NYS Medicaid MRT Changes 2021-2022

New Lookback, Home Care Eligibility and Assessment + Other Changes

October 2021

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New York Legal Assistance Group

ABOUT NYLAG

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

The Evelyn Frank Legal Resources Program (EFLRP) at NYLAG focuses on access to Medicaid for older people and people with disabilities for long term care.

https://nylag.org/evelyn-frank-legal-resources/

Agenda

1. Recent changes – Lock-In and Long Term Nursing Home Disenrollment from MLTC
2. Medicaid Home Care Eligibility & Assessment Changes may begin Nov. 8, 2021
3. New regs make it easier for MLTC plans to Reduce Services after "Transition Period" – and new MLTC Lock-In rules re Voluntary plan changes
4. Nursing Home disenrollment from MLTC – recent changes
5. Not covered but see online:
   - Changes for Medicaid recipients who newly enroll in Medicare – "Default Enrollment" http://www.wnylc.com/health/entry/226/
   - New fair hearing system for Medicaid Advantage Plus (MAP) http://www.wnylc.com/health/entry/225/
   - Special fair hearing protections for homebound consumers appealing denial of a home care increase - http://www.wnylc.com/health/entry/228/

NOW IMPLEMENTING CHANGES ENACTED IN EARLIER YEARS

MLTC Lock-In

Disenrollment from MLTC plans if in Nursing Home 3+ Months

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MLTC Lock-In – Limit on Voluntary MLTC Plan Changes

- Until 12/2020, you could voluntarily change MLTC plans any time.
- **New MLTC enrollees** or those who changed MLTC plans **on or after Dec. 1, 2020**:
  - Have a **90-day grace period** to change plans for any reason
  - May change plans only for **good cause** during the next 9 months. See next slide for what is Good Cause.
- MLTC Members who enrolled before 12/1/20 may change plans any time, but after 90-day grace period, locked into new plan for 9 mos.
- **Which plans –** Lock-in only for "MLTC plans" - may transfer to or from a PACE or Medicaid Advantage Plus (MAP) plan any time.
- First 9-month lock-in period will end Nov. 30, 2021 for people who enrolled or changed plans on Dec. 1, 2020. NY Medicaid Choice will send "end of lock-in notices" 60 days before (Oct. 1st)

Sample notice to current MLTC members of new lock-in in Appendix and posted at http://www.wnylc.com/health/download/753/; see more at http://www.wnylc.com/health/entry/114/#LOCK-IN

MLTC Lock-In – What is Good Cause to Change plans?

- **Good Cause** to change plans after 90-day grace period:
  1. Member moves from the plan's service area,
  2. Plan fails to furnish services,
  3. Member did not consent to enrollment
  4. Plan and member mutually agree that transfer is appropriate
  5. Aide is no longer working with current plan
- If enrolled in MLTC plan before 12/1/20, may change plans any time, but then after initial 90-day grace period in new plan, locked in for 9 months.

See DOH MLTC Policy 21.04 and FAQ at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm

MLTC Lock-in

BEWARE – No transition Rights if Change Plans

- **BEWARE** when changing plans!
- Even within 90-day grace period, of later if member has Good Cause to change plans, DOH considers it a **VOLUNTARY** plan transfer
- Member has ***no continuity of care*** **rights in a voluntary plan transfer**
- **New plan is not required to continue the same plan of care of former plan**
  - **New plan may give fewer hours,** without proving a change in medical condition or circumstances
  - **Member has right to request an increase and appeal** if denied, but has no “Aid Continuing” rights to keep old hours during appeal – not considered a “reduction” in hours

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COMPARE: Involuntary MLTC plan changes – Member DOES have Transition Rights

With INVOLUNTARY changes member has more rights:

1. When an MLTC **plan closes.***
2. Received Immediate Need personal care or CDPAP from local Medicaid agency for 120 days, then was required to enroll in an MLTC plan
3. Received home care from a "mainstream" managed care plan, then got Medicare – and was switched to MLTC or Medicaid Advantage PLUS (MAP)("Default enrollment")**

- **Transition Rights:** The NEW MLTC plan is required to continue the **same plan of care** (same hours of home care or other services) for **90 days** (**120 days** if MLTC plan closed).

*Rights when Plan closes – see **MLTC Policy 17.02** and NYLAG Fact Sheet at http://www.wnylc.com/health/download/757/

**Default Enrollment - see http://www.wnylc.com/health/entry/226/

Involuntary MLTC plan changes – What happens after Transition Period (90 or 120 days?)

- Until Nov. 8, 2021, after transition period, plan may reduce hours only for "cause" – it must specify in Notice and prove:
  1. medical condition improved,
  2. change in social circumstance
  3. Mistake in original authorization
  4. Other reason (less common) in MLTC Policy 16.06:
- **BEWARE**: Eff. Nov. 8, 2021, new State regulation allows plans to reduce hours after transition period based on plan's view that old hours not "medically necessary," without proving any change. Plan only has to give notice that:
  - indicates a clinical rationale that shows review of the client's specific clinical data and medical condition**

Rights when Plan closes – see **MLTC Policy 17.02** and NYLAG Fact Sheet at http://www.wnylc.com/health/download/757/.

