

SECTION V.1. Application & Eligibility Determination Procedures

A. Choices for Care Applications

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 *Section II. Eligibility*. 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.***

1. Consistent with Act 123, hospitals and nursing facilities staff shall provide information on how to apply to Choices for Care to individuals in need of assistance to pay for long-term services and supports, at the time of admission or as soon as possible following admission.
 - a. Facility staff shall assist those individuals who want to apply for Choices for Care waiver services, regardless of what setting they may be interested in (home-based, nursing facility, enhanced residential care or Adult Family Care).
 - b. Facility staff shall complete assessments, as needed according to their internal protocols.
 - c. DAIL staff shall provide hospital and nursing facilities with information regarding long-term services and supports options for individuals whom facility staff believes could benefit from receiving the information.
 - d. Facility staff shall send the completed Choices for Care application on behalf of the individual, to the DCF-ESD Application and Document Processing Center in a timely manner.

2. Individuals who wish to enroll in the Choices for Care shall complete obtain an application obtained by calling 1-800-479-6151 or online at http://dcf.vermont.gov/esd/ltc_medicaid. Application are submitted to the Application and Document Processing Center (ADPC) of the Economic Services Division (ESD) of the Department for Children and Families (DCF): DCF – Economic Services Division.
Application and Document Processing Center
103 South Main Street
Waterbury, VT 05671-1500

3. Individuals in a nursing facility (or hospital swing bed) who require continued coverage beyond their private resources or insurance benefit coverage (e.g. Medicare, Vermont Medicaid, VA private insurance) may apply for Choices for Care for assistance to pay for continued coverage. The DAIL LTCCC nurse shall visit the individual in the facility setting as necessary to assess the individual, determine clinical eligibility, and discuss care/support options. ***Continued payment to the nursing facility (or hospital swing bed) will only occur after the individual has been found clinically and financially eligible for Choices for Care under the long-term care Medicaid rules.***

4. When an individual's circumstances present a clear emergency, and DAIL staff is unavailable, he or she may be admitted to services without prior approval from the Department. Under these circumstances, an application shall be completed prior to admission to services (if possible) and the Department shall complete a retrospective review to determine eligibility. If individuals are determined to be ineligible, the Department shall not be responsible for the cost of services provided to the individual.

B. Initial Choices for Care Screening

1. When DCF-ESD receives the 202 LTC Choices for Care application a copy will be forwarded electronically to DAIL staff.
2. When DAIL staff receives the Choices for Care application from DCF-ESD, DAIL staff will contact the individual and/or referral source to gather additional information as needed and to schedule a clinical eligibility assessment. DAIL staff will contact the individual and/or referral source within three (3) working days.
3. Department staff may utilize existing assessment information to assist in determining clinical eligibility.
4. When DAIL LTCCC nurses receive a Choices for Care application for individuals in the hospital who are dependent upon Choices for Care coverage for their discharge, he or she shall make reasonable efforts to assess the individual and explain options, prior to discharge. If a face-to-face visit is not possible prior to discharge, DAIL LTCCC nurses shall make arrangements to see the individual as soon as possible following discharge.

C. Clinical Assessment

DAIL staff will determine the clinical eligibility (Highest or High Needs Group) from gathering information during a face-to-face assessment. **DAIL staff** will complete an assessment using the "Choices for Care Clinical Assessment" (CFC 802) to determine clinical eligibility. DAIL shall make a decision regarding clinical eligibility for Choices for Care within 30 days of receiving the application, unless the application is put "on hold" status. (E.g. the individual has not decided on the setting in which to receive services, remains in the hospital).

1. **Highest Needs Group**: All individuals who apply and meet both the clinical criteria for Highest Need and the financial criteria for Long-term Care (LTC) Medicaid services shall be enrolled in the program. Active program participants who meet the Highest Needs group clinical criteria at reassessment shall not be terminated from services, provided that they continue to meet all other eligibility criteria.
2. **High Needs Group**: Enrollment in the High Needs group shall be limited by the availability of funds. Individuals who apply and meet both the clinical criteria for the High Needs group and the financial criteria for Long-term Care (LTC) Medicaid services may be enrolled in the program.

a. If funds are unavailable, the names of eligible applicants shall be put on a waiting list. Applicants on a waiting list shall be admitted to the Choices for Care waiver as funds become available, according to procedures established by the Department and implemented by regional Choices for Care waiver teams. The Choices for Care waiver teams shall use professional judgment in managing admissions to the Choices for Care waiver, admitting individuals with the most pressing needs. The teams shall consider the following factors:

- i. Unmet needs for ADL assistance;
- ii. Unmet needs for IADL assistance;
- iii. Behavioral symptoms;
- iv. Cognitive functioning;
- v. Formal support services;
- vi. Informal supports;
- vii. Date of application;
- viii. Need for admission to or continued stay in a nursing facility;
- ix. Other risk factors, including evidence of emergency need; and
- x. Priority score.

b. DAIL staff shall send a written notice to individuals whose names are placed on a waiting list, which shall include information about how the waiting list operates.

