an offense of which the defendant was convicted, the prosecutor shall within a reasonable time:

(1) disclose that evidence to an appropriate court or prosecutor's office; or

(2) if the conviction was obtained by that prosecutor's office,

(A) notify the appropriate court and the defendant that the prosecutor's office possesses such evidence unless a court authorizes delay for good cause shown;

(B) disclose that evidence to the defendant unless the disclosure would interfere with an ongoing investigation or endanger the safety of a witness or other person, and a court authorizes delay for good cause shown; and

(C) undertake or make reasonable efforts to cause to be undertaken such further inquiry or investigation as may be necessary to provide a reasonable belief that the conviction should or should not be set aside.

**(d)** When a prosecutor knows of clear and convincing evidence establishing that a defendant was convicted, in a prosecution by the prosecutor's office, of an offense that the defendant did not commit, the prosecutor shall seek a remedy consistent with justice, applicable law, and the circumstances of the case.

**(e)** A prosecutor's independent judgment, made in good faith, that the new evidence is not of such nature as to trigger the obligations of sections (c) and (d), though subsequently determined to have been erroneous, does not constitute a violation of this rule.

## RULE 3.9.

*Advocate In Non-Adjudicative Matters*

A lawyer communicating in a representative capacity with a legislative body or administrative agency in connection with a pending non-adjudicative matter or proceeding shall disclose that the appearance is in a representative capacity, except when the lawyer seeks information from an agency that is available to the public.

## RULE 4.1.

*Truthfulness In Statements To Others*

In the course of representing a client, a lawyer shall not knowingly make a false statement of fact or law to a third person.

## RULE 4.2.

*Communication With Person Represented By Counsel*

**(a)** In representing a client, a lawyer shall not communicate or cause another to communicate about the subject of the representation with a party the lawyer knows to be represented by another lawyer in the matter, unless the lawyer has the prior consent of the other lawyer or is authorized to do so by law.

**(b)** Notwithstanding the prohibitions of paragraph (a), and unless otherwise prohibited by law, a lawyer may cause a client to communicate with a represented person unless the represented person is not legally competent, and may counsel the client with respect to those communications, provided the lawyer gives reasonable advance notice to the represented person's counsel that such communications will be taking place.

**(c)** A lawyer who is acting *pro se* or is represented by counsel in a matter is subject to paragraph (a), but may communicate with a represented person, unless otherwise prohibited by law and unless the represented person is not legally competent, provided the lawyer or the lawyer's counsel gives reasonable advance notice to the represented person's counsel that such communications will be taking place.

## RULE 4.3.

*Communicating With Unrepresented Persons*

In communicating on behalf of a client with a person who is not represented by counsel, a lawyer shall not state or imply that the lawyer is disinterested. When the lawyer knows or reasonably should know that the unrepresented person misunderstands the lawyer's role in the matter, the lawyer shall make reasonable efforts to correct the misunderstanding. The lawyer shall not give legal advice to an unrepresented person other than the advice to secure counsel if the lawyer knows or reasonably should know that the interests of such person are or have a reasonable possibility of being in conflict with the interests of the client.

## RULE 4.4.

*Respect for Rights of Third Persons*

**(a)** In representing a client, a lawyer shall not use means that have no substantial purpose other than to embarrass or harm a third person or use methods of obtaining evidence that violate the legal rights of such a person.

**(b)** A lawyer who receives a document, electronically stored information, or other writing relating to the representation of the lawyer's client and knows or reasonably should know that it was inadvertently sent shall promptly notify the sender.

## RULE 4.5.

*Communication After Incidents Involving Personal Injury or Wrongful Death*

**(a)** In the event of a specific incident involving potential claims for personal injury or wrongful death, no unsolicited communication shall be made to an individual injured in the incident or to a family member or legal representative of such an individual, by a lawyer or law firm, or by any associate, agent, employee or other representative of a lawyer or law firm representing actual or potential defendants or entities that may defend and/or indemnify said defendants, before the 30th day after the date of the incident, unless a filing must be made within 30 days of the incident as a legal prerequisite to the particular claim, in which case no unsolicited communication shall be made before the 15th day after the date of the incident.

**(b)** An unsolicited communication by a lawyer or law firm, seeking to represent an injured individual or the legal representative thereof under the circumstance described in paragraph (a) shall comply with Rule 7.3(e).

## RULE 5.1.

*Responsibilities of Law Firms, Partners, Managers and Supervisory Lawyers*

**(a)** A law firm shall make reasonable efforts to ensure that all lawyers in the firm conform to these Rules.

**(b)** *(1)* A lawyer with management responsibility in a law firm shall make reasonable efforts to ensure that other lawyers in the law firm conform to these Rules.

*(2)* A lawyer with direct supervisory authority over another lawyer shall make reasonable efforts to ensure that the supervised lawyer conforms to these Rules.

**(c)** A law firm shall ensure that the work of partners and associates is adequately supervised, as appropriate. A lawyer with direct supervisory authority over another lawyer shall adequately supervise the work of the other lawyer, as appropriate. In either case, the degree of supervision required is that which is reasonable under the circumstances, taking into account factors such as the experience of the person whose work is being supervised, the amount of work involved in a particular matter, and the likelihood that ethical problems might arise in the course of working on the matter.

**(d)** A lawyer shall be responsible for a violation of these Rules by another lawyer if:

*(1)* the lawyer orders or directs the specific conduct or, with knowledge of the specific conduct, ratifies it; or

*(2)* the lawyer is a partner in a law firm or is a lawyer who individually or together with other lawyers possesses comparable managerial responsibility in a law firm in which the other lawyer practices or is a lawyer who has supervisory authority over the other lawyer; and

(i) knows of such conduct at a time when it could be prevented or its consequences avoided or mitigated but fails to take reasonable remedial action; or

(ii) in the exercise of reasonable management or supervisory authority should have known of the conduct so that reasonable remedial action could have been taken at a time when the consequences of the conduct could have been avoided or mitigated.

## RULE 5.2.

*Responsibilities of a Subordinate Lawyer*

**(a)** A lawyer is bound by these Rules notwithstanding that the lawyer acted at the direction of another person.

**(b)** A subordinate lawyer does not violate these Rules if that lawyer acts in accordance with a supervisory lawyer's reasonable resolution of an arguable question of professional duty.

## RULE 5.3.

*Lawyer's Responsibility for Conduct of Nonlawyers*

**(a)** A law firm shall ensure that the work of nonlawyers who work for the firm is adequately supervised, as appropriate. A lawyer with direct supervisory authority over a nonlawyer shall adequately supervise the work of the nonlawyer, as appropriate. In either case, the degree of supervision required is that which is reasonable under the circumstances, taking into account factors such as the experience of the person whose work is being supervised, the amount of work involved in a particular matter and the likelihood that ethical problems might arise in the course of working on the matter.

**(b)** A lawyer shall be responsible for conduct of a nonlawyer employed or retained by or associated with the lawyer that would be a violation of these Rules if engaged in by a lawyer, if:

*(1)* the lawyer orders or directs the specific conduct or, with knowledge of the specific conduct, ratifies it; or

*(2)* the lawyer is a partner in a law firm or is a lawyer who individually or together with other lawyers possesses comparable managerial responsibility in a law firm in which the nonlawyer is employed or is a

lawyer who has supervisory authority over the nonlawyer; and

(i) knows of such conduct at a time when it could be prevented or its consequences avoided or mitigated but fails to take reasonable remedial action; or

(ii) in the exercise of reasonable management or supervisory authority should have known of the conduct so that reasonable remedial action could have been taken at a time when the consequences of the conduct could have been avoided or mitigated.

