New York State
Medicaid Redesign Team (MRT) Waiver

1115 Research and Demonstration Waiver

#11-W-00114/2

30-Month Lookback for Community Based Long Term Care Services

Amendment Request

NEW YORK STATE | Department of Health

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Section I. Program Description and Objectives

Goals and Objectives

In July 1997, New York State received approval from the Centers for Medicare and Medicaid Services ("CMS") for its "Partnership Plan" Medicaid Section 1115 Demonstration (the "1115 Demonstration"). In implementing the 1115 Demonstration, the State sought to achieve the following goals:

- Improve access to health care for the Medicaid population;
- Improve the quality of health services delivered; and
- Expand coverage to additional low-income New Yorkers with resources generated through managed care efficiencies.

In furtherance of these goals, the primary objective of the 1115 Demonstration was to enroll most of the State's Medicaid population into managed care, and to use a managed care delivery system to deliver benefits to Medicaid recipients, create efficiencies in the Medicaid program and enable the extension of coverage to certain individuals who would otherwise be without health insurance.

The 1115 Demonstration was last renewed by CMS on December 7, 2016 and, at the time of renewal, the name of 1115 Demonstration was changed from the Partnership Plan to the New York Medicaid Redesign Team ("MRT") Waiver. Since the MRT Waiver's renewal, this waiver has been amended to reflect programmatic needs. Under the waiver, the State is required to seek Federal approval of any amendments**.**

Proposed Implementation

The State intended to implement this Amendment effective January 1, 2021. However consistent with Maintenance of Effort requirements under Section 6008(b)(1) of the Families First Coronavirus Response Act (FFCRA), and the requirements for Home and Community Based Services under the American Rescue Plan Act, the earliest date that the State will seek implementation is March 31, 2024.

Section II. Proposed Amendment

The State of New York (the State or New York) is seeking to implement a 30-month transfer of assets lookback period for coverage of community based long-term care (CBLTC) services, and approval to exclude certain enrollees from these rules.

Pursuant to a state statutory change on April 2, 2020, New York will be submitting a State Plan Amendment to request approval to apply the federal option to impose transfer of assets rules to certain categories of individuals applying for CBLTC services (non-institutionalized individuals). Under the federal statute, the transfer of assets lookback period is 60 months prior to the month the individual is applying for Medicaid. New York is seeking approval to impose a lookback

period of 30 months for non-institutionalized individuals seeking coverage of CBLTC services. Under New York's April 2, 2020 statutory change, the transfer of assets rules for CBLTC services are effective October 1, 2020. The exceptions to the Medicaid transfer of assets rules and provision for an undue hardship waiver that apply under the transfer of assets provisions of the federal Omnibus Budget Reconciliation (OBRA) of 1993 and Deficit Reduction Act (DRA) of 2005 would apply to transfers in these situations.

In New York, community based long-term care services are available through Medicaid fee-for-service, managed long term care (MLTC), and Medicaid mainstream managed care (MMC). Under current standards, the services provided through MMC are included in one benefit package and enrollees are not required to be in need of CBLTC services for MMC plan enrollment. Conversely, under current standards, MLTC plan enrollees are dual eligible, over 21 years of age and assessed as needing CBLTC services for more than 120 days. The State is seeking approval to exclude individuals enrolled in MMC from the non-institutional transfer of assets rules, regardless of whether the individual is in a category that the State has elected to include in the eligibility groups that will be subject to non-institutional transfer penalties.

The State will also seek approval under the Section 1115 to impose the lookback with a modified phase-in, meaning a full 30-month retroactive review will not be applied on January 1, 2022. Under New York's April 2, 2020 statutory change, the transfer of assets rules for CBLTC services are effective October 1, 2020. Therefore, the State is seeking to begin applying the CBLTC transfer rules on January 1, 2022, meaning that applications for CBLTC services submitted on or after January 1, 2022 would be assessed for any transfers made on or after October 1, 2020.

This statutory change was recommended by the Medicaid Redesign Team II and adopted by the New York State Legislature in order to ensure that Medicaid payments are not used when CBLTC services could be covered by an individual's own income and/or resources that were transferred, if the transfer is subject to the imposition of a transfer of asset penalty period.

Following are the community based long-term care services the State plans to impact by this initiative:

- Adult day health care
- Assisted living program (ALP)
- Certified home health agency (CHHA) services
- Personal care services
- Consumer directed personal assistance program
- Limited licensed home care services
- Private duty nursing services
- Managed long-term care in the community*

*Note: Managed long-term care in the community is not a State Plan service and instead refers to enrollment in managed long-term care (MLTC) plans while residing in a community-based setting. These plans include Partial Capitation, Medicaid Advantage Plus and Programs of All-Inclusive Care for the Elderly (PACE). Because this service list includes most of the services in the MLTC benefit package found in Attachment B of the current 1115 Waiver Special Terms and Conditions, the State would not require nor permit enrollment in such plans prior to the proposed 30-month lookback and any imposed penalty period.

This initiative does not pertain to waiver services obtained pursuant to 1915(c) or (d) of the Social Security Act, which are waiver services provided through the Traumatic Brain Injury Program, the Nursing Home Transition and Diversion Waiver Program, the consolidated 1915(c) waiver for children and the Office for People with Developmental Disabilities' (OPWDD) Comprehensive Home and Community-Based 1915(c) waiver.

Eligibility categories determined pursuant to Modified Adjusted Gross Income (MAGI) budgeting rules would not be impacted by the State's intended change. Following are the Medicaid eligibility categories of non-institutionalized individuals impacted by this initiative, which are eligibility groups categorized as Aged, Blind or Disabled and subject to non-MAGI budgeting rules:

Optional Medicaid Eligibility Categories:

- Ticket to Work Basic Group (SSA §1902(a)(10)(A)(ii)(XV))
  Individuals eligible in this category are working individuals with disabilities between ages 16 and 65 whose income does not exceed established levels.