c. When an individual's circumstances present a clear emergency, and DAIL staff is unavailable, the individual may be admitted to services without prior approval from the Department. Under these circumstances, DAIL staff shall complete a retrospective assessment/review to determine eligibility. Individuals who are determined not to be eligible may be responsible for the costs of services that have been received.

d. All active program participants who meet the High Needs group clinical criteria at reassessment shall continue to be enrolled, provided that they continue to meet all other eligibility criteria. Individuals who are enrolled in the Highest Needs group and subsequently fail to meet the eligibility criteria for the Highest Needs group, but meet the High Needs group eligibility criteria, shall be enrolled in the High Needs group and continue to be eligible to receive services.

e. DAIL staff shall review the status of eligible applicants whose names have been on the waiting list for sixty (60) days to ensure that the applicant's needs have not changed.

f. Any eligible applicant whose name has been on the waiting list for 60 days or more shall be given priority for enrollment over eligible applicants with similar needs whose names have been on the waiting list for a shorter amount of time.

D. Financial Assessment

The Choices for Care Long-Term Care Medicaid application (202 LTC) initiates both the clinical

and the financial eligibility determination process.

E. Long-Term Care Options

DAIL staff shall discuss CFC options as part of the application and assessment process. DAIL staff will ensure that options brochures and information will be made readily available as needed.

F. Notifications

If the applicant is found clinically eligible for the Highest Needs group, or the High Needs group with funds available, DAIL staff will send a Clinical Certification (CFC 803) notice to DCF, case management agency, Transition II or Authorized Agency (HB setting), the Enhanced Residential Care provider (ERC/community setting) and the Nursing Facility provider. DCF staff will then complete the Long-Term Care Medicaid financial eligibility process. If the applicant is found clinically ineligible, DAIL staff shall send a written notice to the applicant with appeal rights and will notify DCF.

G. Adult Family Care Tier

For individuals choosing the AFC setting, DAIL staff will send a referral to the participants Case Management (CM) agency of choice. The CM will complete the AFC ILA assessment and review Authorized Agency (AA) options. When the participant has chosen an AA, the CM will forward a copy of the AFC ILA to the AA as a referral. The CM will send the AFC ILA and tier score to DAIL. DAIL staff will complete Utilization Review (UR) and then inform the CM agency of the tier. The CM will then inform the participants chosen AA of the tier. If the AA is able to serve the participant, the AA will begin the home provider matching process. When a home provider match is found, the CM will complete the AFC service plan with the tier and will obtain signatures from the participant and/or authorized representative, the AA and the home provider. The CM will send the service plan to DAIL staff for authorization. DAIL staff will authorize the service plan when DCF staff has notified DAIL that the participant is financially eligible for Long Term Care Medicaid.

H. Final Authorization

When financial eligibility is determined, DCF staff will notify DAIL, applicant and highest paid provider (if patient share due). If the applicant is found financially eligible, DAIL staff will authorize services (a Service Plan for home-based and ERC settings is required before DAIL may authorize services) and send notification to individual and providers. In the nursing home setting, the Notice of Decision from DCF- ESD is the authorization notification of eligibility.

I. Transitional Provision

All individuals who were being served under a preexisting 1915c Medicaid Waiver (Home-Based or Enhanced Residential Care) or who were receiving Medicaid nursing facility care at the time of the implementation of the Choices for Care waiver October 1, 2005, shall be enrolled in the Choices for

Care waiver and shall continue to receive services. Thereafter, these participants shall continue to be enrolled in Choices for Care if, at reassessment, they meet the eligibility criteria for the Highest Needs group, the High Needs group or the Guidelines for Nursing Home Eligibility adopted in April of 1997.

J. Continued Eligibility

1. **Screening**: DAIL staff will screen reassessment and forms for missing or incomplete information. DAIL staff will contact the case manager or individual to gather additional information, as needed.
2. **Clinical Re-Assessment**: DAIL staff will determine clinical eligibility (Highest Needs group or High Needs group) from assessment information submitted with the continued eligibility materials. A face-to-face review may be completed as necessary.
 - a. **Highest Needs Group**: Active program participants who meet the Highest Needs group clinical criteria at reassessment shall continue to be enrolled, provided that they continue to meet all other eligibility criteria.
 - b. **High Needs Group**: Active program participants who meet the High Needs group clinical criteria at reassessment shall continue to be enrolled, provided that they continue to meet all other eligibility criteria. Individuals who are enrolled in the Highest Needs group and subsequently fail to meet the eligibility criteria for the Highest Needs group, but meet the High Needs group eligibility criteria, shall be enrolled in the High Needs group and continue to be eligible to receive services.
 - c. **Ineligible Participants**: Active program participants who do not meet clinical eligibility criteria for any group shall be disenrolled and shall receive written notice of this decision with appeal rights.
3. **Financial Eligibility**: DCF staff shall be responsible for determining whether individuals remain eligible under Long-Term Care Medicaid financial eligibility criteria for the Highest Needs group or the High Needs group.
4. **Final Authorization**: DAIL staff shall authorize services and send written notice to the individual, the legal representative, and the provider(s). If the participant is found to be clinically ineligible, DAIL staff shall send a written notice with appeal rights. If the participant is found to be financially ineligible, DCF staff shall send written notice with appeal rights.
5. **Time Limit**: DAIL staff shall make a clinical eligibility determination within thirty (30) days of receiving the 202 LTC Choices for Care application.