## RULE 5.4.

*Professional Independence of a Lawyer*

**(a)** A lawyer or law firm shall not share legal fees with a nonlawyer, except that:

*(1)* an agreement by a lawyer with the lawyer's firm or another lawyer associated in the firm may provide for the payment of money, over a reasonable period of time after the lawyer's death, to the lawyer's estate or to one or more specified persons;

*(2)* a lawyer who undertakes to complete unfinished legal business of a deceased lawyer may pay to the estate of the deceased lawyer that portion of the total compensation that fairly represents the services rendered by the deceased lawyer; and

*(3)* a lawyer or law firm may compensate a nonlawyer employee or include a nonlawyer employee in a retirement plan based in whole or in part on a profit-sharing arrangement.

**(b)** A lawyer shall not form a partnership with a nonlawyer if any of the activities of the partnership consist of the practice of law.

**(c)** Unless authorized by law, a lawyer shall not permit a person who recommends, employs or pays the lawyer to render legal service for another to

direct or regulate the lawyer's professional judgment in rendering such legal services or to cause the lawyer to compromise the lawyer's duty to maintain the confidential information of the client under Rule 1.6.

**(d)** A lawyer shall not practice with or in the form of an entity authorized to practice law for profit, if:

*(1)* a nonlawyer owns any interest therein, except that a fiduciary representative of the estate of a lawyer may hold the stock or interest of the lawyer for a reasonable time during administration;

*(2)* a nonlawyer is a member, corporate director or officer thereof or occupies a position of similar responsibility in any form of association other than a corporation; or

*(3)* a nonlawyer has the right to direct or control the professional judgment of a lawyer.

## RULE 5.5.

*Unauthorized Practice of Law*

**(a)** A lawyer shall not practice law in a jurisdiction in violation of the regulation of the legal profession in that jurisdiction.

**(b)** A lawyer shall not aid a nonlawyer in the unauthorized practice of law.

## RULE 5.6.

*Restrictions On Right To Practice*

**(a)** A lawyer shall not participate in offering or making:

*(1)* a partnership, shareholder, operating, employment, or other similar type of agreement that restricts the right of a lawyer to practice after termination of the relationship, except an agreement concerning benefits upon retirement; or

*(2)* an agreement in which a restriction on a lawyer's right to practice is part of the settlement of a client controversy.

**(b)** This Rule does not prohibit restrictions that may be included in the terms of the sale of a law practice pursuant to Rule 1.17.

## RULE 5.7.

*Responsibilities Regarding Nonlegal Services*

**(a)** With respect to lawyers or law firms providing nonlegal services to clients or other persons:

*(1)* A lawyer or law firm that provides nonlegal services to a person that are not distinct from legal services being provided to that person by the lawyer or law firm is subject to these Rules with respect to the provision of both legal and nonlegal services.

*(2)* A lawyer or law firm that provides nonlegal services to a person that are distinct from legal services being provided to that person by the lawyer or law firm is subject to these Rules with respect to the nonlegal services if the person receiving the services could reasonably believe that the nonlegal services are the subject of a client-lawyer relationship.

*(3)* A lawyer or law firm that is an owner, controlling party or agent of, or that is otherwise affiliated with, an entity that the lawyer or law firm knows to be providing nonlegal services to a person is subject to these Rules with respect to the nonlegal services if the person receiving the services could reasonably believe that the nonlegal services are the subject of a client-lawyer relationship.

*(4)* For purposes of paragraphs (a)(2) and (a)(3), it will be presumed that the person receiving nonlegal services believes the services to be the subject of a client-lawyer relationship unless the lawyer or law firm has advised the person receiving the services in writing that the services are not legal services and that the protection of a client-lawyer relationship does not exist with respect to the nonlegal services, or if the interest of the lawyer or law firm in the entity providing nonlegal services is de minimis.

**(b)** Notwithstanding the provisions of paragraph (a), a lawyer or law firm that is an owner, controlling party, agent, or is otherwise affiliated with an entity that the lawyer or law firm knows is providing nonlegal services to a person shall not permit any nonlawyer providing such services or affiliated with that entity to direct or regulate the professional judgment of the lawyer or law firm in rendering legal services to any person, or to cause the lawyer or law firm to compromise its duty under Rule 1.6(a) and (c) with respect to the confidential information of a client receiving legal services.

**(c)** For purposes of this Rule, "nonlegal services" shall mean those services that lawyers may lawfully provide and that are not prohibited as an unauthorized practice of law when provided by a nonlawyer.

## RULE 5.8.

*Contractual Relationship Between Lawyers and Nonlegal Professionals*

**(a)** The practice of law has an essential tradition of complete independence and uncompromised loyalty to those it serves. Recognizing this tradition, clients of lawyers practicing in New York State are guaranteed "independent professional judgment and undivided loyalty uncompromised by conflicts of interest." Indeed, these guarantees represent the very foundation of the profession and allow and foster its continued role as a protector of the system of law. Therefore, a lawyer must remain completely responsible for his or her own independent professional judgment, maintain the confidences and secrets of clients, preserve funds of clients and third parties in his or her control, and otherwise comply with the legal and ethical principles governing lawyers in New York State.

Multi-disciplinary practice between lawyers and nonlawyers is incompatible with the core values of the legal profession and therefore, a strict division between services provided by lawyers and those provided by nonlawyers is essential to protect those values. However, a lawyer or law firm may enter into and maintain a contractual relationship with a nonlegal professional or nonlegal professional service firm for the purpose of offering to the public, on a systematic and continuing basis, legal services performed by the lawyer or law firm as well as other nonlegal professional services, notwithstanding the provisions of Rule 1.7(a), provided that:

*(1)* the profession of the nonlegal professional or nonlegal professional service firm is included in a list jointly established and maintained by the Appellate Divisions pursuant to Section 1205.3 of the Joint Appellate Division Rules;

*(2)* the lawyer or law firm neither grants to the nonlegal professional or nonlegal professional service firm, nor permits such person or firm to obtain, hold or exercise, directly or indirectly, any ownership or investment interest in, or managerial or supervisory right, power or position in connection with the practice of law by the lawyer or law firm, nor, as provided in Rule 7.2(a)(1), shares legal fees with a nonlawyer or receives or gives any monetary or other tangible benefit for giving or receiving a referral; and

*(3)* the fact that the contractual relationship exists is disclosed by the lawyer or law firm to any client of the lawyer or law firm before the client is referred to the nonlegal professional service firm, or to any client of the nonlegal professional service firm before that client receives legal services from the lawyer or law firm; and the client has given informed written consent and has been provided with a copy of the "Statement of Client's Rights In Cooperative Business Arrangements" pursuant to section 1205.4 of the Joint Appellate Divisions Rules.

**(b)** For purposes of paragraph (a):

*(1)* each profession on the list maintained pursuant to a Joint Rule of the Appellate Divisions shall have been designated sua sponte, or approved by the Appellate Divisions upon application of a member of a nonlegal profession or nonlegal professional service firm, upon a determination that the profession is composed of individuals who, with respect to their profession:

(i) have been awarded a bachelor's degree or its equivalent from an accredited college or university, or have attained an equivalent combination of educational credit from such a college or university and work experience;

(ii) are licensed to practice the profession by an agency of the State of New York or the United States Government; and

(iii) are required under penalty of suspension or revocation of license to adhere to a code of ethical conduct that is reasonably comparable to that of the legal profession;

*(2)* the term "ownership or investment interest" shall mean any such interest in any form of debt or equity, and shall include any interest commonly considered to be an interest accruing to or enjoyed by an owner or investor.

