NYLAG
New York Legal Assistance Group

September 9, 2020

NYS Department of Health
Office of Health Insurance Programs
Waiver Management Unit
99 Washington Ave., 7th Fl., Suite 720
Albany, NY 12210

By e-mail to 1115waivers@health.ny.gov

RE: Proposed amendment of 1115 Research and Demonstration Waiver to Impose 30-Month Lookback for Community Based Long Term Care Services

To Whom It May Concern:

NYLAG submits these comments on the request to amend the 1115 Waiver to impose a lookback (the "Lookback") on Medicaid applicants seeking enrollment in Community Based Long Term Care ("CBLTC") services. Preliminarily, the intended start date of imposing the lookback, which is Jan. 1, 2021, will have to be pushed back if the HHS Secretary extends the public health emergency, which would in turn extend the Maintenance of Effort requirements under Section 6008(b)(1) of the Families First Coronavirus Response Act ("FFCRA") until at least the end of the first quarter of 2021.

Summary

1. **Do Not Apply the Lookback to MBI-WPD (Ticket to Work) Category and Provide Local Districts with Clear Guidance and Screening Tools to Exempt Categorically Eligible Applicants From the Lookback**
2. **Exempt CHHA Services from the Lookback – and Reconsider LLHCSA**
3. **Adapt Exceptions to the Transfer Penalty for Community -- No Penalty on Transfers of the Home and Adapt Undue Hardship Exception**
4. **Clarify Who is Grandfathered In -** Those Who Applied for Medicaid with Community-Based Long Term Care Coverage or received MAGI Medicaid before Jan. 1, 2021, including those who Must Reapply Because Medicaid was Discontinued
5. **The Start Date of the Transfer Penalty Must Begin when Applicant is Determined Functionally Eligible for LTC Services,** up to 3 Months Before Filing the Medicaid application, Rather Than the First Day She is Receiving Such Services
6. **Allow Attestation that No Transfers Made for "Immediate Need" Applications**
7. **Evaluation design and Beneficiary Impact Should Track Actual Savings and Cost of Implementation and Cost to Consumers of Delays in Enrollment**

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The New York Legal Assistance Group (NYLAG) is a leading non-profit that provides free civil legal services and financial counseling, and engages in policy advocacy efforts to help people experiencing poverty and facing barriers accessing health care and long term care.

1. WHICH APPLICANT CATEGORIES ARE SUBJECT TO THE LOOKBACK

We support the proposal to submit a State Plan Amendment ("SPA") that limits the categories of applicants who will be subject to the Lookback. However, as currently proposed, the Department would include the Medicaid Buy-In for Working People with Disabilities or Ticket to Work category. We recommend that the l=Lookback requirement only be imposed on the Medically Needy and exclude the MBI-WPD category. In other words, categorically eligible people who have no spenddown should not be subject to the Lookback. We support the Department's decision not to impose the Lookback requirement for those who are categorically eligible, as these are the poorest Medicaid applicants, as well as those eligible through MAGI budgeting and those enrolled in mainstream Medicaid managed care plans. We address some concerns below about to whom the Lookback will apply..

A. Exempt MBI-WPD (Ticket to Work) Category From Lookback

The MBI-WPD (Ticket to Work) group should be excluded from the Lookback. These are individuals under age 65 who, despite being disabled, are working, and rely on home care to continue to work and otherwise maintain independence. Many of these individuals have severe disabilities, and without Medicaid home care would be forced into nursing homes. New York policy encourages these individuals to work by giving them a higher resource allowance and by not requiring their retirement accounts to be in payout status. Exempting them from the Lookback would augment these work incentives. Also, the state's proposal to impose the Lookback on the Medically Needy would implicitly exempt the Categorically Needy. The two Ticket to Work groups are among the optional categorical eligibility groups under federal law. 42 U.S.C. 1396a(a)(10)(A)(ii)(XV-XVI).

Additionally, since MBI-WPD consumers must be under age 65they are eligible to transfer any excess assets into a supplemental needs trust without incurring an institutional Medicaid penalty period. Given that they have this right, there is no real gain for the State of imposing the Lookback on this group; if such person had transferred assets, the assets could be returned, if still available, and then deposited into an SNT, eliminating any penalty. If the funds are not available, the applicant may qualify for an undue hardship exception. With Olmstead concerns particularly high for this younger disabled population, and because the Lookback will inevitably delay care needed to prevent institutionalization, it would be good policy to exempt this category from the Lookback.