**New regs 18 NYCRR 505.14(b)(4)(viii)(c)(3)(vii), 505.28(i)(4)(iii)(h) –Personal Care reg at https://regs.health.ny.gov/regulations/recently-adopted pp. 60, 137

Involuntary MLTC plan changes – What happens after Transition Period (90 or 120 days?)

Now and after Nov. 8th – Member has the right to appeal a reduction in 2 stages:

1. Initial Adverse Determination to reduce or deny an increase → request internal PLAN APPEAL.
2. Final Adverse Determination to reduce or deny increase (you lost plan appeal) → request FAIR HEARING.

- Involuntary plan change – right to **AID CONTINUING** if appeal quickly within 10 days of date of BOTH above notices. This means old hours continue while appeal pending.
- Voluntary plan changes – no right to AID CONTINUING.

CONTACT **ICAN** for HELP **1-844-614-8800**

NYLAG Fact Sheet on MLTC appeals at http://www.wnylc.com/health/downloads/654/ and longer article at http://www.wnylc.com/health/entry/184/

LONG TERM NURSING HOME STAY DISENROLLMENT FROM MLTC

If in nursing home 3+ months and approved for Nursing Home Medicaid

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MLTC members disenrolled if in Nursing Home 3+ months (“LTNHS”)

- Since 8/1/20 -- MLTC members who are ‘**Long Term Nursing Home Stay**’ – in NH 3+ months + approved for Nursing Home (NH) Medicaid after 5-year lookback → disenrolled from plan.
- Should NOT be disenrolled if Plan, NH or Open Doors says member has an **active discharge plan**.
- Members receive 2 notices before disenrollment:
  1. **NEW 30-day notice from plan** – 1st ones sent in Sept. 2021 with heads up that will be disenrolled because in NH 3+ months. Explains they can request assessment to return home, Copy sent to designated rep.
  2. **10-day Notice from NY Medicaid Choice** with right to (1) request fair hearing or (2) call NY Medicaid Choice 1-888-401-6582 and request assessment to be discharged home
- If disenrolled, right to re-enroll within 6 months – CONTACT NY Medicaid Choice
- Only NY Medicaid Choice, not plan, may initiate disenrollment for LTNHS

* Copy at http://www.wnylc.com/health/download/722/
GIS 20-MA-06; More at http://www.wnylc.com/health/entry/199

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MLTC members disenrolled "LTNHS" con'd.

- Only person listed as Authorized Rep on the Medicaid app receives a copy of the notice. To be listed, submit *Form DOH-5247 - Medicaid Authorized Representative Designation/ Change Request*** to Local Dept. Social Services (DSS).
- In NYC-
  - if the nursing home Medicaid application was approved, fax form to 917-639-0736.
  - If the Medicaid application is still pending, ask nursing home to submit it or fax to 917-639-0735. Note the name and address of nursing home. Read more here.

Call ICAN 844-614-8800 and Dept. of Health MLTC Complaints – **1-866-712-7197 if:**

- MLTC Plan refuses to reinstate home care when member ready for discharge, claiming not "safe" to go home. After 3 months, will be disenrolled and then it will be harder to go home.
- If someone was already disenrolled who should not have been.

**https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/17ma017_english.pdf

Update on status of batch disenrollments

- The State has to date successfully completed four "Batch Process" Nursing Home disenrollments in August 2020, November 2020, April 2021 and October 2021.
- A total of 20,353 individuals (1,285 for Oct. 2021) have been disenrolled through the "Batch Processes."
- This number does not include the 200 individuals who were identified but not disenrolled because they had an active transition plan, were in the community or requested another assessment or requested a fair hearing

NY Dept. of Health, MMCARP Slides 10/7/21

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CHANGES IN HOME CARE ELIGIBILITY & ASSESSMENT

Regulations to implement budget changes adopted 8/31/21 – regs will be effective Nov. 8, 2021 but implementation later

ADOPTED REGS eff. 11/8/2021 posted at https://regs.health.ny.gov/regulations/recently-adopted or direct link

https://regs.health.ny.gov/sites/default/files/pdf/recently_adopted_regulations/Personal%20Care%20Services%20and%20Consumer%20Directed%20Personal%20Assistance%20Program.pdf

NYLAG COMMENTS on proposed regs http://www.wnylc.com/health/download/771/ (3/13/21)

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Personal Care (PCS) & CDPAP changes – Overview

1. New **minimum number of ADLs** required for eligibility for Personal Care Services (PCS)/Consumer Directed Personal Assistance (CDPAP) & MLTC enrollment
2. **New Independent Assessor procedure** for both HRA/DSS, MLTC and mainstream managed care plans – Expanded role for Maximus
   - New "high need" review if need > 12 hours/day
3. **Easier for plans to REDUCE hours** after an involuntary MLTC plan enrollment **(discussed below** with new LOCK IN rules slides 8-10)

When?

