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Legal Services Journal

HIPAA HYSTERIA AND BEYOND

By: Catherine Callery, Trilby de Jung, Louise Tarantino Amy Schwartz

The Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) went into effect on April 14, 2003 amid a great deal of consternation among health care providers. Questions and concerns are percolating among legal services providers as well – does HIPAA apply to our organizations? Should we be concerned?

GULP provided some answers in the article, **HIPPA Hysteria Hits, Disability Law News - May 2003.** The current article expands upon that framework to provide a bit more background and address concerns of legal services agencies more generally.

What is HIPAA?

HIPAA was enacted in 1996 as part of a broad Congressional attempt at health care reform. The Act is three-pronged in its approach to reform. First, the Act aims to improve portability and continuity of health insurance for individuals and groups. Second, HIPAA takes aim at fraud and abuse by dedicating new resources to enforcement activities. Finally, and most relevant to our concerns, the third prong of HIPAA seeks to achieve "Administrative Simplification" of the health care system.

Under the guise of "Administrative Simplification," HIPAA purports to create a framework for the standardization of electronic data interchange in health care. Standardizing data and encouraging electronic transmissions were viewed as a means for saving money and improving the functioning of both private health care and public programs such as Medicare and Medicaid.

Within this framework of standardization, HIPAA seeks to protect the privacy and security of individually identifiable health information. This is the thrust of HIPAA that we are all beginning to hear so much about. The Act directed that the Department of Health and Human Services (HHS) develop a privacy rule in the event that Congress failed to pass privacy legislation by 1999, which it did. HHS then promulgated the final so called "privacy rule" with modifications, on October 15, 2002. "Covered enti-

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ties" were not required to comply until April 14, 2003. (45 C.F.R. § 160 *et. seq*.)

Who is Covered by the Privacy Rule and what is Required?

"Covered Entities" under HIPAA include all health care providers and health care plans that transmit health care information in electronic form. "Health plans" are broadly defined as individual or group health plans that provide, or pay the cost of medical care. Health plans include the Medicaid program, the State Children's Health Insurance Program (SCHIP or CHIP in NYS), Medicare Parts A and B, health maintenance organizations (HMOs), and health insurance companies. (45 C.F.R. §160.103)

HIPAA's privacy rule prohibits covered entities from using or disclosing protected health information (PHI) except as the regulations specifically permit or require. Health information is defined as any information created or received by a covered entity that relates to past, present or future health or condition; the provision of health care, and the past present or future payment for health care. (45 C.F.R. §160.103) This broad definition encompasses information about an individual's application for, or receipt of, health related benefits.

The regulations allow use or disclosure of PHI without authorization for treatment, payment and operations. The regulations also permit a variety of specific uses and disclosures including public health activities, judicial and administrative proceedings (in response to a court order or court issued subpoena), and when "required by law." For all other purposes, an authorization is required. (45 C.F.R. §164.502)

HIPAA sets a floor for privacy – state laws on confidentiality may require an even higher standard. Thus, while generally HIPAA will preempt a contrary state law, the reverse is true where the state law relates to privacy and is more stringent, i.e. more protective of an individual's privacy. (45 C.F.R. §160.203) For a summary of New York's privacy laws, visit http://www.heathprivacy.org/usr_doc/NY2002.pdf).

HIPAA's privacy rule also provides patients with new rights. For example, individuals have the right to obtain their own medical records from covered entities. (45 C.F.R. §164.524), request amendments to records (45 C.F.R. §164.526), and learn where the records have been disclosed (45 C.F.R. §164.528). Covered entities must supply individuals with medical records within thirty days of a request and notify patients of their privacy polices. *See* HHS's four-page fact sheet summarizing the major components of HIPAA's privacy rule at www.hhs.gov/news/facts/privacy.

Any patient who believes his or her health care information has been illegally exchanged may file a complaint with either the provider or HHS's Office for Civil Rights. See http://www.hhs.gov/ocr/privacyhowtofule.htm. Covered entities can be liable for both civil and criminal penalties of up to $250,000. Needless to say, health care providers and health plans are anxious to comply, which is where legal services agencies fit in.

What does HIPAA mean for Legal Services Agencies?

Legal services agencies are not covered entities or business associates of covered entities (attorneys who represent hospitals, health care providers, or health care plans presumably would be business associates of covered entities – see HHS's guide for covered entities at http://www.cms.hhs.gov/hipaa/hipaa2/support/tools/decisionsupport/default.asp). Thus, we will not be obligated to comply with HIPAA's copious notice requirements. Most of us, and likely our clients as well, have received an example of the required notices in several pages

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Money for Medicaid

Big Victories with Even Bigger Battles Ahead

By: Trilby de Jung

First the Good News. As many people have heard, the New York State Legislature showed backbone of historic proportion this year. First, they passed a budget that restored $85 million of the $1.2 billion that Governor Pataki proposed to cut from New York's health care budget. Then, in the face of 119 vetoes by the Governor, they stood by their program and overrode every veto in less than four hours.

This impressive legislative action came about after much hard work by the Medicaid advocacy community, including a statewide group new on the scene this year, the Medicaid Defense Group. The efforts of other concerned parties (labor unions, provider organizations) undoubtedly had a significant impact as well. Specific legislative action includes:

- Restoring Family Health Plus eligibility levels from 133% of Federal Poverty Level (FPL) as recommended by the Governor, to the current level of 150% of FPL;
- Maintaining Medicaid eligibility for children between 100% and 133% of FPL and preserving presumptive eligibility for children;
- Rejecting proposed co-pays for the Early Intervention Program and prescription drugs in Medicaid managed care;
- Preserving the Medicaid Managed Care Advisory Review Panel; and
- Calling for a halt to the Governor's expansion of prior approval procedures within the Medicaid Preferred Drug Program, unless authorized by statute.

The legislature also restored huge cuts to education and worked hard to identify new revenue sources. The willingness of state leaders in both parties to tax higher income New Yorkers to help pay for vital services such as Medicaid provides welcome recognition that in tough fiscal times, we all need to share the pain.

More Good News. Celebration is also in order because of news from Capitol Hill. Congress included $20 billion in state fiscal relief in its recently passed tax cut legislation, with ten billion going directly to Medicaid as a temporary increase in the federal share of state Medicaid costs. Medicaid advocates have been fighting for an increase in the federal share of Medicaid for years (some had all but given up hope!). The New York Delegation showed solid support for aid to states, with all but one of the House Republicans from New York voting for the increase. (Vito Fossella of Staten Island was the hold out).

New York will receive a lump sum payment based on a 2.95% increase in its FMAP share as measured at some yet to be specified point in time. Estimates of the amount New York will receive are as high as $1.5 million. This major victory should bolster the state legislature's resolve to avoid drastic cuts in Medicaid benefits and eligibility, at least in the near future.

The Not So Good News. On the state level, astute readers might have noticed that the state legislature's health care restorations fall short of the full level of cuts proposed by the Governor. Who took the hit? A common target -- long term care. While the legislature rejected some of the Governor's cost saving measures and assessments (code for taxes) on nursing homes, the legislature left intact the Governor's budget proposal for implementing utilization review (UR) in home care.

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Although no language is yet available on the UR proposals, rumor has it that the intent is to limit home attendant and personal care services in high-hour, high-need cases. Associated cuts are projected to be over $18.5 million in combined state and federal dollars. The legislature also made only partial restorations to public health funding, Medicaid co-pays for dual eligibles, and pharmacy reimbursement rates.

State leaders are also looking ahead to the next session and thinking about broad proposals for revamping Medicaid. Senator Bruno has recently announced the creation of a bipartisan Task Force on Medicaid Reform. The task force is charged with developing a long term vision for making the Medicaid program in New York state more efficient (i.e. less costly). An advisory panel composed of representatives of providers, local governments, employee unions and health care experts will hold public hearings and roundtables throughout the State to receive input. Noticeably lacking from the panel at least in initial descriptions, are consumer representatives.

The Really Bad News. On the federal level, the door is still very much open to Medicaid reform. The recently passed budget resolution creates a reserve fund for Medicaid "modernization," a term coined by the Bush Administration, which has proposed what amounts to a block grant for Medicaid. The Bush proposal would theoretically be optional for states, with immediate fiscal relief dangling as a significant carrot. The fiscal relief would come in the form of a loan of $12.7 billion to be paid back over 10 years.