B. Clear Guidance and Screening Tools are Needed for Districts to Identify Applicants who are Exempt From the Lookback – and to Inform Public who Must submit Lookback

Clear guidance and screening tools will be needed for the local districts to identify who is and who is not subject to the Lookback, and to inform the public about who does and does not have to submit the lookback documents. It has always been challenging for local district staff to screen Aged, Blind, and Disabled applicants -- who may appear to be Medically Needy with a spend-down -- for alternate budgeting methodologies, with which they would be categorically eligible with no spenddown. The notoriously antiquated electronic eligibility systems, at least in New York City, lack the technological ability to assist workers in this important screening function. Now the consequence of classifying an applicant as Medically Needy may not only result in a "spend down" where there

should no none, but would also subject them to the Lookback. Workers will need clear guidance and screening tools - including enhanced electronic eligibility systems -- to ensure that they do not require Lookback-related documentation for categorically eligible groups listed below, as well as others that the waiver proposal states will not be subject to the Lookback:

- Person receiving SSI or eligible to receive but not receiving SSI;
- Aged/Blind/ Disabled with countable income and resources under the Medicaid levels;
- Medicaid continuation groups -- Pickle, Disabled Adult Child (DAC), Widows and Widowers grandfathered from 1973. 42 C.F.R. §§ 435.131, 435.132, 435.133, 435.135(a); and
- MAGI – Even though age 65 or older, or receiving Medicare, caretaker relatives of children or other relatives have the choice to use the more favorable of MAGI or Non-MAGI budgeting. 42 C.F.R. § 435.603(j)(2-4); 13 OHIP-ADM 4. For lack of training or sufficient screening tools, DSS workers often mistakenly assume that a person who is Aged, Blind or Disabled is non-MAGI, failing to ascertain their caretaker relative status and/or realize that that status qualifies them for MAGI. The consequence for failing to offer MAGI budgeting to these applicants is now compounded. Not only are they improperly subjected to a resource test, and have a spend-down wrongfully budgeted, but they will also be subject to the Lookback.
- People applying for 1915(c) Waivers (Traumatic Brain Injury Program, Nursing Home Transition and Diversion Waiver Program, consolidated waiver for children, and Office for People with Developmental Disabilities' (OPWDD) Comprehensive Home and Community-Based 1915(c) waiver) – Though we commend the Department for exempting waiver services authorized by 1915(c) or (d) of the Social Security Act from the Lookback, operationalizing this exemption requires clear policy and procedures because at the time the lookback is required – in the Medicaid application – the applicant is not yet enrolled in the waiver. The Medicaid application will need to be modified to ask if an applicant is seeking enrollment in one of these waivers. The State policies and procedures must require districts to exempt applicants from the Lookback who indicate their intention to apply for one of these waivers.

It will be challenging to educate the public about who does and does not have to submit the lookback documents. Clear information must be posted on the consumer-oriented pages on the DOH website. Of course explaining who is "medically needy" and who is "categorically needy" is not simple.

2. Certified Home Health Agency (CHHA) services must be exempt from the list of long term care services requiring a lookback.

Certified Home Health Agency (CHHA) services should not be subject to the Lookback when accessed on a fee for service basis. When MLTC enrollment became mandatory, MLTC enrollment was made mandatory for people needing CHHA services for 120 or more days, but CHHA services remain available on a short-term, fee for service basis. CHHA services are often critically needed after discharge from a hospital or rehabilitation facility, when patients often need a visiting nurse, physical or occupational therapy, and/or

home health aide services. While Medicare often covers this service for dual eligibles, Medicaid is needed as a back up for dual eligibles and for those without Medicare who are not in a managed care plan. Some dual eligibles may not be "homebound" or have a daily skilled need required under the strict Medicare requirements for these services,but qualify for and need CHHA services paid for by Medicaid.[1]

State policy already ensures that if CHHA services extend for longer than 120 days, the individual is then required to enroll in an MLTC. See DOH MLTC Policy 13.10. A Lookback would presumably be required for MLTC enrollment, thus accomplishing the State's goals that individuals use their assets to pay for *long-term* care. However, the same policy does not apply to *short-term* CHHA services. Unlike MLTC, which by definition is expected to be needed for more than 120 days, CHHA services are often needed short-term only. The lookback should not be required to initiate CHHA services as it will cause excessive delays in accessing post-acute services, causing hospitals to be backed up with patients who cannot be discharged, and may result in denial of vital services both to the individual needing CHHA services and other individuals who cannot be admitted to a hospital due to the lack of an available bed.

The waiver request also lists Limited Licensed Home Care Services Agency services (LLHCSA) as subject to the Lookback. According to 98 OCC ADM-01 - Limited Licensed Home Care Services Agencies (LLHCSAs, these are LHCSAs operated by adult home operators to provide home care services not covered for adult home residents. We question how extensively this service is utilized, which may not make it worth the administrative cost to administer the Lookback for these residents. Also, for these residents, if these services are not available, the individual would likely have to be transferred to a higher cost nursing home. It makes sense to ensure availability of these services that can maintain consumers in their residence rather than force transfers to a nursing home.

