VERMONT

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Agency of Human Services

M E M O R A N D U M

To: Senator Mark MacDonald, Chair, Legislative Committee on Administrative Rules

From: Mark Larson, Commissioner, Department of Vermont Health Access

Cc: Doug Racine, Secretary, Agency of Human Services
Dave Yacovone, Commissioner, Department for Children and Families

Date: July 3, 2014

Re: Health Benefits Eligibility and Enrollment Final Proposed Rule (14P014)

The Agency of Human Services' Department of Vermont Health Access (DVHA) and Department for Children and Families (DCF) (collectively referred to as "the Agency") are providing this memorandum in order to:

- Explain how the proposed Health Benefits Eligibility and Enrollment (HBEE) rule, including section 8.05(k), meets the statutory criteria for LCAR approval (pages 1-3).
- Present proposed amendments to the rule text that were agreed to with stakeholders after the final proposed rule was filed with LCAR and the Secretary of State (pages 3-6).

1. Statutory requirements for LCAR approval pursuant to 3 V.S.A. §842

The Agency maintains that this proposed HBEE rule meets the requirements of 3 V.S.A. § 842 as follows:

- the proposed rule is within the authority of the Agency as provided in 3 V.S.A. § 3053, 33 V.S.A. §105(c)(2), 3 V.S.A. §801(b)(11) and 33 V.S.A. § 1901(a);
- the proposed rule is not contrary to the intent of the Legislature as the rule implements Vermont Act nos. 48 of 2011, 171 of 2012, 79 of 2013 and the Affordable Care Act (ACA);
- the proposed rule is not arbitrary because it consolidates and streamlines the health benefits eligibility process in furtherance of Vermont's health care reform goals as passed by the legislature without changing Medicaid eligibility and enrollment provisions as existed in Vermont's Medicaid rules prior to the ACA; and
- the Agency adhered to the strategies of maximizing public input. The Agency not only hosted a public hearing, but also met repeatedly with stakeholders (Vermont Legal Aid and health insurance carriers) to address their concerns. In this proposed rulemaking, these meetings took place before the end of the public comment period as well as after the final proposed rule was filed.

Additionally, the Agency maintains that the Choices for Care eligibility criteria under the proposed HBEE rules meet the statutory requirements for LCAR approval pursuant to 3 V.S.A. §842:

- The Agency has not restricted in any way the eligibility criteria for Medicaid coverage of Vermont's Choices for Care program. As a result, it meets the criteria for legislative approval.
- The Choices for Care criteria is within the authority of the Agency and meets legislative intent.

  Section 8.05(k) of this HBEE rule follows legislative intent and is within the authority of the Agency because it carries forward the Vermont Medicaid and Choices for Care eligibility criteria in effect prior to the ACA. Vermont's Medicaid rules prior to the ACA listed the same categorical eligibility requirements for Medicaid and Choices for Care in one, overarching section. The proposed rules consolidate and clarify the eligibility for CFC that previously applied. They do not change the applicability or the substance of the eligibility requirements.[1] Consolidating and clarifying the health benefits eligibility process without changing the substance of the eligibility criteria meets the goal set out in Sec. 2 of Act no. 48 (2011) of a more simplified administration process.

  If the Agency eliminated the categorical eligibility criteria, as suggested by advocates, it would actually be acting beyond its authority. Federal Medicaid law and Vermont's state plan require that, in order for an individual to receive Medicaid-coverage of long-term care services, the individual must meet categorical, functional (clinical), financial and non-financial criteria. *See* 42 C.F.R. §§ 435.201, 435.211 & 435.236. In Vermont, the Department of Disabilities, Aging and Independent Living (DAIL) performs the functional/clinical evaluation and DCF determines whether an individual applying for long-term care Medicaid services meets the categorical, financial and non-financial criteria. The clinical level of care criteria that DAIL evaluates for the Choices for Care program is not now and never has been a substitute for the disability determination to meet categorical eligibility for long-term care Medicaid in Vermont.

  The Agency reached out to the Centers for Medicare and Medicaid Services (CMS) for confirmation that, in Vermont, a determination that a person meets clinical level of care is not a substitute for categorical eligibility. CMS confirmed in a written response, which is attached to this memorandum, the Agency's understanding and stated the following:

  > "Under the state plan, level of care cannot be the sole basis for Medicaid eligibility. To be eligible for Medicaid an individual must be eligible under an eligibility group that is defined under the Social Security Act and the state covers under its approved Medicaid state plan. Individuals must meet the definition of a group, which includes a categorical, financial criteria and other non-financial criteria. Additionally, there are no expansion groups under the 1115 waiver that permits VT to cover individuals without a category."

  Accordingly, the Agency requests approval of the proposed rule as it is currently written in order to stay within its authority. Changing the eligibility criteria as requested by advocates would put the Agency outside of its authority.

- The proposed HBEE rule's Choices for Care eligibility criteria are not arbitrary.

