

Vermont Choices for Care Policy Brief: Eligibility

Purpose of Policy Briefs:

This policy brief is the first of five reviews of policy issues related to the implementation of the Vermont Choices for Care (CFC) initiative. The purpose of these briefs is to examine key policy questions and provide an external perspective that will assist the Vermont Department of Disabilities, Aging and Independent Living (DAIL) in assuring that policies and procedures are as effective as they can be in supporting the goals of Choices for Care. The briefs will cover the following topics:

1. Eligibility
2. Enrollment
3. Service authorization
4. Service delivery
5. Quality management

Key Questions for this review:

- A.** Are there any financial eligibility criteria that retain incentives for institutionalization?
- B.** Are applicants or participants able to access home and community-based services in a sufficiently timely fashion to avoid or delay nursing home admission?
- C.** What strategies have states used to implement a fiscally responsible presumptive eligibility policy for home and community-based services (HCBS)?

Policy Overview:

Vermont has been a national leader in equalizing Medicaid eligibility rules between nursing facility coverage and community-based services. The Vermont Choices for Care (CFC) initiative is a Medicaid research and demonstration waiver designed to eliminate the institutional bias in Medicaid coverage of long-term care.

CFC has three levels of clinical eligibility based on functional need and other risk factors. These levels affect the criteria for financial eligibility and service planning. In brief, the three groups are:

Highest need: Participants have equal entitlement to home and community-based services and nursing facility services

High need: Participants have equal entitlement to home and community-based care and nursing facility services but only if sufficient funds are available

Moderate need: Participants have limited access to case management, adult day health, homemaker and Housing and Supportive Services (HASS), but only if funds are available. The Centers for Medicare and Medicaid Services (CMS) require that enrollment not dip below 250 individuals.

In CFC, Vermont has established equal access to nursing facility and home and community-based services for those identified with the highest needs. Individuals with high needs who do not qualify for the entitlement benefit have equal access to nursing home and home-based services as long as funds are available. For those with moderate needs, who might not previously have qualified for any long-term care services, there is a more limited “preventive” benefit that is also subject to available funds. CMS requires that funds available under the waiver must be at least equal to funds available prior to the waiver.

A Financial eligibility: Are there any financial eligibility criteria that retain incentives for institutionalization?

In large part, the waiver authority for CFC has removed the institutional bias in Vermont’s long-term care system by establishing an equal entitlement for nursing facility and home and community-based care. Nevertheless, the practical implementation of policies can sometimes retain hidden institutional biases that contradict the policy’s intent. We assess three financial eligibility policy issues to determine whether the CFC waiver can be further refined to avoid biases that reinforce nursing home admission:

1. Basic eligibility and spend-down rules

Vermont uses the same special income level for long-term care in the community that is used in nursing facilities. This amount is known as the “institutional income standard” (IIS). In January 2008, the IIS for an individual equals \$1,911 per month or 300 percent of the maximum Social Security Insurance (SSI) federal payment amount for an individual living independently in the community. (The IIS for a couple is

\$3,822.) This income level is similar to what most states use in their HCBS waiver programs (Kassner and Sibley, 2000), and it goes a long way toward assuring equity between the eligibility rules for home and community-based care and nursing home admission.

It is noteworthy that Vermont also has a spend-down option for its highest and high needs applicants seeking home-based services if their income exceeds the IIS. Spend-down rules reduce the individual’s income or assets by the amount of their medical expenses in determining whether he/she qualifies for Medicaid. Long-term care expenses may be counted as medical expenses for individuals in institutions or in the community. However, even if spend-down rules are exactly the same for nursing home and home care applicants, the practical application of these rules can sometimes create a bias against HCBS eligibility for individuals in need.

Long-term care in a nursing facility generally costs more than long-term care in a home or community-based settings, and room and board costs for the nursing facility are treated as medical expenses while the same costs are not considered as medical expenses for individuals in the community. This can make it possible for the same individual to qualify for Medicaid in a nursing facility but not in the community.