3. Definition of Exceptions to Transfer Penalty Need to be Adapted for Community-Based Services

The waiver indicates that an SPA will be submitted that will utilize the same exceptions to the transfer penalty that apply to nursing homes. While some transfer exceptions – such as a transfer to a spouse, a disabled child, or an SNT for an individual under 65 -- are appropriate in both the nursing home and community context, others need to be adapted to the community setting. We recommend that the SPA and any regulations or guidance issued make these adjustments in the definition and application of the transfer penalties for the home and for "undue hardship."

[1] See CMS Dear State Medicaid Director Letter dated July 25, 2000, available at http://www.cms.hhs.gov/smdl/downloads/smd072500b.pdf (stating in part, "The 'homebound' requirement is a Medicare requirement that does not apply to the Medicaid program.")

A. Since the Home is Exempt for an Applicant Living in the Community, Transfer of the Home Cannot Trigger a Penalty, and the Lookback Should Not Include a Transfer of the Applicant's Home

The consumer's home is exempt as an asset, so transfer of the home should not be subject to a penalty. Alternatively, while we do not concede the State's authority to do so, if the State does impose a penalty, the exceptions that apply to a transfer of a home for nursing home care must be adapted to the community setting in order not to drain them of any meaning.

For an applicant for those Medicaid CBLTC services that will require a Lookback, the home in which the applicant resides is exempt. Medicaid imports the definition of resources from the Supplemental Security Income (SSI) statute, which exempts the homestead. 42 U.S.C. §§1396p(h)(5), 1382b(a)(1). It is true that section 1396p(h)(5) provides that the SSI exclusion of the home does not apply "in the case of an institutionalized individual." However, the definition of "institutionalized individual" does not apply to people receiving any of the services for which the State will apply the Lookback. This definition includes only those in a nursing home, those receiving a nursing home level of care in a medical institution, or those receiving services under 1915(c) and (d) home-and-community-base- services waivers, which in New York are the TBI, NHTDW, OPWDD, and children's waivers. 42 USC § 1396p(h)(1).[2] The State has appropriately stated that these 1915(c) waivers will not be subject to the Lookback, which we support.

None of the types of services for which the State proposes to impose the Lookback are ones that would make a recipient an "institutionalized individual" as defined above in federal statute. The MLTC program is under an 1115 Waiver (42 U.S.C. § 1315). Similarly, people receiving fee-for-service personal care, CDPAP, CHHA, Assisted Living Program or private duty nursing services, which are all State plan services and not waiver services, are not "institutionalized individuals" as defined above. Since the SSI exemption of the home as a resource applies to those who are *not* "institutionalized individuals," the home is exempt for all those receiving services listed as those subject to the Lookback. Transfer of an exempt asset does not affect Medicaid eligibility, just as is true for SSI. 42 U.S.C. § 1382b(a)(1); 20 C.F.R. § 416.1212; POMS SI 01130.100, SI 01150.125.E.5.

Because the transfer of a residence will continue to be subject to a nursing home penalty if made during the applicable five-year look back period, there will continue to be a strong disincentive to transfer a residence by applicants who are doing Medicaid planning. Of course, the home equity limit still applies as well.

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[2] In its typically byzantine way, the Medicaid statute arrives at this definition in a circuitous way. In addition to those actually in institutions, the term "institutionalized individual" includes an individual "who is described in section 1396a(a)(10)(A)(ii)(VI) of this title." 42 USC § 1396p(h)(1). The reference to 42 U.S.C. §1396a(a)(10)(A)(ii)(VI) includes those who need an institutional level of care "… and who will receive home or community-based services pursuant to a waiver granted by the Secretary under subsection (c), (d), or (e) of section 1396n of this title." 42 U.S.C. §1396a(a)(10)(A)(ii)(VI). The referenced parts of section 1396n refer to services under 1915(c) and (d) home-and-community-base- services waivers, which in New York are the TBI, NHTDW and OPWDD waivers.

Alternately, without conceding that a penalty may be assessed for transfer of the home when applying for CBLTC, the penalty exceptions that apply to transfer of a home when applying for nursing home care must be adapted to the community context. Both a transfer to a sibling who has an equity interest in the home and a transfer to a child of the applicant require that these relatives have resided in the home for a period of one or two years, respectively, before the date the applicant "becomes an institutionalized individual." 42 U.S.C. §1396p(c)(2)(A)(iii) and (iv); NY SSL §366, subd 5 (e)(4)(i). Since the applicant for the services for which the new lookback would apply has not become an "institutionalized individual," no transfer to the designated family members would be exempt, defeating Congress' intent in enacting these exceptions. Congress presumably intended to protect these relatives as well as incentivize families to provide care for their loved ones to delay resorting to Medicaid. The definitions for these exceptions to the penalty must be adapted to exempt transfers of the home to these same family members, if they resided in the home for the same one-or –two year periods before the date the applicant began receiving community-based long term care services, rather then before the date the applicant became institutionalized.