**(c)** This Rule shall not apply to relationships consisting solely of non-exclusive reciprocal referral agreements or understandings between a lawyer or law firm and a nonlegal professional or nonlegal professional service firm.

# RULE 6.1.

*Voluntary Pro Bono Service*

Lawyers are strongly encouraged to provide pro bono legal services to benefit poor persons.

**(a)** Every lawyer should aspire to:

*(1)* provide at least 50 hours of pro bono legal services each year to poor persons; and

*(2)* contribute financially to organizations that provide legal services to poor persons. Lawyers in private practice or employed by a for-profit entity should aspire to contribute annually in an amount at least equivalent to (i) the amount typically billed by the lawyer (or the firm with which the lawyer is associated) for one hour of time; or (ii) if the lawyer's work is performed on a contingency basis, the amount typically billed by lawyers in the community for one hour of time; or (iii) the amount typically paid by the organization employing the lawyer for one hour of the lawyer's time; or (iv) if the lawyer is underemployed, an amount not to exceed one-tenth of one percent of the lawyer's income.

**(b)** Pro bono legal services that meet this goal are:

*(1)* professional services rendered in civil matters, and in those criminal matters for which the government is not obliged to provide funds for legal representation, to persons who are financially unable to compensate counsel;

*(2)* activities related to improving the administration of justice by simplifying the legal process for, or increasing the availability and quality of legal services to, poor persons; and

*(3)* professional services to charitable, religious, civic and educational organizations in matters designed predominantly to address the needs of poor persons.

**(c)** Appropriate organizations for financial contributions are:

*(1)* organizations primarily engaged in the provision of legal services to the poor; and

*(2)* organizations substantially engaged in the provision of legal services to the poor, provided that the donated funds are to be used for the provision of such legal services.

**(d)** This Rule is not intended to be enforced through the disciplinary process, and the failure to fulfill the aspirational goals contained herein should be without legal consequence.

## RULE 6.2.

***[Reserved]***

## RULE 6.3.

*Membership in a Legal Services Organization*

A lawyer may serve as a director, officer or member of a not-for-profit legal services organization, apart from the law firm in which the lawyer practices, notwithstanding that the organization serves persons having interests that differ from those of a client of the lawyer or the lawyer's firm. The lawyer shall not knowingly participate in a decision or action of the organization:

**(a)** if participating in the decision or action would be incompatible with the lawyer's obligations to a client under Rules 1.7 through 1.13; or

**(b)** where the decision or action could have a material adverse effect on the representation of a client of the organization whose interests differ from those of a client of the lawyer or the lawyer's firm.

## RULE 6.4.

*Law Reform Activities Affecting Client Interests*

A lawyer may serve as a director, officer or member of an organization involved in reform of the law or its administration, notwithstanding that the reform

may affect the interests of a client of the lawyer. When the lawyer knows that the interests of a client may be materially benefitted by a decision in which the lawyer actively participates, the lawyer shall disclose that fact to the organization, but need not identify the client. In determining the nature and scope of participation in such activities, a lawyer should be mindful of obligations to clients under other Rules, particularly Rule 1.7.

## RULE 6.5.

*Participation in Limited Pro Bono Legal Service Programs*

**(a)** A lawyer who, under the auspices of a program sponsored by a court, government agency, bar association or not-for-profit legal services organization, provides short-term limited legal services to a client without expectation by either the lawyer or the client that the lawyer will provide continuing representation in the matter:

*(1)* shall comply with Rules 1.7, 1.8 and 1.9, concerning restrictions on representations where there are or may be conflicts of interest as that term is defined in these Rules, only if the lawyer has actual knowledge at the time of commencement of representation that the representation of the client involves a conflict of interest; and

*(2)* shall comply with Rule 1.10 only if the lawyer has actual knowledge at the time of commencement of representation that another lawyer associated with the lawyer in a law firm is affected by Rules 1.7, 1.8 and 1.9.

**(b)** Except as provided in paragraph (a)(2), Rule 1.7 and Rule 1.9 are inapplicable to a representation governed by this Rule.

**(c)** Short-term limited legal services are services providing legal advice or representation free of charge as part of a program described in paragraph (a) with no expectation that the assistance will continue beyond what is necessary to complete an initial consultation, representation or court appearance.

**(d)** The lawyer providing short-term limited legal services must secure the client's informed consent to the limited scope of the representation, and such representation shall be subject to the provisions of Rule 1.6.

**(e)** This Rule shall not apply where the court before which the matter is pending determines that a conflict of interest exists or, if during the course of the representation, the lawyer providing the services becomes aware of the existence of a conflict of interest precluding continued representation.

# RULE 7.1.

*Advertising*

**(a)** A lawyer or law firm shall not use or disseminate or participate in the use or dissemination of any advertisement that:

*(1)* contains statements or claims that are false, deceptive or misleading; or

*(2)* violates a Rule.

**(b)** Subject to the provisions of paragraph (a), an advertisement may include information as to:

*(1)* legal and nonlegal education, degrees and other scholastic distinctions, dates of admission to any bar; areas of the law in which the lawyer or law firm practices, as authorized by these Rules; public offices and teaching positions held; publications of law related matters authored by the lawyer; memberships in bar associations or other professional societies or organizations, including offices and committee assignments therein; foreign language fluency; and bona fide professional ratings;

*(2)* names of clients regularly represented, provided that the client has given prior written consent;

*(3)* bank references; credit arrangements accepted; prepaid or group legal services programs in which the lawyer or law firm participates; nonlegal services provided by the lawyer or law firm or by an entity owned and controlled by the lawyer or law firm; the existence of contractual relationships between the lawyer or law firm and a nonlegal professional or nonlegal professional service firm, to the extent permitted by Rule 5.8, and the nature and extent of services available through those contractual relationships; and

*(4)* legal fees for initial consultation; contingent fee rates in civil matters when accompanied by a statement disclosing the information required by paragraph (p);

range of fees for legal and nonlegal services, provided that there be available to the public free of charge a written statement clearly describing the scope of each advertised service; hourly rates; and fixed fees for specified legal and nonlegal services.

**(c)** An advertisement shall not:

*(1)* include a paid endorsement of, or testimonial about, a lawyer or law firm without disclosing that the person is being compensated therefor;

*(2)* include the portrayal of a fictitious law firm, the use of a fictitious name to refer to lawyers not associated together in a law firm, or otherwise imply that lawyers are associated in a law firm if that is not the case;

*(3)* use actors to portray a judge, the lawyer, members of the law firm, or clients, or utilize depictions of fictionalized events or scenes, without disclosure of same; or

*(4)* be made to resemble legal documents.

**(d)** An advertisement that complies with subdivision (e) of this section may contain the following:

*(1)* statements that are reasonably likely to create an expectation about results the lawyer can achieve;

*(2)* statements that compare the lawyer's services with the services of other lawyers;

*(3)* testimonials or endorsements of clients, and of former clients; or

*(4)* statements describing or characterizing the quality of the lawyer's or law firm's services.

