NYLAG
New York Legal Assistance Group

May 6, 2021

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Proposed amendment of 1115 Waiver 11-W-00114/2 to Impose 30-Month Lookback for Community-Based Long Term Care Services

To Whom It May Concern:

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

NYLAG submits these comments to oppose and recommend conditions on amending the 1115 Waiver to impose a lookback (the "lookback") on Medicaid applicants seeking enrollment in Community Based Long Term Care ("CBLTC") services, including Managed Long Term Care (MLTC) plans authorized by the 1115 waiver. Preliminarily, however worthy the State's reasons may be for shortening the lookback period from 60 to 30 months, the federal statute does not authorize a lookback for less than 60 months.[1] The length of the statutory lookback period is not a provision that may be waived under Section 1115. 42 U.S.C. 1315(a)(1). While claiming it may diverge from the federal statute by shortening the lookback period to 30 from 60 months, New York insists that otherwise, "…[t]he State is bound by federal statute at 42 U.S.C. § 1396p for the treatment of transfer of assets, including transfers of a home." Waiver request at p. 15. The State invokes the strict letter of the statute by refusing to exempt a transfer of a home to a caregiver child or sibling who provided care before the inception of community long term care, as opposed to before institutionalization, as discussed below. This rigid and inconsistent interpretation creates an incentive to enter nursing homes. Only the State legislature may expand the lookback to 60 months.[2] N.Y. Social Services Law § 366, subd. 5(e)(1)(vi), as amended, L. 2020 Ch. 56 Part MM.

Additionally, the intended start date of the lookback, Jan. 1, 2022, must be pushed back if the public health emergency is extended, to comply with the Maintenance of Effort requirements under Section 6008(b)(1) of the Families First Coronavirus Response Act.

If the lookback is approved, we ask CMS to implement the following protections in the waiverapproval. These protections are needed to ensure the this massive shift in the CBLTC benefit is administered fairly and equitably. Additionally, these protections will ensure that the lookback does not further incentivize institutionalization and delay access to home care.

[1] "The look-back date specified in this subparagraph is a date that is …in the case of any other disposal of assets made on or after February 8, 2006, 60 months before the date specified in clause (ii)." 42 U.S.C. §§ 1396p(c)(1)(B)(i).

[2] An amendment to the state statute is also needed to fix another drafting error that applies the new lookback for CBLTC to transfers made after February 2006, instead of adding a new provision for transfers after the stated effective date of October 1, 2020. DOH has tried to correct this obvious mistake – which would unfairly penalize transfers made before the law's effective date -- by stating the lookback will only apply to transfers made after Oct. 1, 2020, but this requires a statutory change.

IF CMS APPROVES A 30-MONTH LOOKBACK, PROTECTIONS ARE NEEDED TO ENSURE THAT THERE ARE NO INCENTIVES AND DELAYS THAT WILL FORCE CONSUMERS INTO NURSING HOMES

1. CERTIFIED HOME HEALTH AGENCY (CHHA) SERVICES MUST BE EXEMPT FROM THE LIST OF SERVICES REQUIRING A LOOKBACK.
2. SINCE THE STATE PROPOSES TO IMPOSE THE LOOKBACK SOLELY ON THE MEDICALLY NEEDY AND TICKET TO WORK GROUPS, IT SHOULD NOT BE IMPOSED FOR THE CATEGORICALLY NEEDY DISABLED, AGED & BLIND GROUPS
   - **A.** The Lookback Should be Limited to the Groups Requested by the State – the Medically Needy Aged, Blind, and Disabled – and exclude the Categorically Needy
   - **B.** Exempt MBI-WPD (Ticket to Work) Category From lookback
   - **C.** Clear Guidance and Screening Tools are Needed for Districts to Identify Applicants who are Exempt from the lookback – and to inform Applicants and their Representatives Who Is and Is Not Subject to the Lookback
3. CLEAR GUIDANCE IS NEEDED ON WHO IS GRANDFATHERED IN AND WILL NOT BE SUBJECT TO THE LOOKBACK IN 2022 OR LATER
   - **A.** Recipients whose Medicaid eligibility temporarily lapses due to problems with Medicaid renewal or because of an unmet spend-down should be grandfathered
   - **B.** MAGI Medicaid Recipients who are Required to Transition to Non-MAGI Eligibility after Jan. 1, 2022 Should be Grandfathered, Including those who are Subject to Default Enrollment to Medicaid Advantage Plus Plans
4. WE SUPPORT THE PROPOSED POLICY OF SETTING THE START DATE OF A PENALTY PERIOD BASED ON A PHYSICIAN'S VERIFICATION OF THE NEED FOR THE COMMUNITY-BASED LONG TERM CARE SERVICES.
5. THE PENALTY EXCEPTIONS FOR TRANSFER OF THE HOME AND OTHER PROVISIONS MUST BE ADAPTED TO NON-INSTITUTIONAL CARE
   - **A.** Transfer of a Home that is Exempt for an Applicant Living in the Community Cannot Trigger a Penalty, or Alternatively, the Exceptions to the Penalty for Transfer of a Home to Certain Relatives Must be Adapted for Applicants Seeking Community-Based Long Term Care Rather than Nursing Home Care
   - **B.** Deposits into Supplemental Needs Trusts are Made with the Intent to Dispose of Them for Fair Market Value So Should Not be Subject to a Transfer Penalty
   - **C.** The Undue Hardship Exception to the Transfer Penalty Must be Adapted for Community-Based Applications
6. In Immediate Need Applications, Allow Attestation that No Transfers were Made
7. Evaluation Design and Beneficiary Impact Should Track Actual Savings and Cost of Implementation and Cost to Consumers of Delays in Enrollment