B. The Undue Hardship Exception to the Transfer Penalty Must be Adapted for Community-Based Applications

Federal law requires states to establish a policy to waive the transfer penalty if denial of eligibility would cause an undue hardship that would deprive the individual of medical care such that the individual's health or life would be endangered, or would deprive the individual of food, clothing, shelter, or other necessities of life. New York SSL Section 366(5)(e)(4)(iv) directs the commissioner of health to develop a hardship waiver process. The Commissioner issued directive 06 OMM/ADM-5 ("2006 ADM") to apply for transfers before receiving nursing home care, since at the time there was no transfer penalty imposed for CBLTC services. With the recent amendment to NY SSL Section 366(5)(e), guidance is now required with respect to applications for community-based long-term care services.

Of particular concern is the provision of the 2006 ADM that provides that "[u]ndue hardship cannot be claimed: …If after payment of medical expenses, the individual's or couple's income and/or resources are at or above the allowable Medicaid exemption standard for a household of the same size." The hardship standard set forth in the 2006 ADM may be appropriate for an institutionalized individual. Under institutional Medicaid budgeting, virtually all of their income is their "Net Available Monthly Income" (NAMI) that must be paid to the cost of their care. Thus most nursing home residents could at least apply for this hardship waiver. After payment of their NAMI toward the cost of their care, their income is well below the Medicaid standard. A nursing home resident can afford to make this monthly payment toward their expenses because all of their needs are provided for by the facility. They receive medical care, food and shelter.

In contrast, for an individual residing in the community to request an undue hardship waiver, they must pay all of their income above $875/month (the current Medicaid exemption standard for an individual) for their medical expenses. Unlike a nursing home resident, the individual residing in the community must pay for all of their own living expenses. It is unrealistic to believe that a person residing in the community in New York State can provide for all their non-medical needs with only $875 per month. Any hardship

determination must examine the applicant's actual living, medical, and other expenses. Also, they should not be required to rely on savings under the allowed resource limit to pay living expenses.

Accordingly, we ask that in its proposed SPA to implement the Lookback, or through promulgating a regulation or other guidance, that the Commissioner develop a standard and procedure for requesting an undue hardship waiver for applications for CBLTC services. This standard must entitle all applicants to request the hardship waiver, and then set standards to determine eligibility for the waiver that take into account the individual's actual living expenses, medical expenses, and other expenses. This standard would apply in the community instead of the hardship standard in the 2006 ADM, which would apply solely to nursing home care.

C. Transfers Made while an Applicant was on MAGI Medicaid should be Presumed to be Exempt.

The DOH has wisely exempted individuals on MAGI Medicaid from the new lookback requirement, recognizing that such individuals are not subject to a resource test. An analogous rule should be implemented to deal with the situation that a person who is now on non-MAGI budgeting applies for the first time for CBLTC services and had made a transfer within the previous 30 months while still on MAGI Medicaid. It is difficult to imagine that this specific set of facts will arise frequently and exempting such transfers will prevent a penalty from being imposed for an action which was permissible when done.

4. Clear Guidance is Needed on who is Grandfathered in and Will not be Subject to the Lookback in 2021 or Later.

When the State submits a SPA or issues regulations or guidance implementing the Lookback, it must specify exactly who is grandfathered in and will not be subject to the lookback in 2021 or later. The waiver request's grandfather provision states at page 6:

> … the State will implement these proposed transfer of assets rules only to those newly seeking CBLTC services on or after January 1, 2021, and not to individuals already receiving CBLTC services on that date. This is in keeping with Federal and State practice implementing transfer of asset rules by "grandfathering" in individuals already in eligibility groups and receiving services that would be subject to transfer of assets rules.

Elsewhere, the waiver request states, "applications for CBLTC services submitted on or after January 1, 2021 would be assessed for any transfers made on or after October 1, 2020." Waiver request, p. 4. These descriptions appear to be internally inconsistent and could lead to substantial confusion by applicants, their advocates, and by local district workers.