[1] Prior section 4202 of the Vermont Medicaid rules, of which 4202.3 was a subpart, identified the categorically needy coverage groups for "SSI-related Medicaid" (now known as "Medicaid for the aged, blind and disabled" (MABD)). Subsection 4202.3 identified the SSI-related coverage groups for long-term care Medicaid. Current HBEE section 8.05(k) also identifies those groups and states, in one location, the eligibility standards. In both rules, the prior Vermont rules and this proposed HBEE rule, this categorical group for eligibility requires that a person be aged (65 or older), blind, or disabled, as defined by DCF's disability determination services unit, as required by 42 C.F.R. §435.541.

The proposed HBEE rule does not change the state or federal requirements for Choices for Care eligibility criteria. At the same time, it furthers the goal of consolidating and simplifying the health benefit eligibility process. As a result, it is not arbitrary and is necessary to further the legislative goals of health care reform.

- The Agency maximized public input on the proposed HBEE rule's Choices for Care eligibility criteria.

  The Agency met frequently with Vermont Legal Aid over the last year and is committed to ongoing collaboration to improve the contents and understanding of the Agency's rules for HBEE.

In conclusion, the Agency requests that LCAR approve the final proposed HBEE rule, including section 8.05 and its subpart, 8.05(k), without objection.

2. Amendments to the Final Proposed Rule as agreed upon by the Agency and stakeholders

Stakeholders and the Agency have agreed upon amendments to the Health Benefits Eligibility and Enrollment Final Proposed Rule filing and respectfully request that these amendments be incorporated into the rule as follows:

Section 5.01(a) Assistance offered through AHS/In general

Clarify that all individuals, not just individuals with known disabilities, can get assistance with the application or renewal process if needed.

(a) In general[2]	AHS will provide assistance to any individual seeking help with the application or renewal process in person, over the telephone, and online, and in a manner that is accessible to individuals with disabilities and those who are limited English proficient. Eligibility and enrollment assistance that meets the accessibility standards in paragraph (c) of this subsection is provided, and referrals are made to assistance programs in the state when available and appropriate. These functions include assistance provided directly to any individual seeking help with the application or renewal process.

Section 31.00 Definitions

Definition of Employer: Remove reference to associations to reflect current Vermont law.

Employer[3]	(a) The term "employer" means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan~~; and includes a group or association of employers acting for an employer in such capacity~~.

[2] 42 CFR § 435.908; 45 CFR § 155.205(d). Note: While the consumer-assistance responsibilities of Medicaid agencies and Exchanges may be distinct, "[s]ome aspects of [the Medicaid agency's] applicant and beneficiary assistance may be integrated with the consumer assistance tools and programs of the Exchange." See, CMS "Summary of Proposed Provisions and Analysis of and Responses to Public Comments," 77 Fed. Reg. 17144, 17166 (Mar. 23, 2011). Vermont has opted to operate one health-benefits assistance call center, serving the needs of all applicants and beneficiaries of health benefits.

[3] 45 CFR § 155.20. [Applies the definition in PHSA §2791, 42 U.S.C. 300gg-91(d)(5) which applies the definition in 29 U.S.C. §1002(5).]

	(b) Such term includes employers with one or more employees, and (c) All persons treated as a single employer such as a controlled group of corporations; partnerships, proprietorships, etc., which are under common control; affiliated service groups; and other arrangements such as separate organizations and employee leasing arrangements.[4]

Definition of Full-time Employee: Remove "factors to consider" to avoid confusion. In federal law, these factors are used to determine full-time employee for the purpose of qualified employer.

Full-time employee[5]	An employee who is employed on average at least 30 hours of service per week, for effective plan years beginning on or after January 1, 2014. ~~Factors to consider when determining whether a new employee is a full-time employee include:~~ (a) ~~Whether the employee is replacing an employee who was or was not a full-time employee;~~ (b) ~~The extent to which employees in the same or comparable positions are or are not full-time employees; and~~ (c) ~~Whether the job was advertised, or otherwise communicated to the new employee or otherwise documented as requiring hours of service that would average 30 or more hours of service per week or less than 30 hours of service per week.~~[6] For purposes of the definition of small employer, full-time employee does not include seasonal workers. For purposes of the definition of qualified employer, full-time employee does not include seasonal employees.

Section 32.00 Employer eligibility

Clarify current standards around eligibility determinations.

(b) Employer eligibility requirements[7]	~~(1)~~ To the extent permitted by HHS: (1) VHC shall permit small employers to purchase QHPs directly from a health insurer under contract with VHC. (2) Upon request, VHC must provide a small employer with an eligibility determination as to whether it is a qualified employer with a notice of approval or denial of eligibility and the employer's right to appeal such eligibility determination. ~~(2) Before permitting the purchase of coverage in a QHP, VHC must determine that the employer who requests coverage is eligible in accordance with the requirements of §§~~

[4] 45 CFR § 155.20 referencing 26 U.S.C. § 414.
[5] 45 CFR § 155.20.
[6] 79 FR 8544, 8555 (Feb. 12, 2014).
[7] 45 CFR § 155.710(b)(2), § 155.715(a); "A Direct New Path to SHOP Marketplace Coverage" viewed on Dec.11, 2013, http://www.hhs.gov/healthcare/facts/blog/2013/11/direct-new-path-to-shop-marketplace.html .

