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B14-04FP Health Benefits Eligibility and Enrollment Rule

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Vermont Legal Aid Objects to Substantive Changes Made to Choices for Care and Waiver Programs

The rule at 8.05(k) substantively revises and restricts eligibility for Choices for Care and other waiver programs. Please see the attached summary dated June 21, 2014, with attachments. Since we first raised this issue in August 2013, we have been repeatedly assured that the Department for Children and Families (DCF) did not intend to substantively change these programs. We believe significant substantive changes have been made, contrary to legislative intent and beyond DCF's rulemaking authority.

VLA Summary CFC/Hospice Issues
June 21, 2014

1. CFC and Hospice are optional coverage groups and should be added to section 9.0 of the proposed rule.

Individuals can access Medicaid if they belong to one of these optional coverage groups that are included in the State Medical Assistance Plan (State Plan). Their Medicaid eligibility is based on the fact that they belong to one of these clearly defined groups. It is not based on disability.

CFC
Under its State Plan, Vermont has elected to cover all individuals in nursing homes for more than 30 days who meet the special income test. The state specifically chose not to limit coverage to individuals who are aged, blind or disabled. *State Plan Attachment 2.2-A, B.12.* The state also had elected to cover individuals receiving home and community based services under our former 1915(c) waiver. *State Plan Attachment 2.2-A,B.4.* Both these optional coverage groups were rolled into the new 1115 waiver. *Operational Protocol, Section H, page 20*.

Hospice
Under its State Plan, Vermont has elected to cover all individuals who receive Hospice care. The state specifically chose not to limit coverage to individuals who are aged, blind or disabled. *State Plan Attachment 2.2-A, B.5.*

2. The proposed rules are inconsistent with the state plan, long standing regulations and waiver documents.

Until recently, to qualify for CFC, individuals were only required to meet the nursing home level of care criteria and the CFC financial eligibility requirements. This has been the rule since the waiver began. *M4201K, M4202 and M4202.3.*

M4202 clarifies that you qualify for SSI-related Medicaid if you meet the criteria in one or more coverage groups listed in subsequent sections of the rule, including long term care coverage groups. M4202.3 explains that the Long Term Care coverage groups include individuals in nursing homes, in hospice and those receiving HCBS. Individuals qualify for Medicaid if they meet the nursing home, hospice or HCBS criteria set out in sections A, B or D of M4202.3. None of these criteria require participants to be aged, blind or disabled.

M4201 K. gives the disability determination services (DDS) at DCF responsibility for determining if an in individual meets the Medicaid disability criteria. However, there are specific exceptions to this rule. The first exception gives DAIL the authority to make level of care determinations for individuals applying for waiver services. To infer that this provision would still require DDS to make a disability determination undermines the exception.

The state now proposes to delete these long standing provisions from its proposed rules. Under its proposal, the state would require individuals who fall within the Long Term Care optional coverage groups to meet additional criteria that are not required in the State Plan.

All CFC related policies, procedures, waiver documents, and materials published by DAIL are clear about CFC's eligibility requirements. There is nothing in any of these documents to support the state's position that individuals under 65 must meet SSA's disability criteria. The Operational Protocol states clearly that clinical eligibility will be determined by the LTCCC. With regard to the process, it states simply, "If the individual is found clinically eligible [by the LTCCC], a clinical certification form is sent to the Department for Children and Families/Economic Services division for a determination of financial eligibility." *Operational Protocol, page 21*.

3. <u>The proposed rule violates the purpose of the CFC waiver</u>.

The goal of the waiver is to give everyone who needs long term care services equal access to those services regardless of where they receive them. Under the proposed rules, this right to equal access will be significantly compromised.

The state maintains that it is violation of the federal law to enroll individuals in CFC who are not aged blind or disabled. However, they concede that an individual eligible under MCA does not need a disability determination to be eligible for CFC. Therefore, this new requirement will only impact younger individuals with income above 138% of the poverty level. They will be forced to go through the lengthy disability determination process. This could significantly impact their ability to receive long term care services when and where they need and want them.

State: _____VERMONT_____

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
42 CFR 435.217		B. Optional Groups Other Than the Medically Needy (Continued)

☒ 4. A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.

*Agency that determines eligibility for coverage.

State: _____VERMONT_____

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered

1902(a)(10)(A)(ii)(VII) of the Act

B. Optional Groups Other Than the Medically Needy (Continued)

☒ 5. Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.

☒ The State covers all individuals as described above.