**(e)** It is permissible to provide the information set forth in subdivision(d) of this section provided:

*(1)* its dissemination does not violate subdivision(a)of this section;

*(2)* it can be factually supported by the lawyer or law firm as of the date on which the advertisement is published or disseminated;

*(3)* it is accompanied by the following disclaimer: "Prior results do not guarantee a similar outcome"; and

*(4)* in the case of a testimonial or endorsement from a client with respect to a matter still pending, the client gives informed consent confirmed in writing.

**(f)** Every advertisement other than those appearing in a radio, television or billboard advertisement, in a directory, newspaper, magazine or other periodical (and any web sites related thereto), or made in person pursuant to Rule 7.3(a)(1), shall be labeled "Attorney Advertising" on the first page, or on the home page in the case of a web site. If the communication is in the form of a self-mailing brochure or postcard, the words "Attorney Advertising" shall appear therein. In the case of electronic mail, the subject line shall contain the notation "ATTORNEY ADVERTISING."

**(g)** A lawyer or law firm shall not utilize meta tags or other hidden computer codes that, if displayed, would violate these Rules.

**(h)** All advertisements shall include the name, principal law office address and telephone number of the lawyer or law firm whose services are being offered.

**(i)** Any words or statements required by this Rule to appear in an advertisement must be clearly legible and capable of being read by the average person, if written, and intelligible if spoken aloud. In the case of a web site, the required words or statements shall appear on the home page.

**(j)** A lawyer or law firm advertising any fixed fee for specified legal services shall, at the time of fee publication, have available to the public a written statement clearly describing the scope of each advertised service, which statement shall be available to the client at the time of retainer for any such service. Such legal services shall include all those services that are recognized as reasonable and necessary under local custom in the area of practice in the community where the services are performed.

**(k)** All advertisements shall be pre-approved by the lawyer or law firm, and a copy shall be retained for a period of not less than three years following its initial

dissemination. Any advertisement contained in a computer-accessed communication shall be retained for a period of not less than one year. A copy of the contents of any web site covered by this Rule shall be preserved upon the initial publication of the web site, any major web site redesign, or a meaningful and extensive content change, but in no event less frequently than once every 90 days.

**(l)** If a lawyer or law firm advertises a range of fees or an hourly rate for services, the lawyer or law firm shall not charge more than the fee advertised for such services. If a lawyer or law firm advertises a fixed fee for specified legal services, or performs services described in a fee schedule, the lawyer or law firm shall not charge more than the fixed fee for such stated legal service as set forth in the advertisement or fee schedule, unless the client agrees in writing that the services performed or to be performed were not legal services referred to or implied in the advertisement or in the fee schedule and, further, that a different fee arrangement shall apply to the transaction.

**(m)** Unless otherwise specified in the advertisement, if a lawyer publishes any fee information authorized under this Rule in a publication that is published more frequently than once per month, the lawyer shall be bound by any representation made therein for a period of not less than 30 days after such publication. If a lawyer publishes any fee information authorized under this Rule in a publication that is published once per month or less frequently, the lawyer shall be bound by any representation made therein until the publication of the succeeding issue. If a lawyer publishes any fee information authorized under this Rule in a publication that has no fixed date for publication of a succeeding issue, the lawyer shall be bound by any representation made therein for a reasonable period of time after publication, but in no event less than 90 days.

**(n)** Unless otherwise specified, if a lawyer broadcasts any fee information authorized under this Rule, the lawyer shall be bound by any representation made therein for a period of not less than 30 days after such broadcast.

**(o)** A lawyer shall not compensate or give any thing of value to representatives of the press, radio, television or other communication medium in anticipation of or in return for professional publicity in a news item.

**(p)** All advertisements that contain information about the fees charged by the lawyer or law firm, including those indicating that in the absence of a recovery no fee will be charged, shall comply with the provisions of Judiciary Law §488(3).

**(q)** A lawyer may accept employment that results from participation in activities designed to educate the public to recognize legal problems, to make intelligent selection of counsel or to utilize available legal services.

**(r)** Without affecting the right to accept employment, a lawyer may speak publicly or write for publication on legal topics so long as the lawyer does not undertake to give individual advice.

## RULE 7.2.

*Payment for Referrals*

**(a)** A lawyer shall not compensate or give anything of value to a person or organization to recommend or obtain employment by a client, or as a reward for having made a recommendation resulting in employment by a client, except that:

*(1)* a lawyer or law firm may refer clients to a nonlegal professional or nonlegal professional service firm pursuant to a contractual relationship with such nonlegal professional or nonlegal professional service firm to provide legal and other professional services on a systematic and continuing basis as permitted by Rule 5.8, provided however that such referral shall not otherwise include any monetary or other tangible consideration or reward for such, or the sharing of legal fees; and

*(2)* a lawyer may pay the usual and reasonable fees or dues charged by a qualified legal assistance organization or referral fees to another lawyer as permitted by Rule 1.5(g).

**(b)** A lawyer or the lawyer's partner or associate or any other affiliated lawyer may be recommended, employed or paid by, or may cooperate with one of the following offices or organizations that promote the use of the lawyer's services or those of a partner or associate or any other affiliated lawyer, or request one of the following offices or organizations to recommend or promote the use of the lawyer's services or those of the lawyer's partner or associate, or any other affiliated lawyer as a private practitioner, if there is no interference with the exercise of independent professional judgment on behalf of the client:

*(1)* a legal aid office or public defender office:

(i) operated or sponsored by a duly accredited law school;

(ii) operated or sponsored by a bona fide, non-profit community organization;

(iii) operated or sponsored by a governmental agency; or

(iv) operated, sponsored, or approved by a bar association;

*(2)* a military legal assistance office;

*(3)* a lawyer referral service operated, sponsored or approved by a bar association or authorized by law or court rule; or

*(4)* any bona fide organization that recommends, furnishes or pays for legal services to its members or beneficiaries provided the following conditions are satisfied:

(i) Neither the lawyer, nor the lawyer's partner, nor associate, nor any other affiliated lawyer nor any nonlawyer, shall have initiated or promoted such organization for the primary purpose of providing financial or other benefit to such lawyer, partner, associate or affiliated lawyer;

(ii) Such organization is not operated for the purpose of procuring legal work or financial benefit for any lawyer as a private practitioner outside of the legal services program of the organization;

(iii) The member or beneficiary to whom the legal services are furnished, and not such organization, is recognized as the client of the lawyer in the matter;

(iv) The legal service plan of such organization provides appropriate relief for any member or beneficiary who asserts a claim that representation by counsel furnished, selected or approved by the organization for the particular matter involved would be unethical, improper or inadequate under

the circumstances of the matter involved; and the plan provides an appropriate procedure for seeking such relief;

(v) The lawyer does not know or have cause to know that such organization is in violation of applicable laws, rules of court or other legal requirements that govern its legal service operations; and

(vi) Such organization has filed with the appropriate disciplinary authority, to the extent required by such authority, at least annually a report with respect to its legal service plan, if any, showing its terms, its schedule of benefits, its subscription charges, agreements with counsel and financial results of its legal service activities or, if it has failed to do so, the lawyer does not know or have cause to know of such failure.