- Regulations adopted 8/31/21 are effective **11/8/21** but will likely be rolled out gradually (Link on slide 15)
- ADL thresholds need CMS approval because of COVID ARPA "Maintenance of Effort" requirements – since they restrict eligibility.
- DOH has said the Independent Assessor changes will be implemented first, before the ADL thresholds

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RAISING THE BAR OF WHO is ELIGIBLE for PCS/CDPAP – Minimum 2 or 3 ADLs

- **CURRENT LAW:** Personal Care (PCS) or CDPAP requires need for **any** assistance with just **ONE** "Activity of Daily Living"
  - ADLs = Walking/locomotion, bathing, personal hygiene, dressing, toileting/incontinence care, eating, transfer on/off toilet
- If qualify for PCS or CDPAP – you obtain it from:
  1. An MLTC plan (mandatory to enroll if you have Medicare), or
  2. Local Dept. of Social Services [**DSS**]/CASA ("Immediate Need" or if excluded/exempt from MLTC ie. in home hospice, OPWDD or NHTD/TBI waiver), or
  3. If don't have Medicare – from "mainstream" managed care plan
- If don't need ADL assistance, you may still get "Level 1" personal care a/k/a "Housekeeping" service **up to 8 hrs/week** from LDSS/HRA – for help with "Instrumental ADLs" (IADLs) – laundry, shopping, cleaning, meal prep

18 NYCRR § 505.14(a)

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NEW: 3 ADL "minimum needs requirement"

Eligibility for PCS/CDPAP & MLTC will require the need for:

1. *Limited assistance* with **physical maneuvering** with **3 ADLs** ("more than 2" ADLs) **or**
2. **SOLE EXCEPTION** for **dementia or Alzheimer's** diagnosis - need **cueing or supervision** with **2 ADLs** ("more than one ADL")

WHEN?

- Applying at LDSS – could be as early as Nov. 8, 2021
- Applying for MLTC – New criteria can't be used until CMS approves it, which they haven't as of 9/7/21. So TBD.

Current recipients grandfathered in – If assessed and authorized for services before Nov. 8, 2021(or later implementation date) –continue to receive Level 1 "Housekeeping" thru LDSS, or personal care/CDPAP thru LDSS or managed care plan, even if don't meet new criteria

§ 2-a, 2-b, 3, 21, amending S.S.L. §§ 365-a subd.2 (e), 365-f, subd. 2

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3- or 2- ADL requirement

Leaves out IADLs – Housekeeping services

- **Instrumental ADLs (IADLs)** = housekeeping tasks – shopping, laundry, cleaning, meal prep, phone use, medication administration
  - Not considered in whether eligible for PCS/CDPAP (this has always been true – even now you need one ADL)
  - If meets the ADL requirement, the personal care/CDPAP aide assists with both ADLs and IADLs.
- If only need IADL and NOT ADL assistance, *until now* could apply to DSS for Housekeeping 8 hours/week. **THIS IS ENDING because this is a type of Personal Care, which now requires 3 ADLs.**
  - **Current "Housekeeping" recipients grandfathered in** (614 NYC cases in 6/2021)
  - **No NEW applications will be accepted** for Housekeeping – possibly after Nov. 8, 2021
- Will lead to falls, accidents -- PREVENTIVE service.
- **Only option** – *If age 60+* - non-Medicaid **EISEP** services through County Office of the Aging/ NYC DFTA.**

*18 NYCRR 505.14(a)(5)(i)