Under the Administration's proposal, states accepting federal fiscal relief would be required to agree to a cap on future federal Medicaid dollars for optional services and optional populations. Optional populations are those falling outside the traditional federal categories of families with children, people with disabilities, and the elderly, or falling outside of income restrictions for these groups; optional services are those not mandated by federal law and include significant benefits such as prescription drugs, mental health care, rehabilitation services and many varieties of home health care services.

The capped funding would essentially put an end to Medicaid as an entitlement for optional services and populations, which together account for two-thirds of current Medicaid spending. States would be left with no protection against rising costs or unforeseen events. In exchange for the funding cap, states would be granted "flexibility" to limit or eliminate their optional programs and services.

Reaction from the states has been mixed, with Governors from both parties initially wary of the Bush proposal's funding limits (even Governor Bush in Florida expressed reservations). Interestingly, not a peep has been heard from Governor Pataki, despite the devastating impact a federal cap would have on New York State. New York, with its extensive and creative use of federal Medicaid dollars, has been rated number one among the states by Families USA in terms of the economic activity stimulated by Medicaid spending.

Initial wariness notwithstanding, a bipartisan task force from the National Governor's Association (NGA) embraced the "flexibility" components of the Bush Administration's proposal and has been hard at work on its own plan to reign in Medicaid spending. A leaked draft of the NGA proposal caused considerable alarm among Medicaid advocates, as it does contain capped funding for optional programs (with "safety valves" for recessions or unpredicted events, and a quid pro quo demand for a federal buy out of dual eligibles). The draft also proposes to give mandatory beneficiaries the choice of selecting a SCHIP-like product in lieu of Medicaid, which would have serious repercussions on beneficiaries' ability to access critical

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GULP Testifies at Child Care Hearings

By: Allison Sesso

The Office of Children and Family Services (OCFS) recently proposed its multi-year plan to receive federal assistance under the Child Care and Development Fund. The purpose of the block grant is to increase the availability, affordability and quality of child care services. The plan must demonstrate how New York intends to meet the guidelines set forth by the federal program. It also guides New York's priorities for child care. The proposal can be viewed at the following website: www.ocfs.state.ny.us/main/becs/stateplan.htm.

In keeping with federal requirements, New York recently completed its public comment period during which interested parties were invited to submit written and provide oral testimony regarding the plan's specific provisions. The Greater Upstate Law Project testified at the Albany hearing, focusing on several key areas.

The majority of our testimony discussed the multitude of problems associated with the current formula used to calculate a family's share of child care costs. For example, the method used at present, and supported by the proposal, creates wide disparities in co-payment amounts between families that are similarly situated. Currently, a great deal of discretion is given to local social services districts in calculating parental co-payments, and according to the plan, disparities between localities warrant this local control. However, as is demonstrated by our testimony, counties that have similar characteristics in key areas such as per capita income and child care costs often have vastly different family contribution requirements. For example, the annual per capita income in Livingston County for 2001 was $24,250, only $65 higher than Greene County's $24,315; yet in Livingston County families contribute the lowest allowable amount to child care while families in Greene County must make contributions at the highest allowable level. Differences between counties then, appear to have

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services such as EPSDT, long term care, family planning and other services that are not required in SCHIP. Fortunately, the draft has failed to attract sufficient support from the nation's Governors. It appears the NGA Task Force has ground to a halt, at least for now.

Meanwhile, reform proposals could also emerge from the House Commerce Committee, which has recently announced formation of its own Medicaid Task Force. The Commerce Committee Task Force is comprised entirely of Republican members with Representative Heather Wilson of New Mexico at the helm. Recommendations and a series of hearings are planned for the very near future.

So, while recent funding victories are worthy of celebration, the fight is far from over. Proposals for reform that will drastically reduce services and eligibility levels for Medicaid recipients will undoubtedly keep coming, and may well be taken very seriously in Washington. Those advocates who can spend time in the political arena need to keep the pressure on and do all that they can to defend Medicaid. We are in it for the long haul.

GULP Testifies at Child Care Hearings—continued

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absolutely no bearing on the amount a family pays, thereby removing any logical support for the current family share calculation method.

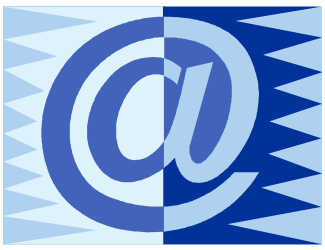
The current system is not only inequitable, but also works against the affordability goals laid out by the federal government. According to the Federal Administration of Children and Families, "a fee that is no more than 10% of a family's income would generally be considered to be an affordable co-payment (45 C.F.R. §98.43(b)(3))." Unfortunately, the current system in New York forces families in a number of counties to contribute more than 10% of their income to child care. Since many low income families leave regulated care when co-payments exceed 10% of their income, GULP called on the State to create a formula that limits a family's share to no more than 10% of their income.

The success of facilitated enrollment programs are also hindered by the application of the current parental fee formula. These pilot projects, currently in Westchester County and the Liberty Zone in New York City allow families with income up to 275% of poverty to obtain child care subsidies, which is 75% higher than the normal eligibility level. This year's state budget has appropriated funds for the expansion of these programs to four more districts. According to New York's calculation method, families with higher incomes are expected to contribute a larger percentage of their income toward care. In some instances, families at 275% of poverty must dedicate as much as 22.3% of their income toward child care; for a family of three this is an annual co-payment of $9,346.75. At these rates, these pilot programs are bound to have low take-up rates. The programs' ability to expand access to child care, its stated goal, will be severely limited without the simultaneous implementation of a 10% cap on family contributions.

A number of our comments also focused on the payment to providers. For instance, GULP suggested that local social services districts be required to pay deposits to providers who require them; pointing out that parental choice is limited when they are not paid. We also recommended that a higher market rate for care provided during non-traditional hours and by accredited providers be fixed. By paying a higher rate for care during nights and weekends, we argued, more providers would be willing to offer care during these hours. Likewise, a guaranteed higher rate will encourage providers to gain accreditation, boosting the quality of care available.

We also urged OCFS to remove the application process for families moving from, what is labeled, "transitional care" (the guaranteed year of child care benefits a person receives after leaving public assistance) to income eligible care, thereby, protecting families from a possible break in service. This application process is no more necessary than the recently removed application requirement for a family moving from public assistance to transitional care. GULP's comments also discussed the need for local social services districts to keep accurate waiting lists in order to provide OCFS with the information it needs to make informed budgetary decisions. Finally, we discussed the importance of revising the recruitment and retention strategy used from the current cash award system to a less administratively burdensome tax credit. Overall our comments appeared to be well received by OCFS.

To view the Greater Upstate Law Project's testimony in its entirety go to: http://gulpny.org/Child_Care/Testimony/childcaretestimony.pdf.



Supreme Court Restricts Anti-Attachment Statute

By: Catherine Callery and Louise Tarantino

In a decision holding that the State of Washington's use of respondents' Social Security benefits to reimburse itself for the costs of foster care does not violate 42 U.S.C. §407(a), the U. S. Supreme Court reversed the Washington State Supreme Court in *Washington State Dept. of Social and Health Servs. v. Guardianship Estate of Keffeler*. The lower court had enjoined the state's welfare department's practice of reimbursing itself for foster care assistance payments out of SSI and Title II benefits payable to the agency as representative payee for the children in foster care.

The Plaintiffs (respondents in the Supreme Court), who were children in foster care, had filed this class action alleging that the department's use of their SSI and Title II benefits violated 42 USC §407(a) and §1383(d)(1), which protect such benefits "from execution, levy, attachment, garnishment or other legal process." The Supreme Court, however, interpreted the phrase "other legal process" restrictively, concluding that neither the Department's effort to be appointed representative payee, nor its use of the respondent's Social Security benefits when it acts in that capacity, amounts to employing "execution, levy, attachment, garnishment, or other legal process" under §407. It disagreed with the Washington court's finding that that the department was in a "creditor-type" role. The funds used by the department, in the Court's view, were already under the department's possession and control; no sort of judicial or quasi-judicial authority was used to gain control over the property.