## RULE 7.3.

*Solicitation and Recommendation of Professional Employment*

**(a)** A lawyer shall not engage in solicitation:

*(1)* by in-person or telephone contact, or by real-time or interactive computer-accessed communication unless the recipient is a close friend, relative, former client or existing client; or

*(2)* by any form of communication if:

(i) the communication or contact violates Rule 4.5, Rule 7.1(a), or paragraph (e) of this Rule;

(ii) the recipient has made known to the lawyer a desire not to be solicited by the lawyer;

(iii) the solicitation involves coercion, duress or harassment;

(iv) the lawyer knows or reasonably should know that the age or the physical, emotional or mental state of the recipient makes it unlikely that the recipient will be able to exercise reasonable judgment in retaining a lawyer; or

(v) the lawyer intends or expects, but does not disclose, that the legal services necessary to handle the matter competently will be performed primarily by another lawyer who is not affiliated with the soliciting lawyer as a partner, associate or of counsel.

**(b)** For purposes of this Rule, "solicitation" means any advertisement initiated by or on behalf of a lawyer or law firm that is directed to, or targeted at, a specific recipient or group of recipients, or their family members or legal representatives, the primary purpose of which is the retention of the lawyer or law firm, and a significant motive for which is pecuniary gain. It does not include a proposal or other writing prepared and delivered in response to a specific request.

**(c)** A solicitation directed to a recipient in this State shall be subject to the following provisions:

*(1)* A copy of the solicitation shall at the time of its dissemination be filed with the attorney disciplinary committee of the judicial district or judicial department wherein the lawyer or law firm maintains its principal office. Where no such office is maintained, the filing shall be made in the judicial department where the solicitation is targeted. A filing shall consist of:

(i) a copy of the solicitation;

(ii) a transcript of the audio portion of any radio or television solicitation; and

(iii) if the solicitation is in a language other than English, an accurate English-language translation.

*(2)* Such solicitation shall contain no reference to the fact of filing.

*(3)* If a solicitation is directed to a predetermined recipient, a list containing the names and addresses of all recipients shall be retained by the lawyer or law firm for a period of not less than three years following the last date of its dissemination.

*(4)* Solicitations filed pursuant to this subdivision shall be open to public inspection.

*(5)* The provisions of this paragraph shall not apply to:

(i) a solicitation directed or disseminated to a close friend, relative, or former or existing client;

(ii) a web site maintained by the lawyer or law firm, unless the web site is designed for and directed to or targeted at persons affected by an identifiable actual event or occurrence or by an identifiable prospective defendant; or

(iii) professional cards or other announcements the distribution of which is authorized by Rule 7.5(a).

**(d)** A written solicitation shall not be sent by a method that requires the recipient to travel to a location other than that at which the recipient ordinarily receives business or personal mail or that requires a signature on the part of the recipient.

**(e)** No solicitation relating to a specific incident involving potential claims for personal injury or wrongful death shall be disseminated before the 30th day after the date of the incident, unless a filing must be made within 30 days of the incident as a legal prerequisite to the particular claim, in which case no unsolicited communication shall be made before the 15th day after the date of the incident.

**(f)** Any solicitation made in writing or by computer-accessed communication and directed to a pre-determined recipient, if prompted by a specific occurrence involving or affecting a recipient, shall disclose how the lawyer obtained the identity of the recipient and learned of the recipient's potential legal need.

**(g)** If a retainer agreement is provided with any solicitation, the top of each page shall be marked "SAMPLE" in red ink in a type size equal to the largest type size used in the agreement and the words "DO NOT SIGN" shall appear on the client signature line.

**(h)** Any solicitation covered by this section shall include the name, principal law office address and telephone number of the lawyer or law firm whose services are being offered.

**(i)** The provisions of this Rule shall apply to a lawyer or members of a law firm not admitted to practice in this State who shall solicit retention by residents of this State.

## RULE 7.4.

*Identification of Practice and Specialty*

**(a)** A lawyer or law firm may publicly identify one or more areas of law in which the lawyer or the law firm practices, or may state that the practice of the lawyer or law firm is limited to one or more areas of law, provided that the lawyer or law firm shall not state that the lawyer or law firm is a specialist or specializes in a particular field of law, except as provided in Rule 7.4(c).

**(b)** A lawyer admitted to engage in patent practice before the United States Patent and Trademark Office may use the designation "Patent Attorney" or a substantially similar designation.

**(c)** A lawyer may state that the lawyer has been recognized or certified as a specialist only as follows:

*(1)* A lawyer who is certified as a specialist in a particular area of law or law practice by a private organization approved for that purpose by the American Bar Association may state the fact of certification if, in conjunction therewith, the certifying organization is identified and the following statement is prominently made: "The [name of the private certifying organization] is not affiliated with any governmental authority."

*(2)* A lawyer who is certified as a specialist in a particular area of law or law practice by the authority having jurisdiction over specialization under the laws of another state or territory may state the fact of

certification if, in conjunction therewith, the certifying state or territory is identified and the following statement is prominently made: "Certification granted by the [identify state or territory] is not recognized by any governmental authority within the State of New York."

*(3)* A statement is prominently made if:

(i) when written, it is clearly legible and capable of being read by the average person, and is in a font size at least two font sizes larger than the largest text used to state the fact of certification; and

(ii) when spoken aloud, it is intelligible to the average person, and is at a cadence no faster, and a level of audibility no lower, than the cadence and level of audibility used to state the fact of certification.

## RULE 7.5.

*Professional Notices, Letterheads and Signs*

**(a)** A lawyer or law firm may use internet web sites, professional cards, professional announcement cards, office signs, letterheads or similar professional notices or devices, provided the same do not violate any statute or court rule and are in accordance with Rule 7.1, including the following:

*(1)* a professional card of a lawyer identifying the lawyer by name and as a lawyer, and giving addresses, telephone numbers, the name of the law firm, and any information permitted under Rule 7.1(b) or Rule 7.4. A professional card of a law firm may also give the names of members and associates;

*(2)* a professional announcement card stating new or changed associations or addresses, change of firm name, or similar matters pertaining to the professional offices of a lawyer or law firm or any nonlegal business conducted by the lawyer or law

firm pursuant to Rule 5.7. It may state biographical data, the names of members of the firm and associates, and the names and dates of predecessor firms in a continuing line of succession. It may state the nature of the legal practice if permitted under Rule 7.4;

*(3)* a sign in or near the office and in the building directory identifying the law office and any nonlegal business conducted by the lawyer or law firm pursuant to Rule 5.7. The sign may state the nature of the legal practice if permitted under Rule 7.4; or

*(4)* a letterhead identifying the lawyer by name and as a lawyer, and giving addresses, telephone numbers, the name of the law firm, associates and any information permitted under Rule 7.1(b) or Rule 7.4. A letterhead of a law firm may also give the names of members and associates, and names and dates relating to deceased and retired members. A lawyer or law firm may be designated "Of Counsel" on a letterhead if there is a continuing relationship with a lawyer or law firm, other than as a partner or associate. A lawyer or law firm may be designated as "General Counsel" or by similar professional reference on stationery of a client if the lawyer or the firm devotes a substantial amount of professional time in the representation of that client. The letterhead of a law firm may give the names and dates of predecessor firms in a continuing line of succession.