** https://aging.ny.gov/expanded-home-services-elderly-eisep

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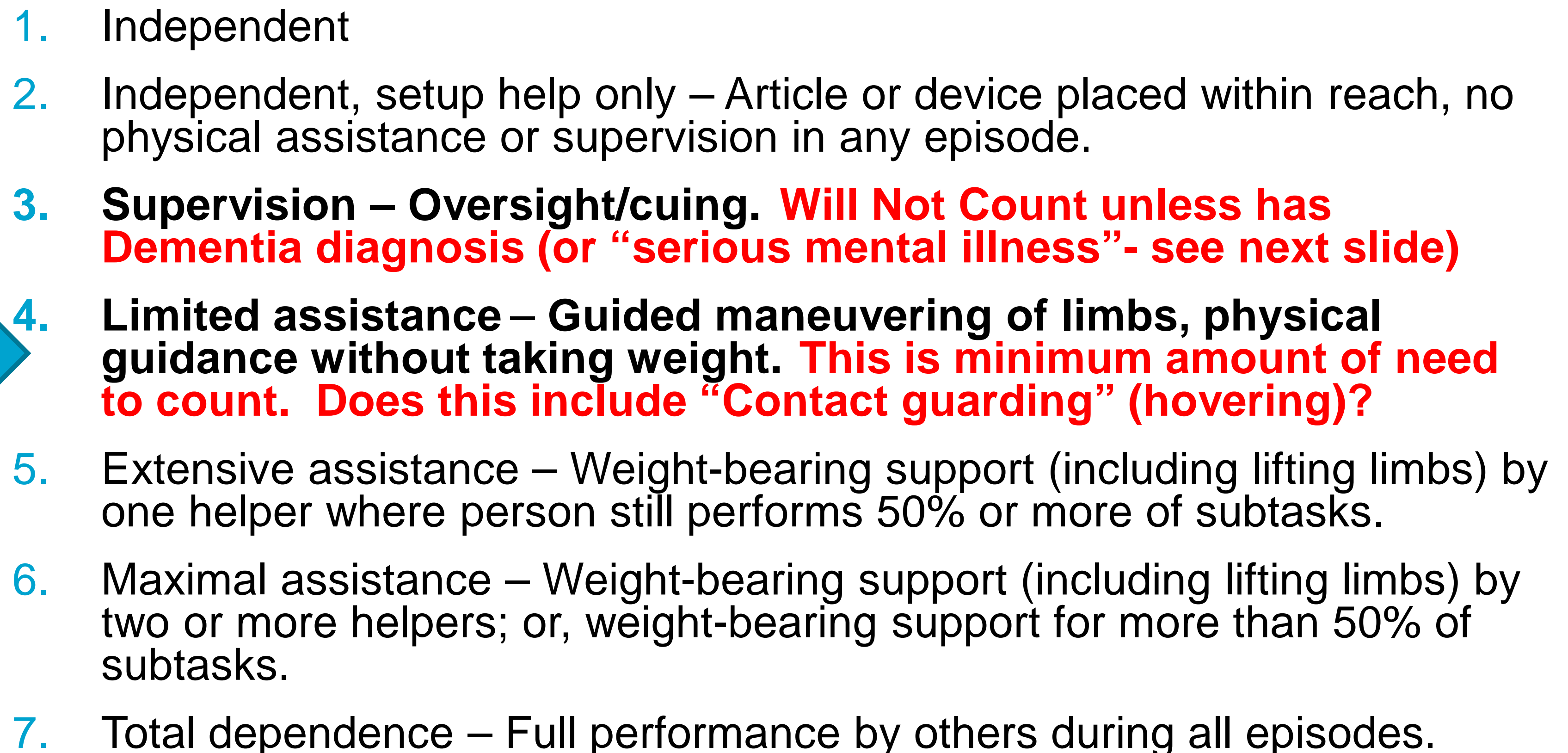
3 ADL Requirement

ADL counts only if need “Limited Assistance with “Physical Maneuvering”

Unless dementia or Alzheimer’s diagnosis, ADL counts toward the minimum only if needs “at least limited assistance with physical maneuvering.” The **UAS instructions** define seven degrees of assistance as follows, with “7” being the most assistance:



1. Independent
2. Independent, setup help only – Article or device placed within reach, no physical assistance or supervision in any episode.
3. **Supervision – Oversight/cuing. Will Not Count unless has Dementia diagnosis (or “serious mental illness”- see next slide)**
4. **Limited assistance – Guided maneuvering of limbs, physical guidance without taking weight. This is minimum amount of need to count. Does this include “Contact guarding” (hovering)?**
5. Extensive assistance – Weight-bearing support (including lifting limbs) by one helper where person still performs 50% or more of subtasks.
6. Maximal assistance – Weight-bearing support (including lifting limbs) by two or more helpers; or, weight-bearing support for more than 50% of subtasks.
7. Total dependence – Full performance by others during all episodes.

Who is left out - needs “supervision” but not physical maneuvering with ADLs?

- Only **Dementia** or **Alzheimer’s** diagnosis qualifies with 2 ADL’s based on needing “supervision” not hands-on assistance
- Leaves out:
    1. Traumatic Brain Injury
    2. Developmental Disability
    3. Visual impairments
    4. Other cognitive, neurological or **psychiatric impairment***
- This discriminates based on diagnosis and is illegal in our view. Should include anyone who needs supervision because of *any* impairment.
- *In final regulations, DOH agreed to qualify people with “**Serious Mental Illness**” who need cueing assistance with 2 ADLs – treat the same as Dementia. But ***no one else***. And not added to regulation – only says in comments that they will create a procedure to request an exemption as a reasonable accommodation*

*See slide 15 to link to final regulations – see p. 244

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Caution on "Supervision"

- The new thresholds count an ADL if a person has dementia and needs cueing or supervision with 2 ADLs.
- Even a person who has dementia will not be eligible if they need general **"safety monitoring" or "supervision."**
  - Since a 1999 court decision,* NY Medicaid PCS **does not** include "stand alone" *supervision* or *safety monitoring*.
  - Medicaid **DOES** cover safety monitoring, supervision or cognitive prompting ***to assure safe completion of ADLs.***
- **TIP: Always identify the ADL for which client needs supervision or cueing to assure safe performance.**
  - Eg**.** Needs cueing and prompting **for** safe ambulation, or **for** toileting, etc. And describe **how** supervises (remind to use walker, remind to do post-elimination hygiene), etc.
- New regulation doesn't change the rule but will lead to more denials for people with dementia, if don't cite which ADL client needs supervision with. Will not help people without dementia diagnosis.

*Rodriguez v. DeBuono, 175 F.3d 227 (2nd Circ. 1999; MLTC Policy 16.07

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New Assessment System – DSS & Plans

NY Medicaid Choice ("NYMC" or Maximus) has huge new role. Until now they just do Conflict Free Assessment for MLTC.