The Court also rejected plaintiffs' argument that allowing the state agency to reimburse itself is antithetical to the best interests of the children. Plaintiffs had argued that a representative payee should not use benefits to satisfy debts, but should conserve funds. The Court, however, found that the best interests of the children were served by meeting basic needs, which in the Court's view included the department paying itself back under its accounting system that typically allowed reimbursement at least two months after it expended its own funds, rather than "maximizing a trust fund attributable to fortuitously overlapping state and federal grants."

A synopsis of the unanimous decision and Justice Souter's opinion are Web-accessible at: http://supct.law.cornell.edu/supct/html/01-1420.ZS.html

What does this mean for the future of §407? Challenges to banks for freezing accounts containing exempt social security funds on behalf of judgment creditors should survive, as judicial or quasi-judicial authority is usually involved. This Court's view of "other legal process," however, may not bode well for those cases that have challenged banks' practices of "self-help" remedies to collect bank fees out of otherwise exempt funds. The Ninth Circuit has already so held in the *Lopez* case, allowing banks to collect fees out of exempt Social Security bank accounts. *Lopez* v. *Washington Mutual*, 302 F.3d 900 (9th Cir. 2002).

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worth of privacy policy explanation from our own health care plans or providers.

Notifications may alarm clients who are learning for the first time about the uses to which their medical information may legally be put. The key point here is to reassure clients that, for the most part, HIPAA has not given health care providers or insurers the right to use information in new ways, but instead has required that the consumer be informed as to what existing practices may involve. For an example of a provider notification policy, see http://www.strongh ealth.com/about/pdf/NoticeofPrivacyPracticesHIPAA.pdf.

The most significant day-to-day effect HIPAA's privacy rule will have on legal services agencies will undoubtedly be increased vigilance regarding "HIPAA compliant" releases and authorizations. Because we are not covered entities, we are not subject to requirements for authorizations prior to release of PHI, but the medicals providers and health plans we deal with will be. When we request information from a hospital or a Medicaid office, that entity will likely insist upon a release that conforms to HIPAA, even though the legal services office requesting the information is not subject to HIPAA. It is the release of information that is protected.

It is conceivable that HIPAA could have some seriously negative consequences for initial informal client service with Medicaid agencies. Because health information is defined broadly enough to include information about an application for benefits, some agencies may refuse to discuss any aspect of a client's case, even with his/her advocate, without a written, HIPAA complaint authorization on file. Clearly, such a position will be detrimental to clients for whom a trip to the advocate's office to sign an authorization may be a significant burden.

Query – Can a fair hearing office insist upon a HIPAA authorization prior to providing access to the case record pursuant to a request for a fair hearing? Do state (or federal) discovery regulations authorizing disclosure of evidentiary material to attorneys representing fair hearing applicants qualify for the "required by law" exception to HIPAA's authorization requirements? Are the discovery access regulations mandates? Is there a preemption issue?

As a practical matter, it is likely advisable to obtain an authorization from your client at intake in order to minimize the chances of a HIPAA hurdle down the road. Undoubtedly, we will be hearing more about exceptions to authorization requirements in the context of administrative hearings and other litigation.

What is a HIPAA Compliant Authorization?

The answer to this question may vary somewhat depending on the judgment of the agency or provider from whom you are requesting information. We can expect providers and agencies to insist that authorizations contain at least six basic pieces of information, referred to in the regulation as "core elements" (See 45 C.F.R §164.508)

1. The name of the person or entity (or category of persons or entities) authorized to make the disclosure,

2. The name of the person or entity (or category of persons or entities) to whom the use or disclosure may be made;

3. A specific description of the information to be used or disclosed;

4. A list of the specific purposes for the use or disclosure, or if the authorizing individual prefers, a statement such as "at the request of the individual";

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5. A statement describing the time period during which the authorization will be in effect including an expiration date or event;

6. The individual's signature and date of execution or, when applicable, the signature of Personal Representative, which must be accompanied by a description of the Personal Representative's authority to act.

A number of hospitals and other health care providers, including the Health & Hospitals Corporation facilities in NYC, have already issued new authorization forms that contain the required HIPAA elements. Samples can be obtained by requesting DAP #377 from GULP, or on either the Disability or the Health page of the GULP website (www.gulpny.org). Although some releases may require witnessed signatures, this is not mandated by the HIPAA regulations. The preamble to the Privacy Rule regulations specifically states that verification of the individual's identity or authentication of the individual's signature is not required. (*See* 65 Fed. Reg. 82518.) The preamble also makes clear that copies of original signatures, as well as certain electronic signatures, are permissible. (65 Fed. Reg. 82660.)

Some provider releases indicate that additional authorization will be required for mental health records. In all likelihood, the regulations at 45 C.F.R §164.508(a)(2) will be interpreted to require specific requests for such records. We would probably be well-advised to incorporate language specifying psychiatric records into our releases as well. In some instances, providers may require separate release for mental health records, as they are likely to do for drug treatment information and information protected by the New York State HIV Confidentiality Law. The AIDS Institute has developed a new, post-HIPAA version of their Release of Confidential HIV-related Information, which can be found at http://www.health.state.ny.us/nysdoh/hivaids/hivpartner/pdfs/authoriz.pdf.

The advantage to utilizing the specific authorization forms developed by the provider or agency you are dealing with is that you are less likely to have your request returned for additional information or more specific language. The disadvantages include the lack of consistency this may involve for staff preparing authorizations, and the fact that provider forms may not cover additional items of information referenced in the HIPAA rule.

For example, several of the sample HIPAA compliant forms fail to include a "re-disclosure" provision. Although some federal and state laws prohibit re-disclosure without specific authorization, HIPAA does not. See e.g., 42 C.F. R. §2.32, NY Mental Hygiene Law §33.13, and NY Public Health Law §2782.5(a), prohibiting re-disclosure of records pertaining to alcohol or substance abuse, mental health treatment of HIV status, respectively, without express written consent. The HIPAA regulations call for a statement regarding the possibility of re-disclosure in authorizations for release (45 C.F.R. §164.508(c)(2)).

Similarly, provider forms may fail to include a statement regarding the individual's right to revoke the authorization, which is also referenced in the HIPAA regulations as a statement that should be included in an authorization. We recommend that legal services HIPAA releases reference both the possibility of re-disclosure and the right to revocation with language such as:

I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person (s) or Organization(s) may not be protected

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by those laws. I also understand that this consent is subject to revocation, in writing, at any time, unless action based on it has already begun.

If the health care provider or facility insists on its own particular release, perhaps a separate release/authorization could be included that sets forth the re-disclosure and revocation language. Sample forms by the Legal Aid Society's Health Law Unit in NYC and Greater Boston Legal Services can be found on the Health page of GULP'S website. For additional samples (including an authorization for psychotherapy notes) see the National Health Law Project website: http://www.healthlaw.org/pubs/HIPAAforms.html.

The Social Security Administration (SSA) has developed a new HIPAA complaint authorization of its own. SSA is not a covered entity under HIPAA, but, like legal services advocates, needs to provide HIPAA complaint authorizations to health care providers. Form SSA-827 is available as DAP# 378 and on the GULP website. It can also be found on SSA's website: http://ssa.gov/online/ssa-827.pdf.

HIPAA's Future Effects?

In the end, legal services advocates will need to have authorization forms at the ready, but should not expect too many other changes as the result of HIPAA. Keep us posted on any problems or questions that do come up – and send us your sample forms for posting. Look for future articles in the LSJ and elsewhere on potential ramifications of HIPAA in other areas, such as attorney-issued subpoenas, business associates of health care providers, and more. We are also in the process of researching and reporting on the impact of the HIPAA regulations on victims of domestic violence (i.e. notice provisions and disclosure of abuse, neglect and domestic violence, batterer's access to a victim's health information, and whether certain domestic violence programs might be considered "covered entities")

In the meantime, for your HIPAA reading pleasure, check out the HHS Office for Civil Rights at www.hhs.gov/ocr/hipaa (190 frequently asked questions on the new privacy rule and other fun things). For preemption analysis by DOH and OMH, see www.health.state.ny.us/nysdoh/hipaa/hipaa_preemption charts.htm and www.omh.state.ny.us/omhweb/hipaa/preemption_html/. The Health Privacy Project has a significant amount of information on its website at www.healthprivacy.org and current journal articles on HIPAA are available online at Medscape's HIPAA Compliance Center.