Vermont appears to have dealt with this effectively to date through its application of the spend-down rules. For individuals qualifying under the highest or high needs groups who choose HCBS, the initial spend-down calculation is based on the average HCBS cost, approximately \$3,000 per month in 2007. This assures that individuals with lower-than-average HCBS costs will not be penalized in applying for the spend-down. If the individual still does not meet the financial eligibility through the initial calculation, the eligibility worker looks at the actual HCBS and other medical costs to determine if a higher spend-down calculation should be applied.

It appears that anyone who could not afford HCBS services has been granted eligibility based on this spend-down calculation. Individuals with countable income greater than \$1,911 per month and with monthly long-term care medical expenses equal to or less than \$3,000 may have trouble spending down to qualify for HCBS even if they would be able to spend down for nursing facilities (where the monthly cost is closer to \$6,500). However, since most people prefer to stay at home, it is likely that individuals with income at this level will find ways to meet their needs at home by using their own resources rather than seek nursing home access through CFC under a spend-down status.

Individuals with assets above the eligibility limit (\$2,000 for an individual) have many opportunities to reduce their assets and qualify for CFC. For instance, the burial exclusion is \$10,000 and the principal on annuities and other retirement assets are excluded, provided Medicaid is named primary remainder beneficiary. Personal items and household goods such as furniture, appliances, electronic equipment, are not counted

among assets in determining eligibility. Moreover, couples with at least one individual living in the community may retain a much higher amount of assets (\$104,400) due to the amount protected for the community spouse.

Vermont also has generous asset disregards that allow individuals to not count some assets for the determination of financial eligibility. For example, long-term care participants who own their own homes are allowed to set aside up to \$30,000 for home modifications from their assets. They are also allowed to keep certain annuities and exclude them from the assets used in determining eligibility. Moreover, for housing upkeep costs, individuals may retain an additional \$500 in income for up to six months after their date of eligibility to provide for general upkeep. Finally, individuals who are not homeowners are able to retain an additional \$5,000 in resources (beyond the basic \$3,000 threshold) for upkeep of their homes. Vermont's eligibility policies have created strong incentives to enable individuals needing long-term care to remain in the community.

2. Client contributions to cost of care (“patient share”)

Once individuals are eligible for long term care, Vermont begins the process called “post-eligibility treatment of income.” This involves computing how much of the individual's gross income must be contributed to the cost of care and paid to the long term care provider each month (patient share). Individuals in the community and in nursing facilities are required to pay any excess income toward the cost of their care, after allowable deductions for dependents, basic needs and unmet medical needs. For individuals receiving home-based services, the department applies a standard community maintenance deduction (\$950 per month in 2008).

When determining the patient share amount for individuals in the community, the department first disregards public assistance benefits (such as SSI). Vermont also allows individuals in the community to retain the community maintenance allowance.

If allowable disregards and deductions exceed the individual's income, the patient share payment is zero. This is true for many CFC participants. If the individual has a patient share amount due but has incurred reasonable medical expenses, these will be deducted from the patient share amount for as many months as needed to exhaust the medical expenses against the individual's available income.

The department requires that providers collect the patient share amount and deducts the Medicaid payment to the provider by the amount of the patient share. Adjustments are made when an individual transitions from one living arrangement to another. This is an area in which the implementation in the community is more complex than the implementation in nursing facilities. Nursing facilities have the ability to receive the individual's income directly, deduct

the amount of the individual's personal needs allowance, and apply the remaining income toward the cost of care. Medicaid then reduces its payment to the facility based on the amount that they expect the facility to receive from the client's income.

In the case of community providers there are three problems:

- a)** The providers do not receive the individual's check and therefore must depend on the individual to pay for his/her required contribution after the individual has received the check. This puts the community providers in the position of acting as bill collectors.
- b)** There is often more than one provider involved in an individual's community-based care. Vermont's approach has been to identify the highest cost provider and require that they be the ones to collect the client's contribution. This puts a higher burden on some providers while other lower cost providers may never encounter this issue.
- c)** Since federal rules do not allow the program to refuse to serve individuals based on their inability (or unwillingness) to pay, providers who agree to serve the individual before they have been determined eligible become responsible for collecting an unknown applied income amount and then risk the possibility of losing reimbursement for their services if the individual subsequently refuses to pay.