- Ticket to Work Medical Improvement Group (SSA § 1902(a)(10)(A)(ii)(XVI))
  Individuals eligible in this category are working individuals with disabilities between ages 16 and 65 whose income does not exceed established levels, who lose eligibility in the Ticket to Work Basic Group due to medical improvement and who are employed at least 40 hours per month and earn at least the federally required minimum wage.

Medically Needy Medicaid Eligibility Categories:

- Medically Needy Aged (SSA § 1902(a)(10)(C), 42 CFR 435.320 and 435.330)
  Individuals eligible in this category are age 65 and over with income above the federal poverty level thresholds and who incur large medical expenses. These individuals may subtract these medical bills from their actual income and become eligible if their adjusted income falls below the established poverty level thresholds.

- Medically Needy Blind (SSA § 1902(a)(10)(C), 42 CFR 435.322 and 435.330)
  Individuals eligible in this category are blind with income above the federal poverty level thresholds and who incur large medical expenses. These individuals may subtract these medical bills from their actual income and become eligible if their adjusted income falls below the established poverty level thresholds.

- Medically Needy Disabled (SSA § 1902(a)(10)(C), 42 CFR 435.324 and 435.330)
  Individuals eligible in this category are disabled with income above the federal poverty level thresholds and who incur large medical expenses. These individuals may subtract these medical bills from their actual income and become eligible if their adjusted income falls below the established poverty level thresholds.

Section III. Waiver Authority

The State seeks such waiver authority as necessary under the demonstration to implement a 30-month transfer of assets lookback period for coverage of CBLTC services, and approval to exclude certain Mainstream Managed Care enrollees from these rules. This initiative was adopted to eliminate Medicaid payments that could be covered by an individual's own income and/or resources that were transferred, if the transfer is subject to the imposition of a transfer of asset penalty period.

Pursuant to the State's statutory change, New York will be submitting a State Plan Amendment to request CMS approval to apply transfer of assets rules beginning January 1, 2022 to certain categories of individuals applying for coverage of CBLTC services (non-institutionalized individuals). In addition to the request to amend our State Plan, New York is seeking further approval through this proposed amendment to our Section 1115 waiver in order to implement this change more efficiently, contain costs and conform with changes in State law. 42 USC § 1396p(c)(1)(B)(i) requires a 60-month lookback / transfer penalty for institutionalized individuals, or, at the option of the state, for non-institutionalized individuals as well. As provided for in the recently enacted State law, New York will be seeking approval under the Section 1115 waiver to apply a look-back period of thirty (30) months, rather than the federally required sixty (60) months.

In addition, for individuals covered in the Medicaid eligibility groups that will be impacted by the State's intended change, CBLTC services are provided primarily through Medicaid fee-for-service and managed long-term care (MLTC) plans. Some individuals in the Medicaid eligibility groups that will be impacted may receive these services through Medicaid mainstream managed care (MMC) plans. Under current standards, the services provided through MMC plans are included in one benefit package and enrollees are not required to be in need of CBLTC services for MMC plan enrollment. Conversely, MLTC plan enrollees are required to be in need of more than 120 days of CBLTC services. Therefore, the State is seeking approval through this proposed amendment to the State's Section 1115 waiver to exclude from this initiative all individuals that are enrolled in MMC plans, regardless of whether an individual is in a category that the State has elected to include in the eligibility groups that will be subject to non-institutional transfer penalties, and include MLTC plan enrollees receiving CBLTC services.

Further, the State will implement these proposed transfer of assets rules only to those newly seeking CBLTC services on or after January 1, 2022, and not to individuals already receiving CBLTC services on that date. This means that individuals 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.

In summary, and in relation to the Comparability provisions of SSA §1902(a)(10(B), New York is seeking such waiver authority as necessary under the demonstration to, effective January 1, 2022:

(i) Implement a 30-month transfer of assets lookback period for coverage of CBLTC services, rather than the federally required 60 months (See 42 USC § 1396p(c)(1)(B)(i));

(ii) Impose the 30-month transfer of assets provision on individuals newly seeking CBLTC services through Medicaid fee-for-service or Managed Long Term Care plan enrollment on or after January 1, 2022, but exclude individuals seeking CBLTC services through Mainstream Managed Care or a Medicaid Advantage Plan; and

(iii) Phase in the application of the CBLTC transfer rules and 30-month lookback on January 1, 2022, meaning that applications for CBLTC services submitted on or after January 1, 2022 would be assessed for any transfers made on or after October 1, 2020.

Section IV. Expenditure Authority

The State seeks such expenditure authority as necessary under the demonstration to implement a 30-month transfer of assets lookback period for coverage of CBLTC services through Medicaid fee-for-service and Managed Long Term Care Plans, and approval to exclude Mainstream Managed Care enrollees from these rules to maintain uniformity in the Mainstream benefit package. This initiative was adopted to eliminate Medicaid payments that could be covered by an individual's own income and/or resources that were transferred, if the transfer is subject to the imposition of a transfer of asset penalty period. Therefore, the State is not seeking approval of additional expenditures for healthcare related costs for any Demonstration-Eligible populations.

Section V. Beneficiary Impact

The State reviewed current utilization of services while preparing this proposal, and developed estimates of potential asset transfers. It is estimated that in 2022 and annually thereafter, approximately 3,700 new non-institutionalized applicants seeking Medicaid coverage of CBLTC through enrollment in a Managed Long Term Care Plan and approximately 70 new applicants through Medicaid fee-for-service would be subject to an average penalty period of 0.91 months as a result of an average $11,700 prohibited transfer during the 30-month transfer of assets lookback period. These are services that might be necessary for an individual to avoid institutionalization and remain in the community. However, these transfers would also result in a penalty period for Medicaid coverage of nursing home care, for consumers who are admitted to a nursing home during a transfer penalty period. It should be noted that once a penalty is imposed, the penalty impacts both levels of care - the same penalty period is not applied twice.