**(b)** A lawyer in private practice shall not practice under a trade name, a name that is misleading as to the identity of the lawyer or lawyers practicing under such name, or a firm name containing names other than those of one or more of the lawyers in the firm, except that the name of a professional corporation shall contain "PC" or such symbols permitted by law, the name of a limited liability company or partnership shall contain "LLC," "LLP" or such symbols permitted by law and, if otherwise lawful, a firm may use as, or continue to include in its name the name or names of one or more deceased or retired members of the firm or of a predecessor firm in a continuing line of succession. Such terms as "legal clinic," "legal aid," "legal service office," "legal assistance office," "defender office" and the like may be used only by qualified legal assistance organizations, except that the term "legal clinic" may be used by any lawyer or law firm provided the name of a participating lawyer or firm is incorporated therein. A lawyer or law firm may not include the name of a

nonlawyer in its firm name, nor may a lawyer or law firm that has a contractual relationship with a nonlegal professional or nonlegal professional service firm pursuant to Rule 5.8 to provide legal and other professional services on a systematic and continuing basis include in its firm name the name of the nonlegal professional service firm or any individual nonlegal professional affiliated therewith. A lawyer who assumes a judicial, legislative or public executive or administrative post or office shall not permit the lawyer's name to remain in the name of a law firm or to be used in professional notices of the firm during any significant period in which the lawyer is not actively and regularly practicing law as a member of the firm and, during such period, other members of the firm shall not use the lawyer's name in the firm name or in professional notices of the firm.

**(c)** Lawyers shall not hold themselves out as having a partnership with one or more other lawyers unless they are in fact partners.

**(d)** A partnership shall not be formed or continued between or among lawyers licensed in different jurisdictions unless all enumerations of the members and associates of the firm on its letterhead and in other permissible listings make clear the jurisdictional limitations on those members and associates of the firm not licensed to practice in all listed jurisdictions; however, the same firm name may be used in each jurisdiction.

**(e)** A lawyer or law firm may utilize a domain name for an internet web site that does not include the name of the lawyer or law firm provided:

*(1)* all pages of the web site clearly and conspicuously include the actual name of the lawyer or law firm;

*(2)* the lawyer or law firm in no way attempts to engage in the practice of law using the domain name;

*(3)* the domain name does not imply an ability to obtain results in a matter; and

*(4)* the domain name does not otherwise violate these Rules.

**(f)** A lawyer or law firm may utilize a telephone number which contains a domain name, nickname, moniker or motto that does not otherwise violate these Rules.

## RULE 8.1.

*Candor in the Bar Admission Process*

**(a)** A lawyer shall be subject to discipline if, in connection with the lawyer's own application for admission to the bar previously filed in this state or in any other jurisdiction, or in connection with the application of another person for admission to the bar, the lawyer knowingly:

*(1)* has made or failed to correct a false statement of material fact; or

*(2)* has failed to disclose a material fact requested in connection with a lawful demand for information from an admissions authority.

## RULE 8.2.

*Judicial Officers and Candidates*

**(a)** A lawyer shall not knowingly make a false statement of fact concerning the qualifications, conduct or integrity of a judge or other adjudicatory officer or of a candidate for election or appointment to judicial office.

**(b)** A lawyer who is a candidate for judicial office shall comply with the applicable provisions of Part 100 of the Rules of the Chief Administrator of the Courts.

## RULE 8.3.

*Reporting Professional Misconduct*

**(a)** A lawyer who knows that another lawyer has committed a violation of the Rules of Professional Conduct that raises a substantial question as to that lawyer's honesty, trustworthiness or fitness as a lawyer shall report such knowledge to a tribunal or other authority empowered to investigate or act upon such violation.

**(b)** A lawyer who possesses knowledge or evidence concerning another lawyer or a judge shall not fail to respond to a lawful demand for information from a tribunal or other authority empowered to investigate or act upon such conduct.

**(c)** This Rule does not require disclosure of:

*(1)* information otherwise protected by Rule 1.6; or

*(2)* information gained by a lawyer or judge while participating in a bona fide lawyer assistance program.

## RULE 8.4.

*Misconduct*

A lawyer or law firm shall not:

**(a)** violate or attempt to violate the Rules of Professional Conduct, knowingly assist or induce another to do so, or do so through the acts of another;

**(b)** engage in illegal conduct that adversely reflects on the lawyer's honesty, trustworthiness or fitness as a lawyer;

**(c)** engage in conduct involving dishonesty, fraud, deceit or misrepresentation;

**(d)** engage in conduct that is prejudicial to the administration of justice;

**(e)** state or imply an ability:

*(1)* to influence improperly or upon irrelevant grounds any tribunal, legislative body or public official; or

*(2)* to achieve results using means that violate these Rules or other law;

**(f)** knowingly assist a judge or judicial officer in conduct that is a violation of applicable rules of judicial conduct or other law;

**(g)** unlawfully discriminate in the practice of law, including in hiring, promoting or otherwise determining conditions of employment on the basis of age, race, creed, color, national origin, sex, disability, marital status or sexual orientation. Where there is a tribunal with jurisdiction to hear a complaint, if timely brought, other than a Departmental Disciplinary Committee, a complaint based on unlawful discrimination shall be brought before such tribunal in the first instance. A certified

copy of a determination by such a tribunal, which has become final and enforceable and as to which the right to judicial or appellate review has been exhausted, finding that the lawyer has engaged in an unlawful discriminatory practice shall constitute prima facie evidence of professional misconduct in a disciplinary proceeding; or

**(h)** engage in any other conduct that adversely reflects on the lawyer's fitness as a lawyer.

## RULE 8.5.

*Disciplinary Authority and Choice of Law*

**(a)** A lawyer admitted to practice in this state is subject to the disciplinary authority of this state, regardless of where the lawyer's conduct occurs. A lawyer may be subject to the disciplinary authority of both this state and another jurisdiction where the lawyer is admitted for the same conduct.

**(b)** In any exercise of the disciplinary authority of this state, the rules of professional conduct to be applied shall be as follows:

*(1)* For conduct in connection with a proceeding in a court before which a lawyer has been admitted to practice (either generally or for purposes of that proceeding), the rules to be applied shall be the rules of the jurisdiction in which the court sits, unless the rules of the court provide otherwise; and

*(2)* For any other conduct:

(i) If the lawyer is licensed to practice only in this state, the rules to be applied shall be the rules of this state, and

(ii) If the lawyer is licensed to practice in this state and another jurisdiction, the rules to be applied shall be the rules of the admitting jurisdiction in which the lawyer principally practices; provided, however, that if particular conduct clearly has its predominant effect in another jurisdiction in which the lawyer is licensed to practice,

the rules of that jurisdiction shall be applied to that conduct.

# Speaker Biographies

# *HON. ARTHUR M. DIAMOND*

## *BIOGRAPHICAL DATA*

Arthur M. Diamond has served as a Justice of the New York State Supreme Court since January, 2004. He was re-elected to his second fourteen year term in November of 2017.

Justice Diamond is a graduate of Rutgers University (New Brunswick 1974) and Hofstra University School of Law (JD 1978). He began his legal career in the Office of the Nassau County

District Attorney Denis Dillon where he spent eight years and served as Deputy Chief of the Trial

Bureau. In 1999 and 2000 he was appointed to the County Court by Gov. George Pataki.

His column, *Evidentially Speaking,* appears regularly in the Nassau Lawyer, the official publication of the Nassau County Bar Association. He has lectured on evidence at the Nassau County Bar Association, the New York State Bar Association, the New York County Lawyers Association, the Judicial Seminars at the New York State Judicial Institute in White Plains, New York, the Second and Third Departments Attorney for the Child panels and the Hofstra University Continuing Legal Education Institute, among others. He was a co-editor of the Evidence chapter and a peer reviewer of the Article 81 chapter of the 2013 revision of the *Bench Book for Judges.* In 2016 he was named Clinical Instructor at Stony Brook University School of Medicine where he teaches a course he created, *Law and Medicine for Medical Students*. In October of 2018 he received the Medical School's Citizenship Award for outstanding service and contribution to the school.