IF CMS APPROVES A 30-MONTH LOOKBACK, PROTECTIONS ARE NEEDED TO ENSURE THAT THERE ARE NO INCENTIVES AND DELAYS THAT WILL FORCE CONSUMERS INTO NURSING HOMES

1. CERTIFIED HOME HEALTH AGENCY (CHHA) SERVICES MUST BE EXEMPT FROM THE LIST OF SERVICES REQUIRING A LOOKBACK.

There is no justification for imposing a lookback requirement prior to initiation of Certified Home Health Agency (CHHA) services, since these services are most frequently initiated on a short-term rather than long-term basis, and since procedures exist to transition long-term CHHA recipients to enroll in MLTC plans, where the lookback would apply. CHHA services are generally initiated for short-term care by a visiting nurse, physical or occupational therapist and home health aide after discharge from a hospital or rehabilitation facility. In contrast, an MLTC by definition is expected to be needed for more than 120 days. NYS Public Health Law § 4403-f, n. 1 supra. Requiring a lookback to initiate CHHA services will cause excessive delays in accessing vital post-acute services, causing hospitals to be backed up with patients who cannot be safely discharged.

There is already a policy and procedure to mandate enrollment of any adult dual eligible into an MLTC plan after they receive CHHA services for more than 120 days.[3] Since the lookback review will be required as a condition of that MLTC enrollment, there is no need to impose a penalty on the initial receipt of CHHA services. The transition procedure outlined in DOH MLTC Policy 13.10 (n. 3, supra) may need to be modified to incorporate the lookback, perhaps by requiring the CHHA or Maximus to refer the individual to the local social services district to conduct a lookback review prior to the transition from short-term CHHA to MLTC. The procedures must ensure that the CHHA services continue until the lookback determination is made,and require that the local district provide the consumer with advance written notice with hearing and "Aid Continuing" rights should the determination be to impose a transfer penalty. Requiring the lookback at the point that a short-term CHHA service becomes long-term care makes more sense than imposing this burdensome requirement before the initiation of short-term CHHA services.

While Medicare often covers CHHA services for dual eligibles, Medicaid CHHA services are often needed short-term because the Medicare criteria are so strict, or for those who do not have Medicare who are not in a managed care plan. 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.[4]

In its waiver proposal, the State responds that short-term CHHA services will still be available for up to 29 days to applicants who "attest" rather than verify that the amount of their resources are within the allowed limits. The State is describing the short-term rehabilitation benefit that is available based on "attestation" of assets, without requiring

---

[3] See DOH MLTC Policy 13.10, available at https://www.health.ny.gov/health_care/medicaid/redesign/mltc_policy_13-10.htm and NYS Public Health Law §4403-f, subd. 7(b)(requiring enrollment in MLTC plans for adults requiring community-based long term care services for a continuous period of more than 120 days).

[4] 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.")

the usual verification of assets. N.Y. Soc. Ser. L. § 366-a, subd. 2(b); 18 N.Y.C.R.R. §360-2.3(c)(3). This short-term rehab benefit may be either CHHA services or short-term services in a rehabilitation facility. Id. However, attestation of *current* resources is a different concept than a lookback to *past* resources. Because short-term rehabilitation is, by its very name, a short-term rather than a long-term service, we ask that it be made clear that no lookback will be imposed to initiate CHHA services. If the services continue for 120 days, then existing procedures will be used to transition the recipient to an MLTC, and the lookback review could be completed as part of that transition.

2. SINCE THE STATE PROPOSES TO IMPOSE THE LOOKBACK SOLELY FOR THE MEDICALLY NEEDY AND TICKET TO WORK GROUPS, THE LOOKBACK SHOULD NOT BE IMPOSED FOR THE CATEGORICALLY NEEDY DISABLED, AGED & BLIND GROUPS

The State's request to amend the 1115 waiver specifically lists the eligibility groups for which the lookback will be required as the Medically Needy Aged, Blind and Disabled eligibility categories, and the two optional Ticket to Work categories -- the Basic Group and the Medical Improvement Group (known in New York as the Medicaid Buy-In for Working People with Disabilities). We ask CMS to limit the lookback what the State had requested, namely the Medically Needy groups specified by the State, and to exclude the categorically needy groups. Also, we oppose inclusion of the Ticket to Work groups as defeating the purpose of this program to provide an incentive for people with disabilities under age 65 to work.