The proposal to apply a 30-month look-back rather than 60 months will decrease the documentation required at application as compared to applications for Medicaid coverage of nursing home care, and reduce the review of transactions that may potentially result in a transfer of assets penalty for non-institutionalized individuals seeking CBLTC services through Medicaid fee-for-service or enrollment in MLTC.

If the proposal to exclude beneficiaries enrolled in MMC and Medicaid Advantage from transfer of assets penalties for CBLTC services is approved, there will be no impact to these beneficiaries.

Section VI. Budget Neutrality

The State reviewed current utilization of services while preparing this proposal, and developed estimates of potential asset transfers. This statutory change was recommended by Medicaid Redesign Team II and adopted by the New York State Legislature in order to ensure that Medicaid payments are not used when CBTLC services could be covered by an individual's own income and/or resources that were transferred, if the transfer is subject to the imposition of a transfer of asset penalty period. It is estimated that in 2022 and annually thereafter, approximately 3,700 new non-institutionalized applicants seeking Medicaid coverage of CBLTC through enrollment in a Managed Long Term Care Plan and approximately 70 new applicants through Medicaid fee-for-service would be subject to an average penalty period of 0.91 months as a result of an average $11,700 prohibited transfer during the 30-month transfer of assets lookback period. Assuming an effective date of January 1, 2022, and as a result of this amendment, the State estimates approximately 3,770 new members will be impacted against an annual total enrollment of 2.8 million demonstration recipients. This amendment is expected to reduce the average annual total demonstration cost of $40 billion by $8.865 million in federal savings through the end of 2022. Accordingly, any impact on the annual total enrollment of 2.8 million demonstration recipients, or individuals enrolled in Medicaid fee-for-service, is expected to be fairly small. Please refer to the following excel file: NY MRT Budget Neutrality - 30-month lookback.xlsx.

Section VII. Compliance with Tribal Consultation and Public Notice

Consistent with notice requirements, the State notified and sought input from Tribal leaders and colleagues in Indian Health Centers, posted public notice to the New York State Register and performed other notification and outreach seeking public input regarding implementation of a 30-month transfer of assets lookback period for coverage of CBLTC services, and approval to exclude Mainstream Managed Care and Medicaid Advantage enrollees from these rules. Refer to Appendix A for tribal consultation communications and Appendix B for public notice posting.

Public Notice Process
The State certifies that public notice of the formal waiver amendment was published in the New York State Register on August 19, 2020[1] and tribal notification for the formal waiver amendment was issued August 14, 2020, with written comments accepted by electronic or written mail through September 18, 2020 and September, 21, 2020, respectively.

The State also certifies that it used an electronic mailing list to notify the public of the State's intent to seek a waiver amendment to CMS. The State used its Medicaid Redesign Team Listserv (MRT Listserv) in order to notify interested parties that the Department is seeking to implement a 30-month transfer of assets lookback for Medicaid coverage of community based long-term care services and that public comments could be submitted through September 18, 2020 via the electronic mail and written submission methods outlined in the State Register. The MRT Listserv electronic mailing was sent August 24, 2020 and provided subscribers with the

[1] August 19, 2020 New York State Register, available at https://www.dos.ny.gov/info/register/2020/081920.pdf (pg. 75).

website link to the August 19, 2020 public notice in the New York State Register. The State further certifies that the public was notified of the intent to submit this waiver amendment to CMS, as evidenced by the announcement posted on the New York MRT website.[2]

The State also conducted six (6) stakeholder outreach sessions in July, 2020 with consumer and advocacy groups, managed care plan representatives and local social services district representatives seeking public input regarding implementation of a 30-month transfer of assets lookback period for coverage of CBLTC services, and approval to exclude Mainstream Managed Care and Medicaid Advantage enrollees from these rules.

Public Comment

Overview. The State received 12 written comments from a combination of advocacy groups, community providers, local social services districts, pooled trust representatives and other stakeholders. No comments in response were received from Tribal leaders or Indian Health Center colleagues. The State appreciates all of the comments and feedback shared by stakeholders. Most of the comments relate to Medicaid eligibility policy and process, or the specific CBLTC services and Medicaid eligibility groups the State seeks to apply the lookback to through its State Plan Amendment, or expressed opposition to the implementation of lookback period for coverage of community-based long term care services in the first instance. No comments were specific to the express authority sought through this Amendment, which is implementation of a 30-month rather than 60-month transfer of assets lookback period for coverage of CBLTC services, and approval to exclude Mainstream Managed Care and Medicaid Advantage enrollees from these rules. A summary of the comments submitted and the State's responses to those comments are provided below. Comments have informed the State's overall implementation of this initiative but did not result in any change to this application.

Public Comment Topics and State Responses

Concerns About Delays in Application Processing, Access to Care

One commenter stated that applicants not subject to the 30-month transfer of assets lookback period will bear the burden of this initiative and face delays having their Medicaid applications processed due to the diversion of local social services district staff to review documentation on cases subject to a lookback. ***Response***: The State disagrees. Local social services districts must comply with application processing timeframe requirements, regardless of application type. The State will monitor application processing timeframes in conjunction with this initiative to ensure compliance.