Vermont may wish to explore the possibility of establishing a monthly premium for individuals who must contribute to the cost of care and collecting it directly so that individual providers do not need to be involved in collections. This could allow the state to establish clear and consistent rules about whether and when an individual will have services terminated if they do not contribute to the cost of care. It would also remove the burdensome requirement for collections from individual providers. However, to date CMS regulations have not permitted the use of such premiums except in capitated programs, and it is not clear whether the agency would approve such an approach under a waiver. It should also be noted that such a change would require Vermont to develop additional internal capacity to handle the collections function, something that is less likely in the current financial climate.

3. Liens

In other states, Medicaid often places liens on the property of individuals receiving Medicaid long-term care in order to assure that it can recoup its expenses from the estate of the individual. The prospect of recovery and having a lien on one's home sometimes discourages individuals from applying for Medicaid except as a last resort.

In particular, placing a lien on the home of an individual who is living in the community can raise fears of losing the home and thus lead the individual to forgo assistance. Individuals may decline home care and risk exacerbation of their conditions.

This, in turn, may accelerate their need for greater levels of long-term support and eventually a nursing facility placement. Vermont has avoided this scenario by its policy of not placing a lien on the home of an individual still living in the community and to place liens on the homes of nursing home residents only at the time of the settlement of the estate. This avoids this psychological barrier to service utilization of Medicaid long-term care services.

A recent report by AARP (Wood and Klem, 2007) explored estate recovery practices across the country and identified best practices for notification, etc. Vermont officials have reviewed the recommendations in this report and may wish to examine strategies used by other states to enhance recovery of Medicaid long-term care expenditures while continuing to ensure adequate safeguards for beneficiaries such as early information, clear notification, appeal rights and hardship waivers.

B Timeliness: Are applicants or participants able to access home and community-based services in a sufficiently timely fashion to avoid or delay nursing home admission?

The timing of eligibility determinations and service start-up can have a critical impact on an individual's ability to access home and community-based services in lieu of a nursing home. Particularly if a hospital patient is ready for discharge, time pressures can lead discharge planners to encourage nursing home placement since services are ready and eligibility can be handled retrospectively. In this section, we address aspects of timeliness that can have an impact on individual choice of setting. Another aspect of timeliness relates to the individual's ability, with assistance, to set up a workable service plan of community supports that addresses his/her immediate needs following a hospitalization or other exacerbation of his/her condition. This latter issue will be addressed in a future policy brief on service delivery issues.

1. Timing of clinical review

Timing of the clinical review is critical for ensuring that individuals are able to access long-term care services when they need them. When an individual without Medicaid applies for a nursing facility, the facility is able to conduct their own preliminary screening and admit the individual on the same day if a bed is available. The DAIL clinical eligibility determination can be made retrospectively and the individual will experience no gap in service. In practice, the retroactive review is rarely needed because most individuals are admitted to nursing facilities from hospitals and have initial coverage from Medicare while waiting for the Medicaid clinical (and financial) review.

The clinical review process for HCBS is technically the same as for nursing facilities and can be handled retrospectively "when an individual's circumstances present a clear emergency and Department staff is unavailable" (CFC regulations, 10/05). However, when the individual's situation is not an emergency, DAIL policy allows the clinical eligibility determination be made within 30 days of the application, and then the case manager has up to two weeks to complete the comprehensive assessment. The result is that it could take more than six weeks before the individual begins receiving services. Medicare coverage of HCBS is limited to home health, so the individual may need to wait several weeks or even longer for critical services.

While staff expedites decisions for urgent cases, the policy creates the impression that a month is a reasonable amount of time to wait for the clinical determination and that receiving a determination in three weeks and starting services within a month is efficient. However, any delays in making a clinical determination for HCBS may increase the likelihood that individuals or their families may seek nursing facility admission, particularly following a hospitalization. Once in the nursing home, they may find it more difficult to make the transition home. Therefore, it is important to address any factors that may delay this clinical determination.