A. The Lookback Should be Limited to the Groups Requested by the State – the Medically Needy Aged, Blind, and Disabled – and Exclude the Categorically Needy

The State specifically identifies the groups proposed to be subject to the lookback as the Medically Needy aged, blind, and disabled groups and Ticket to Work group, identifying them by the federal statutory and regulatory citations that describe these groups. SSA § 1902(a)(10)(C); 42 CFR §§ 435.320, 435.322, 435.324, and 435.330. Waiver submission at p. 5. When the same list of eligibility groups appeared in the State's draft posted for public comment,[5] consumers noted that this list omitted Categorically Needy aged, blind, and disabled groups, implying that this omission meant that these groups would not be subject to the lookback. Consumers expressed support for exempting the categorically needy aged, blind and disabled groups from the lookback since they are the poorest Medicaid recipients -- eligible for but not receiving SSI or they lost SSI because of certain reasons described below.[6] Given their level of poverty, they would be unlikely to possess

[5] Available at https://health.ny.gov/health_care/medicaid/redesign/mrt2/proposals/30-month_lookback.htm.

[6] 42 CFR § 435.4 defines these terms, in pertinent part:

"*Categorically needy* refers to … aged, blind, or disabled individuals... described under subparts B and C of this part who are eligible for Medicaid. Subpart B of this part describes the mandatory eligibility groups who, generally, are receiving or deemed to be receiving cash assistance under the Act…. Subpart C of this part describes the optional eligibility groups of individuals who, generally, meet the categorical requirements

assets to transfer. Relieving them of the burden of the lookback would reduce delays in processing not only their applications but all applications, by reducing the burden on the local districts.

The State's final submission to CMS, however, says that "the State is not making a distinction between the medically needy and categorical eligibility; the State is seeking to impose the 30-month lookback on the eligibility groups categorized as Aged, Blind or Disabled and subject to non-MAGI budgeting rules, which are the Ticket to Work categories and the Medically Needy Aged, Medically Needy Blind and Medically Needy Disabled." Respectfully, it appears that the State agency meant to apply the lookback to all eligibility groups categorized as Aged, Blind or Disabled and subject to non-MAGI budgeting rules, including not only the Medically Needy but also at least some mandatory or optional categorically needy groups. However, despite comments to the State's draft waiver submission that called this issue to the State's attention, the final waiver amendment submission uses the same definition. The State should be held to its request, and the lookback should be limited to the Medically Needy Aged, Blind and Disabled.

The following mandatory categorically eligible Aged, Blind or Disabled groups are not "medically needy" and should not be subject to the lookback based on the State's submission:[7]

- § 435.120 - Individuals receiving SSI[8]

---

or income or resource requirements that are the same as or less restrictive than those of the cash assistance programs and who are not receiving cash payments…."

"Medically needy refers to … aged, blind, or disabled individuals… listed under subpart D of this part who are not listed in subparts B and C of this part as categorically needy but who may be eligible for Medicaid under this part because their income and resources are within limits set by the State under its Medicaid plan (including persons whose income and resources fall within these limits after their incurred expenses for medical or remedial care are deducted) (Specific financial requirements for determining eligibility of the medically needy appear in subpart I of this part.);

[7] Additionally, these categorical eligibility groups are closed to new enrollment –new applicants who could be subject to the lookback are unlikely but possible**:**

- § 435.130 mandatory State supplements – suffered reduction of income when converted from public assistance to new SSI program in Jan. 1974 and States required to supplement difference in income and provide Medicaid
- § 435.137 - Certain "Additional Reduction Factor (ARF)" Widow(er)s - were entitled to Social Security and SSI benefits in December 1983 and have continuously received Social Security benefits since, lost SSI/SSP eligibility because of the elimination of the ARF in 1984, filed for Medicaid continuation before 1988.
- § 435.134 - Recipients of a 1972 Social Security COLA - states must provide Medicaid for individuals who would be eligible for SSI/SSP in the absence of a Social Security COLA enacted in 1972, if they were entitled to Social Security and SSI or other cash assistance benefits in August 1972
- Certain individuals who, in December 1973, were essential spouses (§ 435.131), institutionalized (§ 435.132) or blind or disabled (§ 435.133) and were grandfathered in

[8] Presumably the State does not intend to impose the lookback on SSI recipients since New York is a §1634 state so does not separately determine Medicaid eligibility for recipients of SSI or State Supplemental Payments (SSP); they receive Medicaid automatically when approved for SSI by the SSA or for SSP by the

- § 435.122 Individuals who are ineligible for SSI or optional State supplements because of requirements that do not apply under title XIX of the Act (i.e. Certain immigration status requirements, lower asset threshold, receive in-kind income or other income excluded for Medicaid but not for SSI)
- Former SSI Recipients entitled to Continuation of Medicaid:
    - § 435.135 Individuals who become ineligible for SSI as a result of OASDI cost-of-living increases received after April 1977 ("Pickle" people).
    - Section 1619(b) – Received SSI in one of the prior 12 months, which was suspended because of income from work;
    - Disabled Adult Child -- (DAC) individuals age 18+ who became disabled before age 22, lost SSI eligibility when received Social Security Disabled Adult Child (DAC) benefits, and meet asset test ($2000 limit)
    - Disabled Surviving Spouses not yet Entitled to Medicare Part A- who lost SSI when received Social Security surviving spouse benefits at age 50+