Three (3) commenters state that because of the local social services district's need to review documentation of the lookback at application and because of any penalty period assessed as a result of asset transfers, implementation of a 30-month transfer of assets lookback period would limit an individual's access to community-based care, which will lead to poorer health outcomes and trigger higher costs to Medicaid for expensive services such as hospital care. One of the commenters stated the lookback will hurt New York's economy, as middle-income individuals spend down assets, become poor, decrease their consumer spending and increase reliance on public assistance. Another of the commenters stated it was irresponsible to implement this policy change during a global pandemic based on an unconfirmed fear that wealthy individuals are taking advantage of Medicaid home care; the commenter stated home care services are key to survival during the COVID-19 pandemic because the services help keep individuals out of institutions experiencing COVID-19 related infections and deaths. The commenter also stated

[2] https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/proposals/index.htm

that this initiative should only be implemented with processes that ensure care will not be delayed for the many applicants who have not made transfers. ***Response***: The State acknowledges that a 30-month lookback period increases documentation requirements for an individual applying for community-based long term care services but reiterates that local social services districts must comply with application processing timeframe requirements, regardless of application type. As the State explains in Section V., the proposal to apply a 30-month look-back rather than 60 months will decrease the documentation required at application as compared to applications for Medicaid coverage of nursing home care, and reduce the review of transactions that may potentially result in a transfer of assets penalty for non-institutionalized individuals seeking CBLTC services through Medicaid fee-for-service or enrollment in MLTC. The State confirms that, in accordance with statutory requirements, individuals applying for community-based long term care services who are subject to a penalty period as a result of transferring assets will not be eligible for coverage for community-based long term care services for the duration of the penalty period, which ensures that Medicaid payments are not used when CBLTC services could be covered by an individual's own income and/or resources that were improperly transferred. Lastly, as the State explains in Section I., implementation of this initiative is delayed until at least January 1, 2022 in light of the January 22, 2021 letter to Governors issued by Health and Human Services Secretary Cochran indicating the federal COVID-19 public health emergency declaration will likely remain in place for the entirety of 2021, and the Maintenance of Effort requirements under Section 6008(b)(1) of the FFCRA.

<u>Use of Pooled Trusts</u>

Five (5) commenters, four (4) of which are comprised of pooled trust administrators and a pooled trust coalition, expressed similar or identical concerns or recommendations in a similar letter format regarding an individual's use of a pooled trust, opposing any restriction on the ability of older adults and individuals with disabilities to utilize a pooled trust. Commenters refer to a pooled trust established and managed in accordance with 42 U.S.C. §1396p(d)(4)(C). Commenters state that without further clarification from the State, particularly with regard to individuals age 65 or older, imposition of a 30-month lookback risks rendering pooled trusts obsolete, violating an individual's right to receive care in the most integrated setting and impeding the ability of non-profit organizations that manage pooled trusts to support individuals with disabilities. Commenters stated their belief that overall administrative cost to the State and its impact on pooled trust beneficiaries and non-profit organizations that administer pooled trusts will outweigh any speculated benefit derived from treating a transfer to a pooled trust as a disqualifying transfer. Commenters recommended the State implement the following policies with the 30-month lookback initiative:

(i) A presumption that all transfers or contributions made by an individual age 65 and older to a pooled trust are exempt for purposes of eligibility for Medicaid coverage of community-based long term care services, with the burden on the Medicaid agency to rebut the presumption;

(ii) Funds deposited and spent from the pooled trust for the sole benefit of the Medicaid recipient shall be deemed for fair market value, and thereby exempt;

(iii) The Medicaid agency should only review the unexpended funds in a pooled trust on an annual basis;

(iv) Medicaid recipients with a pooled income trust should be entitled to an exempt "reserve amount" equal to the allowable resource level (eg. $15,750 resource level for one, 2020);

(v) On annual review by the Medicaid agency, notice by the agency should be issued of any excess of the "reserve amount" and a 12-month period extended for the funds to be spent for the sole benefit of the Medicaid recipient; if spent within 12 months,

transfers which created the excess amount in the pooled trust shall be treated as a transfer for fair market value and therefore exempt under Medicaid transfer of asset rules;

(vi) In the event the Medicaid agency determines that a transfer to a pooled trust is a disqualifying transfer, the Medicaid recipient would be entitled to "aid continuing" under existing Medicaid rules;

(vii) In the event that a transfer penalty is imposed based on deposits to a pooled trust, the Medicaid recipient's eligibility should not terminate or be suspended during any penalty period because most individuals will be enrolled in MLTC plans and suspension would be very disruptive, especially if the length of the penalty is a fraction of a month because an individual cannot be disenrolled for a fraction of a month;

(viii) Funds in pooled trust accounts should be determined to be exempt if funded with transfers prior to October 1, 2020;

(ix) Funds in pooled trust accounts should be determined to be exempt from transfer of asset rules regardless of the beneficiary's age, if transferred as an exempt transfer at the time of the transfer, eg. a pooled trust beneficiary who participates in the State's OPWDD Comprehensive Home and Community-Based Services 1915(c) waiver.

Response: The State is required to implement this initiative in a manner that complies with federal Medicaid transfer-of-asset rules. In doing so, the State will seek to operationalize this initiative in a way that is not overly administratively burdensome to disabled applicants/recipients utilizing pooled trusts, non-profit organizations and the Medicaid agency and the State will consider comments in establishing policy guidance in this area to the extent allowable under federal Medicaid transfer-of-asset rules.