If you have a question about HIPAA and would like to hear a human voice, try New York's Regional OCR Office at 212-264-3313. Rumor has it that each regional office has a privacy team, consisting of one or two staff with special expertise to address HIPAA questions and handle complaints.

Legal Services Advisory Committee Can Bring Your Concerns to the Office of Temporary & Disability Assistance

Fair Hearing Subpoena Rule to Change

By: Susan Antos

The Legal Services Advisory Committee (LSAC) is a group of Legal Services attorneys from across the State of New York who meet on a regular basis with the Office of Counsel at the Office of Temporary and Disability Assistance (OTDA). The LSAC, which meets by invitation, has the express purpose of facilitating communication between OTDA and attorneys that represent recipients of public assistance benefits. Particularly, the group focuses on "litigation avoidance", and attempts to resolve problems in advance of litigation. Additionally, the group discusses issues that can be easily resolved by the change of a regulation or policy.

A recent example of this, is a proposed regulatory addition to fair hearing regulations at 18 NYCRR 358-5.9(e) (See Regulatory Round-up, page 25). In 1995, the Third Dept. issued a decision in the matter of *Chang II Moon v. NYSDSS* (207 A.D. 2nd 103) which held that administrative subpoenas issued at fair hearings were not enforceable because Social Services Law §34(5)(b) granted subpoena power only to the commissioner and his designees, and no other statute or regulation delegated that subpoena power to a party's attorney. Similarly, §304(2) of the State Administrative Procedure Act, which references the authority of an attorney to issue subpoenas under the provisions of the Civil Practice Law and Rules, does not apply when administrative bodies derive their subpoena power from a specific statutory grant such as Social Services Law §34(5)(b). As a result of the decision in *Moon*, the Greater Upstate Law Project began to receive complaints from attorneys who were unable to enforce their administrative subpoenas We brought this concern to the Legal Services Advisory Committee, and a regulation has finally been proposed which will authorize attorneys to issue subpoenas in fair hearings before the Office of Temporary and Disability Assistance.

We encourage you to share your concerns with the Legal Services Advisory Committee so that we may discuss them with the Office of Counsel at OTDA. You may contact Susan Antos at the Greater Upstate Law Project or any other member of the LSAC. The current members of LSAC are:

Penny Selmonsky, Neighborhood Legal Services, Buffalo 716-847-0650

Alicia Plotkin, Chemung County Neighborhood Legal Services, Ithaca 607-273-3666

Bryan Hetherington, Public Interest Law Offices of Rochester 585-325-2533

Peter Racette, North Country Legal Services 516-563-4022

Douglas Ruff, Nassau/Suffolk Law Services 516-292-8100

Don Friedman, Community Food Resource Center 212-894-8081

Sr. Mary Ellen Burns, Northern Manhattan Improvement Corp. 212-822-8300

Bob Bacigalupi, Legal Services for New York City 212-431-7200

Ian Feldman, Legal Services of the Bronx 718-991-4758

Susan Antos, Greater Upstate Law Project, Inc. 518-462-6831

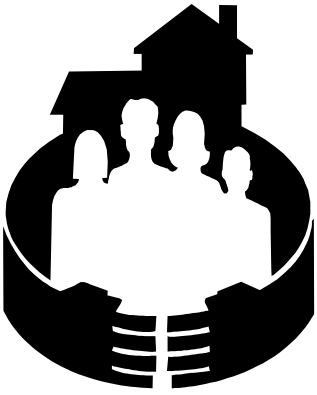
LifeBridge: Free Life Insurance for Low Income Parents

By: Peter Dellinger

Life insurance has a long been an effective tool for exploiting poor people. Charles Dickens wrote that "a Life Assurance Office is at all times exposed to be practiced upon by the most crafty and cruel of the human race". At the turn of the last century "industrial life insurance" was marketed to the working class, and sold door-to-door by agents who collected the premiums the same way on a weekly or monthly basis. Agents often convinced consumers to purchase policies they could not afford to maintain, and thus many polices subsequently lapsed.

Much like rent-to-own tactics used today, this distribution and collection system, together with the high lapse rate, made industrial life insurance very expensive. Supreme Court Justice Louis Brandeis believed that the entire industry principally served to defraud working people of their life savings.

According to the American Council of Life Insurers (1999), fewer than 18 percent of U.S. workers at or below the poverty level have life insurance. For those that do, it is not uncommon for them to buy life insurance in amounts of $1,000 to $5,000 by paying premiums of $50 per month for years on end. At these premiums, the face amount of the life insurance is paid within a few years, yet the purchaser is often not aware of that fact and continues to make payments.



Given this historical background, I was justifiably suspicious when I first learned of Massachusetts Mutual's new and free life insurance program for low income parents, "LifeBridge", but it appears to be authentic. In essence, the company is willing to issue a $50,000 life insurance policy and pay the premiums for 10 years for a low income parent or legal guardian. If the insured parent/guardian dies during this time, the $50,000 is to be used to pay the education expenses for his/her children. This life insurance coverage is free; there is no out-of-pocket cost to any covered insured or her/his children.

Applicants for LifeBridge insurance must be:

- Between the ages of 19 and 42;
- Employed full time or part time with a total annual family income of at least $10,000 but less than $40,000;
- The parent or legal guardian of one or more dependent children under age 18;
- In good health.

As with all insurance, there are additional important limitations. Individuals must be the primary financial provider in a household and eligible for the federal Earned Income Tax Credit. Persons who have been diagnosed with heart disease, cancer, or HIV are ineligible. Persons who have abused drugs or alcohol within the last 10 years or who have been convicted of DWI in the last five years are not eligible. Persons applying for LifeBridge will probably be required to undergo a physical examination.

According to the sponsors, LifeBridge will be available until 20,000 policies have been issued or through December 31, 2997, whichever comes first. Mass Mutual is distributing LifeBridge information and eligibility forms through Big Brothers/Big Sisters, the Urban League, Habitant for Humanity and other community organizations. Additional information and eligibility forms are also directly available at: www.massmutual.com/lifebridge or by calling 1-800-272 2216.

More Fugitive Felon Conundrums

By: Catherine Callery

Advocates continue to be frustrated by the ramifications of SSI's "fugitive felon" provisions, discussed at length in the November 2002 edition of the *Disability Law News.* Under 42 U.S.C. §1382(e)(4) and 20 C.F.R. §416.1339, "fugitive felons" are ineligible for SSI benefits. Legislation ("Social Security Protection Act of 2003") already approved by the House of Representatives (H.R. 743) and now pending in the Senate (S. 439) will extend the prohibition to the Title II program as well, although at least more humane "good cause" considerations have been proposed for Title II beneficiaries. The Committee Report for the bill encourages the Commissioner to review what constitutes "flight" in light of varying interpretations given by different agencies.

Even if the warrant is dismissed…

In the meantime, advocates continue to battle the draconian ramifications of the SSI provisions. As reported previously, and again in the January 2003 edition, some advocates have been successful in fighting suspensions. Alan Block of Neighborhood Legal Services in Buffalo reports that he was able to intercede on behalf of a 51 year-old Title II/Title XVI recipient whose benefits had been suspended based on 1993 warrant from Los Angeles County resulting from the client's failure to complete a drug treatment program. The underlying felony charges had apparently involved criminal possession of controlled substances. Alan was able to supply the LA Public Defender with documentation of the client's Type II diabetes, renal failure, and hypertension requiring dialysis three times per week. (Jennifer Light of South Brooklyn Legal Services reports that the PD's office in LA – at least in Van Nuys – is very receptive to these cases, as our the judges. Her contact is Joe Ronson: 818-374-2351). The PD in Alan's case successfully moved for a dismissal of the charges "in the interests of justice." Alan diligently tried to furnish all the proper paperwork to SSA in Buffalo to support his client's reconsideration. The client, however, passed away before it was resolved.