Additionally, States may provide Medicaid for various optional "categorically needy" groups, which are not "medically needy." New York has opted to cover Aged, Blind, and Disabled individuals who meet the income and resource requirements for but do not receive SSI. SSA §1902(a)(10)(A)(ii)(I); 42 C.F.R. §§ 435.210, 435.230(c)(1). New York also covers optional Aged, Blind and Disabled categories eligible for 1915(c) waivers, which the State has said will be exempted from the lookback.

The State correctly did not request that the lookback apply to these groups, since these categorically eligible groups include people who are so poor that they have no spenddown. Therefore, the above mandatory and optional categorically needy groups should not be subject to the lookback.

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

As stated above, 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 categorically needy eligibility groups under federal law. 42 U.S.C. 1396a(a)(10)(A)(ii)(XV-XVI). Therefore, the State should be held to its request and not subject the Ticket to Work groups to the lookback.

Additionally, the MBI-WPD (Ticket to Work) group should be excluded from the lookback as a matter of policy. The lookback would defeat the purpose of this program as a work incentive to encourage individuals under age 65 to work, despite being disabled, and will cause delays in accessing home care. These individuals have severe disabilities, and denial or delay in obtaining Medicaid home care could force them 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 enhances these incentives.

NYS Office of Temporary & Disability Administration. SSI eligibility and thus Medicaid for these recipients is already subject to a lookback.

Finally, since MBI-WPD consumers must be disabled and under age 65, they are eligible to transfer any excess assets into a supplemental needs trust without incurring a penalty. As such, there is no real gain for the State to impose 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. 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.

C. Clear Guidance and Screening Tools are Needed for Districts to Identify Which Applicants are Exempt From the Lookback – and to Inform Applicants and their Representatives who is and is not Subject to the Lookback

Whether the lookback applies only to the Medically Needy and the Ticket to Work group, or also to the Categorically Needy groups described above, which we oppose, clear guidance and screening tools will be needed for local districts to identify who is and who is not subject to the lookback, and to inform the public who must submit the lookback documents with the application and who is exempt.

The State says that the 1915(c) Waivers will not be subject to the lookback, which we support. These include the Traumatic Brain Injury Program, Nursing Home Transition and Diversion Waiver Program, and Office for People with Developmental Disabilities Home and Community-Based waiver. Operationalizing this exemption requires clear policy and procedures because at the time the lookback might be required – in the Medicaid application – the applicant is not yet enrolled in the waiver. The Medicaid application and procedures will need to be modified to allow applicants to indicate their intention to apply for one of these waivers, and not be subject to the lookback.

The State also says that MAGI recipients will be exempt, but this also is challenging to operationalize. Not all people age 65 or older or receiving Medicare are non-MAGI. If they are caretaker relatives of children or other relatives, they have the choice to use the more favorable of MAGI or non-MAGI budgeting. 42 C.F.R. § 435.603(j)(2-4); 13 NYS DOH 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 an improper spend-down, but they will also be subject to the lookback.

If the lookback applies only to the Medically Needy and not the Categorically needy, as we request above, this poses other challenges. It has always been challenging for local district staff to screen Aged, Blind, and Disabled applicants for "DAC" or other categorically needy groups described above, and they automatically classify them as Medically Needy. The notoriously antiquated electronic eligibility systems, at least in New York City, contributes to this problem. Now the consequence of misclassifying an applicant as Medically Needy may not only result in a "spend down" where there should be 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 a lookback for the various categorical eligibility groups listed above.

Finally, it will be challenging to educate the public about who must submit the lookback documents. Clear information must be posted on the consumer-oriented pages on the DOH website explaining who is and is not subject to the lookback – including information that Aged, Blind, and Disabled people can be MAGI and have no lookback if they are caretaker relatives, and explaining that 1915(c) waiver applicants are not subject to the lookback.

3. Clear Guidance is Needed on who is Grandfathered and not Subject to the Lookback in 2022 or Later

We appreciate that the State has drawn a clearer line as to which individuals will be grandfathered and not be subject to a lookback review, but we continue to have some concerns about who is grandfathered , which we ask CMS to address in the waiver approval if such approval is granted. The State clarified that individuals who had filed applications but were not yet approved for CBLTC, or who were approved for but not yet receiving CBLTC services, would be grandfathered. We support that clarification:

> …[I]ndividuals who apply for Medicaid coverage of CBLTC before the implementation date will not be subject to the 30-month lookback, including those individuals who file a pre-implementation date application for Medicaid coverage of CBLTC but who are not yet receiving CBLTC services under that application on the implementation 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.