<u>Exclude Ticket to Work Categories from List of Groups to be Impacted</u>

Two (2) commenters state that individuals eligible in the Ticket to Work categories (those eligible to participate in the State's Medicaid Buy-In for Working People with Disabilities (MBI-WPD) program) should be excluded from the 30-month lookback for several reasons: (i) individuals must be disabled and under age 65 to participate, making many eligible to transfer excess assets to an exception trust, such as a supplemental needs trust, without incurring a transfer penalty and therefore the State's review of financial records would be unproductive; (ii) the State encourages these individuals to work by giving them a higher resource allowance and by not requiring their retirement accounts to be in payout status, and exempting them from the lookback would add to these work incentives; (iii) many individuals eligible in the MBI-WPD category have severe disabilities and rely on home care to remain independent, without which they could require nursing home care; (iv) the State's proposal appears to make a distinction between the medically need, and those categorically eligible in the Ticket to Work categories, which are optional eligibility categories the State has chosen to include. Commenters conclude that the State's imposition of the lookback on the medically needy would implicitly remove the categorically needy from the lookback and contend that the medically needy who are eligible for Medicaid generally have a greater amount of lifetime assets and/or income, which justifies a 30-month lookback for this group. ***<u>Response</u>***: The State acknowledges that many disabled individuals eligible for Medicaid, not just those eligible in the Ticket to Work categories, may be eligible to transfer excess assets to an exception trust without incurring a transfer penalty and that many individuals in the Ticket to Work categories rely on home care services. Individuals currently enrolled in the Ticket to Work categories and receiving or applying for CBLTC services on or before the implementation date will be grandfathered in and not subject to the 30-month lookback. Otherwise, individuals applying for participation in the Ticket to Work categories after the implementation date, regardless of use of an exception trust, will be subject to the 30-month

lookback, the same as individuals applying for any other Aged, Blind or Disabled category subject to the lookback. The State acknowledges that an impact of a transfer penalty is that individuals will not be eligible for CBLTC services during the penalty period, services that might be necessary for an individual to avoid institutionalization and remain in the community. However, as stated previously in Section V., these transfers would also result in a penalty period for Medicaid coverage of nursing home care, for consumers who are admitted to a nursing home during a transfer penalty. Finally, the State is not making a distinction between the medically need 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.

Exclude Short-Term Certified Home Health Agency (CHHA) Services from Lookback

Three (3) commenters stated that a 30-month lookback should not be required to initiate or receive certified home health agency (CHHA) services on a short-term basis, either stating or implying that a need for CHAA services under 120 days should be considered short-term. Commenters state CHHA services are often critically needed after hospital or rehabilitation facility discharge and the 30-month lookback would cause excessive delays in accessing post-acute services. **Response:** The State allows individuals seeking Medicaid coverage for short-term rehabilitation services to attest to the amount of their resources. Short-term rehabilitation services include one commencement/admission in a 12-month period, up to a maximum of 29 consecutive days of each of the following: certified home health care and nursing home care. In the event that the short-term rehabilitation services extend beyond 29 days, the individual is required to provide proof of resources in order to obtain Medicaid coverage for these services beyond the 29th day. Proof of resources includes resource documentation for the past 60 months for nursing facility services, and certified home health care services, which require proof of current resources today, will require 30 months of documentation upon implementation of this initiative. Proof of resources also must be provided in order to have Medicaid coverage for a second commencement/admission of short-term rehabilitation within 12 months from the start of the first commencement/admission.

Review Inclusion of Limited Licensed Home Care Services in Lookback

One (1) commenter recommended the State review its decision to include limited licensed home care services in the list of CBLTC services, to the extent these are limited licensed home care services agencies operated by adult home operators to provide home care services not covered for adult home residents. The commenter questioned how extensively this service is utilized in adult homes, perhaps not enough to justify the administrative cost to administer the lookback for adult home residents, and expressed concern that individuals who cannot obtain these services would likely have to transfer to a higher cost nursing home. **Response:** The State will apply the 30-month lookback to any setting where an individual seeks Medicaid coverage for limited licensed home care services, including to adult home residents.

Clear Guidance to Local Departments of Social Services Regarding Eligibility Categories Subject to 30-Month Lookback; Website Information

Three (3) commenters stated that local social services districts will need clear guidance and screening tools to distinguish which applicants are Aged, Blind and Disabled applicants and therefore subject to the 30-month lookback requirement to ensure that applicants excluded from the lookback are not subjected to the lookback and to help reduce administrative burdens and costs and potential service delays. Commenters stated the State should also post clear information on the Department's website about the lookback, including explanations of the terms "medically needy" and "categorically needy", to help applicants compile necessary documents

and navigate the eligibility process more smoothly. **Response:** The State will issue administrative guidance, direction and training to the local social services districts regarding implementation of the 30-month lookback and will provide information on the Department's website about the 30-month lookback and which applicants seeking Medicaid coverage of CBLTC are subject to the lookback requirements. To confirm, the State is not making a distinction between the medically needy and categorical eligibility in implementing the 30-month lookback; 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, and the State's guidance and information will include an explanation of the eligibility groups and applicants impacted by the 30-month lookback.

Beneficiary Impact, Budget Neutrality, Evaluation Design

Four (4) commenters shared the following combined comments with regard to waiver sections on Beneficiary Impact, Budget Neutrality and Evaluation Design: (i) the requirement to gather and submit documentation for a 30-month lookback increases the burden on individuals seeking CBLTC, and the fact that the lookback is 30 months as opposed to 60 months is not dispositive of the increased burden that will be placed on those applying for CBLTC; (ii) costs, fiscal benefits, transfer data and application processing times resulting from this waiver amendment should be tracked to evaluate whether the lookback is worth continuing once it's implemented; (iii) costs of delays to applicants while waiting for services or the lookback review should be tracked and compared with pre-lookback expenditures for similarly-situated applicants; (iv) data regarding number of nursing home placements pre- and post- lookback implementation should be compared; (v) the State has failed to provide a complete and meaningful assessment of the savings and costs of implementing a 30-month lookback because the projected savings of $2.525 million through the end of the current waiver period is not balanced against the costs that will be imposed on all applicants subject to the lookback who must gather and produce 30 months of financial records, or against any costs that will be imposed on the local social services districts responsible for reviewing this documentation and implementing penalty periods; (vi) the proposed 30-month lookback does not result in budget neutrality because it will significantly increase workload at local departments of social services, delay application processing times, increase fair hearing requests and any purported savings will be dwarfed by additional workload and staffing requirements at the local social services districts; (vii) the proposal fails to take into account that fact that a 30-month lookback for Medicaid coverage of CBLTC may result in an individual abandoning hope for services at home and seeking institutionalization and Medicaid coverage of nursing home care instead because a penalty period for CBLTC may mean that no appropriate services are available or in place, as opposed to nursing home residents who still receive appropriate care if a penalty period is imposed.
Response: The State acknowledges that a 30-month lookback period increases documentation requirements for an individual applying for community-based long term care services but reiterates that local social services districts must comply with application processing timeframe requirements, regardless of application type, and that the State is soliciting input and concerns from local districts as part of implementation of this initiative. The State confirms that, in accordance with statutory requirements, individuals applying for community-based long term care services who are subject to a penalty period as a result of transferring assets will not be eligible for coverage for community-based long term care services for the duration of the penalty period, which ensures that Medicaid payments are not used when CBLTC services could be covered by an individual's own income and/or resources that were transferred. The State will monitor implementation of the 30-month lookback, including application processing times, and will implement system coding to identify cases with a transfer during the 30-month lookback, the number of penalty months, and the month and year of