New assessment procedure for MLTC, mainstream managed care AND all Local DSS applications for PCS/CDPAP:

A. **TWO "Independent assessments" by *NY Medicaid Choice (NYMC)* –**
   1. **Independent Assessment (IA) –** by NYMC ***nurse.*** Now***,*** after NYMC does the Conflict Free assessment for new MLTC enrollee, MLTC plan will no longer do a separate assessment. Also this replaces nurse assessment by LDSS in Immediate Need or other cases.
   2. **Independent Practitioner Panel (IPP)**- exam by NY Medicaid Choice PHYSICIAN, physician's ass't. or nurse practitioner.

B. **HRA/DSS or Plan authorizes services if find needs < 12 hours/day.** But may also dispute the IA if plan/DSS has "material disagreement" affecting plan of care. Then IA may make change or do *new assessment* in 10 days.

C. **If HRA or Plan say needs > 12 hours per day** → see next slide.

DOH encouraging **TELEHEALTH** for all assessments (not telephone)

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See new state regs – cite slide 15

New Assessment System – DSS & Plans *con'd*

Independent Review Panel (IRP) for High-Need cases > 12 Hrs/day

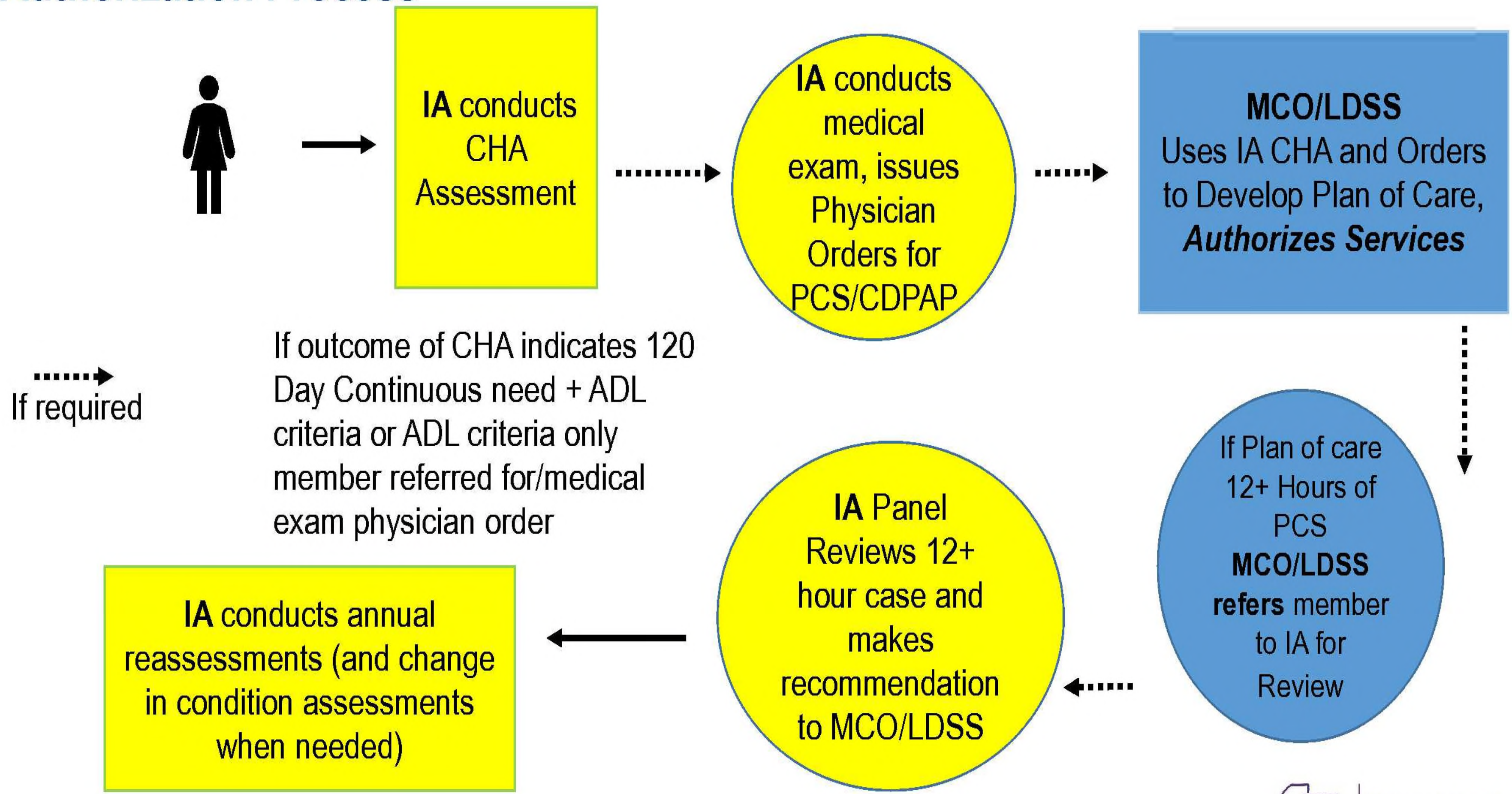
C. **If DSS or Plan say needs > 12 hours/day →Must refer for High–Need "Independent Review Panel"** (IRP) ***by NY Medicaid Choice*** – recommends whether proposed plan of care is "reasonable and appropriate" to maintain health & safety in the home.