We urge that the SPA, regulation or guidance implementing the lookback provide that anyone who has applied for Community Medicaid with CBLTC prior to December 31, 2020 be grandfathered in and not be subject to the lookback. An Aged, Blind or Disabled applicant has the choice of two forms of Community Medicaid coverage: Community Medicaid *with* CBLTC or Community Medicaid *without* CBLTC. See DOH 08-ADM-04 and its Attachment 4. Both forms of coverage have the same eligibility requirements but differ in the documentation required regarding assets. A person who chooses to attest as to

the amount of their assets is only eligible for Community Medicaid without CBLTC. A person who documents their current assets, along with submitting "Supplement A" with the official state Medicaid application, is eligible for Community Medicaid with CBLTC. Id. Community Medicaid with CBLTC is necessary and sufficient for an individual to enroll in an MLTC plan, be admitted to an Assisted Living Program, or apply for any State plan CBLTC services – personal care, CDPAP, adult day health care, private duty nursing, provided they meet any other criteria for these services (i.e. be exempt or excluded from MLTC). Therefore, we recommend that the statement on page 4 of the waiver request be slightly amended in the SPA or regulations as follows: "applications for Medicaid with CBLTC services submitted on or after January 1, 2021 would be assessed for any transfers made on or after October 1, 2020."

We strongly oppose imposing the lookback on individuals who did apply for Medicaid with CBLTC but who are not actually receiving services as of January 1, 2020, as some language in the waiver amendment suggests may be DOH's intended policy. Here are reasons for instead grandfathering in those who applied for Medicaid with CBLTC in 2020.

a. **Maintenance of Effort (MOE) Requirements** -- Anyone who applied for Community Medicaid with CBLTC prior to Dec. 31, 2020 is entitled to have eligibility determined under the same methodology in use on January 1, 2020, under the FFCRA Section 6008 MOE requirements. If they are not yet receiving CBLTC by December 31, 2020, for whatever reason, if the lookback applies to anyone not receiving services in 2020, these individuals would be required to have their eligibility redetermined in 2020 under the lookback before accessing CBLTC. This essentially requires people who had been protected by the MOE in 2020 to re-apply under a more restrictive eligibility methodology that the MOE prohibited in 2020. In other words, it would be an end run around the MOE requirements and potentially violate them. If the Public Health Emergency is extended beyond October 25, 2020, then the lookback should not be applied to anyone who applies for Community Medicaid with CBLTC through the end of the quarter in which the Public Health Emergency ends. [3]

b. **Imposing a Lookback in 2021 for People who Applied for Community Medicaid with CBLTC Prior to Dec. 31, 2020 would Burden Local Districts and Applicants**

   There are many reasons why an individual who files an application for Community Medicaid with CBLTC in late 2020 may not yet be receiving CBLTC services by Dec. 31, 2020. The application may still be pending with the local district, subject to myriad types of delays, including requests for more information or delays resulting from COVID-19, such as a shortage of workers reviewing applications. Even if the local district approved the application in 2020, it can take months to enroll in an MLTC plan. One must first schedule the Conflict-Free evaluation (CFEEC), then if that result is favorable, schedule assessments by individual MLTC plans to sign the enrollment form. If the MLTC plan does not submit the enrollment form by the 18th of

[3] The Public Health Emergency was extended on July 25, 2020, available at https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-23June2020.aspx. Unless renewed again, it expires on or about October 25, 2020. The MOE requirements continue until the end of the quarter in which the PHE expires.

the month, the MLTC enrollment will be delayed potentially six weeks until the first of the following month. Alternately, even if the CFEEC approves enrollment, an MLTC plan may contest this through the dispute resolution process; though the consumer may prevail, enrollment could be delayed past Jan. 1, 2021.

If only people actually receiving CBLTC on January 1, 2021 are grandfathered in, rather than anyone who applied for Community Medicaid with CBLTC prior to Dec. 31, 2020, the result will be unfair to many who face delays in accessing CBLTC. If New York Medicaid Choice could not schedule a CFEEC in time for Susan to enroll in an MLTC plan for Jan. 1, 2021, will Susan be subject to the Lookback review before she enrolls in the MLTC plan in January 2021 -- further delaying her enrollment? How about Patrick, who signed an MLTC enrollment form on December 15, 2020 but the plan failed to submit it by the 18th so his enrollment is delayed until February 1, 2021? Will his enrollment also be blocked because he now must reopen his Medicaid application to submit the Lookback documentation? What about Margarita, who did enroll in a plan effective Jan. 1, 2021 but the plan did not yet initiate services? Or Vladimir, who submitted a complete Medicaid application for coverage with CBLTC in mid-November 2020, but the local DSS still had not approved it by the end of December?

In all of these situations, the consumer had applied for community Medicaid with CBLTC but was not actually receiving CBLTC on Jan. 1, 2021. Only a bright line rule grandfathering in anyone who submitted an application for Community Medicaid with CBLTC prior to Dec. 31, 2020 (or later if the PHE is extended further) would be feasible to administer and not cause prohibitive delays in accessing services.