penalty expiration. The State will also investigate adding other tracking components to its implementation monitoring. The State's Budget Neutrality analysis is accurate and sufficiently assesses the impact of this proposal on the annual total enrollment of 2.8 million demonstration recipients, and individuals enrolled in Medicaid fee-for-service.

Implementation of the 30-month Lookback and *Olmstead*

Seven (7) of the commenters referred generally to *Olmstead (Olmstead v. L.C.)* when expressing concerns about the State's implementation of a 30-month lookback for CBLTC services and the potential impact on disabled individuals, stating that imposition of the lookback itself, any restriction of the use of pooled trusts or failure to clarify pooled trust policy, and delays in individuals receiving services needed to prevent institutionalization as a result of the lookback could potentially violate Olmstead integration provisions. **Response:** The State will continue to clarify policy and seek CMS guidance in the implementation of the 30-month lookback, and will implement this initiative consistent with all applicable laws, regulations, rules and policies.

Comments from Local Departments of Social Services

Two (2) of the State's 58 local social services districts submitted comments. One expressed concern regarding the ability to process Medicaid applications within required timeframes if applicants for CBLTC services will need additional time to obtain documents necessary for a resource review because of the 30-month lookback. The same district expressed concern regarding implications of the 30-month lookback on processing Medicaid applications based on immediate need for personal care or consumer directed personal assistance services, expressing doubt that applicants will be able to provide the required documentation needed to obtain a Medicaid eligibility decision within 7 days of application and also concern that "presumptive" coverage based on attestation would create a loophole. The second local social services district submitted several questions related to their administrative processing of Medicaid applications in areas such as which applicants or cases will be subject to the lookback, how the lookback and any transfer penalty applies to individuals with pooled trusts, what the undue hardship provisions will be for cases subject to 30-month lookback, spousal budgeting, and phase-in dates for the 30-month lookback. **Response**: The State will issue administrative guidance, direction and training to the local social services districts regarding implementation of the 30-month lookback, which will include direction regarding application processing, how to address situations when an applicant needs additional time to obtain information and applications submitted based on an immediate need for personal care and consumer directed personal assistance services.

Approximately seven (7) of the commenters expressed similar or identical concerns or recommendations in a similar letter format, summarized as follows:

Maintenance of Effort Requirement

Commenters pointed out the State's January 1, 2021 intended implementation date would be impacted by any extension of the federal public health emergency by the Secretary of Health and Human Services, and by the Maintenance of Effort requirements under Section 6008(b)(1) of the FFCRA. ***Response:*** As now stated in Section I., the State will seek a January 1, 2022 implementation date given the federal COVID-19 public health emergency declaration will likely remain in place for the entirety of 2021 and the Maintenance of Effort requirements under Section 6008(b)(1) of the FFCRA.

Undue Hardship and Other Exceptions to a Transfer Penalty

Commenters noted the State's proposed waiver includes a statement that Medicaid transfer of assets rules and provision for an undue hardship waiver that apply under the transfer of assets

provisions of the federal Omnibus Budget Reconciliation (OBRA) of 1993 and Deficit Reduction Act (DRA) of 2005 would apply to transfers in situations involving applications for community-based long term care. However, commenters proposed that for applications for community-based long term care services, the State should include additional exceptions, including: (i) a broader definition of what would constitute undue hardship; (ii) exceptions for the transfer of a home to a sibling with equity interest or a caregiver child; and (iii) a presumed exception for transfers made while an applicant received Medicaid in a MAGI eligibility group.

Undue hardship: Commenters stated the State's existing policy for an undue hardship exception to a transfer penalty must be modified for purposes of individuals applying for coverage of community-based long term care, including to either increase limits of or remove the provision that precludes claiming of an undue hardship if after payment of medical expenses, the individual's or couple's income and/or resources is at or above the allowable Medicaid exemption standard for a household of the same size. For reference, at the time of comment, the 2020 Medicaid Non-MAGI exemption standard for a household of one was monthly income of $875 and resources of $15,750. Commenters compared institutionalized individuals, who pay almost all of their Net Available Monthly Income (NAMI) to the cost of care and whose needs are arguably met by the nursing home to providing the individual with medical care, food and shelter, with individuals living in the community who are left with $875 to pay for food, shelter and other services. Commenters expressed concern that the $875 monthly income level would make undue hardship waivers unavailable for most individuals applying for Medicaid coverage of community-based long term care, estimating that most individuals have income of more than $875 per month. Commenters requested that the State create a new standard for individuals applying for Medicaid coverage of community-based long term care that considers an individual's actual living, medical and other expenses. ***Response***: The State shares the commenters' interest in an undue hardship policy with adequate provision for individuals applying for Medicaid coverage of community-based long term care and will take their comments under advisement in establishing policy guidance in this area.