K. Short-term Rehab in a Vermont Nursing Facility

A Choices for Care application is not required for people who have both Medicare and/or Vermont Medicaid coverage for short-term rehabilitation in a nursing facility. Medicare coverage rules may be found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf>. Refer to the Department of VT Health Access (DVHA) Operating Procedures, *Medicaid Nursing Facility Short Stays*, for more details on Vermont Medicaid coverage.

Steps for authorizing Dual Medicare/VT Medicaid and VT Medicaid only covered short-term rehab stays:

1. **Referral**: The nursing facility receives a referral for short-term rehab.
2. **Choice**: The nursing facility verifies the person's choice to receive care in their facility.
3. **Insurance Verification**: Nursing facility verifies the person's Medicare and/or Medicaid insurance coverage. Malcolm phone system: **1-800-925-1706, out of state 802-878-7871**
4. **Clinical Verification, Dual Medicare/Medicaid Stays**: Medicare is always the primary payor for people with both Medicare and VT Medicaid coverage. VT Medicaid co-insurance coverage starts day 21 to day 100 of Medicare stay, following all Medicare standards, including a 3-day qualifying hospital stay. Medicare standards found at: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf>
NOTE: Medicare must be utilized before VT Medicaid when the person meets Medicare standards of coverage.
5. **Clinical Verification, Medicaid Only Stays**: If a person has no Medicare or private insurance coverage, VT Medicaid rehab benefit covers up to 30 days per episode/60 days per calendar year following the Department of VT Health Access (DVHA) Operating Procedures, *Medicaid Nursing Facility Short Stays*.
NOTE: Medicare and private insurance must be used before Medicaid only coverage.
6. **Admission to Nursing Facility**: After the nursing home verifies coverage, the nursing facility must notify DCF within 10 days of the admission using required DAIL form CFC 804C, and makes plans for admission, following all existing state and federal regulations.
7. **DCF Long Panel Dual Medicare/Medicaid Stays**: DCF verifies Medicare and VT Medicaid coverage based on the notification from the nursing facility. DCF enters a long panel in the ACCESS system using the Highest Need category. The start date is the 21st day after admission (the start of Medicaid co-insurance payments). The end date is the "last day of coverage" date reported by the nursing facility, up to day 100 of the Medicare covered stay. If the nursing facility does not report the end date on the admission notification, DCF enters a 30-day segment starting on day 21 and ending on day 50 of the Medicare admission. When the nursing facility submits the new CFC 804C with the "last day of coverage" date, DCF will update the long panel with the new end date provided by the nursing facility, not to exceed a total of 100 days from admission.
8. **Long Panel Medicaid Only Stays**: DCF verifies VT Medicaid coverage based on the notification from the nursing facility. DCF enters a long panel in the ACCESS system with both a start and end date using the Highest Need category. The start date is the admission

date. The end date is the discharge date reported by the nursing facility up to 30 days total (60 days per calendar year). If the nursing facility does not report the end date on the admission notification, DCF enters 30 days total.

9. **Dual Medicare/Medicaid Claims**: The nursing facility bills Medicare following Medicare rules. After the Medicare claim is paid, VT Medicaid automatically pays the co-insurance “crossover claim” following the Medicare period of coverage.
10. **Medicaid Only Claims**: The nursing facility bills VT Medicaid using revenue code 128 up to 30 days (60 days per calendar year).
11. **Discharge Planning**: The nursing facility must assist the individual with discharge planning prior to the end of the rehab stay.
12. **DCF Notice of Discharge**: The nursing facility must notify DCF of the actual discharge date using the CFC804C.
13. **Changes in payer source for rehab stay**: The nursing facility must notify DCF and DVHA using the CFC 804B if there is a change in payer source during a stay.
14. **Continued Choices for Care Eligibility**: If at any time during a short-term covered stay, the nursing facility believes the individual continues to need nursing home level of care, the nursing facility must discuss options with the individual and assist the individual in submitting an application for Choices for Care if desired by the individual or their legal representative.
15. **Active Choices for Care participants**: Active Choices for Care (CFC) participants continue to have a choice of setting and may transition to an approved VT Medicaid nursing facility following existing CFC program standards.
16. **Specialized Out-of-State Rehab**: A person seeking “specialized rehab” at an out-of-state facility considered a “specialized rehabilitation” facility must receive prior-authorized by DAIL for each admission. This includes a clinical review of need, verification that the need cannot be met in any standard Vermont nursing facility or other CFC covered service, approval of the plan of care and a rate-setting review.