Additionally, any applicant for Community Medicaid who applies from now through the end of 2020, must be clearly told that if they are seeking CBLTC, they must submit the Supplement A with their Application before December 31, 2020. If they do not, not only will they be denied MLTC enrollment or any CBLTC but will also be subject to the Lookback if they seek to upgrade coverage to include CBLTC in 2021.

c. Grandfather Individuals Whose Community Medicaid with CBLTC Coverage Temporarily Lapsed Due to Renewal Problems or because Medicaid was Inactivated when the Spend-down Was Not Met

People forced to reapply after January 1, 2021 because their Community Medicaid with CBLTC lapsed due to a renewal or spend-down problem should not be subject to a Lookback. Unfortunately, it is common for Medicaid to be discontinued because the recipient allegedly failed to submit their annual renewal on a timely basis. Likewise, Medicaid may be inactivated if the recipient fails to meet their spenddown for several months, requiring them to reapply. Through October 31, 2020, the federal FFCRA MOE protections bar states from discontinuing Medicaid on these grounds; Medicaid

may be discontinued only upon the consumer's request or if the consumer moved out of state.. FFCRA Section 6008(b)(3);[4] GIS 20 MA/04.

If the PHE is not extended, this moratorium will end on October 31, 2020. During the last two months of 2020, local districts will then resume discontinuing Medicaid for alleged failure to submit the renewal or other requested documents, or on other grounds. NYLAG represents hundreds of people whose Medicaid is improperly discontinued – even now in the moratorium on case closings, mistakes are made. See, e.g. NYC HRA MICSA Alert, "Defective Renewal Notices During Covid-19 Emergency," dated May 28, 2020 (while Alert does not say, HRA reported that 32,056 case closing notices in error for renewals due May 2020),, available at http://www.wnylc.com/health/download/740/. While a fair hearing usually succeeds in reinstating coverage, some individuals must reapply for Medicaid. Where individuals previously had active Community Medicaid with CBLTC that lapsed or was discontinued, requiring a new application after January 1, 2021, they should not be treated as new applicants and a Lookback should not be required.

d. People Who Had MAGI Eligibility and Were Required to Transition to Non-MAGI Eligibility Should be Grandfathered In, With No Lookback Required

The waiver amendment wisely proposes to exempt individuals on MAGI Medicaid from the new lookback requirement, recognizing that such individuals are not subject to a resource test. Every month, hundreds of Medicaid MAGI recipients turn age 65 or become eligible for Medicare based on disability, and are required to transition to Non-MAGI Medicaid, either immediately if they are turning 65, or at the end of their 12-month continuous eligibility period if Medicare is based on disability. Some remain eligible for MAGI Medicaid even after they reach 65 or become enrolled in Medicare if they are caretaker relatives for children or grandchildren; when their children or grandchildren reach age 18 (or 19 if in school full time), these individuals must transition from MAGI to Non-MAGI Medicaid.

When their eligibility is redetermined under non-MAGI rules, they are not newly applying for Medicaid. Nor are they requesting an increase in their coverage, since MAGI Medicaid is full Medicaid coverage, including coverage of CBLTC. They are simply going through a redetermination necessary to retain the same comprehensive community Medicaid coverage they already had. Since this is not a new application, a Lookback should not be imposed in such circumstances.

We propose that no Lookback be imposed when MAGI recipients go through the redetermination of eligibility for non-MAGI. This is especially vital for those MAGI recipients who received CBLTC as MAGI recipients, whether through mainstream managed care or MLTC plans or fee for service. Since MAGI has no asset test, an individual is allowed to transfer assets. It would be unfair to impose a penalty on a transfer that was allowed at the time it was made.

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[4] Under section 6008(b)(3) of FFCRA, states must ensure that anyone who had Medicaid on or after March 18,2020 retains eligibility. This requirement continues, through the end of the month in which the Public Health Emergency ends, which unless extended is October 31, 2020.

EXAMPLE: A grandfather is caretaker for his grandson, after the child's mother died, and has MAGI Medicaid even though he has Medicare. If the grandfather helps pay for the grandson's college, this could be subject to a transfer penalty when he transitions to Non-MAGI Medicaid when the grandson turns age 19, if there is a lookback for him to continue receiving CBLTC services he had already been receiving because of Parkinson's disease.

