Report to
The Vermont Legislature

CHOICES FOR CARE – ELIGIBILTY PROCESS REVIEW

In Accordance with 2015 Act 58, Sec E.307.3

An act relating to making appropriations for the support of government

Submitted to:	**Senate Committee on Health and Welfare** **Senate Committee on Appropriations** **House Committee on Human Services** **House Committee on Appropriations**
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Report Date:	**January 15, 2016**

VERMONT

AGENCY OF HUMAN SERVICES
Department for Children and Families

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Executive Summary

Per the 2015 Act 58 Sec. E.307.3, the Appropriations bill, the Department for Children and Families (DCF); the Department Aging, and Independent Living (DAIL); and the Department of Vermont Health Access (DVHA) to report on the following:

H. 490 Sec. E.307.3 CHOICES FOR CARE – ELIGIBILITY PROCESS REVIEW

(a) The Commissioners for Children and Families, of Disabilities, Aging, and Independent Living, and of Vermont Health Access shall evaluate the processes for determining an individual's eligibility for Choices for Care and shall identify any areas that result in consistent delays in such eligibility determinations. The Commissioners shall report their findings and recommendations to ensure determinations are expeditiously processed to the Senate Committees on Health and Welfare and on Appropriations and to the House Committees on Human Services and on Appropriations on or before January 15, 2016.

This is a one-time report on the processes of the Choices for Care program, its eligibility procedures, delays and recommendations for improvements.

Section I:

Overview of Vermont's Long Term Care Eligibility Process

There are two parts to determining long term care eligibility: Clinical eligibility performed by DAIL and financial eligibility performed by the Economic Services Division (ESD) of DCF.

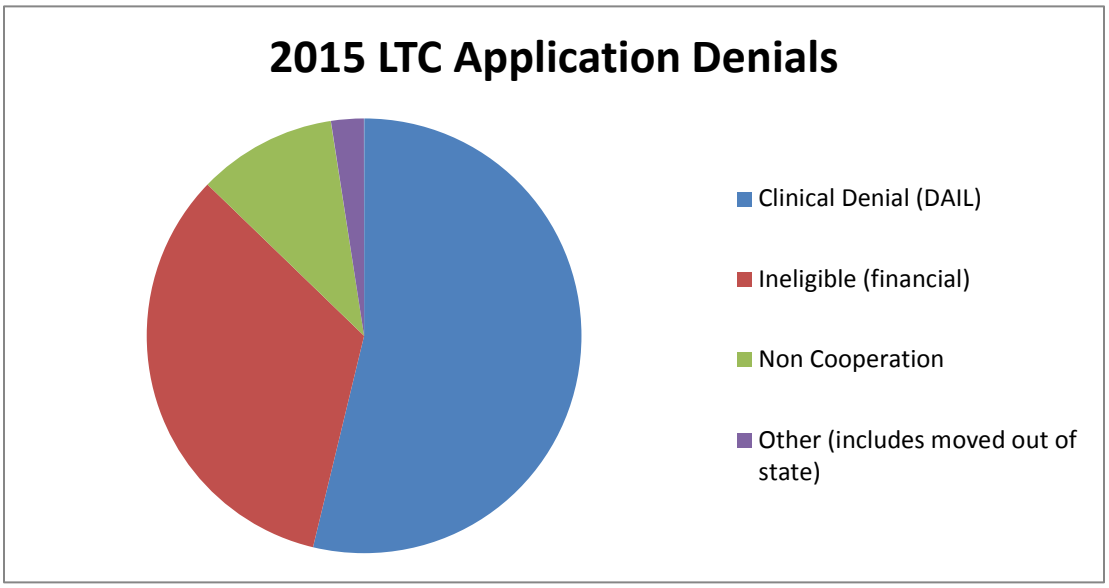
A joint application is submitted to ESD and forwarded to DAIL for the clinical assessment. A nurse visits the person in their home or at the facility where they reside to determine if they meet the medical need for Choices for Care services.