Judge Diamond has served on the Chief Judge's statewide Judicial Advisory Council, a committee of Justices dedicated to improving trial practices in New York courts and in 2015 was appointed to the New York State Advisory Committee on Guardianship Matters. In January of 2016 he was appointed Supervising Judge of Guardianship matters for Nassau County.

## Hon. David H Guy

Judge Guy has served as Broome County Surrogate Court Judge since January, 2011. In addition to Broome County Surrogate's Court, Judge Guy handles the Mental Hygiene Law Article 81 Guardianship matters throughout the 6th Judicial District and MHL Article 9 cases in Broome County. He serves on the New York State OCA Guardianship Advisory Committee and the OCA Second Special Commission on Fiduciary Appointments. Before becoming Surrogate, Judge Guy was with the Binghamton firm of Coughlin & Gerhart, LLP. Judge Guy received his BS from University of Rochester (1978) and JD from Albany Law School (1986). He is a member of the New York State and Broome County Bar Associations, and the NYS Surrogate's Association, currently serving as Secretary/Treasurer

HON. TANYA R. KENNEDY is a Supreme Court Justice of the State of New York, Civil Term and the former Supervising Judge of Civil Court, New York County. She is also the Immediate Past President of the National Association of Women Judges. Justice Kennedy previously served for ten years as an Adjunct Professor at Fordham University School of Law. She is Chair of the New York City Bar Committee to Encourage Judicial Service and member of the Board of Overseers of the Benjamin N. Cardozo School of Law, where she received her law degree. Justice Kennedy is also an Advisory Board Member of Penn State Law. She promotes the advancement and empowerment of women through her membership in various women's organizations. Justice Kennedy serves as a mentor through her visits to various churches, schools and other organizations as a youth motivational speaker and is the recipient of numerous professional achievement and community service awards. She is also a frequent speaker at various panels and conferences.

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# Domenique Camacho Moran

**LABOR & EMPLOYMENT**

## Partner

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## About Domenique

Domenique Camacho Moran represents employers—from startups to large corporations—in connection with all types of employment litigation, including matters arising under Title VII, the Americans with Disabilities Act, the Age Discrimination in Employment Act,

the Family and Medical Leave Act, the Fair Labor Standards Act, and the New York Human Rights Law.

As lead counsel, Domenique has represented management in jury trials and hearings in federal and state courts, arbitrations and administrative proceedings. She uses her extensive knowledge of employment law to help business owners comply with the many federal, state and local laws, rules and regulations that govern the employment relationship. She often provides companies with advice on the practical and legal implications of everyday employment decisions.

Additionally, Domenique regularly prepares and reviews employee handbooks and personnel policies, negotiates and drafts separation agreements, and provides guidance to employers faced with reorganizations and reductions in workforce. She conducts sexual harassment training for local and national employers that include investment banks, professional sports organizations, retail operations, manufacturing companies, and food service providers. She is also a contributor to Farrell Fritz's New York Construction Law blog.

A dynamic speaker, Domenique has significant experience providing training on a myriad of employment-related topics including effective management techniques, human resources fundamentals, litigation avoidance, preventing

workplace harassment and discrimination, conducting workplace investigations, and diversity awareness.

Prior to joining Farrell Fritz, she was a shareholder at Littler Mendelson, P.C.

## Experience

- Won a landmark defense verdict for an employer in a multimillion-dollar 2009 class action wage and hour trial.

## Credentials

**EDUCATION**

- State University of New York at Stony Brook
- University of Notre Dame Law School

**BAR ADMISSIONS**

- New York

**COURT ADMISSIONS**

- U.S.D.C., Southern District of New York
- U.S.D.C., Eastern District of New York
- U.S.D.C., Northern District of New York
- U.S.C.A., 2nd Circuit

## Affiliations & Appointments

- New York State Bar Association

BIOGRAPHY – FELICIA PASCULLI, ESQ. CELA

Felicia Pasculli, Esq. concentrates her practice in the areas of Elder Law & Special Needs Law, Trusts and Estates, and Veterans Law. She takes great pride in introducing the area of VA pension benefits to the Elder Law bar in 2001. She is certified as an elder law attorney ("CELA") by the American Bar Assn. accredited National Elder Law Foundation and has been designated a "NY Metro Area Super Lawyer" for seven consecutive years, as well as a *Best Lawyer in America*. She is a founder of the Long Island Alzheimer's Foundation and the Family Council at the Northport, New York VA Medical Center.

Felicia serves as a member of the Executive Committee of the Elder Law & Special Needs section of the New York State Bar Association and has served as Secretary of NYNAELA (National Academy of Elder Law Attorneys). She has lectured extensively for NAELA, the NY State Bar Assn., the NYS Women's Bar Assn., National Organization of Veterans Advocates (NOVA), as well as many other professional groups. Her topics have included the intersection of public benefits, including Medicaid with veterans' benefits, Trusts, Ethics, and Guardianships. She is accredited to train attorneys for the right to represent veterans before the VA.

Felicia has had articles published in bar association journals and newsletters, as well as public media. She is presently working on a book about aging based on her experiences as an elder law attorney.

She is very excited being part of the creation of a new firm, Futterman, Lanza, & Pasculli, LLP. As her past practice did, the new practice will focus on a holistic approach to clients' needs which includes maximum availability and accessibility, and taking into account their lifestyles, medical needs, and familial relationships.


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## LOUIS W. PIERRO, ESQ.

Louis W. Pierro is the founder and principal of Pierro, Connor & Strauss, LLC, and concentrates his law practice in the areas of Estate Planning, Estate and Trust Administration, Business Succession Planning, Elder Law and Special Needs Planning.

Mr. Pierro has been selected to the Best Lawyers in America, The Best Lawyers in New York, Super Lawyers of the Hudson Valley, Top 25 Lawyers in Upstate New York, NY Times Top Attorneys in NY, and he has maintained an AV preeminent rating from the Martindale-Hubbell since 2001. In addition, Mr. Pierro was selected by his peers as "2018 Lawyer of the Year" for Elder Law in New York's Capital Region.

Mr. Pierro has served as Chair of the Estate Planning Committee, and Committee on Taxation of the Trusts & Estates Section, and the Elder Law Section, of the NYS Bar Association, and he is currently a member of the Elder Law Section Executive Committee. He is founder and Director of ElderCounsel, a national organization of Elder Law and Special Needs law firms, which provides proprietary document drafting software and education to over 950-member firms in all 50 states. He is also the Founder of EverHome Care Advisors, a business that integrates home care coordination, legal planning and connected health technology for families and caregivers. In addition, Pierro is President & CEO of Advocates Planning Group LLC, an attorney membership organization dedicated to providing a range of support services to attorneys who prepare and maintain sophisticated trust plans for clients, with a focus on Delaware law.

Pierro is currently a member of the National Academy of Elder Law Attorneys; the American Bar Association, Probate and Trust Section; the NYS Bar Association Trusts and Estates and Elder Law Sections; and the Albany County Bar Association.

A graduate of Lehigh University and Albany Law School, Mr. Pierro was admitted to the New York State Bar in January of 1984, and is licensed to practice in all New York State Courts, the US Supreme Court and the Second Circuit Court of Appeals.