☐ The State covers only the following group or groups of individuals:

- ☐ Aged
- ☐ Blind
- ☐ Disabled
- ☐ Individuals under the age of--
  - ☐ 21
  - ☐ 20
  - ☐ 19
  - ☐ 18
- ☐ Caretaker relatives
- ☐ Pregnant women

*Agency that determines eligibility for coverage.

State: _____VERMONT_____

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.231, 1902(a)(10)(A)(ii)(V) of the Act

☒ 12. Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 1 to ATTACHMENT 2.6-A.

☒ The State covers all individuals as described above.

☐ The State covers only the following group or groups of individuals:

1902(a)(10)(A)(ii) and 1905(a) of the Act

- ☐ Aged
- ☐ Blind
- ☐ Disabled
- ☐ Individuals under the age of--
  - ☐ 21
  - ☐ 20
  - ☐ 19
  - ☐ 18
- ☐ Caretaker relatives
- ☐ Pregnant women

Section H: Eligibility & Enrollment

Eligibility Determination Process

Elderly persons and younger adults with physical disabilities who meet the clinical and financial eligibility requirements of the LTC Medicaid program will be enrolled in the demonstration. At the time existing participants in the state's current HCBS waiver programs are auto-enrolled into the demonstration program, enrollment in the 1915(c) programs will cease. Individuals who were eligible under the previous 1915(c) waivers or those who are residing in a nursing facility will be automatically enrolled in the demonstration and will continue to receive the services on their current plan of care. When these auto-enrolled individuals have their next re-assessment their clinical eligibility for the demonstration will continue provided that they meet the clinical criteria for the Highest or High Need groups. This will be the case regardless of the level of funding available for the High Need group.

New applicants will be enrolled in the demonstration if they meet the clinical criteria for the Highest Need group and also meet the financial eligibility requirements for the LTC Medicaid program. If pre-demonstration participants do not meet Highest or High Need at their next assessment, they will be assessed using pre-demonstration criteria to determine their continued eligibility. New applicants who do not meet the clinical criteria for the Highest Need group but do meet the criteria for the High Needs group (and are otherwise financially eligible) will be enrolled and served through the demonstration to the extent that funding is available.

Moderate Need group applicants must meet the clinical criteria for that group, as well as the financial criteria established for this demonstration program. DAIL has established the following financial criteria for the Moderate Need group:

- Income at or below 300 percent of SSI (includes all sources of income)[3]
- Resources of less than $10,000.

Individuals applying for Moderate Group service will be complete an application. Upon receipt of that application, the provider of service will complete an abbreviated ILA assessment. In that assessment, an individual will respond as to their Medicaid status. They will complete clinical and financial application. Individuals who are Medicaid eligible will receive priority in the receipt of service. If the Moderate Needs group has a waiting list, that waiting list has an indication as to the individuals Medicaid status. Providers are instructed and it is stipulated in regulation, that individuals who are categorically eligible for traditional Medicaid shall receive priority access to the Moderate Needs group. The waiting list will be sent to the LTCCC monthly, who will track applicants and their status. When an application is received to add an individual to the Moderate Group service, the LTCCC will check the wait list to determine if the individual is on the wait list, is Medicaid eligible and, if not, there are no other Medicaid eligible persons on the list.

[3] *Monthly medical expenses (including but not limited to prescription and non-prescription medication, physician, hospital or other medical provider bills, health insurance premiums, copayment or deductible costs paid by the individual, and medical equipment and supplies) are deducted from the individual's gross monthly income to determine their adjusted income for purposes of determining eligibility as a Moderated Need enrollee under this demonstration.*

Individuals who meet the Moderate Need group clinical criteria will be identified by local demonstration network providers, including Adult Day, Homemaker, and HASS providers. These providers will also manage the enrollment process for this group by screening for clinical and financial eligibility. The providers will then arrange for the provision of any of the three covered services for this group that are deemed appropriate and necessary. DAIL will ensure the provision of case management services for the Moderate Needs group. The participants who are receiving HASS services will be case managed by the HASS Service Coordinators. There may be Moderate Needs individuals placed on a waiting list due to a shortage of funding. These waiting lists will be coordinated by the local providers and they will be administered on a first-come, first-served basis. Copies of any waiting list will be provided to DAIL, which will maintain a consolidated list by region.

A detailed description of the clinical and financial eligibility criteria, assessment and re-assessment procedures, and level of care determination processes applicable to this demonstration are included in Attachment D.