Can the benefits be reinstated…

Securing reinstatement of benefits, it turns out, may prove to be even more frustrating than dealing with the criminal justice system. As recent exchanges on the DAP Listserv demonstrate, resolving the criminal charges will not enough for reinstatement of benefits in many, if not most, cases. The experience of Peter Racette of North County Legal Services in Plattsburg is a case in point. After his client spent five months in jail in Massachusetts serving out an outstanding warrant, SSA refused to reinstate his benefits. Peter argued that POMS SI 00501.050(A)(3) provides for reinstatement the month after the month in which SSA is notified in writing that the claimant is no longer "fleeing." SSA, however, took the position that the claimant's benefits had been suspended retroactive to of the issuance of the warrant in 1999, a year prior to when he even began collecting SSI benefits. As he had technically been in "suspense" for more than one year his benefits were *terminated* under 20 C.F.R. §416.1335, and thus had no recourse but to reapply. Peter argued that the suspension should not take effect until the date that SSA learned of the warrant and/or notified the claimant. Unfortunately, 20 C.F.R. §416.1339(b) can be read to make such a suspension effective the date of warrant.

When SSA suspends retroactively…

This is certainly how SSA is interpreting this reinstatement issue, not only in Peter's case, but in other cases reported on the Listserv as well. Also, Peter has learned though his discussions

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Fugitive Felon—continued

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with Jerry McIntyre at the National Senior Citizen Law Center in Los Angeles that this is SSA's current policy. Given that most of the warrants reported to SSA have been "outstanding" for some time, this policy will lead to a large number of claimants losing their benefits rather than being reinstated. Again, because 20 C.F.R. §416.1335 provides that benefits will be terminated following twelve consecutive months of suspension, SSA will require claimants whose benefits have been "retroactively" suspended for more than one year to reapply. Query whether 20 C.F.R. §416.1335 and 20 C.F.R. §416.1339 must be read together, especially in light of §416.1339 (c), which specifically provides that payments of benefits will be resumed when the claimant is determined to no longer be fleeing prosecution? Undoubtedly this is an issue that will need to be resolved through litigation – which is no consolation to the client who is without benefits and who faces a potentially lengthy and frustrating reapplication process.

Another variation on this is an issue raised recently by David Ralph of Chemung Legal Services: what if, as in Alan's case described above, the charges are dismissed? Shouldn't that negate the existence of the warrant at all, and consequently allow for immediate reinstatement? This argument worked in David's case, but this may be yet another issue that will have to be tested in the administrative process and the courts. In the meantime, however, it is important to exhaust administrative remedies by appealing this and other related fleeing felon issues through the ALJ and Appeals Council stages.

And whose warrant was it anyway…

Another thorny issue arising in these cases includes mistaken identities. In a scenario raised on the Listserv, one man lost his SSI benefits because of an outstanding warrant in Massachusetts. Despite the fact that the Massachusetts warrant involves a woman with the same name and date of birth but a different social security number and address, SSA is nonetheless less demanding that this claimant return to Massachusetts to clear up the warrant! This should be the type of problem amenable to resolution through SSA's appeal process, right? Well, we'll see….but, again, it is crucial to appeal – within ten days if possible to ensure continuation of benefits while reconsideration is pending – and then to appeal some more if necessary.

Expect to see an increased number of these mistaken identity cases, as well as identity theft cases. The identity theft cases may prove to be especially complicated. Again, as reported by Peter Racette, a claimant may very well be unaware of criminal charges incurred by some one who has stolen his identity. Putting aside the difficulties the claimant will face in clearing up the criminal charges (which cannot be ignored), he will also have to exhaust administrative remedies within SSA as well. These are clearly cases where one can argue that the claimant could not be fleeing from charges of which she or he was unaware. Such claims, however, will probably only be resolved through litigation – unless, pursuant to the pending legislation discussed above, SA actually does promulgate more helpful regulations in this regard. At this point, however, even in the few reported cases where ALJs have ruled in the claimant's favor, the Appeals Council has apparently reversed. On this and other issues, Peter refers us to an excellent article by Jerry McIntyre that appeared in *Clearinghouse Review* in January 2003 and is available at www.nsclc.org/news/03/03/fleeingfelon_CRjanfeb2003.pdf.

And will the history of the warrant live on?

McGregor Smyth of the Bronx Defenders Office offers some additional helpful points in these cases. He advised advocates to make sure

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Fair Hearing Bank Update

By: Susan Antos

The Greater Upstate Law Project is happy to announce that Colleen Glavin, a third year student at Albany Law School, is the new Fair Hearing Bank Intern. Colleen will be summarizing and posting hearings to the Online Resource Center (ORC) fair hearing data base. Additionally, Colleen will be sending monthly updates to alert users to new hearings posted on the ORC. She will help GULP integrate fair hearing decisions into its welfare training materials and will be working to integrate GULP's fair hearing bank with "An Advocate's Guide to Work Rules", by Don Friedman of the Community Food Resource Center. By the end of the year, the manual will be online to the fair hearing bank.

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that the warrants actually get removed from your client's criminal history – otherwise he or she runs the risk or being arrested again or having SSI benefits suspended again. He suggests trying to convince an "official" in the court where the mistaken claim arose to write a letter to that effect on official letterhead. Then follow up with the court clerk where the warrant was issues to make sure the warrant listing is removed from the client's rap sheet – or if need be the state agency that handles criminal history information. In Massachusetts, information about criminal history can be found at http://www.lawlib.state.ma.us/aboutcrimrecord.html. Presumably similar websites exist for other jurisdictions. McGregor has also provided us with information about clearing warrants in New York. If not successful with the court clerk, he advises writing to the state Division of Criminal Justice, noting the case number that was dismissed, citing the warrant number that still appears on the client's record, and requesting that it be cleared. The address is: New York State Division of Criminal Justice Services, Record Review Unit, 4 Tower Place, Albany, NY 12203-3764, 518-485-7675

As if all that were not enough, don't forget another fall-out from fleeing felon suspensions: the resulting overpayments. As noted above, if SSA considers the suspension period to commence with the date the warrant is issued, claimants will face large overpayments – at the point when they have no income! Some claimants will legitimately – and maybe successfully- be able to argue that they were unaware of the warrants, and thus without fault. As Peter Racette so aptly reminds us, these overpayments are but one of three distinct problems created by the fleeing felon provisions, along with the suspension itself and, as discussed above, the problems of reinstatement. It's easy to lose sight of an overpayment when so much else is at stake, but reinstatement will be further complicated if they are left unattended.

Thanks to all those, especially Peter and McGregor, who have shared their insights and strategies on this ongoing problem. We will continue to see these and other variations of fleeing felon cases in the months to come. Please keep us posted on your successes and frustrations as we try to seek solutions. And continue to share with us those strategies that have worked, and those contacts that have been helpful. GULP will compile a clearinghouse of those resources.

Significant Changes Proposed in New Child Care Regulations

By: Susan Antos

The Office of Children and Family Services (OCFS) has proposed a comprehensive set of regulations which make significant changes to the administration of child care subsidies in New York State. In particular, the regulations impose new budgeting rules and a child support cooperation requirement. Additionally, rules are clarified about district responsibility in the case of inter-district moves, rates to be paid for care provided outside the district and payment for breaks in activity. Two new requirements are imposed on legally exempt providers and the rules regarding payment for absences have been expanded.

These proposed regulations, which were published in the New York State Register on May 28, 2003, have a 45 day comment period which ends July 14, 2003. Comments should be addressed before that date to:

Public Information Office
New York State Office of Children and Family Services
52 Washington Street
Rensselaer, NY 12144

According to the Regulatory Impact Statement, the regulations were drafted in consultation with a work group composed of staff from over 40 Social Services districts. Additionally, a draft of the proposed regulations was sent to every Social Services District Commissioner, who was then invited to a meeting which was attended by 57 participants representing 30 social services districts, as well as a representative from the New York Public Welfare Association. There was no indication that any input on these regulations was sought from child care providers, parents, or their advocates.

This article will highlight a number of the more significant changes in the regulations, and will include recommendations for change.