## Ira Salzman

Ira Salzman is a partner in the law firm of Goldfarb Abrandt Salzman & Kutzin LLP. Ira is the former Chair of the Elder Law Committee of the New York County Lawyers' Association. He is currently a member of the Executive Committee of the Elder Law Section of the New York State Bar Association and the co-chair of its Guardianship Committee. He is the former co-chair of its Medicaid Committee and former co-chair of its Legislation Committee.

Ira is a Fellow of the Brookdale Center on Aging. He is a member of the National Academy of Elder Law Attorneys and a former editor of its quarterly journal. He has written articles for the quarterly journal of the National Academy of Elder Law Attorneys, the Elder Law News (a publication of Little, Brown & Company), and for the Elder Law Attorney (published by the Elder Law Section of the New York State Bar Association). He is the co-author of the Guardianship Section of the New York Lawyer's Form Book (published by the New York State Bar Association). He is the author of the chapter on the responsibilities of the attorney for an alleged incapacitated person in Guardianship Practice In New York (published by the New York State Bar Association).

Ira has lectured at numerous Office of Court Administration certified training programs for Court Evaluators and Guardians in New York County and Bronx County. In 1999 he received the Leonard Lerner Award for pro bono service from the New York County Lawyers' Association. In 2012 he received an award from the Elder Law Section of the New York State Bar Association in recognition of his work drafting a New York version of the Uniform Adult Guardianship and Protective proceedings Jurisdiction Act.

## *Hon. Bernice Daun Siegal*

Bernice Daun Siegal, elected Justice of the Supreme Court in 2008 and Judge of the Civil Court of New York for Queens County in 2001, has been appointed to serve as an Associate Justice of the Appellate Term, Second Department commencing January 2018. During her term as Civil Court Judge, she was appointed Supervising Judge of the Civil Court, Queens County, one of the busiest trial courts in the State, and served in that capacity for almost two years. Justice Siegal has been appointed to the *Pattern Jury Instructions Committee of the Association of Justices of the Supreme Court of the State of New York. She also serves on the New York State Continuing Legal Education Board.* She actively participated in the deliberations and Revision of the CLE Rules which now include mandatory "Diversity, Inclusion and Elimination of Bias" CLE Training.

With dozens of published opinions, she has lectured in continuing legal education courses for the Queens County Bar and Queens Women's Bar Associations and the Jag Officers of the New York Guard, as well as training programs for judges, and authored an article, "Non Military Affidavits: Providing Civil Relief at Home" exploring legal precedent to protect litigants who are in the military. A decision of note currently on appeal to the Court of Appeals denied dismissal to defendants National Grid and Long Island Power Authority holding that providing electricity in this matter was a proprietary act, rather than a governmental action, and that the for profit private company and Long Island Power Authority are not shielded by governmental immunity. (*Baumann v. Long Island Power Authority*, 45 Misc.3d 257 affd by *Baumann v. Long Island Power Authority*, 141 A.D.3d 554 [2nd Dept 2016][holding that the provision of electricity was properly categorized as a proprietary function and therefore governmental function immunity doctrine did not apply].) In another significant decision, affirmed by the Second Department, the Court held that a nurse, despite playing an active role in an operation but who was acting under the direct supervision of an attending anesthesiologist, did not exercise independent medical judgment nor commit an independent act constituting a departure, therefore, could not be held liable for medical malpractice. (*Yakubov v. Jamil*, 121 AD3d 884 [2nd Dept 2014].)

Currently, after presiding over complex cases including medical malpractice litigation, she was asked to preside over one of two Guardianship Parts

in the 11th Judicial District. In addition to her responsibilities in the Guardianship arena, she continues to handle foreclosure matters and litigation involving the Long Island Power Authority as a consequence of Super Storm Sandy filed in the 11th judicial district. Previously, as Supervising Judge in Civil Court she implemented new programs to assist pro se litigants involved in consumer transaction litigation and to ensure the fair administration of justice.

Active in professional associations, she is a vice president of the Supreme Court Justices Association of the City of the New York. As the past president of the Network of Bar Leaders and former Chairwoman and President of the Brandeis Association, she is credited with bringing in a new generation of attorneys and judges into these vibrant associations. Justice Siegal is former board member for National Association of Women Judges Region 2, member of the Queens County Bar Association and the New York State Bar Association, past president & Board Member of the Queens County Women's Bar Association. An member of the Queens County Bar Association, she actively participates in the Academy of Law and Elder Law Committee. Throughout her judicial career, Justice Siegal planned and participated in programs at law schools and Universities to mentor and support students. Her chambers has welcomed interns from High School to Law School, and she was honored to have participated in the Sonia & Celina Sotomayor High School Judicial Internship Program and the Ronald Brown Law School Prep program of St. John's University School of Law by working with young aspirants to the legal profession. Complementing her service to the legal community, Justice Siegal serves on the Board of Directors of the Workmen's Circle, a 501(c)3 corporation, which is dedicated to promoting Jewish Culture, Yiddish Learning and Social Justice.

Justice Siegal holds a Juris Doctorate from New York Law School, where she graduated Magna Cum Laude and was a proud member of the Law Review, National Barristers and the National Lawyers Guild.

Previously, in the public sector, Justice Siegal was Counsel to a member of New York City Council. With extensive knowledge of zoning and land use, educational issues, housing matters and the legislative process, she crafted legislation and strategies to win significant legal and political battles. She also has special expertise in health care policy with a Master in Public Administration from New York University and extensive experience overseeing the use of government funds at medical centers. Justice Siegal earned her Bachelor's with honors from

Queens College, City University of New York.

Prior to becoming a lawyer, she was a community activist, working with tenants, home owners and small business owners organizing tenants and merchant associations and lobbying legislators. She has worked professionally in the health care field as an administrator at the Albert Einstein College of Medicine and as Assistant Director at Lincoln Medical Center. As an attorney, she represented tenants, poor and working class people and small business owners and provided legal services to members from a number of unions, including Local Three of the RWDSU, Local 840 of IBT, and District 15 of the International Association of Machinists.

She has been happily married to an exceptional person and a well respected labor leader, Kevin Lynch, for over three decades. They have two wonderful daughters, Rebecca Lynch, currently Deputy Director for the Working Families Party of Wisconsin and Sara Lynch, currently with the Public Defenders in Philadelphia, Pennsylvania and recently sworn into the Pennsylvania.

*Updated December, 2018*

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**EDWARD V. WILCENSKI, ESQ.**

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EDWARD V. WILCENSKI, Esq., is a co-owner and co-manager of the law firm of Wilcenski & Pleat PLLC, with offices in Clifton Park and Queensbury, New York. He practices in the areas of Elder Law, Special Needs Planning, and Trust and Estate Planning.

Ed is a Trustee of the NYSARC Pooled Trust, and serves as a Trustee of the Wildwood Programs Pooled Trust, a trust program serving individuals with developmental and learning disabilities. In 2009 and again in 2013, he received the Marie Ivancich Memorial Award from the Brain Injury Association of New York State for professional commitment to the organization's mission of advocacy for individuals living with brain injuries.

He is a member and former President of the Special Needs Alliance, www.specialneedsalliance.org, a not for profit organization of attorneys who practice in the areas of special needs trusts and public benefits. His professional affiliations include membership in the National Academy of Elder Law Attorneys, and the New York State Bar Association's Elder Law and Trusts and Estates Sections.

Ed is a contributing author to various publications of the New York State Bar Association, including Representing People with Disabilities, and Planning for Incapacity, and Guardianship Practice in New York State.

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