Resource Limits

Under the demonstration the resource limit for single individuals in the Highest and High Need Groups who own and reside in their own homes will begin at $3,000 (in addition to the existing $2,000, totaling $5,000) and raised in phases up to $10,000 provided funding is available. This will permit individuals to maintain adequate assets to ensure they are able to make any home repairs necessary to allow them to safely remain in their home (e.g., a working furnace, a leak-proof roof, etc.).

Determining Level of Care & the Intake, Assessment & Enrollment Process

For the Highest and High Need group members, LTCCC will receive referrals from multiple sources in the community. (Attachment E includes the referral form). Current assessments, if they exist, will accompany the referral. This will include existing long-term care service assessments, nursing home admission assessments, residential care home assessments, and/or hospital admission assessments. The determination of clinical eligibility will be based upon the referral, assessment, and any other available information. If the information needed to make a determination of clinical eligibility is not readily available, LTCCC will contact the applicant or their representative to obtain more information and complete a clinical assessment. A face-to-face interview will be conducted, if necessary. If the individual is found clinically eligible, a clinical certification form is sent to the Department for Children and Families/Economic Services Division for a determination of financial eligibility. If the individual is found clinically ineligible, a denial notice with a description of appeal rights is sent to the applicant.

If the case manager and the home-based or Enhanced Residential Care provider believe that the applicant meets the long-term care Medicaid financial eligibility criteria, services may begin immediately after the DAIL clinical certification is made. While the financial eligibility determination is pending, LTCCC will determine the minimum level of services necessary to maintain the applicant at home. The decision to start services prior to the financial eligibility determination will be made between the provider of service and the applicant. Any services provided during this interim period will be in accordance with an agreement between the provider and the individual or his/her legal

representative. The provider may not bill the Medicaid program for long-term care Medicaid services until the Department for Children and Families/Economic Services Division has determined that the individual is financially eligible and DAIL has authorized the Service Plan. If the individual is ultimately found ineligible for long-term care Medicaid services, DCF staff will notify DAIL, the participant, and the highest provider of service (if patient share due). The provider may bill the individual for any services provided from the date of clinical certification through the date a denial notice was received by the provider.

If the individual elects to receive his/her long-term care services in a nursing facility and the facility believes that the individual will meet the long-term care Medicaid financial eligibility criteria, the facility may start delivering services immediately after LTCCC provides a clinical certification. The nursing facility provider will inform the individual that admission prior to the final financial eligibility determination may result in a personal financial liability if they are subsequently found ineligible for long-term care Medicaid program.

DAIL protocols document the process and parameters for making clinical and financial determinations for each of the three clinical groups (Highest, High and Moderate Needs). These documents are included as Attachment D. The LTCCC will be responsible for making clinical and level of care determinations. In cases that are unclear, LTCCC may also consult with the staff of the Division of Licensing and Protection.

Individuals with an active mental health status or developmental disability who elect to utilize nursing facility care for their long-term care needs will initially be screened using the Preadmission Screening and Resident Review (PASARR) instrument. If the PASARR screen results in a determination that the individual may need active mental health treatment, the screener will contact the Department of Health/ Division of Mental Health for assistance with further evaluation of the individual.

Once an individual is determined to be clinically eligible for the program, a Long-Term Care Clinical Coordinator (LTCCC) will make a determination as to whether the individual meets the Highest or High Need group criteria. The LTCCC will discuss long-term care Medicaid service options with the individual as part of the application/assessment process. Individuals may also request additional options information and education by marking that request on their referral form. The LTCCC will assure that options brochures and educational information are available as needed.

As previously discussed, clinical eligibility for the Moderate Needs group is determined at the local provider level based on DAIL criteria.

If the individual is found to meet all of the clinical eligibility criteria, the LTCCC will forward the Clinical Certification Notice (see Attachment F) to the case management agency that the individual selected on the initial referral form. The local case manager will contact the individual and make arrangements for the completion of the Independent Living Assessment. A registered nurse will complete the health assessment portion of the ILA. The case manager will assess the individual's circumstances, resources, program eligibility, and formal and informal support systems. The results of the assessment will serve as the basis for the development of the individual's plan of care. The case manager will conduct a review of service options and discuss any limitations with the individual or their representative. The case manager will, in conjunction with the individual or his/her

representative, develop a comprehensive service plan that addresses his/her needs. The participant will review and sign-off on the service plan. The completed assessment and signed service plan will be sent to DAIL for a staff level review. LTCCC will conduct a thorough utilization review prior to authorizing a new annual service plan. If the individual chooses a nursing facility as their long-term care setting the case manager will assist them in locating a facility, if necessary.

The case manager may also assist the participant in completing any financial eligibility reviews that DCF requires to maintain long-term care Medicaid eligibility if such assistance is requested.