Upon receipt of the Long Term Care (LTC) application, ESD starts the financial eligibility determination process including the requirement to evaluate income, resources, and transfer of assets. There are complicated rules that address which assets and transfers are allowed. Transfers made in the 60 months prior to the month of application must be carefully reviewed to determine if a penalty period is required, for instance. Many applicants have complex financial histories and have hired elder law attorneys to assist them with planning and sheltering their assets. The more complicated applications take a significant amount of worker time to analyze before making a determination due to the complexity of the client's assets and issues related to the transfer of resources.

The most current 2015 data for the LTC Program indicates an average LTC Medicaid customer's age is 72 years old. The Vermont LTC average monthly caseload is 6,335. In 2015, approximately 1,210 LTC applications were approved and approximately 571 applications were denied.

The 2015 LTC Medicaid application denials were for the following reasons:

- 307 (54%) for clinical ineligibility;
- 191 (33%) did not meet financial eligibility;
- 59 (10%) did not cooperate with the financial application process;
- 14 (2%) were denied for "other" reasons (including moved out of state).



Section II:

Clinical Eligibility Determination

Clinical eligibility is one of the first steps for Choices for Care (CFC) eligibility when a person applies for services. The time in which eligibility is determined can have a direct effect on a person's access to services. Currently CFC regulations require that clinical eligibility be determined within 30 days of receiving the person's CFC application. DAIL determines clinical eligibility and controls the timeframe for which it is determined.

The Adult Services Division of DAIL has created a Scorecard for tracking clinical eligibility timeframes with the goal of completing at least 95% of all clinical determinations within 30 days. Data is tracked each month through the SAMS data management system. Factors that typically affect the timeframe for processing clinical eligibility include:

1) Timeframe for receiving the CFC application from the Department for Children and Families;
2) Complications in reaching the applicant to schedule a clinical assessment;
3) Timeframe to receive verification of clinical information from other healthcare professionals when needed;
4) Current workload of the Long-Term Care Clinical Coordinator (LTCCC) nurse;
5) Position vacancies and time-off.

As of July 2015, about 96% of clinical eligibility determinations were completed with 30 days; about 85% of those were completed within 14 days.

Section III:

Financial Eligibility Determination

The CFC financial application process includes a review of the submitted application and supporting documents as well as a phone interview (periodically, a client prefers a face-to-face interview). The worker sends a written request for additional verification or other needed documents found to be necessary from the interview.

When potential transfers/gifts are discovered during the review, a phone call is made to the client in an attempt to get needed information so the issue can be quickly resolved. Staff often needs more information from the client which takes additional time for the client to gather and submit to the LTC worker.

Once staff has received the client's supplemental documentation, they must organize and analyze it all to make an eligibility determination consistent with the complicated LTC rules.

ESD workers also review the client's application to determine if the client is eligible for Waiver While Waiting (WWW) or for other community Medicaid benefits.

Factors Contributing to Delays in LTC Eligibility Determinations:

- **Required Documentation and Complex LTC Eligibility Rules**

Staff is working with various individuals per case including elderly individuals, their adult children, guardians and/or powers of attorneys. It is sometimes very difficult to promptly get the information required for an eligibility decision. In addition, since five years of information is required, the client or representative must often research transfers and locate appropriate documents. Clients are also delayed in submitting required documentation because it takes them time to get necessary documents from banks, annuity companies, Veterans Affairs, etc.

Some financial companies are slower than others in processing requests from the applicants for more in-depth information. ESD staff cannot make a financial eligibility determination until all documents are received and analyzed. Workers report that they often get a 6-12 inch stack of documents for review. The required analysis is very time consuming and can take 3-7 hours of a worker's time for one review.

When the submitted documentation indicates that a resource must be counted rather than excluded, rather than denying the application, Vermont practice is for staff to advise the client or their representative that the application can be pended while the client makes necessary changes so those resources can be excluded rather than counted (e.g., camps that can be put-up for sale or increasing the income from IRAs or annuities).