Compounding the confusion and unfairness of changing the rules for individuals who are already on Medicaid is another temporary moratorium caused by the COVID-19 pandemic. Those who had MAGI Medicaid and turn 65, or obtain Medicare based on disability, whose Medicaid would normally be redetermined under non-MAGI Medicaid rules, have Medicaid automatically extended as MAGI for 12 months. Also, they remain enrolled in their mainstream Medicaid managed care plan even though normally anyone with Medicare is disenrolled from these plans. As stated above, these rules may end October 31, 2020 if the PHE is not extended. Whenever this emergency ends – effective November 1, 2020 or later, there will be a huge amount of confusion as this backlog of thousands of MAGI Medicaid recipients must have their eligibility determined under non-MAGI rules, and must be transitioned from mainstream plans to MLTC, if they receive home care, or to fee for service Medicaid and Medicare. Since they are not newly applying for Medicaid that includes coverage of CBLTC, having already had this coverage under MAGI rules, they should not be subject to a Lookback.

5. The Start Date of the Transfer Penalty Must Begin On the First Date the Applicant is Determined to be Functionally Eligible for CBLTC Services, up to Three Months Prior to Filing of the Medicaid Application, Rather Than the First Day She is Receiving Such Services

The waiver amendment does not address the start date of the penalty, which if not adapted from how it is used in the nursing home setting for the community, will cause harmful delays in MLTC enrollment. Under the amendments enacted in the MRT Budget statute, an uncompensated transfer of assets begins to run the "first day the otherwise eligible individual is receiving services for which medical assistance coverage would be available based on an approved application" but for the transfer of assets. NY SSL Section 366(5)(e), as amended, L. 2020 Ch. 56, Part MM Sections 13 and 14. This rule is the same rule that applies in the context of penalties that apply to skilled nursing home applications; however, the provision ignores the actual and practical differences between how community Medicaid applicants "receive services" as opposed to those in nursing homes.

In order to apply the Lookback for CBLTC, the State must, in any SPA, regulation or guidance, define the start date of the transfer penalty as the first day of *functional* eligibility for Medicaid CBLTC services -- rather than the first day of receipt of services that Medicaid would pay for a Medicaid recipient. To determine eligibility for services we recommend that local districts use the same "physician statement of need" form that DOH has proposed to develop for applications based on an Immediate Need for PCS or

CDPAP.[5] Once the Local District determines a penalty applies, the start date of the penalty should run retroactively from the date of the application, based on finding that the applicant was eligible for services on that date using the physician statement of need form, or retroactively for up to three months.

The penalty period start date in the nursing home setting will not work in the community. In the nursing home setting, to apply for institutional Medicaid, the individual must, by definition, already be in a nursing home receiving services at the time they apply. Nursing home services meet the definition of "services for which medical assistance coverage *would be* available based on an approved application." That means that, for an institutionalized person who is determined to have a 3-month transfer penalty, the penalty starts running retroactively to the month they applied for Medicaid, or even three months earlier, if they are seeking retroactive coverage. During the entire application period, and any retroactive period, the individual is safely receiving the needed nursing home care. In contrast, in the community setting, it is almost impossible for an applicant to be "receiving services for which medical assistance coverage *would be* available based on an approved application."

Unlike nursing home care, home care services that an applicant for Medicaid is already receiving at the time of application filing would almost *never* be services for which Medicaid coverage is available. This is because most Medicaid home care services are unique creations of statute, for which Medicaid payment may be made only after a lengthy "prior approval" process: one simply cannot privately pay for MLTC or CDPAP services. While those few who can afford it can private pay LHCSAs, which also provide Medicaid personal care services, LHCSAs are generally not Medicaid providers, so cannot generally bill Medicaid directly. Instead, LHCSAs contract with CHHAs or MLTC plans which bill Medicaid and pay the LHCSAs as subcontractors.[6] The only circumstance in which LHCSAs may bill Medicaid directly is when they contract with local districts to provide personal care services authorized by the local district for Medicaid *recipients*, not applicants. There is no scenario where a Medicaid applicant who has home care at the time of application and is assessed as having a transfer penalty can begin their penalty period, because an applicant can almost never RECEIVE homecare services for which Medicaid coverage "would be" available. Additionally, Medicaid "would be" available only if they have gone through the applicable prior approval system – whether the Maximus conflict-free eligibility assessment or the local district's prior authorization procedure in 18 NYCRR 505.14 or 505.28.

In the absence of clarification regarding the start date of the penalty period, the penalty period will either never begin or will be very delayed compared to the nursing home

[5] Proposed regulations implementing the Enacted SFY 2020-21 Budget Changes amending 18 NYCRR § 505.14(b)(6)(i)(a)(2)(i); 505.28(k), available at https://regs.health.ny.gov/regulations/proposed-rule-making.

[6] NYS Public Health Law Section 3605, subd. 8.

setting, making it more difficult, if not impossible to access Medicaid-funded CBLTC, potentially violating Olmstead protections.