This is an area in which DAIL has an opportunity to improve its procedures. In addition to retaining adequate staff to fulfill review functions, DAIL may also want to consider alternative approaches to conducting the clinical assessment/determination.

One option is for DAIL to allow providers to complete the initial assessment information and forward it to the long-term care clinical coordinators (LTCCC) who would then make a verification visit in-person within the first month. DAIL could allow providers to start services immediately based on their initial assessment as long as they maintained a consistent degree of accuracy in these determinations (e.g. 90 percent consistency with the LTCCC).

Another option, particularly for individuals who do not have a current provider, is for DAIL staff to gather clinical information from the prospective client by telephone and make a determination based on that self-reported information. The provider's subsequent assessment visit could be used to verify the information documented in the clinical review and confirm that the determination is appropriate.

Finally, Vermont may want to explore the possibility of modifying its SAMS database to include information for the pre-enrollment clinical determination, thus allowing community providers to conduct the review and submit the information to support the determination of clinical eligibility. This could include an automated review and determination function for cases in which an algorithm can be used to confirm eligibility.

These suggested approaches to expediting clinical determinations would obviously need to be coordinated with financial eligibility determinations in order for DAIL to ensure Vermont's community providers that they would be reimbursed for services provided on or after this preliminary determination of eligibility. Moreover, if the Choices for Care program is operating with a waiting list, as has been the case since February 1, 2008, the need to expedite clinical determinations may be less critical.

2. Timing of financial review

Vermont has implemented several procedures to help expedite financial eligibility for individuals applying for Choices for Care. No look-back period is required for individuals applying for the Moderate Needs group or for individuals applying for home-based care under the High or Highest needs groups if their income is less than the protected income level (100 percent of the Federal Poverty Level (FPL)). This eliminates the look-back period regarding transfers of assets for many applicants. (The look-back period is currently three years but will shift to five years based on the phase-in provisions of the Deficit Reduction Act that will be fully effective in 2011.) Eliminating the look-back period for low-income individuals focuses the staff resources within the Department for Children and Families on verifications of assets for individuals whose incomes make it more likely that they could have accumulated and/or transferred assets.

In 2005, a Kaiser report entitled "Strategies to Keep Consumers Needing Long-term Care in the Community and Out of Nursing Facilities" identified "expediting eligibility determinations" as a key issue for encouraging nursing facility diversion (Sumner, 2005). Washington and Indiana were featured for a team approach in which the clinical and eligibility workers made joint visits to initiate eligibility. Other states involved case management staff or staff from the Area Agencies on Aging in helping the individual complete the financial eligibility application. While Vermont case managers do assist individuals to some extent, the possibility of conducting joint visits approaches may be worth discussion in Vermont; although the cost may be prohibitive.

The Kaiser report noted that Vermont had initiated an innovative approach to conducting electronic eligibility verification. This approach had been under discussion with the Vermont Bankers Association, but unfortunately the banks couldn't follow through on their plans at that time. Vermont may want to reintroduce these discussions to explore options for such electronic verifications.

3. Expedited Eligibility

Currently, Vermont's policy states that providers may start services while an individual's application is being processed but the provider and/or applicant is responsible for all costs if the individual is determined to be ineligible. This kind of

"passive presumptive eligibility" operates effectively in nursing homes for some of the reasons that also make it easier for nursing facilities to collect the patient's share toward the cost of care. However, while the likelihood of being determined ineligible is low, particularly for individuals whose income is under 100 percent of the FPL level, this is a financial risk that community providers are not readily able or willing to incur due to limited cash flow, inability to assure that clients will cover the costs if determined ineligible, and limited options for covering services through Medicare and other private insurances.

At the time of this writing, Vermont had just begun to informally implement new procedures to identify individuals whose applications could be expedited. This new procedure operates as an informal presumptive eligibility process for certain applicants. When resources appear to be below the maximum, Vermont grants eligibility immediately after the interview for applicants who have received SSI, Food Stamps, or Medicaid at some point during the past 12 months as long as their monthly income remains below the protected income level (PIL) (in 2008, \$950/month for individuals in Chittenden county and \$883/month for all others). Vermont may want to formalize and expand these informal procedures related to presumptive eligibility to allow individuals access to home-based services more quickly.