- **ALERT: Saying "unsafe" can be pretext for denying needed high hours → force into nursing home – violate *Olmstead* and ADA.** A "public entity must ensure that its safety requirements are based on **actual risks**, not on **mere speculation, stereotypes, or generalizations** about individuals with disabilities."*
- IRP may recommend changes in plan of care but NOT specific amount of hours.
- IRP not required on reassessment if IRP previously reviewed plan of care of > 12 hours/day

D. Plan/DSS make final decision and issue notice

* ADA regulation 28 CFR §35.130(h)

Role Independent Assessor and MCO/LDSS in New PCS/CDPAP Authorization Process



The new Assessments will cause delays!

New assessments will cause inevitable delays – required in each of these instances:

1. MLTC enrollment
2. MLTC or mainstream managed care authorization of services
3. Annual renewals by DSS/MLTC (these will no longer be every 6 months)
4. Immediate Need applications at HRA/DSS
5. Requests for increases in hours - DSS, MLTC, mainstream managed care
6. All Hospital & Rehab discharges - the IA is always required.

The proposed regulations say:

- HRA/DSS must determine hours within **7 days** of receiving back all of the assessments…but no deadlines on conducting assessments!*
  - Immediate Need deadline – 12 Days after application filed to approve Medicaid AND home care
  - Plan deadlines are on next slide. Impossible to meet these time limits!
- **DSS/Plan *may* (not *must*) authorize "temporary" care > 12 hours/ day pending the High Need IRP Review* if can't meet deadlines****
- Added delay if DSS/Plan dispute "material fact" in IA – IA may have to be REPEATED. NY Medicaid Choice has **10 days** to schedule 2nd assessment (reg pp. 44, 111).

* 505.14(b)(3)(ii), 505.28(g)(2) (p. 51, 127)
**505.14(b)(4)(vi), 505.28(e)(4) (pp. 54, 121).

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Delays –MLTC/ mainstream plan have short deadlines to decide requests for Increase or New Services

Type of Request	Maximum time for Plan to Decide
Expedited*	**3 business days from receipt of request,** though plan may extend up to 14 calendar days if needs more info.
Standard	**14 calendar days from receipt of request,** though plan may extend up to 14 calendar days if needs more info.
Medicaid covered home health care services following an inpatient admission**	(1) business day after receipt of necessary info; except when request made the day before a weekend or holiday, **no more than three (3) business days** after receipt of the request for services.

42 C.F.R. 438.210(d). *Expedited if delay would seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. 42 CFR 438.210
**NY Insurance Law § 4903(c)(1).

STATE BUDGET – NEW LOOKBACK FOR HOME CARE

DOH request to CMS to amend MLTC waiver –

https://health.ny.gov/health_care/medicaid/redesign/mrt2/proposals/30-month_lookback-final.htm (March 2021)

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NEW 2.5 Year Lookback for Home Care + CB-LTC

- **DEFINITIONS:**
  - **Lookback** = Application to obtain Community-Based Long Term Care (CB-LTC) must include copies of all financial records for applicant and spouse for the "lookback period."
  - **Lookback period** – Either 30 months prior to month of application, or since 10/1/20, whichever is longer
  - **Transfer Penalty -** If a "non-exempt" transfer was made in the lookback period, Medicaid will not pay for CB-LTC services for the penalty period. Will use **same penalty rate** as for nursing homes (more below).
- **WHEN: Nothing definite – waiting for federal approval. Now earliest is April 1, 2022** to start for applications filed after this date because of federal COVID-19 "maintenance of effort" protections – States can't restrict eligibility. **Could be July 1, 2022 or later**

More on Lookback for Home Care & CB-LTC

- **BACKGROUND** - Under federal law, states **MUST** do a **5-year** lookback for nursing home care.
- States **MAY** require a lookback for Medicaid home care and other **community-based long term care services** (**CB-LTC**).
- NYS never had a lookback for CB-LTC *until* enacted in State Budget April 2020.
- New Lookback is only for **long term care** services -- States **may NOT** require a lookback for hospital care, acute & primary care.
- No CMS approval yet. No final regulations or guidance issued yet. Some details in DOH request to CMS to amend the MLTC "waiver"*

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*https://health.ny.gov/health_care/medicaid/redesign/mrt2/proposals/30-month_lookback-final.htm

Which Community-Based Long Term Care Services WILL Require a LOOKBACK?

1. Personal care services (PCS) (a/k/a home attendant)
2. CDPAP (Consumer-Directed Personal Assistance Program)
3. Private Duty Nursing
4. Assisted Living Program (ALP)
5. Adult Day Health Care
6. MLTC, Medicaid Advantage Plus and PACE plan enrollment
7. Certified home health agency (CHHA) – *if > 29 days?*

No lookback for:

1. Waivers (but how does applicant show she wants these?)
   a. Nursing Home Transition (NHTDW)
   b. Traumatic Brain Injury waiver
   c. OPWDD waiver
2. Mainstream Managed care (these plans provide most of the above LTC services for those without Medicare)
3. Acute, primary care, hospital, ER

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Who is Grandfathered in – so does Not have to do Lookback? And who MUST do lookback?