The ILA measures cognitive status as well as functional status. The ILA also assesses mental health status and will provide the case manager with the information needed to develop a care plan to address these needs as well.

Annual Re-Assessments

Participants will have a comprehensive assessment completed on a regular basis. The reassessment procedure is determined by the particular long-term care Medicaid setting in which the individual is served.

For those receiving home-based services, the case manager will complete a re-assessment of the individual using the ILA at least annually and prior to the anniversary of the participant's admission into the program. The case manager will assess any changes in the individual's circumstances, resources, program eligibility, and formal and informal support systems since the time of the original assessment or last re-assessment. If needed, an RN will complete a re-assessment of the individual's health condition.

The case manager will also conduct a review of any new or more appropriate service options that should be considered with the individual or their representative. The case manager will modify the comprehensive service plan, as appropriate, in conjunction with the individual or their representative. The participant will review and sign-off on the revised service plan. The completed re-assessment and signed service plan will be sent to DAIL for a staff level review. LTCCC will conduct a thorough utilization review prior to authorizing any modifications to the annual service plan.

For participants residing in an Enhanced Residential Care (ERC) facility, the residential home care provider will complete a comprehensive reassessment or RCHRAT (see Attachment G). Annually, prior to the end of the current annual plan of care, a registered nurse must complete a reassessment. The ERC provider will send a copy of the RCHRAT to the participant's case manager. The case manager will complete an ERC tier worksheet and ERC service plan. The participant will sign the revised service plan and the case manager will submit the completed re-assessment packet to the LTCCC for utilization review and acceptance.

For individuals residing in nursing facilities, the nursing facility provider will continue to complete the Minimum Data Set or MDS according to current federal and state nursing facility regulations.

Re-assessments are required annually for home-based settings, at a minimum, and prior to the anniversary of the participant's enrollment. Re-assessments are also conducted when there is a

4201 Definitions (02/01/2007, 06-46)

This section defines terms used throughout rules 4200-4284.

A. Community Medicaid means Medicaid services other than long-term care.

B. Community spouse (CS) means the spouse of an institutionalized individual who is not living in a medical institution or a nursing facility. A person is considered a community spouse even when receiving waiver services if that person is the spouse of an individual who is receiving long-term care.

C. Coverage group refers to individuals who meet the specific financial and nonfinancial requirements of eligibility for Medicaid payment of particular medical services.

D. Financial responsibility group means the people whose income and resources are considered when determining eligibility for a Medicaid group.

E. Institutionalized individual means a person requesting Medicaid coverage for long-term care, whether the care is received at home in the community pursuant to a waiver or in a long-term care facility licensed by the Department of Disabilities, Aging and Independent Living.

F. Institutionalized spouse (IS) means an institutionalized individual whose spouse qualifies as a community spouse.

G. Long-term care means highest need and high need care, as determined by the licensing division of the Department of Disabilities, Aging and Independent Living received by people living in nursing facilities, rehabilitation centers, intermediate care facilities for the mentally retarded (ICF-MR), and other medical facilities for more than 30 consecutive days. It also includes waiver and hospice services.

H. Medicaid group means one of two kinds of groups in SSI-related Medicaid: or spouses where at least one spouse is aged, blind or disabled, or an aged, blind or disabled individual with no spouse. The countable income and resources of the financial responsibility group are compared against the income and resource standards applicable to the Medicaid groups size.

I. Medicaid services means medical services funded through Medicaid. They include Medicaid services (rules 7201-7508.7), long-term care (rules 7601-7608), and services defined in the Department for Disabilities, Aging and Independent Living (DAIL) Choices for Care regulations.

J. SSI-related Medicaid means health care coverage available to members of the Medicaid group who are aged, blind, or disabled and pass financial and nonfinancial eligibility criteria for Medicaid. SSI-related Medicaid is based on two financial assistance programs federally administered by the Social Security Administration: the supplemental security income program (SSI) and aid to the aged, blind and disabled program (AABD).

K. Waiver services means specialized medical services approved under an exception to standard Medicaid rules for a specific population.

It includes certain services administered by the DAIL:

1. home-based and enhanced residential care services for the aged and disabled (known as “Choices for Care”),

2. traumatic brain injury services (TBI waiver), and

3. home-and-community-based waiver services for the developmentally disabled (DS waiver).

It also includes services administered by the Vermont Department of Mental Health:

4. children's mental health waiver services.