4. Tracking of eligibility determinations and start dates

Regardless of what approaches Vermont uses for improving the timeliness of eligibility determinations, it will be critical for the state to establish a method for monitoring the impact. Vermont's current data system (SAMS) does not retain the date of application if different from the date that services can start (retroactively). However, an important outcome to be considered in the evaluation of the success of the Choices for Care initiative is the difference in the average amount of time from the individual's date of application to the actual start of services, particularly for home and community-based services.

Reductions in the average processing times for individuals who chose community options will be an indicator of improvement in access that is likely to have an impact on nursing home admissions. Therefore, we recommend that Vermont explore options to review of the system's performance regarding the timeliness of eligibility determinations and service start dates. One option may be to link the SAMS data base with information in the eligibility files to monitor the time between application, eligibility determination and service start date. Another option may be to take advantage of optional fields in the SAMS data base and require that such information be entered consistently.

C Presumptive eligibility: What strategies have states used to implement a fiscally responsible presumptive eligibility policy for HCBS?

Vermont had considered implementation of presumptive eligibility policy prior to the development of the CFC waiver. The state proposed to allow this under the waiver, but the CMS would not authorize Medicaid coverage of the costs for individuals who were eventually determined ineligible. In the event that Vermont chooses to formalize and/or expand its presumptive eligibility practices, experiences from other states provide effective models for maintaining a fiscally responsible policy. A recent report by the Community Living Exchange at Rutgers University focused specifically on issues related to “Expediting Medicaid Financial Eligibility” (Mollica, 2004). The report documented activities in eight states to establish some form of presumptive eligibility including practices to assure fiscal viability and approaches for covering costs for ineligible persons.

1. Factors to include if Vermont pursues a formal presumptive eligibility policy

If Vermont chooses to adopt a formal presumptive financial eligibility policy, the following components should be included:

- assuring that the individual understands that the services provided are temporary and will not continue if eligibility is not confirmed; some states have required that the client sign a statement to this effect which becomes part of the application;
- requiring that the individual complete a full Medicaid application prior to or within a certain number of days before the start of services (several states used 10 business days, and the case manager or other reviewer would follow-up to be sure this was completed);
- establishing in regulation a limit on the number of days that the service could be provided before eligibility was determined (range from 60 to 90 days); and
- taking a proactive role in assisting the applicant in providing documentation of eligibility (e.g. photocopying documents, working directly with banks and the Social Security Administration (SSA)); in most states, this is a role assumed by the case manager or other support workers from the case management agency.

The most successful states were able to make an eligibility determination within 1-4 days after application; even states that had longer periods for the determination were able to dramatically reduce the average time for making a decision to authorize services.

2. Financial coverage for ineligible persons

When states have implemented presumptive eligibility, they have generally made provisions to reimburse providers for costs incurred when services were started for individuals who were ultimately determined to be ineligible. Since CMS has not authorized federal matching funds for such costs, states have generally covered these costs using general revenues, Older Americans Act funds, Social Services Block grant funds, or individual/family contributions.

However, this is a rare occurrence. For example in Pennsylvania, only 2 percent of the cases presumed to be eligible were determined ineligible upon a full verification of income and resources (Mollica, 2004). Washington did not provide a specific percentage in the report (although informally they have estimated no more than 3 percent of cases presumed to be eligible are later found ineligible). State officials in Washington estimated that they saved \$1,964 per person per month by authorizing community services for individuals who would have entered an institution if services were delayed.

To date, CMS has not allowed Medicaid matching funds for such expenses, but this could be changing. The Deficit Reduction Act includes a provision that allows Medicaid coverage for presumptive eligibility for individuals served under the new state plan option. Given this clear evidence of legislative support, CMS may now be willing to reconsider proposals under an 1115 waiver to allow for Medicaid coverage of presumptive eligibility.

Vermont will need to review the practical implications of such a formal change in eligibility policy. At the time of this writing, Vermont had just begun to informally implement new procedures to identify individuals whose applications could be expedited and to move them more quickly through the system. Vermont may want to evaluate the impact of these changes before making additional changes in its eligibility policy.