Vermont allows the federal maximum community spousal allocation, which allows applicants a higher resource limit. Due to this higher resource limit, many applicants consult elder law attorneys for creative solutions to exclude assets so they can meet the eligibility requirements. The increasing number of applicants who have significant assets requires more analysis and thus makes the Vermont LTC worker's job quite complicated. Workers frequently receive phone calls from private attorneys and advocates who want to debate the application or the LTC rules. There are increasing numbers of highly

complicated cases requiring assistance from a LTC Supervisor, Benefits Programs Administrator, or LTC Attorney to help interpret the rule/s or to review legal documents (i.e., trusts).

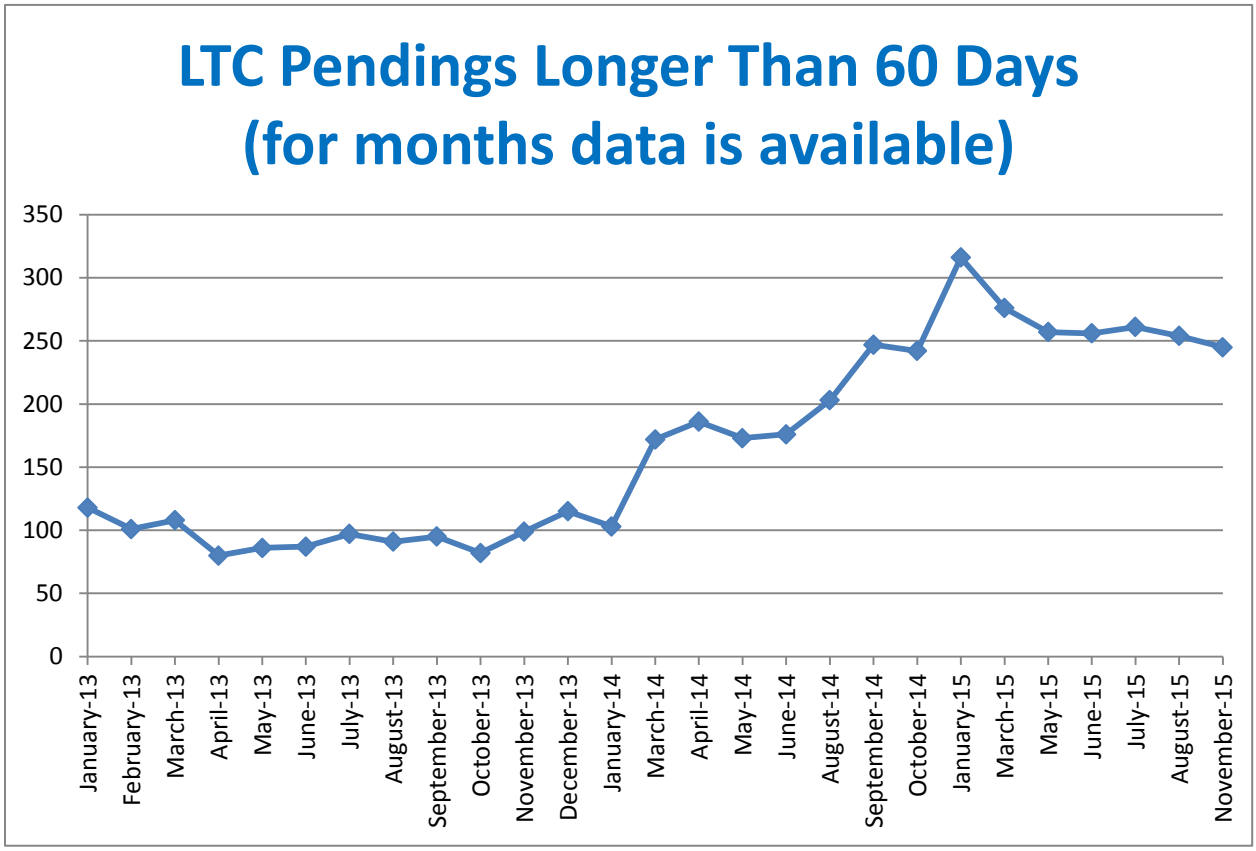
- **90 Day Reasonable Opportunity Period (ROP)**

The January 1, 2014 HBEE rule 57.00 (c)(2)(ii) change allowing 90 days to submit documentation has resulted in delays in LTC eligibility processing times.