I. Budgeting Rules/Financial Eligibility

A. The Child Care Services Unit [415.1(l), 415.1(h)]

The "Child Care Services Unit" is a new term of art defining whose income in the household will be considered for the purpose of determining a family's eligibility for child care services. For families who are receiving public assistance, the Child Care Services Unit is the caretaker, his or her children and any other member of the public assistance unit.

For families where no adult family member is in receipt of public assistance, the Child Care Services Unit will be comprised as follows:

1. Each adult, along with his or her children, will be considered a separate child care services unit unless the adults have a child in common;

2. When the adults reside together and have at least one child in common, the child care services unit will be comprised of the adults who have children in common, the children those adults have in common, and the other children of each such adult.

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3. Where a custodial parent is under the age of 21 and residing with his or her parent, or residing with an adult who is an individual other than his or her parent, the child care services unit will be comprised of the custodial parent who is under 21 years of age, his or her children, and any other individual in the household with any legal responsibility for the custodial parent's children.

4. When eligible children reside with only individuals who are not the children's parents, stepparents, adoptive parent, or legal guardian with financial responsibility for the children, the child care services unit will be comprised of eligible children only. This means that most grandparent and other kinship relative caregivers will not have their income counted when determining child care eligibility.

5. Individuals who are temporarily absent will be counted as part of the child care services unit unless they are away from home as a result of foster care placement.

B. Treatment of 18, 19 and 20 Year Olds [415.1(l)]B.

The Social Services district has the option to include 18, 19 or 20 year old individuals in the same child care services unit as their parent(s) by indicating such option in its consolidated services plan (CSP) or integrated county plan (ICP). Districts have the options to include all 18, 19, or 20 year olds or to include only those 18, 19 and 20 year olds whose inclusion in the child care services unit would benefit the family.

The inclusion of an 18, 19 or 20 year old individual in the unit could either help or hurt any low income families. By including them in the unit, the household size increases, as does the financial eligibility level. However, if the 18, 19 or 20 year old has income, the inclusion could be detrimental to the household because that income is counted towards eligibility.

Recommendation: Allowing local districts to make this determination creates an inconsistent patchwork of eligibility rules across the state. The OCFS recognizes in its regulatory impact statement that many older teenagers live at home so that they can take advantage of educational opportunities and minimize expenses. As a practical matter these teenagers rarely, if ever, contribute to their household's income. Rather than leave it to county option, there should be one uniform statewide rule, which requires that 18, 19 or 20 year olds only be included in the child care services unit when it would benefit the family.

C. Eligible Providers Within the Child Care Services Unit [415.1 (h)]

No members of the child care services unit are eligible to provide subsidized child care unless they are the child's siblings. Additionally, members of the child's or caretaker's public assistance unit are not eligible to provide subsidized child care. This latter restriction may need reexamination.

Recommendation: In three generation households where a grandparent is on public assistance, the grandparent should be permitted to meet her work requirement by providing child care to a grandchild.

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II. Child Support Cooperation Requirement [415.3(c), (d), (e)]

These regulations would impose a new eligibility requirement upon child care recipients, requiring them to "actively pursue" child support from the non-custodial parent. The parent could either pursue support through the district's child support enforcement program or through other legal means.

This proposal was first made in 99 ADM-5 four years ago, but the effective date was delayed until OCFS had the regulatory authority to impose such a requirement. The cooperation requirement creates a host of administrative and legal problems, which are not addressed in this proposed regulation. These problems need to be firmly resolved before any child support cooperation requirement is imposed.

Low-income parents should be encouraged and given every opportunity to obtain child support to benefit their children. However, unless significant changes have been made to the proposal from when it was original conceived in 1999, this proposal is little more than a cost recovery mechanism, which primarily benefits local social services districts.

The following problems are raised by this proposal:

1. Parents pursuing child support are not entitled to assigned counsel. Family Court Act §262. Nevertheless 99 ADM-5 at page 21 requires that an applicant for or recipient of child care services who is not a client of the Support Collection Unit must demonstrate that they are pursuing child support by presenting a letter from a representing firm or organization which attests to a laundry list of information. Many petitioners in family court support proceedings proceed pro se. Most child support enforcement units do not provide legal representation without charging a fee to non-public assistance recipients. The verification requirements are difficult for some and impossible for non-represented persons, and have the potential to delay applications for child care services and thus disrupt employment.

Recommendation: Pro se petitioners should be permitted to provide a self-attestation to verify cooperation (date petition filed, return date, etc.) The regulation should clearly state that no application for child support shall be delayed pending verification of child support cooperation.

2. The Administrative Directive makes clear that a person with a child support order must cooperate in modifying the order to address child care costs. 99 ADM-5 at page 18. The Family Court Act permits an "add-on" for child care costs. Family Court Act §413 (l)(c)(4). A parent who is required to pursue an add-on for child care costs may likely incur expenses for legal representation that do not ultimately benefit her but instead benefit the social services district.

The child care add-on provided to a recipients of child care services does not go to defray the custodial parent's cost of child care but instead reduces the subsidy paid by the Social Services District. Additionally, when a non-custodial parent ceases to pay the child care add-on, it is the custodial parent who must pay the non-custodial parent's share to retain her slot (an amount that was formerly paid by subsidy), until there has been one month of non-payment and the custodial parent has gone to family court and filed a violation petition

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against the non-custodial parent. OCFS has indicated that districts do not have to resume paying the non-custodial share until a violation petition has been filed. Once that petition is filed, OFCS has not made clear who is liable for the non-custodial's share which accrues between the default and the filing of the petition.

To complicate matters, it is unclear whether Courts will hold respondents in violation of orders where the add-on goes to the county. One Family Court hearing examiner held that:

The fact that the action of an agency has significantly reduced the cost of child care should not be to the detriment of the non-custodial parent. The essence of the Child Support Standards Act is that the parents share proportional to their income, the burden of raising the child. Petitioner's eligibility for a government subsidy should not be to Respondent's detriment. The cost to the petitioner is the relevant amount. Anonymous v. Anonymous, Chenango County Family Court (3/3/00), *citing* Bronstein v. Bronstein, 203 A.D. 2d 703, 610 N.Y.S. 2d 638 (3rd Dep't 1994). (Anonymous is on file at the Greater Upstate Law Project, Inc.)

This proposal creates an accounting nightmare for providers who will have to collect from three sources: the custodial parent, the non-custodial parent and the county. When the non-custodial parent defaults, providers become the collector of first resort (instead of the child support enforcement unit) for the unpaid child care add-on.

Recommendation: A parent with a child support order should not be required to seek a child care add-on as a condition of eligibility. However, if the Office of Children and Family Services is intent on requiring parents to seek a child care add-on they should:

a) Guarantee counsel to such parents;
b) Provide that the add-on defray the parent share of the subsidy for the custodial parent;
c) Require that the child care add-on be paid to the child support collection unit and be transmitted directly from the child support collection unit to the county;
d) Make the child support enforcement unit the enforcer in the event of a default.

In response to inquires from Legal Services programs when the rule was first proposed in 1999, the OCFS answered a number of questions with respect to the interface between child support collection and child care.

First, OCFS indicated that the child support cooperation requirements would not apply for those receiving preventative or protective day care.

Recommendation: If this is still the case it should be made clear in the regulations.

Additionally, if a recipient of child care services has two children with different fathers and mom cooperates in establishing paternity for one but not the other, neither child is eligible for child care assistance. This is a harsher penalty than the one applied in the Family Assistance program, which imposes a 25% sanction in such cases. Social Services Law §131 (16).

Recommendation: If OCFS must impose a penalty, it should not be more harsh than the penalty imposed upon public assistance recipients.

In 1999 OCFS indicated that they would apply the child support cooperation requirement to grandparents unless they had good cause. This makes no sense in light of the fact that their in-

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come is not counted in determining the eligibility for children in their care. Proposed regulation 415.1(l)(1)(iv).

Recommendation: The regulations should expressly exclude the non-legally responsible caregivers from the cooperation requirement.

III. Application Issues

A. Funding Set Asides, Waiting Lists and Denial of Services [415.2(d)(2)(2),(3)]

The regulations make clear that local social services districts may set aside portions of their child care block grant allocations or their Title XX allocations to serve particular priority populations. These funding set asides must be described in the district's CSP or ICP along with a rationale for the set aside. These amounts may be adjusted up or down by 10% without the prior written approval of the OCFS provided that such adjustments are reported to OCFS within 30 days of adjustment. Prior approval is needed for adjustments in excess of 10%.