Conclusions/Recommendations:

Overall, Vermont has established eligibility policies and procedures that equalize the choice between nursing facility and home and community-based long-term care. Vermont's eligibility approach under the Choices for Care 1115 Waiver is, in fact, a national model that many states are watching to see the impact on long-term nursing home and HCBS utilization. This review has identified several opportunities for Vermont to explore in order to improve its eligibility policies and procedures:

1. Streamline patient share collection process for home based individuals;
2. Explore ways in which Vermont estate recovery practices could be improved to mirror best practices in other states;
3. Shorten the timeline for making clinical eligibility determinations through implementation of telephone reviews and/or retrospective validation of provider assessment information;
4. Explore opportunities for expediting financial eligibility determinations such as more proactive involvement of staff or providers and/or electronic verifications of eligibility;
5. Modify the SAMS data system to include algorithms and automatic feedback mechanisms for electronic clinical eligibility determinations;
6. Explore the possibility of linking the SAMS data base with information in the eligibility files or other approaches to allow for tracking of the time between application, eligibility determination and service start date;
7. Monitor the impact of new eligibility procedures and assess whether further waiver amendment changes such as presumptive financial eligibility for home-based care could benefit program applicants. If there is a need for a formal presumptive eligibility policy, incorporate the lessons learned from other states in the implementation procedures.

Appendix

Vermont Resources Reviewed

As part of the formative component of the evaluation of Choices for Care, UMass Medical School/Center for Health Policy Research conducted key informant interviews with 16 staff in DAIL and the Department for Children and Families (DCF) and six community advocates. Interviews with the following individuals were particularly informative for this policy review:

- Janet Pare, DCF Benefits Program Assistant Administrator
- Marybeth McCaffrey, Esq., DCF Health Care Eligibility Policy Analyst
- Megan Tierney-Ward, DAIL Long-term Care Clinical Coordinator Supervisor

Interviews and focus groups with individuals, family members, and providers were also conducted but had not been completed at the time of this deliverable; if additional issues related to eligibility are raised through those sources, this policy brief will be updated accordingly. Materials reviewed for this policy brief also include relevant CFC regulations, policies and procedures, application forms, and national reports. National sources are listed in the references section of this document. The following is a list of DAIL documents that were reviewed for this policy brief:

- Choices for Care: 1115 Long-term care Medicaid Waiver Regulations, State of Vermont, Agency of Human Services, Department of Disabilities, Aging and Independent Living, Division of Disability and Aging Services, Effective October 7, 2005 (and annotated draft revised March 2, 2007)
- Choices for Care, Long-term Care Medicaid Program Manual, Section V.1, Application & Eligibility Determination Procedures, Revised 01/06
- Choices for Care, Long-term Care Medicaid Program Manual, Section V.3, Assessment & Reassessment Procedures, Revised 10/1/05
- Choices for Care Program Application, CFC 801, 02/07
- Choices for Care Moderate Needs Group Application for Services, CFC MOD 902 02/05
- Licensing and Operating Rules for Nursing Homes, Agency of Human Services, Department of Aging and Disabilities, December 15, 2001
- "Vermont Choices for Care" Demonstration Waiver: Operational Protocol, Section G, Notification of Program Participants, Revised 11/14/06

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Kassner, Enid and Lee Shirley. "Medicaid Financial Eligibility for Older People: State Variations in Access to Home and Community Based Waiver and Nursing Home Services." AARP Public Policy Institute, April 2000, #2000-06.

Mollica, Robert. "Expediting Medicaid Financial Eligibility." Community Living Exchange, Rutgers Center for State Health Policy and National Academy for State Health Policy, July 2004.

Summer, Laura. "Strategies to Keep Consumers Needing Long-Term Care in the Community and Out of Nursing Facilities." Kaiser Commission on Medicaid and the uninsured, October 2005, p. 15.

Wood, Erica F. and Ellen M. Klem. "Protections in Medicaid Estate Recovery: Findings, Promising Practices, and Model Notices." AARP Public Policy Institute, May 2007, #2007-07.

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