Prior to that rule change, applicants were given an initial verification letter with a due date of ten days to submit verification documents. When necessary, clients were also given a second verification letter for another ten days to submit required documentation.

The LTC workers have advised management that the longer ROP has resulted in application processing delays. Clients wait to submit required verification documents until they near the department's "due date". The increased period from ten to 90 days means more tasks including client reminder notices at 30 and 60 days that ESD was waiting for verification documents to complete the financial eligibility review.

Available DCF and DAIL data supports that the extended ROP contributed to consistent application processing delays as demonstrated by chart below. The data indicates that LTC application pending times were directly impacted by the implementation of the 90 day ROP in January of 2014 (note that some of the months did not have complete data so those months were not included in the chart below).



An updated emergency rule was filed January 11, 2016 changing the verification period back to ten days for the first verification and another ten days for the second verification. AHS expects this rule change to have a positive impact on the length of time LTC Applications are pending.

- **Five Year Look Back Period**

The 60 month (5 year) Look Back Period (LBP) is completed for most LTC applications to determine if any assets were transferred for less than fair market value. In order to complete this assessment, the worker must request financial information for the previous 60 months from the application date.

The worker must review all documents that are received and request further information on any questionable transactions. Any resource that is sold, transferred or given away during the LBP must be evaluated to see if the transfer is allowable per Medicaid rules or if a penalty must be applied.

Before the Federal Deficit Reduction Act of 2005, transfers could have occurred during the LBP and not be subject to a current problem because the penalty got applied at the time the transfer was made. Presently, the penalty starts when the person is "otherwise eligible" for LTC Medicaid. This requires more analysis of financial statements and is time consuming for LTC workers.

- **Waiting for Available Bed for Applicant**

The agency must hold applications pending and cannot complete eligibility determinations until staff is able to locate an available bed in a facility for the client. This is more common with applicants who are in hospitals and have special needs as it is more difficult for staff to find suitable placements.

Improvements Implemented and Planned to Reduce LTC Application Processing Timeframes:

- **Verification Period Changed Back to Ten Days (with a second 10 ten day period if needed)**

An updated emergency rule was filed January 11, 2016 changing the verification period back to ten days for the first verification and another ten days for the second verification. AHS expects this rule change to reduce the length of time Long Term Care Applications are pending.

Another benefit for both clients and nursing facilities is that the shorter verification period will reduce the number of clients who are unable to get coverage back to their first LTC application date. When clients do not cooperate with their first application and are subsequently denied coverage, if they submit a new application promptly with the required documentation, the worker can retroactively grant three months and can usually go back to or before the original application date as needed if it is determined they are eligible for Choices for Care.

Under the 90 day ROP, if clients had not submitted their documentation within the 90 days and workers denied the client coverage, by the time a new application was submitted and approved the worker often could not go back far enough to cover the entire period the client was in a facility. This had a negative impact on the facility and the client because the facility could not bill Medicaid and may have requested payment for services directly from the client.

- **LTC Eligibility Operational Changes in 2015:**
    - Balanced caseloads for all case workers for a more equitable workload and better client service. The average caseload is now approximately 350; in the past it could range from 250 – 500+.
    - Reviewed all forms; eliminated unnecessary forms and improved remaining forms
    - Worked internally to remove 3SquaresVT and Supplemental Fuel casework from LTC Staff. We expect to implement this change in the first quarter of 2016. This should reduce LTC staff work burden and allow them to spend more time on LTC work.
    - Worked with call center to provide scripts to better assist LTC clients with 3SquaresVT questions.
    - Created two temporary part-time LTC BPS positions. Both workers in these positions have previously worked for LTC and are already trained. These staff carry partial caseloads to assist permanent workers.
    - Created and posted two temporary part-time clerical positions to assist BPS staff by performing routine, front-end administrative duties, such as sending application pages to the DAIL nurse; sending bank search forms to banks; and entering basic information into the computer system. This will free up worker time so they can focus on eligibility work.
    - Trainings:
        - New workers receive one week of training for LTC Medicaid and ongoing one-on-one mentoring/training with their supervisor or mentor for as many months as needed.
        - Ongoing training for all staff:
            - Complicated financial statements
            - Change in setting – what to enter in computer system
            - Traumatic Brain Injury (TBI) applicants
            - Hospice
            - How to write a clear and concise verification request
            - Efficiency on what is required for the Look Back Period (LBP)
            - Waiver While Waiting (WWW) criteria
            - Life Insurance policies
            - Community Medicaid overview
        - Trainings are done at monthly in-person meetings in good weather months and via monthly conference call during bad weather months
    - More mentoring from BPAA's
        - BPAA's are sending out updates via email as needed
        - Review problem area's with staff
        - Regular meetings between BPAA's and supervisors