Waiver p. 6. We further appreciate the State's acknowledging that it "shares the commenters' interest in a policy that provides certain 'grandfather' provisions for individuals receiving CBLTC services as of the implementation date and will take their comments under advisement in establishing policy guidance in this area." We urge that the waiver approval make clear that individuals are grandfathered in the following situations.

A. Medicaid eligibility temporarily lapses due to problems with the Medicaid renewal or because of an unmet spend-down

People forced to reapply after January 1, 2022 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 t recipients allegedly failed to submit their annual renewal on a timely basis, even though many of these discontinuances are not the consumers' fault. Likewise, Medicaid may be inactivated if recipients do not meet their spenddown for several months, requiring them to reapply. Since March 2020, the federal FFCRA MOE protections have barred states from discontinuing Medicaid on these grounds, but once the public health emergency is over, discontinuances of Medicaid will resume 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.[9] 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, 2022, they should not be treated as new applicants and a lookback should not be required.

B. MAGI Medicaid Recipients who are Required to Transition to Non-MAGI Eligibility after Jan. 1, 2022 Should be Grandfathered In, Including those who are Subject to Default Enrollment to Medicaid Advantage Plus Plans

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. However, the question remains as to whether the thousands of Medicaid MAGI recipients who become enrolled in Medicare each month – either based on reaching age 65 or based on disability – should be subject to a lookback when their eligibility for non-MAGI Medicaid is redetermined. We urge that this cohort be grandfathered in, and alternatively, that at least those who received CBLTC services from their Medicaid managed care plan prior to being enrolled in Medicare be grandfathered in.

Though MAGI Medicaid recipients who newly become enrolled in Medicare have retained MAGI Medicaid because of the MOE during the Public Health Emergency, once the PHE is over, they will again be required to transition to Non-MAGI Medicaid. This redetermination process is particularly lengthy in New York, as it also involves transfer of administration of their Medicaid case from the New York State of Health exchange to the local district Medicaid offices.[10] Since their redetermination for non-MAGI Medicaid is not a new application, this cohort should be grandfathered under the same principle that the State will apply to anyone else who applied for Medicaid including coverage of CBLTC prior to the effective date.

Alternately, if all formerly MAGI Medicaid recipients are not grandfathered in when they transition to non-MAGI Medicaid, at least those recipients who received CBLTC services from their managed care plans should be grandfathered. Under new procedures the State is just implementing this spring, members who received CBLTC from their mainstream managed care plans are being "default enrolled" into Medicaid Advantage Plus (MAP) plans, which combine in one plan a Dual-SNP, an MLTC plan, and all other Medicaid

---

[9] 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 were sent in error for renewals due May 2020), available at http://www.wnylc.com/health/download/740/.

[10] This transfer and redetermination process occurs immediately if they are turning 65, or at the end of their 12-month continuous eligibility period if Medicare is based on disability. Either way, the process takes about four months. See NYS DOH GIS 16 MA/004 -*Referrals from NY State of Health to Local Departments of Social Services for Individuals who Turn Age 65 and Instructions for Referrals for Essential Plan Consumers*; GIS 15 MA/022 - *Continuous Coverage for MAGI Individuals*; 2014 LCM-02 - *Medicaid Recipients Transferred at Renewal from New York State of Health to Local Departments of Social Services* (all directives available at https://www.health.ny.gov/health_care/medicaid/publications/index.htm)

services.[11] A big challenge in default enrollment is identifying those members who will become enrolled in Medicare, and redetermining their non-MAGI eligibility, to occur before notices of the default enrollment are sent to the consumer, which must be 60 days before Medicare becomes effective. 42 CFR § 422.66(c)(2)(iv). The redeterminations are critical because -- after the PHE ends -- some individuals may not be eligible for non-MAGI Medicaid because of excess resources, or may not be eligible for a Dual-SNP because they would have a spend-down.[12]

The State has taken advantage of the moratorium provided by the MOE to launch default enrollment during the pandemic, during which non-MAGI redeterminations are not being conducted, and individuals simply maintain their MAGI eligibility despite now having Medicare. However, the State has acknowledged that timing these redeterminations with the notice requirements of default enrollment will be challenging when the PHE is over. If simple redeterminations of non-MAGI eligibility are challenging – with the resource limits, different income rules and lower income limits -- how much more difficult and time consuming will they be if a lookback is also required?

When a MAGI recipient becomes enrolled in Medicare and 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, this cohort should be grandfathered.

The State says that federal law gives no exception from the transfer penalty for transfers made while an individual had MAGI Medicaid. We cannot disagree with that statement and wish to re-frame our argument. Rather, we submit that the grandfather clause as articulated by the State's waiver request includes "…individuals who apply for Medicaid coverage of CBLTC before the implementation 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." A mainstream Medicaid managed care member who is receiving CBLTC from the managed care plan prior to Jan. 1, 2022, and who is required to have non-MAGI Medicaid eligibility determined upon enrolling in Medicare, should be grandfathered in under the State's proposed grandfather definition. That individual applied for Medicaid coverage of CBLTC before the implementation date. They must still undergo the redetermination of non-MAGI Medicaid eligibility, but that redetermination should not include the lookback. Otherwise, that individual is being treated less favorably than everyone else who is grandfathered in because they applied for non-MAGI Medicaid coverage of CBLTC before Jan. 1, 2022. There is no basis to treat such persons less favorably than others.