Who is grandfathered in?

- If ***applied*** for Medicaid with CB-LTC before implementation date (even if not receiving services by that date)
- Application must include complete, signed Supplement A

TIP: People who transferred assets since 10/1/20 should apply before 4/1/22 (or later if delayed) so will have NO LOOKBACK or PENALTY for home care or ALP

Who will have to Submit Lookback with Application?

- **NEW Applicants** for Medicaid coverage of CB-LTC filed after 4/1/2022 (unless delayed til 7/1/22 or later)
- **Current Recipients who applied for Medicaid *without* long term care coverage** and "attested" to the amount of resources, without verifying the amount.** If they want CB-LTC after effective date, they must **request an "increase**" in coverage by submitting Supplement A and the **lookback** documents.
- *During pandemic, ALL applicants may attest to amount of resources* See slide 47.

*https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf

**04ADM-06 - Resource Documentation Requirements for Medicaid Applicants/Recipients (Attestation of Resources

Supplement A TIPS & New form in NYC Jan. 1, 2021

– Starting Jan. 1, 2021, NYC has a **new Supplement A** form --DOH-5178A (Was already used upstate) https://www.health.ny.gov/forms/doh-5178a.pdf.
  - **NEW**: **Spouse** must sign it, **even if doing spousal refusal** or **not applying**.
  - **NEW**: Supplement A must now be submitted even if NOT seeking CB-LTC. Before, it was required only if seeking CB-LTC.
  - Item #8 of form asks "What care & services are you applying for?" -- check 2nd of 3 boxes - seeking CB-LTC.
  - See http://www.wnylc.com/health/news/89/ (HRA Medicaid Alert posted).

**04ADM-06 - Resource Documentation Requirements for Medicaid Applicants/Recipients (Attestation of Resources

Gray area - who is "Grandfathered in" and does not have to do lookback

NYLAG asked State to grandfather these groups in without a lookback:

- **New Dual Eligibles who received home care from Mainstream managed care plan,** with MAGI Medicaid. When became enrolled in Medicare, Medicaid eligibility was redetermined under non-MAGI rules --
  - We said should not need to do lookback with the redetermination because received CB-LTC. No policy yet.
- **If Medicaid was discontinued** for a renewal problem, etc. and client has to reapply (ie client is *re*-applying not *newly* applying)
  - DOH said they'll think about it

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Phase-In Period

- **Any transfers of assets BEFORE 10/1/2020 will NOT be subject to a penalty.**
- Lookback is only back to 10/1/20. This is true even if lookback is delayed past 4/1/22

Apply on or after	Length of lookback
Apr. 1, 2022	18 months
Add 1 month every month so that:	
Jan. 1, 2023	27 months
April 1, 2023	30 months

TIP: If transfer was made after Oct. 1, 2020, apply before April 1, 2022! May have until later but no official word yet.

Lookback for Married Applicants – Spouse's Records

- Must include **all financial records for applicant and spouse** for lookback period
  - Even if using "spousal refusal!" **THIS IS A BIG CHANGE**.
- **Spousal Refusal** is still allowed (not repealed as proposed in April 2020 budget) but this doesn't protect applicant from transfer penalty if spouse transferred assets
- **Example**: Applicant Andy's spouse Sammy transferred $50,000 during lookback period. Sammy still has $200,000.
- Sammy may do spousal refusal so $200,000 won't count as Andy's asset (subject to DSS claim for spousal support)
- But the $50,000 transfer will give Andy a transfer penalty, unless it was an exempt transfer.

How long is the Transfer Penalty?

1. **Total up every uncompensated transfer** in the lookback period to determine the length of the penalty.
2. Divide that total amount by a number called the **Regional Nursing Home Rate** – DOH publishes it every year.* The result is the **penalty period** – the number of months that Medicaid will NOT pay for the nursing home stay OR for home care/ALP.

* This is NYC. See rate for other regions at https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/20ma12.pdf

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Lookback will likely delay Medicaid application

- Medicaid applications must be decided within **45 days***
  - **90 days** if require a determination of disability* (i.e. with pooled trust for person age 65+ or < 65 and SSD was denied)
  - **12 days** for "**Immediate need**" applications** – DOH not likely to allow applicant to "attest" no transfers made as advocates asked.
- Lookback adds work for the local district. Even though the poorest applicants won't have transfers, delays of obtaining & processing financial records will affect them too.
  - **Asset Verification System (AVS)***** – DSS can use electronic data in lieu of requiring bank statements & real property records. But investment accounts, life insurance cash value, IRAs not in AVS. Plus need bank statements to identify and explain why large payments and withdrawals are not "transfers."
- In nursing home, delay doesn't hurt client because they are getting the needed care. Not true when apply for home care!