Transfer of a home: Commenters stated that because the individual's home is not counted as an asset for purposes of Medicaid eligibility for coverage of community-based long term services, the transfer of a home by an applicant for community-based long term services should not trigger a penalty and that the lookback should not include a transfer of an applicant's home, reasoning that transfer of an exempt asset does not impact eligibility for Supplemental Security Income (SSI) and therefore should not impact Medicaid eligibility. Commenters stated that none of the services identified in the proposed waiver amendment would make an applicant an "institutionalized individual" as defined under 42 U.S.C. § 1396p(h). Commenters further stated that if the State does impose a penalty for transfer of a home, then the exceptions under federal and state statute that apply to a transfer of a home by an institutionalized individual seeking coverage of nursing home care must be applied to an individual applying for coverage of community-based long term care, with one commenter stating that otherwise Congress' intent in enacting exceptions for transfer of a home to certain family members will be defeated. Commenters specifically reference transfer of a home to a caregiver child or to a sibling with equity interest. ***Response***: The State is bound by federal statute at 42 U.S.C. § 1396p for the treatment of transfer of assets, including transfers of a home. A transfer of a home to a spouse, or a child under age 21, or a child who is certified blind or certified disabled in the 30-month lookback period by a non-institutionalized individual seeking Medicaid coverage of community-based long term care would be considered an exempt transfer in accordance with 42 U.S.C. § 1396p(c)(2)(A)(i)-(ii). However, 42 U.S.C. § 1396p(c)(2)(A)(iii)-(iv) provides to only an institutionalized individual an exception for transfer of a home to a caregiver child or to a sibling with equity interest. Therefore, pursuant to federal statute, the State cannot exempt transfer by

a non-institutionalized individual of a home to a caregiver child or to a sibling with equity interest in conjunction with an application by the non-institutionalized individual for community-based long term care services and the applicable 30-month lookback.

Transfers Made While an Applicant Received Medicaid in a MAGI Eligibility Group: Commenters stated the State should exempt transfers made by an individual in the 30-month lookback period if the transfer was made while the individual received Medicaid in a MAGI eligibility group, reasoning MAGI eligibility does not consider resources and provides coverage for community-based long term care services. ***Response***: The State is bound by federal statute at 42 U.S.C. § 1396p for the treatment of transfer of assets. There is no provision that exempts transfers made while an individual received Medicaid in a MAGI eligibility group. While individuals enrolled in a MAGI eligibility group may receive home and personal care services if needed, those over age 21, dually eligible for both Medicaid and Medicare and needing community-based long term care services for more than 120 days are required to enroll in an MLTC plan and would be subject to the 30-month lookback. Similarly, individuals seeking coverage of nursing home care are subject to a 60-month lookback and there is no exception for transfers made during the 60-month lookback if the transfer was made while the individual received Medicaid in a MAGI eligibility group. Therefore, pursuant to federal statute, the State cannot exempt transfers made by an individual in the 30-month lookback period if the transfer was made while the individual received Medicaid in a MAGI eligibility group.

<u>Start Date of Transfer Penalty</u>
Commenters seek clarification of the penalty start date and urge that the State define it as the first day an individual is "functionally eligible" for community-based long term care services, up to three (3) months prior to the application date, rather than the first day the otherwise eligible individual is receiving services for which Medicaid assistance coverage would be available based on an approved application. Commenters pointed out that unlike institutionalized individuals seeking Medicaid coverage of nursing home care, individuals in the community seeking Medicaid coverage of community-based long term care services will rarely be able at application to meet the requirement to demonstrate they are receiving the community-based long term care services for which Medicaid would be available based on an approved application given various upfront assessment requirements and the inability of individuals to directly contract with providers for services that Medicaid would pay for. ***Response:*** The State shares the commenters' concern for a penalty period start date that considers the circumstances of an individual in the community and will seek to start a 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.

<u>Allow Attestation for Those in Immediate Need of Personal Care and Consumer Directed Personal Assistance Services</u>
Commenters stated that individuals applying for an expedited Medicaid eligibility determination in relation to an immediate need for personal care or consumer directed personal assistance services by the process the State has established pursuant to New York Social Services Law section 366-a(12) must be allowed to attest to the absence of prohibited transfers within the lookback period or that a transfer met an exemption, in lieu of the requirement to submit documentation of all resources for the applicant and spouse within the lookback period. Only one commenter proposed that documentation would submitted for review to the agency at a later time, after an initial attestation that no disqualifying transfers were made within the 30-month lookback period. Commenters assert this is required in light of the State's requirement to make a final eligibility determination within 7 days of the date of a complete Medicaid application for individuals in immediate need of personal care or consumer directed personal assistance

services and the requirement to complete social and nursing assessments for these services within 12 days of receipt of a completed application. Commenters state that because the applicant attests to their immediate need for these services, they should be allowed to attest to the absence of prohibited transfers within the lookback period and/or that a transfer meets an exemption. Commenters further state the State's current process allowing an applicant who would otherwise be required to document accumulated resources to attest to the current value of real property and to the current dollar amount of any bank accounts should be extended to cover all documentation required for the 30-month lookback. Commenters state that many individuals who submit an application for Medicaid coverage of personal care and consumer directed personal assistance services based on an immediate need for those services are not transferring assets to qualify for those services. ***Response***: The State currently allows an applicant applying for an expedited Medicaid eligibility determination based on an immediate need for personal care or consumer directed personal assistance services, who would otherwise be required to document accumulated resources, to attest to *only* the current value of real property and to the current dollar amount of any bank accounts.
(See https://www.health.ny.gov/health_care/medicaid/publications/adm/16adm2.htm)
That is because for these specific assets, the local social services districts receive information through the Asset Verification System. These applicants must document all other resources. Such coverage in the future will require documentation of the 30-month lookback pursuant to this amendment. For applicants seeking an expedited Medicaid eligibility determination based on an immediate need for personal care or consumer directed personal assistance services, the State will permit initial attestation only to the value of real property and the dollar amount value of any bank accounts owned in the 30-month lookback period if a consumer cannot submit those documents at application, the values of which will be verified through the local district's use of the Asset Verification System. The applicant will be required to submit all other asset information required to document the 30-month lookback in order for the application to be considered complete and subject to the expedited eligibility processing timeframes. If after an eligibility determination is made for an individual in immediate need of personal care or consumer directed personal assistance services the local district obtains information that is inconsistent with the attested information and the inconsistency is relevant to the individual's Medicaid eligibility, the local district is required to request documentation to verify the inconsistency. If upon further review of the information the individual is determined to be ineligible for Medicaid or the individual does not provide the requested documentation within the required time period, the local district is required to issue proper 10-day notice regarding the individual's eligibility.