---

[11] See 42 CFR §§ 422.66(c); 422.68(d); *NYS DOH Model Notice of Default Enrollment to a MAP Plan for Individual Receiving CBLTC/LTSS from Mainstream Managed Care Plan*, available at https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/policy/ltss_default_notice.htm

[12] See CMS MMCO Integrated Care Resource Center, *Using Default Enrollment to Align Coverage for Dually Eligible Medicare-Medicaid Beneficiaries* (July 2019), available at https://www.integratedcareresourcecenter.com/resource/using-default-enrollment-align-coverage-dually-eligible-medicare-medicaid-beneficiaries.

Finally, whenever this public health emergency ends – whether January 1, 2022 or later -- there will be a huge amount of confusion as this backlog of thousands of new dual eligibles has their eligibility determined under non-MAGI rules. Those who received CBLTC services before default enrollment began in April 2021 will have to be transitioned from mainstream plans to MLTC or MAP plans. 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.

4. We Support the Proposed Policy of Setting the Start Date of a penalty period based on a physician's verification of the individual's need for the community-based long term care services.

We appreciate and support the State's proposed policy of setting the start date of any penalty period for an otherwise eligible individual based on a physician's verification of the individual's need for the community-based long term care services. The State has thus responded to concerns raised by consumers that the penalty should not begin on the first day the otherwise eligible individual is *receiving* services for which medical assistance coverage would be available, since unlike nursing home services, applicants will rarely be able to meet that requirement "given various upfront assessment requirements and the inability of individuals to directly contract with providers for services that Medicaid would pay for." DOH Waiver at p. 16.[13] The State's proposed policy on the start date is consistent with the sole federal guidance that applies the transfer penalty to CBLTC as opposed to nursing home services [14] Though this 2018 guidance was issued in the context of 1915(c) waivers rather than an 1115 waiver, it still provides authority for adapting the start date of the penalty to the community-based setting. This adaptation is critical because otherwise, using the start date that applies in the nursing home context, the penalty period will either never begin or will be very delayed compared to the nursing home setting, making it more difficult, if not impossible to access Medicaid-funded CBLTC, potentially violating *Olmstead* protections.

Once the Local District determines that a penalty applies, the start date of the penalty should run retroactively up to three months before the date of the submission of the physician statement of need form with the application, if the form indicates that the

[13] The State recognizes in this policy that most Medicaid home care services in New York 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 consumer-directed personal assistance program (CDPAP) services. While those who can afford it can private pay Licensed Home Care Services Agencies (LHCSAs), 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. NYS Public Health Law § 3605, subd. 8. 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.

[14] State Medicaid Director Letter No. 18-004, *Penalty period start date for certain HCBS waiver participants*, April 17, 2018, available at https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/smd18004_13.pdf.

applicant's condition has been the same for that time period. 42 USC § 1396p(c)(1)(D)(ii); NY Social Services Law § 366(5)(e)(5).

5. If CMS Approves Shortening the Lookback for Community-Based Care to 30 Months, the Penalty Exceptions for Transfer of the Home and Other Provisions Must be Adapted to Non-institutional Care

The waiver amendment proposes to utilize the same exceptions to the transfer penalty that apply to nursing homes. Some transfer exceptions – such as a transfer to a spouse, a disabled child, or a supplemental needs trust for an individual under 65 -- are applicable in both the nursing home and community context. Others, however, such as a transfer to a "caregiver child" who lived with the applicant for two years prior to institutionalization, are drained of any meaning unless they are adapted to the community setting. If such exceptions are not adapted for the community, a bias is created that incentivizes institutional placement. If variance from the federal statute is permitted with respect to the length of the lookback period, a similar flexibility must be afforded to adapt these rules to community-based care.

A. Transfer of a Home that is Exempt for an Applicant Living in It Cannot Trigger a Penalty, or Alternatively, the Exceptions to the Penalty for Transfer of a Home to Certain Relatives Must be Adapted for Applicants Seeking Community-Based Long Term Care Rather than Nursing Home Care

Unlike a permanently institutionalized individual, the home in which an applicant for community-based long term care services lives is exempt as an asset, provided its equity is under the equity limit or exempt from the limit based on which relatives live in the home. Since an applicant seeking community-based long term care services has no need to transfer her home in order to qualify for Medicaid, transfer of the home by such an individual is for a purpose other than to qualify for Medicaid and cannot be subject to a penalty. 42 U.S.C. §1396p(c)(2)(C).[15]

Alternatively, while we do not concede the State's authority to do so, if the State does impose a penalty on transfer of a home with equity under the home equity limit, and for homes with equity above the limit, the exceptions that apply to transferring a home for nursing home care must be adapted to the community setting in order not to drain them of any meaning. Under the federal statute, 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