*42 USC 1396a(a)(8); 42 C.F.R. 435.911; 18 NYCRR 360-2.4; see article at http://www.wnylc.com/health/entry/175/

** Soc. Serv. L. §366-a(12)

*** 17-ADM-02 - Asset Verification System, expanded to NYC 1/1/21 per HRA Alert 12/22/20 at http://www.wnylc.com/health/download/761/

May income still be placed in a pooled trust?

- **This is still unclear.** A ***transfer penalty*** applies not only to transfers of ***ASSETS*** but ***transfers of INCOME***.
  - Transfer of income or assets into a pooled trust is exempt if < 65 and disabled.
  - But what about age 65+? Transfers into trusts are NOT exempt.
- But advocates think CMS policy allows it – No penalty if
  - "…**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…."**
- **Advocates say -- as long as trust paid for expenses to meet the needs of the individual, there should be no penalty**. NYS DOH 2008 GIS MA/020.
- May require spending money quickly every month – a problem if need to save for annual or irregular expenses – property taxes, etc.

**CMS Medicaid Manual § 3259.7(B)(2): https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927 (CH. 3)

Exceptions to Transfer Penalty – Assets other than the home

Exceptions same as for nursing home. No penalty for **transfer by the applicant or spouse** of an asset other than the home to:

1. **spouse**
2. **child** who is **certified blind or disabled**
   - Child may be over age 65 **-** Disability Reviews for Adult Children over 65, GIS 08 MA/036
3. **Supplemental needs trust for disabled person <65**
   - Can be for oneself if <65 and disabled or for someone else
4. **Transfer of an exempt asset** has no penalty – ie. Holocaust restitution, assets under $15,900

18 NYCRR § 360-4.4 (c)(1)(ii); see http://www.wnylc.com/health/entry/38/ .

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More Exceptions to Transfer Penalty (assets other than home)

5. Meant to sell asset for its **fair market value**;
6. Transfer was made **exclusively for purpose other than to qualify for Medicaid long term care** (young, healthy client had stroke after gift)
7. All of the transferred **assets have been returned** to the individual.
   - Partial return reduces penalty proportionally*
8. Individual used assets to purchase:**
   - an annuity or life estate or
   - promissory note, loan, or mortgage

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* 2006 ADM, p. 18.

** must follow rules in SSL §366 subd. 5 (e)(3)(i-iii)

Transfer of the home

Advocates believe ALL transfers of the home should be exempt – Since a home is exempt for community Medicaid (if single and equity < $906,000, or if a spouse, minor or disabled child live there).

But NYS DOH disagrees. No final state policy yet. DOH proposes to allow only the same transfer penalty exemptions that apply for nursing home Medicaid. That would mean transfer of the home to certain people is exempt:

- to spouse or disabled child
- This would mean NO transfer allowed to "caregiver" child or sibling with equity interest – because must have lived with applicant for 1-2 years **before institutionalized**. Makes no sense in the community!

See more in NYLAG lookback comments - http://www.wnylc.com/health/download/746/.

Soc. Serv. L. § 366(5)(e)(4)(i); See *Mondello v. D'Elia*, 39 N.Y.2d 978, 1976 N.Y. LEXIS 2927, 387 N.Y.S.2d 232.

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Transfer Penalty would cause "Undue Hardship"

- No penalty if denial of eligibility because of a transfer would cause an undue hardship - would:
  - **deprive the individual of medical care endangering health or life OR of food, clothing, shelter**, or other necessities of life
    - State definition allows this only if person's income below Medicaid level – can't have a spend-down. That definition was made for nursing homes – makes no sense in community
  - **And applicant is unable to have the resources returned despite best efforts,** or can't obtain fair market value for them, or cannot void a trust fund where funds transferred

* §366 subd. 5 (e)(4)(iv); 96 ADM-8 at 23; 06 OMM/ADM-5 at 19-20;18 NYCRR § 360- 4.4(d)(2)(iii). Hardship if nursing home threatens discharge if Medicaid not secured and payment not made. FH 6657601M Albany, FH 67841713Z Schenectady; FH No. 6660774R Suffolk;

How much cooperation & effort is required of applicant or agent with power of attorney to get funds back – has been the subject of fair hearings. See, e.g,. FH #5153034Y (Albany Co. 5/12/09)(no hardship found), FH No. 6660774R, Suffolk Co. 3/12/2014 (undue hardship exemption granted)

When does penalty period begin?

- New law says "The period of ineligibility shall begin …**the first day the otherwise eligible individual is *receiving* services** for which…" Medicaid would pay but for the transfer penalty. Soc. Serv. L. §366 Subd. 5(e)(5)
  - But - cannot receive MLTC, CDPAP or personal care services until Medicaid is approved. Penalty can't start running until start ***receiving*** those services. Catch-22!!
- **GOOD NEWS -** DOH has indicated it will follow CMS guidance on 1915(c) waivers* (NHTDW, TBI) that penalty begins when consumer "**would otherwise be receiving" home care**.
  - **New form for treating physician to state applicant has functional need for home care** – will be required to submit with application
  - This is good – otherwise policy would be more favorable in nursing home than home care – could violate the ADA. But no written policy yet.

*CMS State Medicaid Director Letter SMD#18-004, https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18004.pdf

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