<u>"Grandfathered" Individuals</u>
Commenters stated the State should clarify the individuals or scenarios that would be grandfathered in and not subject to the 30-month lookback, and also stated certain groups of individuals should be granted "grandfather" or essentially exempt status.

Individuals Who Applied for Medicaid Coverage of CBLTC Services Prior to the Implementation Date:
Commenters state those who apply for Medicaid coverage of CBLTC by December 31, 2020 but who are not yet receiving CBLTC services should not be subject to the 30-month lookback on January 1, 2021 (the former implementation date). ***Response:*** The State agrees and this is the State's intention. As previously stated in Section III above, the State will implement these proposed transfer of assets rules only to those *newly seeking* CBLTC services on or after the implementation date - formerly January 1 2021, now January 1, 2022- and not to individuals already receiving CBLTC services on that date. This means that individuals 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. The State has clarified this language in Section III.

Individuals Receiving CBLTC on or After the Implementation Date:
Commenters state that individuals receiving CBLTC services on the implementation date should be able to maintain "grandfather" status under several circumstances: (i) if their required services change; (ii) if they switch MLTC plans; (iii) if their Medicaid eligibility temporarily lapses due to issues with their Medicaid renewal; and (iv) if their Medicaid eligibility is inactivated due to an unmet spenddown. ***Response:*** The State shares the commenters' interest in a policy that provides certain "grandfather" provisions for individuals receiving CBTLC services as of the implementation date and will take their comments under advisement in establishing policy guidance in this area.

Individuals in a MAGI Eligibility Group Who Transition to a Non-MAGI Eligibility Group on or After the Implementation Date:
Commenters propose the following individuals should be exempt from the 30-month lookback: (i) non-institutionalized individuals in a MAGI eligibility group who are subject to a redetermination of eligibility under a non-MAGI category of assistance, whether or not they were receiving CBLTC services while in a MAGI eligibility group; and (ii) non-institutionalized individuals currently in a MAGI eligibility group for whom the State has suspended redeterminations under a non-MAGI category of assistance during the current public health emergency in compliance with the conditions of FFCRA Section 6008(b)(3), when they are redetermined under a non-MAGI category of assistance at the end of the public health emergency. Commenters assert these individuals are not newly applying for Medicaid and that they are not requesting an increase in coverage because the MAGI eligibility category provides full Medicaid coverage, including coverage of CBLTC. Commenters also state that those individuals in a MAGI eligibility group who received CBLTC as MAGI recipients were not subject to an asset test and transfers were not reviewed or penalized; therefore, it would be unfair to impose a penalty on a transfer that was permitted at the time it was made. Commenters state that when the State returns to transitioning cases for a redetermination after the public health emergency ends, there will be a burdensome backlog of cases for local Medicaid agencies to review and confusion because individuals will have to be transferred from Mainstream Managed Care plans to Managed Long Term Care plans if they receive home care, or to fee-for-service and Medicare, and that it would be unfair to subject this group to the 30-month lookback because it will impose a more restrictive methodology that FFCRA Section 6008 was intended to prohibit and, were it not for the public health emergency, these individuals would have had the benefit of a redetermination under a non-MAGI category before the implementation of the 30-month lookback. ***Response***: As to scenario (i), regarding individuals enrolled in a MAGI eligibility group, as stated above, the State is bound by federal statute at 42 U.S.C. § 1396p for the treatment of transfer of assets. There is no provision that exempts transfers made while an individual received Medicaid in a MAGI eligibility group. While individuals enrolled in a MAGI eligibility group may receive home and personal care services if needed, those over age 21, dually eligible for both Medicaid and Medicare and needing community-based long term care services for more than 120 days are required to enroll in an MLTC plan and would be subject to the 30-month lookback. Similarly, individuals seeking coverage of nursing home care are subject to a 60-month lookback and there is no exception for transfers made during the 60-month lookback if the transfer was made while the individual received Medicaid in a MAGI eligibility group. Therefore, pursuant to federal statute, the State cannot exempt transfers made by an individual in the 30-month lookback period if the transfer was made while the individual

received Medicaid in a MAGI eligibility group and cannot exempt that individual from the required 30-month lookback. As to scenario (ii), the State will request guidance from CMS as to individuals who, because of the public health emergency, the State extended in a MAGI eligibility category in compliance with the conditions of FFCRA Section 6008(b)(3), and for whom the State will redetermine eligibility for under a non-MAGI category of assistance as required under federal rules and the redetermination occurs on or after the implementation date of the 30-month lookback.

Section VIII. Evaluation Design

New York believes this proposal will have minimal change to evaluation design. This initiative is estimated to impact approximately 3,700 new applicants for CBLTC services through MLTC enrollment and approximately 70 new applicants through Medicaid fee-for-service in 2022 and annually thereafter. New York will include a question in its next Evaluation Plan, specifically in Domain 1, that will assess the impact of the implementation a 30-month transfer of assets lookback period. The new lookback period criteria will be assessed by utilizing monthly enrollment data and evaluating any changes.