In the event that the district has set aside funds to serve one or more priority populations and all the available funds that are not set aside are projected to be needed for open child care cases, a district may choose to deny services to a family that does not fall with in the priority population for the set asides. In the alternative, the district may place the family on a waiting list for subsidies. A district that has not established set asides but otherwise has available funds committed to open child care cases may deny services to a family which is not eligible for a child care guarantee or place the family on a waiting list for subsidies.

Recommendation: The regulations should make clear that a family denied child care services for lack of funding must receive a denial notice in writing. If child care need is to be accurately assessed, the social services district should be required to report the number of these denials accrued in each calendar year, as well as data regarding the numbers of children on waiting lists, to OCFS.

B. Transitional Child Care [415.2(a)(1)(iv)(d)]B.

The regulations make clear that transitional child care eligibility may be requested in any month during the twelve month period after the family leaves the assistance. The regulations specifically state that the start date for eligibility may precede the date services were requested and cover any period during the twelve months of the guarantee.

C. Parent Fee/Family Share [415.4(f)]

The Parent Fee provisions are now called "Family Share". The regulations make clear that a family share may now include an overpayment amount for child care services. Logistically this seems somewhat confusing in as much as part of the family share would then go to the provider and part to the social services district. Failure to timely pay the family share can result in the termination or suspension of child care services.

D. A Seamless System? [415.4(b)(1)]D.

The regulations expressly state that "a social services district may not require the submission of a new application merely because an applicant is not longer eligible for public assistance or no longer eligible for child care guarantee." Since transitional child care is guaranteed, this would seem to require that the application requirement between transitional child care and income eligible child care is no longer required.

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E. Interdistrict Moves [415.4(d)]

The child care regulations now adopt a rule similar to the rule for interdistrict moves in public assistance cases. When a recipient of child care services moves from one district to another, the former social services district is obliged to continue to pay for child care services during the month that the family moves from one district to the other and the following full month. The new social services district of residence is responsible for child care thereafter. This provision does not apply in situations where the former social services district has continuing responsibility for providing public assistance such as when the parent or caretaker relative is required to attend a substance abuse program, nor does it apply in foster care situations.

Recommendation: Unfortunately, this provision only applies to families in receipt of public assistance and transitional child care. This regulation should be expanded to include families who receive income eligible child care to allow for a smooth transition to the new district of residence. The Office of Children and Family Services should request that a small amount of money be set aside in next year's state budget for people who move to new districts of residence to assure that their child care may continue despite their move. Local districts could then claim against this amount so they would not disrupt their projected spending patterns. Child care should be a statewide program; the fact that a person moves should not affect eligibility.

F. Child Care Provided Outside the District [415.9(k)]

When a social services district pays for child care services provided by a provider located in another district, the applicable market rate is the rate for the district in which the child care provider is located.

IV. Programmatic Rules

A. Child Care for Sleeping Parents [415.4(c)(3)]

The regulations make clear that up to eight hours of child care services may be provided to enable an employed caretaker who works a second or third shift to sleep. This provision is particularly helpful for parents who work the night shift and who are unable to sleep during the day because their young children are not yet in school.

Recommendation: Unfortunately this is a county option. The regulations should make this a requirement for all parents regardless of county of residence, who need such care. Parents who work the night shift with children who are too young to be in school have no time to sleep without endangering their children. This danger is real regardless of county residence and should not be a county option.

B. 24-Hour Care [415.1(a)(1) thru (3)]

The regulations as they currently exist, provide that child care services cannot be provided for more than a 24-hour period. The new regulations allow exceptions to this in certain circumstances such as when services are provided on a short term emergency basis or when the caretaker's approved activity necessitates care for 24 hours on a limited basis, so long as the social services district chooses this as an option in their consolidated services plan or integrated county plan.

C. Breaks in Activity [415.2(c)]C.

The Seamless Funding Bill (Ch. 569 of the Laws of 2001) amended Social Services Law § 410-w(5), to make it mandatory for social services districts to provide child care for families

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on public assistance who were between breaks in activity, for families in work activities, or community service. Such interim care could be for a period of up to two weeks and renewed for a period of up to one month total if child care arrangements would be lost if the services were not continued. These regulations make clear that social services districts have the option to provide such interim care for non-public assistance families.

Recommendation: The expansion of this rule is a great improvement, but OCFS should seek legislation to provide this protection for all recipients of child care subsidies.

V. Provider Issues

A. Legally Exempt Providers [415.4(f)(7)

Two new requirements are being imposed upon legally exempt providers, also known as "informal" child care providers. Such providers must answer two questions. First, whether or not they have ever been denied a license or registration to operate a day care program or group or family day care home or had such a license or registration suspended or revoked. Additionally, legally exempt providers must attest to whether or not they have ever had their parental rights terminated or had a child removed from

their care pursuant to Article 10 of the Family Court Act. If either of these questions are answered in the affirmative, the social services district may choose to enroll or refuse to enroll such a caregiver as a legally exempt child care provider.

B. Absences - [415.6(e)(4),(5)]

The regulations make several important changes with respect to payments for absences. The requirement that payments for absences be made only to contracted providers is now abolished. The districts must now adopt their absence policies in their consolidated services plan. Social services districts may choose to continue to only allow contracted providers to be paid for absences. Alternatively, they may provide them to all subsided child care services except for informal or legally exempt child care providers. Payment for absences is not allowed to providers who are paid on daily or part-time rate.

The regulations also permit licensed, registered or legally exempt group programs to claim an additional 5 days of reimbursement in the case of natural disasters, severe weather and closures due to state, federal or nationally recognized holidays.

Comment and Recommendation: GULP supports this change but would recommend that payment for absences be required whenever it is required for private pay parents**.**

VI. Miscellaneous

A. Multi-Year Consolidated Services Plan/ Integrated County Plans/ Implementation Reports - [415.4(e)(6)]

The regulations make clear that each social services district must submit a multi-year consolidated services plan or an integrated county plan and any implementation reports as required by OCFS.

Recommendation: The regulations do not state how these plans are made available to the public. The regulations should require that all current plans be made available either upon request

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to the local services district, or to the Office of Children and Family Services, within 5 business days after the request. Additionally, these plans should be available on line on the OCFS website as well as the county or local district website. Easy access to these plans are critical due to the multitude of characteristics that are particular on a county by county basis. In order for parents to clearly understand their rights, or if they are attempting to enforce them through the fair hearing process, it is important that these plans be readily available.

B. Recovery of Overpayments [415.7(i),(j)]

The regulations make clear that an overpayment may only be recovered from a caretaker relative or provider who is responsible for such overpayments, whether the result of acts of omission or commission. A parent who promptly reports a change in circumstances but is overpaid as a result of the district's failure to act promptly, shall not be required to repay said overpayment. In such case neither federal nor state reimbursement can be claimed for such an overpayment.

Applicants who have not repaid past overpayments for previous child care services must agree to and comply with a plan to make full payment of such overpayments as a condition of being eligible for new child care services. Recipients who fail to agree to such plans will have their child care benefits suspended or terminated. A recipient or former recipient of child care services who has voluntarily admitted to fraudulently receiving child care services will not be eligible for a period of time in accordance in the penalties under the intentional program violation rules in 18 NYCRR 359.9. This penalty will be suspended if the recipient is being required to participate in activity for which child care services are necessary.

Overpayments for child care services which result from aid continuing for a caretaker who loses a fair hearing, will be recovered in the same manner as other overpayments.

Comment: We support the provision that bars repayment for overpayments caused by the agency's failure to promptly budget changes.

C. Case Closings for Lack of Funds [415.2(d)(4)]

When districts run out of money, social services districts are permitted to discontinue funding to families that are not eligible for a child care guarantee. The regulations state that the length of time used to close cases may be based on either the shortest or longest time a family has received child care services, but must be consistent for all families with in the district. The county option must be specified in the local district's consolidated services plan or integrated county plan.

Recommendation: The state should develop one consistent rule for the use of this primarily federal funding stream so that all citizens of the State of New York are treated equally.