In order to address the practical realities of the provision of home care in New York State, the State must, in any SPA, regulation or guidance implementing the Lookback, define the start date of the transfer penalty as the first day of *functional* eligibility for – not receipt of – services that Medicaid would pay for a Medicaid recipient. As stated above, to determine functional eligibility for CBLTC services, we recommend using the same "physician statement of need" form that DOH has proposed to develop in the proposed regulations implementing the PCS and CDPAP MRT changes. See n 5 above. Once the Local District determines a penalty applies, the start date of the penalty can run retroactively from the date of the submission of the physician statement of need form with the application, or retroactively for up to three months, if the form indicates that the applicant's condition has been the same for that period of time.

6. In Immediate Need Applications, Allow Attestation that No Transfers were Made

Attestation as to the absence of prohibited transfers within the lookback period, in lieu of requiring submission of documentation of all resources for the applicant and spouse within the lookback period, must be permitted by DOH in Immediate Need applications in order to ensure continuing compliance with the 12-day time limit for authorizing Medicaid and home care services in Soc. Serv. L. § 366-a subd. 12.

The existing procedures in the Immediate Need ADM –16 ADM-02 – provide for appropriate actions for the district and protections for the member that can be adapted easily once the lookback is implemented:

- Within four days of receipt of the "immediate need" application, the district may request additional documents if "…the district receives information through a collateral source such as the Resource File Integration (RFI) System or Asset Verification System (AVS), that requires documentation of information in order to resolve a discrepancy, including bank account information… 16 ADM-02 p. 7.

- The existing ADM provides a practical procedure in the event that the full lookback documentation reveals a transfer for which a transfer penalty must be imposed. 16-ADM-02 further provides, "If after an eligibility determination is made, the local district has information that is … relevant to the individual's Medicaid eligibility, the local district shall request documentation….. If upon further review …, the individual is determined to be ineligible for Medicaid or the individual does not provide the requested documentation within the required time period, proper notice regarding the individual's ineligibility must be sent with 10-day notice of the change." 16 ADM-02 pp. 7-8. This same procedure could apply after the full lookback documentation is submitted. The district would be required to provide a 10-day advance notice of change if a transfer is imposed.

However justified the public policy behind imposing a transfer penalty may be, most Medicaid recipients using the "immediate need" procedure did not in fact transfer assets,

as most of those who made transfers would not be able to sign in good faith the Attestation of Immediate Need Form (OHIP 0103)(Attachment 2 of 16 ADM-2) attesting that they are in immediate need. Attestation that a transfer met an exemption should also be permitted, such as a transfer to a disabled child. Attestation should be allowed in order to make the expedited determination required by the immediate need statute, which was enacted in order to minimize delays for accessing vital home care services.

7. Evaluation design and Beneficiary Impact Should Track Actual Savings and Cost of Implementation and Cost to Consumers of Delays in Enrollment

The waiver amendment projects minimal savings and beneficiary impact from implementing the Lookback, which is all the more reason why its costs and fiscal benefits should be tracked – to evaluate whether the lookback is worth continuing. The document projects that 2,740 new applicants (about ten percent of new enrollees) will be subject to the lookback with an average penalty of only 0.85 months based on an average transfer of under $10,000. Altogether, federal savings are projected to be $2.525 million "through the end of the current waiver period." What is meant by that date is unclear, as the current Special Terms and Conditions are for the term ending March 31, 2021. It is important to track thecosts and benefits so that decisions can be made in the future both by the legislature and DOH as to whether the lookback is worth continuing.

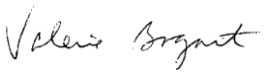
The impact of the lookback is on all applicants, not just those assessed with a penalty, and on local district staff. All applicants now have the burden to compile up to 30 months of financial records, and must endure the inevitable delays that will result from requiring more staff time by the local district. Even those applicants who are clearly exempt and are not required to submit this documentation will face the delays caused by diversion of application staff to review the lookback documents.

Evaluation should track the number of applicants determined to have made transfers, the amount of the transfers, the amount subject to a penalty (no exception granted), and the amount actually saved. Evaluation should also track any increased costs incurred by the local districts in hiring or diverting staff to conduct the lookback reviews, and the federal administrative cost incurred.

Additionally, the processing time of applications should be tracked and compared to processing time of applications before the lookback was implemented, if that is available. The cost to applicants by the delay in waiting for services should be calculated. For those who are charged with a transfer penalty, if the penalty time period runs while the application is processed, based on the average penalty of less than one month, most applicants will have run out their penalty by the time they are ready to enroll in an MLTC plan or start receiving the other CBLTC services. As a result, no federal savings will actually be incurred.

Thank you for the opportunity to submit these comments. As always, NYLAG would welcome the opportunity to participate in a stakeholder workgroup to provide input on implementation of this complex change.

Very truly yours,



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