

# Comments from the Vermont Ombudsman Project

## 1. Regulations:

**The Waiver Proposal should state clearly that the department intends to promulgate regulations to implement the Demonstration.** I understand that the department will submit operational protocols to CMS that will flesh out details that are missing in this proposal. However, DAD should go through the regulatory process so that the consumers can give their input on the rules that will govern this program. There should be clear written policies in place that outline critical aspects of the program like the appeal procedures and eligibility criteria. Consumers should have the opportunity to review and comment on any proposed changes to these policies.

*The Department agrees with the need for regulations for the 1115 Waiver Demonstration program. A large group will be meeting on November 18 from 1-4 p.m. in Waterbury to discuss what should be covered in the regulations. We also agree that consumers should have the opportunity to review and comment on any proposed changes to the policies.*

## 2. Preliminary Assessment:

**Preliminary assessments should occur before someone is discharged from the hospital.** The Demonstration can not just rely on projected nursing home savings. As was stated at the last DAD Advisory Board meeting, the department needs to prime the pump. One way to do this is to slow down the flow of patients from hospitals to nursing homes. The preliminary assessment should occur when the individuals are still in the hospital. This should be the rule. There could still be an exception that would take into account a hospital's need to free up beds for acute patients.

*We agree that reaching individuals and talking with them about their options for long-term care services as early in the process as possible is ideal. Anyone will be able to request an assessment, whether they are in a hospital, at home or in another setting. Part of our outreach efforts will focus on letting individuals know that this assessment and options counseling service is available. We have stated in the proposal, and in many public meetings, that the process we design will not slow down the hospital discharge process.*

## 3. Entitlement Groups and Eligibility Criteria:

**The Demonstration Proposal should include the eligibility criteria for the “high” and “moderate” needs groups.** The language in the proposal is so general that it is difficult to picture who will be included in these two groups and how or if services will be prioritized within each group.

*We have nearly completed the draft criteria for the “High” and “Moderate” Needs groups and will be sending them out shortly for review by the Eligibility Workgroup. Part of our continuing work will be to determine how we will prioritize services to individuals within each of those groups, depending on the availability of funds.*

**The language describing the “highest” needs groups and the eligibility criteria set out in Appendix B are confusing and inconsistent with the stated goals of the Demonstration.**

The proposal says that the state plans to expand the current eligibility criteria for the “highest” needs group, yet in fact it (sic) proposing a more restrictive eligibility criteria than is currently in use.

***We agree that the language was confusing and hope we have clarified this statement in the proposal that was submitted to CMS. What we meant to say is that we have expanded the entitlement to long-term care by including individuals seeking home- and community-based services as well as to those seeking care in a nursing facility.***

Page 5 of (sic) states that the purpose of the proposal is to provide “equal access to long term care options”. But, it appears that individuals with a primary diagnosis of mental illness or mental retardation who also need long term care services will only be eligible for the demonstration if they choose to receive services in a nursing home. They have an entitlement to a nursing home bed, but not to community based services.

***The 1915(c) Home- and Community-Based Waiver administered by the Division of Developmental Services and the 1115 CRT program administered by the Division of Mental Health and designed to meet the needs of these individuals in the community. This Department believes that using a prudent and somewhat cautious approach in the design and implementation of this waiver makes sense.***

Also, Page 13 states that “[N]ursing facility services will be included in the care plan if the individual meets the clinical eligibility criteria”. What is the “clinical eligibility criteria”? Is it the criteria set out in steps 2-5 of Appendix B? What criteria would individuals in the “high” need group have to meet to be eligible for nursing facility services? This should be clarified. In addition, the proposal states on page 13 that “health and welfare issues are central to any decision with respect to the need for nursing facility care”. This concern should be incorporated into the eligibility criteria for both the “highest” and “high” needs groups.

***The statement about clinical eligibility refers to the Highest Need eligibility criteria (see the new Appendix B in the final submittal to CMS). In addition, if an individual who is found clinically and financially eligible for the High Need group prefers care in a nursing facility and funds are available, the 1115 Waiver will pay for care in that setting. As stated above, we are close to releasing the draft criteria for all three groups.***

4. Increased resource limit:

**The resource limit should also be increased for nursing home residents who are likely to return to the community within six months.** Individuals who require a short term nursing home stay should also be able to take advantage of the increased resource limit. If they are forced to spend down to the \$2,000, they will not have the resources to maintain their homes when they leave the nursing home. Increasing the limit to \$10,000 for these individuals will provide an incentive for returning to the community and it will help them remain in the community.

***Short-term nursing home stays usually follow a qualifying hospitalization and are covered by Medicare. If individuals enter a nursing home for a respite stay while they are receiving long-term care services at home, the \$10,000 resource limit will still be in effect. We are considering what length of time would be reasonable to maintain the \$10,000 resource limit after admission to a nursing home.***

5. Waivers:

The state has requested numerous waivers without explaining why the waivers are necessary and what specific policies it will develop if the waivers are granted.

A. *Retroactive Eligibility*

**The Demonstration should not eliminate a Medicaid Recipient’(sic) right to 3 months of retroactive eligibility.** There can be many reasons why an elderly, frail individual with significant physical or cognitive limitations might not apply for long term care services in a timely manner. Given the high cost of nursing home and community based services, it is unfair to deny these Medicaid recipients retroactive coverage simply because they need long term care services.

*We have reviewed the comments received on this idea and have decided to retain the 3-months retroactive benefit as it exists today.*

B. *Amount, Duration and Scope:*

**The Demonstration should not eliminate the Medicaid requirement that services be sufficient in amount, duration and scope to reasonably achieve their purpose.** Without this requirement, the state can offer a wide variety of services in its Demonstration yet limit the amount scope and duration of those services. Without this requirement, the state could restrict community based services, like companion and homemaker thus making equal access meaningless.

*The actual language in the waiver requested states “The State requests this waiver to permit it to restrict the amount, duration and scope of services provided to a Demonstration enrollee to those services included on the approved Comprehensive Care Plan.” An individual’s assessment and resulting care plan will include the services under that 1115 Waiver necessary to address the individual’s needs. The limited Demonstration funds should not be used to pay for services beyond those covered by the Demonstration and identified in the individual’s care plan.*

C. *Income Transfers:*

**The state should clarify why it is requesting a waiver of the existing income transfer rules.** It is unclear if the state wants to reduce the look back period for income transfer from 36 to 12 months or if it wants to keep the 36 month look back but add additional penalties for exempt transfers made in the past 12 months. This should be clarified and the state should not request a waiver for the purpose of adding penalties that are not now allowed under federal law.

*We agree that the language was not clear in the request for this waiver. We definitely want to retain the 36-month look back. We have not considered any approaches yet to the issue of transfer of assets, but will keep the door open to ideas.*

D. *Cost Sharing:*

**The Demonstration should not eliminate current cost sharing protections.** Current law allows only nominal copayments, deductibles, coinsurance or similar payments. It also prohibits cost sharing when individuals in nursing facilities are required to pay all but the personal needs allowance to the facility. Current law also prohibits multiple charges for any service and specifically puts a cap on cost sharing for nursing facility residents.

The state's proposal does not explain which of these protections it wants to waive. The general discussion of enrollee cost sharing in the proposal gives little guidance on how and to what extent the state will ask the elderly and disabled individuals in the waiver to pay an increased portion of the cost of their long term care services.

***The calculation of patient shares for individuals who are in the Highest Need and High Need groups will not change. The waiver request for co-payments or cost sharing would only pertain to the Moderate Need group.***