[15] The provisions of 42 U.S.C §1396p(c)(2) are explained by the Department of Health and Human Services Health Care Financing Administration in section 3258.10 of its Transmittal No. 64 ("HCFA 64"). In the HCFA 64 explanation of what satisfies the requirements of a transfer made exclusively for a purpose other than to qualify for medical assistance, the home is used in its example. Therefore this exception may apply to transfer of the home. It should be noted that the POMS also use the home in its example of a transfer made exclusively for a purpose other than to qualify for SSI. SSA POMS SI 01150.1259, par. E (5)(Example 1) *Exceptions — Transfers for Purposes Other Than to Obtain SSI*, at http://policy.ssa.gov/poms.nsf/lnx/0501150125. Medicaid eligibility rules cannot be more strict than SSI. 42 CFR § 435.601(d)(2).

(iv); NY SSL §366, subd. 5 (e)(4)(i). In defining "institutionalized individual," the statute includes people eligible for and receiving home and community based services (HCBS) under a 1915(c) waiver. 42 USC § 1396p(h)(3). While the statute does not specifically include receipt of HCBS services under an 1115 waiver as meeting the definition of "institutionalized individual," the inclusion of those in 1915(c) waivers demonstrates Congressional intent to incentivize families to provide care for their loved ones to delay resorting to Medicaid for long term care, both in a nursing home and in the community. Moreover, at the time this section of the statute was enacted, Section 1115 waivers were not yet commonly used for CBLTC services. CMS has recognized that the statutory provisions regarding the transfer penalty need to be adapted to make sense in the community, as shown by the guidance on the start date of the penalty for 1915(c) waivers discussed above. See n. 14. The same flexibility must be exercised to exempt transfers of the home to a "caregiver child" or sibling with equity interest if they resided in the home for the same one-or –two-year periods before the date the applicant first needed CBLTC. Otherwise, there is a huge bias in favor of institutionalization, which raises concerns under *Olmstead* and is contrary to the increasing national priority given to providing long term care in the community, as exemplified by the inclusion of a 10% boost in FMAP in the recent stimulus bill, the American Rescue Plan (ARP).

The State inconsistently claims it is bound by the federal statute on this issue, while claiming flexibility to shorten the lookback period to less than sixty months. If CMS allows variance from the statute to shorten the lookback period, then the definitions for these exceptions to the penalty must also be adapted. Because the transfer of a residence will 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.

B. Deposits into Supplemental Needs Trusts are Made with the Intent to Dispose of Them for Fair Market Value So Should Not be Subject to a Transfer Penalty

The waiver should confirm that transfers into a self-settled individual supplemental needs trust or pooled trust are not subject to a penalty. This policy is required by federal statute, which provides that there is no penalty if "… the individual intended to dispose of the assets either at fair market value, or for other valuable consideration." 42 U.S.C. §§ 1396p(c)(2)(C)(i). CMS has specifically applied that provision to clarify that there is no transfer penalty for transfers of income or resources into supplemental needs trusts. "Resources placed in an exempt trust for a disabled individual are subject to …a penalty… unless the resources placed in the trust are used to benefit the individual, and the trust purchases items and services … at fair market value … . These rules apply to both income and resources placed in the exempt trusts…." CMS State Medicaid Manual § 3259.7(B)(2).[16]

[16] Available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927 (CH. 3). Also see *Pfoser v. Harpstead*, 2021 Minn., Lexis 4 (Minnesota Supreme Court, January 20, 2021)(holding that 65-year-old nursing home resident's transfer of $28,000 into a pooled trust was made with intent to dispose of the assets for "other valuable consideration," taking into account his life expectancy and other factors, and did not cause a transfer penalty).

New York has correctly implemented that same policy "…to clarify the treatment of monthly income transferred into pooled trusts by disabled individuals age 65 or over, when determining Medicaid eligibility for nursing facility services."[17] The guidance states, "…amounts paid out of the pooled trust for the benefit of the disabled individual subsequent to the transfer and prior to the Medicaid eligibility determination for nursing home care must be used to offset all or a portion of the assets transferred to the trust." Id. n. 17. In other words, as long as the trust deposits were spent by the trust for the benefit of the Medicaid recipient, the transfer is a compensated transfer not subject to a penalty. Federal and state statutory requirements mandate expenditures from these trusts to be made solely for the benefit of the beneficiary. Under New York's own previous guidance, then, transfers of income or resources into a supplemental needs trust are not uncompensated transfers subject to a penalty, where they are spent by the trust for the recipient's benefit.

