

## **SECTION II. Eligibility**

A Choices for Care application is required for any person who needs Vermont (VT) Medicaid coverage for long-term services and supports and believes they may meet the clinical and financial eligibility standards outlined in this section. An application is not required for people in need of medical care or short-term rehabilitation services covered by insurance such as Medicare, Vermont Medicaid, Veteran's benefits (VA) or private insurance. ***People must refer to their specific insurance coverage standards for medical care and rehabilitation coverage at home or in a nursing facility.*** Refer to section V.1 Application and Eligibility Determination Procedures for detailed instructions on the Choices for Care application process.

### **I. Standards for Eligibility**

To be eligible for the Choices for Care program: (*CFC Regulations, Section IV. Eligibility*)

1. An eligible individual must be a Vermont resident aged 18 or older who meets both clinical and financial eligibility criteria.
2. Choices for Care shall not replace or supplant services otherwise provided under other 1915c Medicaid waivers or other 1115 Medicaid waivers (e. g. Community Rehabilitation and Treatment). Thus, to be eligible for services other than nursing facility services, an individual must have a functional physical limitation resulting from a physical condition (including stroke, dementia, traumatic brain injury, and similar conditions) or associated with aging. Individuals whose need for services is due to a developmental disability, autism, or mental illness shall not be eligible for services.
3. Choices for Care shall not provide or pay for services to meet needs that can be adequately met by services available through other sources. This includes but is not limited to private insurance, Medicaid and Medicare.

**NOTE:** Individuals choosing a nursing home setting who have an active treatment plan for a mental health diagnosis or developmental disability must have a Step II PASRR screening completed prior to admission to the nursing home.

### **II. Short-term Rehab in a Nursing Facility**

***NOTE: Refer to Section V.1 Application and Eligibility Determination Procedures; subsection K. Short-term Rehab in a Vermont Nursing Facility for more detailed procedures.***

- A. **Dual Medicare/Medicaid Stays:** For individuals with both Medicare hospital coverage and Vermont Medicaid coverage and who meet the Medicare eligibility standard for "Coverage for Extended Care" in a nursing facility (<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf>), these individuals are not required to

submit a Choices for Care application. Instead, the facility shall verify eligibility for Medicare and Vermont Medicaid coverage and submit a notice within 10 days of admission and discharge to DCF using the CFC 804C form (06/14). DCF will enter a long panel for the stay using the “Highest Need” category. After the nursing facility bills and is reimbursed by Medicare, Vermont Medicaid will automatically cover the co-insurance “crossover claims” from day 21 through day 100, for as long as Medicare pays. Nursing facility crossover claims will be paid out of the Choices for Care budget.

- B. Vermont Medicaid Only Stays: People with Vermont Medicaid who are not eligible for Medicare coverage (or any other form of insurance coverage) for short-term rehab in a nursing facility, the Vermont Medicaid benefit package includes a short-term Skilled Nursing Facility (SNF) benefit that is limited to not more than 30 days per episode and 60 days per calendar year.

Admission of a person with Vermont Medicaid to a Skilled Nursing Facility (SNF) per the benefit outlined above is based on a physician's order for SNF services with documentation of medical necessity for the treatment of illness or injury. The admitting diagnosis must support all treatment and therapies ordered and maintain that the service cannot be provided at a lower level of care.

As of June 1, 2014, individuals are not required to submit a *Choices for Care* application for short-term SNF stays. Instead, the SNF will verify Vermont Medicaid coverage and submit a notice of admission and discharge to DCF using the CFC 804C form (06/14). DCF will enter a long panel for the stay using the Highest Need category. The facility will submit Vermont Medicaid claims for coverage using revenue code 128 and will be paid out of the Choices for Care budget.

Refer to the Department of VT Health Access (DVHA) Operating Procedures, *Medicaid Nursing Facility Short Stays*, for more eligibility and coverage details.

### **III. Choices for Care Clinical Eligibility**

Determination of clinical eligibility is a skilled nursing function conducted by a registered nurse (RN). Accurate clinical assessment requires the consideration of a number of variables that affect an individual's clinical eligibility. In certain cases the attending physician's input will be sought regarding medical conditions. The RN will consider the required variables including medical conditions when making a determination of the individual's clinical eligibility. In addition, the RN may determine that an individual currently enrolled in the Choices for Care program has significantly improved and because of the improvement, no longer meets clinically eligibility criteria. In such an instance, the RN must determine if the individual's condition will worsen if required to leave the program. In other instances, the RN must determine whether an individual is currently receiving adequate services to meet identified needs from other non-waiver sources. If an individual's needs could be met through private and/or other community resources (whether or not they are), the individual will not be eligible for the Choices for Care program.

## **A. Highest Need Group**

Individuals who apply and meet any of the following eligibility criteria shall be eligible for and enrolled in the Highest Needs group:

1. Individuals who require extensive or total assistance with at least one of the following Activities of Daily Living (ADL):

Toilet use	Bed mobility
Eating	Transferring

AND require *at least* limited assistance with any other ADL.