D. Waivers [415.10]

The regulations permit social services districts to request a waiver of any non-statutory provision of this part.

E. Reports [415.2(d)(5)]

Social Services districts will be required to submit reports in a "form and manner and at time specified" by OCFS "showing the geographic distribution" of children receiving child care services from the district.

Regulatory Roundup

By: Susan Antos

This article reports activity in the New York State Register from March 29, 2003 to May 28, 2003. Ten new rules have been proposed, one rule was adopted and one rule was promulgated on an emergency basis although it is not effective until April 1, 2004. All references are to 18 NYCRR, unless otherwise indicated. If you are interested in reading the text of a proposed rule or the summaries of public comment and the response regarding an adopted rule, please contact Connie Wiggins (clewis@wnylc.com) or Nancy Krupski (nkrupski@wnylc.com) at GULP, Albany.

Notice of Proposed Rulemaking

Date of Filing	Last Day to Comment	Regulations Affected	Summary
	8/2/03	370.10	**Temporary Shelter Supplements (TSS):** This proposed regulation, first filed as an emergency rule in November 2001, and again in February, 2002, June of 2002, and December, 2002, allows families who receive Safety Net Assistance because they have reached the 30-month time limit to receive "Jiggetts" supplements. Under the TSS program, arrears payments can not exceed $3,000 or six times the monthly rental obligation, whichever is higher
5/28/03	7/26/03	358-3.2 387.14 387.17	**Food Stamp Reporting:** These regulations will implement the November 21, 2000 federal Food and Nutrition Service regulations regarding the time for reporting earnings information to Social Services Districts. Between certification periods, households will only be required to report increases in income that exceed 130% of the monthly poverty income guidelines for the household size.
5/28/03	7/26/03	Part 415	**Day Care Regulations:** These regulations make significant changes to the administration of child care subsidies. See related article on page 16.
5/21/03	7/5/03	387.9(b)	**Eligibility for Food Stamps-Vehicle Resource Allowance:** This regulation would exempt the value of one vehicle each for adult household members who use a car to commute to or from work, training or education. The regulation has been superceded by a policy directive which does not require that the vehicle be used for any particular purpose in order to be exempt.

Regulatory Roundup, continued

Notice of Proposed Rulemaking—continued

Date of Filing	Last Day to Comment	Regulations Affected	Summary
5/21/03	7/5/03	352.22(e)	**Trust Assets:** This regulation would revise the current rule regarding assets held in trust for an infant, which currently exempts such assets if they are under $1,000. The change would allow the trust of either an adult or a child to be exempt so long as it does not exceed the resource levels in 352.22(b), currently $2,000, or $3,000 if the applicant or recipient is over the age of 60. On the one hand, this will allow greater amounts to be set aside in trust for infants or adults when there is no other income in the household. On the other hand, for households that do have assets at or near the resource exemption limits, infant trust accounts under $1,000 which were previously exempt will now be subject to invasion.
5/14/03	6/25/03	352.20(c)	**Eligibility for Safety Net Assistance:** This proposed regulation would expand the category of Safety Net Assistance recipients who are eligible to receive the 49% earned income disregard to include households containing a pregnant woman as well as households with a dependent child (the current regulation). The regulation as it currently exists is more narrow that Social Services Law 131-a (8) (a) (iii), and is being amended to conform with the statute.
5/14/03	6/28/03	Part 358	**Fair Hearings:** These regulations revise the fair hearing regulations in Part 358 to clarify many of the administrative changes made as part of welfare reform. For example, reference is made to the Department of Labor and 12 NYCRR Part 1300, and agency names changed as a result of welfare reform are corrected (i.e., Aid to Dependent Children is changed to Family Assistance.) Additionally the regulations respond to the decision in Moon v. New York State Department of Social Services, 207 A.D. 2d 103 (1995), which held that only Administrative Law Judges, not attorneys, had the authority to issue subpoenas in fair hearings. This regulation, if adopted, will specifically state that attorneys have the authority to issue subpoenas in fair hearings.

Regulatory Roundup, continued

Notice of Proposed Rulemaking—continued

Date of Filing	Last Day to Comment	Regulations Affected	Summary
5/14/03	6/28/03	325.35	**Sanctions and Temporary Housing Assistance:** These regulations would amend the regulations regarding temporary housing assistance to impose a sanction of at least 30 days against a family that fails to pay its share of temporary housing assistance costs. The sanction will continue until such time as payment is made. The regulations also require that sanctioned adult caretakers must take their children with them when leaving temporary housing. Finally, the regulations would repeal the provision that requires a protective or preventative services evaluation prior to discontinuing temporary housing assistance.
5/14/03	6/28/03	387.14	**Eligibility for Food Stamps:** These proposed amendments would extend categorical eligibility for food stamps to recipients of non-emergency, non-federally participating Safety Net Assistance. This is less important now that the food stamp vehicle exemption rule is more generous than the public assistance rule.
4/16/03	5/31/03	351.20 352.1 352.31 369.3	**Families in Transition Act:** These regulations implement chapter 477 of the Laws of 2000 which was passed to assist children who lose their primary caregivers to HIV/AIDS. The regulations provide that public assistance to a child can not be discontinued when one adult caretaker relative dies, until the child has been appropriately provided for. The regulations authorize the continuation of assistance for up to three months following the death of the caretaker. Additionally, the proposed amendments eliminate the requirement that overpayments be recovered from children and limit the recovery of overpayments to adult household members.

Regulatory Roundup, continued

Notice of Adoption

Date of Filing	Rules Expires On	Regulations Affected	Summary
5/19/03	6/4/03	350.3 (a) 387.1 (e) (1) 387.5 (j) 387.5 (k)	**Public Assistance and Food Stamps: Authorized Representatives:** This regulation allows authorized representatives appear at public assistance eligibility interviews only if there is a good cause for the appointment of a representative. The regulation also provides for authorized representatives in the fool stamp program, consistent with 7 CFR 273.2 (n). Good cause need not be established for an authorized representative to appear at an interview for food stamps.

Emergency Rulemaking

Date of Filing	Last Day To Comment	Regulations Affected	Summary
4/1/03	6/29/03	413.2 414.11 415.4 416.11 417.11 418-1.11 418-2.11	**Administration of Medication to Children in Child Day Care Settings:** Chapter 253 of the Laws of 2002 requires that the Office of Children and Family Services promulgate regulations governing the administration of medication to children in day care. It is the position of the State Education Department that the Nurse Practitioner Act (Education Law § 6902) makes the administration of medication to children in day care centers illegal, although the statute itself does not actually say that. Although a temporary exemption currently exists, it will expire in June. These regulations, which are not effective until April 1, 2004, are an attempt to establish new standards and resolve the problem. They are available on-line at www.ocfs.state.ny.us/main.

Errata Notice

The April 9, 2003 State Register contains a notice that the Notice of Emergency Rule in the March 19, 2003 State Register regarding Temporary Shelter Supplements should have been labeled as Proposed Rulemaking. It was not a notice of Emergency Rulemaking according to the errata notice.

Child Care for Parents Working Non-Traditional Hours A.8482

By: Susan Antos

Parents who work the night shift, especially those with young children who are not yet attending school, can not sleep during the day without compromising the safety of their children. Although these parents need child care so that they can sleep, fewer than one half of all social services districts offer subsidies for parents who work the night shift and use child care while they sleep during the day.

In our report, *A Patchwork of Policies: A County by County Review of Subsidy Administration* (available at www.gulpny.org) our survey of the 58 social services districts revealed that only 27 districts pay parents for care that enables parents working the night shift to sleep.

By amending Section 410-w of the Social Services Law to define such care as necessary to enable a parent to work, parents who work the night shift will be able to get the sleep they need without endangering the safety of their children.

Additionally, this bill would put in statute, the current regulatory option to pay higher rates for child care provided during non-traditional hours, but without the 15% cap that exists in the regulation. See 18 NYCRR 415.9(h).

The Greater Upstate Law Project strongly supports this bill. We would recommend that with respect to a higher payment rate for care during non-traditional hours, the higher payment not be a county option, but that the statute require that providers receive payment at the actual cost of care up to 15% over market rate in all counties.

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