Additionally, we object to any requirement that the funds in the trust be spent in the same month in which they were deposited. Neither the federal Medicaid law or the CMS State Medicaid Manual have any such requirement. Upon the trust beneficiary's death, any assets remaining in the trust must be used to repay Medicaid or remain in the pooled trust to be used for the benefit of the non-profit trustee's disabled clients. Thus, there is no incentive for an individual to accumulate funds in the trust unspent. Moreover, if the individual is applying for nursing home Medicaid, , any unspent funds will count as a transfer. GIS 08-MA-020, supra. Flexibility is needed to allow time to spend funds deposited into these trusts, given that some routine expenses such as property taxes, property insurance, and home repair and maintenance costs may be irregular or must be paid quarterly or annually. There is no legal basis to penalize individuals because they rely on their own deposits into these trusts to maintain their homes, allowing them to remain in the community.

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

We appreciate the State's acknowledgement in its waiver amendment submission that the current state definition of "undue hardship," developed solely for the nursing home context, may need to be adapted for use in the community-based context. The existing policy would deny a "hardship" exception to any medically needy applicant, which is everyone who will be subject to the lookback. We ask CMS to condition approval of this waiver amendment on the State's promulgation of a hardship policy that would fairly evaluate whether denial of CBLTC services because of a transfer penalty would constitute a hardship for individuals living in the community. The hardship exception must be based on individual circumstances, and not automatically disqualify individuals solely because they are medically needy, meaning they have excess income above the medically needy income standard.

Federal law requires states to develop a policy to waive the transfer penalty if denial of eligibility would cause an undue hardship that would deprive an individual seeking

[17] NYS Dep't of Health, General Information System GIS 08-MA-020 - *Transfers to Pooled Trusts by Disabled Individuals Age 65 and Over,* available at https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/08ma020.pdf.

community-based long term care of food, clothing, shelter, other necessities, or medical care such that the individual's health or life would be endangered. 42 U.S.C. § 1396p(c)(2)(D). 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 to transfer penalties for nursing home care only, since at the time there was no transfer penalty for CBLTC services. With the recent amendment to NY SSL Section 366(5)(e), the hardship guidance must be adapted for 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 income is deemed to be "Net Available Monthly Income" (NAMI) that must be paid to the cost of their care. Thus, most nursing home residents may 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 for medical care, food and shelter are provided for by the facility.

In contrast, an individual residing in the community may only request an undue hardship waiver under the existing state policy if they pay all of their income above $884month (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 expect a person residing in the community in New York State to provide for all their non-medical needs with only $884 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.

The waiver should not be approved until the State develops and implements a standard and procedure that entitles all applicants for CBLTC services to request an undue hardship waiver. This policy should be developed through notice and comment rulemaking pursuant to the State Administrative Procedure Act. This policy must set standards to determine eligibility for the hardship waiver that take into account the individual's actual living expenses, medical expenses, and other expenses.

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 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. We understand that since these services are authorized outside of the 1115 waiver this issue may not be addressed here.

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 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 raise the question of whether it is worth the cost of implementation and is budget-neutral. This 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 3,770 new CBLTC applicants annually will be subject to the lookback with an average penalty of only 0.91 months based on an average transfer of under $11,700. Altogether, federal savings are projected to be $8.865 million through the end of 2022, which is one year. It is important to track the costs 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 potential federal and state savings from denying services based on a transfer penalty is far lower for CBLTC than for nursing home care. In nursing home care, the applicant is in the nursing home incurring charges from the date of the application, and up to three months retroactively. If the application took 4 months to approve, and a 4-month penalty is assessed, the applicant is liable to pay privately for the 4 elapsed months of nursing

home care, saving the Medicaid program that cost. In the community, however, the applicant is not yet receiving CBLTC that Medicaid would pay for because such services do not exist; Medicaid CBLTC must be prior-approved which is not possible retroactively. So if the application takes 4 months to approve, and a 4 month penalty is assessed, if the penalty time period runs while the application is processed as the State proposes and we support, by the time the application is approved the penalty will have run out and the individual is eligible for Medicaid CBLTC. Based on the State's estimated average penalty of only 0.91 month, most applicants will have run out their penalty long before the application is even approved, and certainly by the time they are ready to enroll in an MLTC plan or start receiving other CBLTC services. As a result, no savings will actually be incurred. But great harm will be inflicted on consumers, because applications will be delayed, delaying access to services.

The impact of the lookback is on all applicants, not just those assessed with a penalty, and on local district staff. All applicants for CBLTC will 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 from the lookback and are not required to submit this documentation will face the delays caused by diversion of application staff to review the lookback documents.

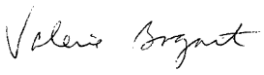
Evaluation should track the number of applicants determined to have made transfers, the amount of the transfers, the amount subject to a penalty (no exception granted), the number and type of transfer penalty exceptions granted, and the amount actually saved. Evaluation should also track any increased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

Additionally, the processing time of applications should be tracked and compared to processing time of applications before the lookback was implemented. The cost to applicants by the delay in waiting for services should be calculated.

* * *

Thank you for the opportunity to submit these comments.

Very truly yours,



Valerie J. Bogart, Director
Evelyn Frank Legal Resources Program
New York Legal Assistance Group
100 Pearl Street, 19th Floor, New York, NY 10004
tel 212.613.5047
fax 212.714.7450
vbogart@nylag.org