Section IV:

2015 Improved Coordination between ESD and DAIL

ESD and DAIL's staff and managers have been working more closely together in 2015. An all Long Term Care (both ESD and DAIL) staff meeting was held for the first time in ten years. All staff involved found this meeting to be very informative and valuable. ESD and DAIL subject matter experts have also been actively engaged in developing business requirements for the new Integrated Eligibility system. This interaction made all involved thoroughly aware of the complex LTC process and the need for frequent coordination between the departments. DAIL invited ESD LTC Financial Eligibility staff to present to the DAIL Advisory Board meeting in September 2015. These active engagements between ESD and DAIL have improved communications and the identification of opportunities for further improving LTC application processing.

DAIL/DCF Aging Disabilities Resource Connections (ADRC) initiative

Vermont's Aging Disabilities Resource Connections (VT ADRC) initiative provides people of all ages, disabilities, and incomes with the information and support they need to make informed decisions about long term services. VT ADRC builds on the infrastructure of eight core partners: the five Area Agencies on Aging (AAAs), the Vermont Center for Independent Living (VCIL), the Brain Injury Association of Vermont (BIAVT) and Vermont 2-1-1.The VT ADRC supports "no wrong door" access to long-term services and reducing the need to contact multiple agencies to get the assistance clients need, when they need it.

In their goal to create sustainable services within Vermont, the ADRC have engaged in a Medicaid Reimbursement Pilot Project to test whether using Enhanced Options Counselors would help shorten the Choices for Care financial eligibility time frames. In partnership with DAIL and DCF, the use of Enhanced Options Counselors in the Newport and Barre DCF district offices is being piloted by the ADRC; the Northeast Kingdom Council on Aging; and the Central Vermont Council on Aging.

Performance*:*

- A total of 430 people were served from February 1, 2014 – October 21, 2015.
- There was a 76% decrease in the number of days a new CFC applicant waited from the date of their application.
- New CFC applications that took 90 days or less to process had lower per person Medicaid claims compared to those that took 91 or more days to process.

Although these results appear promising, it is not clear whether these performance measures were solely based on the pilot project and the pilot interventions or if they were influenced by additional factors like the internal process changes that occurred simultaneously in ESD including caseload balancing. The data still requires verification and analysis so no definite conclusions can be drawn from the pilot. The work remains an example of creativity and commitment on behalf of DAIL and ESD to coordinate and address the eligibility issue.

Summary:

Recommendations

- **Recommendations to Improve LTC Financial Eligibility Determination Timeframes**
    - 45 day application processing time – federal rule allows 45 days for Medicaid Application processing times however; Vermont adopted a 30 day application processing requirement. Adopting the federal rule would increase Vermont workers' processing times and make them more consistent with most other states.
    - More permanent staffing – workload increased with the extended Look Back Period which was fully implemented in March 2011. Permanent LTC staffing has only increased 15% since 2011 however making the LTC workload overwhelming for LTC staff. The current use of temporary staff is helping to alleviate some of the work burden.
    - Ensure DCF/DVHA/DAIL LTC subject matter experts continue to be actively engaged in the development of the new Integrated Eligibility System to ensure all opportunities for better customer service and more timely eligibility determinations can be achieved.
    - An improved Documents Management System will reduce time staffs spend on viewing and organizing imaged documents (this may be part of the Integrated Eligibility System). Staffs currently report they spend extensive amounts of time trying to organize documents because we are currently using an imaging system rather than a Document Management System.