2. Individuals who have a severe impairment with decision-making skills OR a moderate impairment with decision-making skills AND one of the following behavioral symptoms/conditions, which occurs frequently and is not easily altered:

Wandering	Verbally Aggressive Behavior
Resists Care	Physically Aggressive Behavior
Behavioral Symptoms	

3. Individuals who have at least one of the following conditions or treatments that require skilled nursing assessment, monitoring, and care on a daily basis:

Stage 3 or 4 Skin Ulcers	Ventilator/ Respirator
IV Medications	Naso-gastric Tube Feeding
End Stage Disease	Parenteral Feedings
2 <sup>nd</sup> or 3 <sup>rd</sup> Degree Burns	Suctioning

4. Individuals who have an unstable medical condition that require skilled nursing assessment, monitoring and care on a daily basis related to, but not limited to at least one of the following:

Dehydration	Internal Bleeding
Aphasia	Transfusions
Vomiting	Wound Care
Quadriplegia	Aspirations
Chemotherapy	Oxygen
Septicemia	Pneumonia
Cerebral Palsy	Dialysis
Respiratory Therapy	Multiple Sclerosis
Open Lesions	Tracheotomy
Radiation Therapy	Gastric Tube Feeding

5. Special Circumstances: Individuals who do not meet at least one of the above criteria may be enrolled in the Highest Needs Group when the Department determines that the individual has a critical need for long-term care services due to special circumstances that may adversely affect the individual's safety. The Department may, with the consent of the individual, initiate such an action. An individual may also request such an action. Special circumstances may include:

- a. Loss of primary caregiver (e. g. hospitalization of spouse, death of spouse);
  - b. Loss of living situation (e. g. fire, flood);
  - c. The individual's health and welfare shall be at imminent risk if services are not provided or if services are discontinued (e.g. circumstances such as natural catastrophe, effects of abuse or neglect, etc.); or
  - d. The individual's health condition would be at imminent risk or worsen if services are not provided or if services are discontinued (e.g. circumstances such as natural catastrophe, effects of abuse or neglect, etc.).
6. Individuals enrolled in the Highest Needs, High Needs, or Moderate Needs groups who, at reassessment, meet any of these Highest Needs eligibility criteria shall be enrolled in the Highest Needs group.
  7. For individuals choosing nursing facility care, the Department shall determine whether the individual is in need of rehabilitation services or long-term care services.

### **B. High Need Group**

Individuals who meet any of the following eligibility criteria shall be eligible for the High Needs group and may be enrolled in the High Needs group:

1. Individuals who require extensive to total assistance on a daily basis with at least one of the following ADLs:

Bathing	Dressing
Eating	Toilet Use
Physical assistance to walk	
2. Individuals who require skilled teaching on a daily basis to regain control of, or function with at least one of, the following:

Gait training	Speech
Range of motion	Bowel or bladder training
3. Individuals who have impaired judgment or impaired decision-making skills that require constant or frequent direction to perform at least one of the following:

Bathing	Dressing
Eating	Toilet Use
Transferring	Personal hygiene
4. Individuals who exhibit at least one of the following behaviors requiring a controlled environment to maintain safety for self:

Constant or frequent wandering
Behavioral Symptoms
Persistent physically or verbally aggressive behavior

5. Individuals who have a condition or treatment that requires skilled nursing assessment, monitoring, and care on a less than daily basis including (but not limited to) the following:

Wound Care	Suctioning	Tube Feedings
Medication Injections	End Stage Disease	
Parenteral Feedings	Severe Pain Management	

AND who require an aggregate of other services (personal care, nursing care, medical treatments and/or therapies) on a daily basis.

6. Special Circumstances: Individuals who do not meet at least one of the above criteria may be enrolled in the High Needs Group when the Department determines that the individual has a critical need for long-term care services due to one of the following:
- Individuals whose health condition shall worsen if services are not provided or if services are discontinued, as determined by the Department, **or**
  - Individuals whose health and welfare shall be at imminent risk if services are not provided or if services are discontinued, as determined by the Department.
7. Individuals enrolled in the Highest Needs, High Needs, or Moderate Needs groups who, at reassessment, do not meet Highest Needs eligibility criteria but do meet any of these High Needs eligibility criteria shall be enrolled in the High Needs group.
8. For individuals choosing nursing facility care, the Department shall determine whether the individual is in need of rehabilitation services or long-term care services.

## **IV. Financial Eligibility**

### **A. Eligibility**

To be financially eligible, individuals must meet the existing financial criteria for Vermont Long-Term Care Medicaid as determined by the VT Department for Children and Families (DCF), Economic Services Division (ESD). DCF-ESD uses pre-determined income and resource limits, allowing for certain deductions and exclusions.

### **B. Patient Share**

In some cases, individuals may be responsible for paying a portion of the cost of their services (patient share), as determined by DCF-ESD. The amount of the patient share, if any, is based on the individual or couple's monthly income after certain allowable deductions. If a patient share is due, DCF will indicate on the written notice the amount of the patient share and the name of the provider to whom the payment is made each month.

### **C. Coverage**

When an individual is found financially eligible for Choices for Care, Long-Term Care Medicaid the State pays for services as determined by the setting. In addition, the individual becomes eligible for all other Vermont Medicaid state plan health benefits including payment for doctors, hospital stays and prescriptions.

#### **D. Estate Recovery**

The Department of Vermont Health Access (DVHA) has the legal authority to recover the cost of Choices for Care services that have been provided to the individual and paid for by the State of Vermont. The process of Estate Recovery occurs after the individual has passed away and is accomplished through the probate court process. Existing State and Federal laws determine how and when DVHA may recover costs from an individual's estate.

**NOTE: Contact the local DCF-ESD office for more information regarding financial eligibility, patient share, health benefits coverage, or estate recovery 1-800-479-6151.**