DCF determines financial and nonfinancial eligibility, other than disability, for these services. DCF, through the disability determination services unit determines whether individuals are blind or disabled according to the criteria in rules 4213-4215, except as stated below.

- When DAIL administers the waiver services, it determines whether applicants need the level of care provided in a nursing facility, an intermediate care facility for the mentally retarded, or out-of-state rehabilitation facility qualified to serve persons with a traumatic brain injury. For the TBI and DS waivers, DAIL also determines whether applicants meet the disability criteria.
- When VDH administers the waiver services, it determines whether, if waiver services were not available, children under age 22 need the level of care provided in an inpatient psychiatric facility for children.

Categorically Needy Coverage Groups

4202 Categorically Needy Coverage Groups (08/01/2003, 02-11)

To be eligible for SSI-related Medicaid as categorically needy, individuals must meet the criteria in one or more of the following coverage groups, in addition to other nonfinancial and financial requirements. When an individual becomes ineligible for one coverage group, the department tests for other categorical and then medically needy eligibility. Medicaid remains open until an individual no longer passes any of the eligibility tests, per rule 4142.

4202.1 SSI/AABD Recipients (08/01/2003, 02-11)

Individuals granted SSI/AABD by the Social Security Administration are eligible for SSI-related Medicaid. In addition to SSI/AABD recipients, this group includes individuals determined presumptively disabled and those who do not receive an SSI/AABD payment because of recoupment.

4202.2 SSI-Eligible Coverage Groups (08/01/2003, 02-11)

The following individuals are eligible for SSI-related Medicaid as categorically needy.

A. Individuals who would be eligible for SSI/AABD except that they:

1. have not applied for SSI/AABD, or

2. do not meet SSI/AABD requirements not applicable to Medicaid, such as participation in vocational rehabilitation or a substance abuse treatment program.

Individuals in this categorically needy coverage group must have income and resources at or below SSI/AABD maximums and meet the nonfinancial criteria for SSI-related Medicaid.

B. Individuals who the Social Security Administration determines eligible under the Social Security Act §1619(b) because they meet all SSI/AABD eligibility requirements except for the amount of their earnings and who:

1. do not have sufficient earnings to provide the reasonable equivalent of publicly funded attendant care services that would be available if they did not have such earnings; and

2. are seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment.

4202.3 Long-Term Care Coverage Groups (09/01/2005, 05-19)

The following individuals are eligible for SSI-related Medicaid as categorically needy.

A. Medical institution - Individuals who live in a medical institution and have gross income under the institutional income standard.

B. Special income group – Individuals who qualify for waiver services and who:

1. would be eligible for Medicaid if they were living in a medical institution;

2. have gross income between the protected income level and the institutional income standard; and

3. can receive appropriate long-term medical care in the community, as determined by the Department of Disabilities, Aging and Independent Living.

C. Working people with disabilities – Individuals who qualify for home-based care under the waiver serving the aged and disabled and meet the financial eligibility requirements specified in rule 4202.4.

D. Hospice care - Individuals who:

1. would be eligible for Medicaid if they were living in a medical institution;

2. can receive appropriate medical care in the community, the cost of which is no greater than the estimated cost of medical care in an appropriate institution; and

3. receive hospice care as described in rule 4412 and defined in section 1905(o) of the Social Security Act.

E. Disabled Child in Home Care (DCHC, Katie Beckett) - Individuals who:

1. require the level of care provided in a medical institution;

2. would be eligible for Medicaid if they were living in a medical institution;

3. can receive appropriate medical care in the community, the cost of which is no greater than the estimated cost of medical care in an appropriate institution;

4. are age 18 or younger;

5. have income, excluding their parents income, no greater than the institutional income standard; and

6. have resources, excluding their parents resources, no greater than the resource limit for a Medicaid group of one.

4202.4 Coverage Groups For New Applicants (08/01/2003, 02-11)

The following individuals are eligible for SSI-related Medicaid as categorically needy.

A. Breast or cervical cancer - Women found to have breast or cervical cancer, including precancerous conditions, screened through the National Breast and Cervical Cancer Early Detection Program and who:

1. are under age 65;

2. uninsured; and

3. otherwise not eligible for SSI-related or ANFC-related Medicaid.

Coverage under this category begins following the screening and diagnosis and continues as long as a treating health professional verifies the woman is in need of cancer treatment services.

B. Working people with disabilities - Individuals with disabilities who are working and otherwise eligible for SSI-related Medicaid and whose:

1. resources at the time of enrollment in the group do not exceed $5,000 for an individual and $6,000.00 for a couple (see rule 4248.8 for resource exclusion after enrollment);