	~~31.00, and 32.00(b), except to the extent permitted by HHS~~ ~~(i)~~ VHC may accept an employer's attestation of eligibility as eligibility is defined in §§ 31.00 and 32.00(b) instead of determining the employer's eligibility.~~; and~~ ~~(ii) employers may purchase coverage in a QHP before VHC makes an eligibility determination or receives the employer attestation of eligibility.~~

Section 34.00(c) Employer choice

Clarify that after 2014 plan year issuers must provide employers full choice within one issuer.

Two models of employer choice	(a) Except as provided for in 34.00(c), a qualified employer may offer QHPs on VHC to its employees and at the employer's option to the employees' dependents[8] in one of the following ways: (1) Permitting the qualified employee to select any plan from among all QHPs offered on VHC; or (2) Permitting the qualified employee to select any QHP offered on VHC by one issuer of the employer's choice; (b) A qualified employer may choose to offer in addition to QHPs any stand-alone dental plans offered on VHC to its eligible employees and at the employer's option to their dependents. (c) For employers who direct enroll with the issuers <u>for the 2014 plan year</u>, issuers may limit the choice based on consistent standards. <u>For employers who direct enroll with the issuers after the 2014 plan year, issuers must provide the option listed in (a)(2).</u>

Section 37.00 Employer election period

Modify notice requirement to provide greater flexibility for more efficient, less confusing notices.

(b) Notice of election period[9]	VHC shall ~~notify a qualified~~ <u>ensure that</u> employer<u>s are notified</u> of the annual election period 30 days in advance of the start of the employer election period for the 2015 plan year and subsequent plan years.

Amend to federal requirement to provide greater flexibility to employers.

(c) Rolling enrollment[10]	VHC must permit a qualified employer to purchase coverage for its small group ~~beginning on the first of any month~~ <u>at any point</u> during the year ~~in which the employer becomes a qualified employer.~~.

[9] 45 CFR § 155.725(d).
[10] 45 CFR § 155.725(b).

Section 57.00(c)(1) Inconsistencies/Procedures for determining reasonable compatibility

Clarify that the opportunity for individuals to provide statements reasonably explaining discrepancies is not limited to Medicaid applicants or enrollees.

(c)Procedures for determining reasonable compatibility	In circumstances described in paragraph (b) of this section, AHS will: (1) Make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the application filer to confirm the accuracy of the information submitted by the application filer, and~~, for purposes of Medicaid eligibility,~~ by allowing the individual, or the application filer on the individual's behalf, the opportunity to provide AHS with a statement that reasonably explains the discrepancy.

Section 57.00(c)(5) Inconsistencies/Procedures for determining reasonable compatibility

Clarify the basis for the the Agency to deny an application or disenroll an individual if the individual has not responded to a request for additional information or has not provided information sufficient to resolve an inconsistency, or the agency otherwise remains unable to verify an individual's attestation at the end of the 90-day verification period.

(c)Procedures for determining reasonable compatibility	In circumstances described in paragraph (b) of this section, AHS will: (5) In connection with the verification of an attestation for Medicaid eligibility, if, after the period described in paragraph (c)(2)(ii) of this section, the individual has not responded to a request for additional information or has not provided information sufficient to resolve the inconsistency, or AHS otherwise remains unable to verify the attestation, deny the application or disenroll the individual on the basis <u>that there is insufficient information to determine the individual's eligibility for Medicaid</u> ~~of the individual's noncompliance with the verification request~~. Medicaid coverage cannot begin for a new Medicaid applicant until verification of the attestation is received, unless the verification is for purposes of establishing citizenship or immigration status as described in § 54.05(b).

Attachment: Communications with CMS Regarding Choices for Care long term care eligibility and Vermont's authority under the Code of Federal Regulations, the Vermont Medicaid State Plan and Choices for Care 1115 waiver:

Email correspondence with Gene Coffey and Jacqueline Wilder, CMS:
(Yellow highlight added for emphasis)

From: Wilder, Jacqueline (CMS/CMCS) [mailto:Jacqueline.Wilder@cms.hhs.gov]
Sent: Tuesday, July 01, 2014 9:56 AM
To: Parker, Lindsay; Corddry, Mary C. (CMS/CMCS); Coffey, Gene (CMS/CMCS)
Cc: Wolfsfeld, Lynn (CMS/CMCHO); Hickman, Selina; McLemore, Linda; Wisdom, Leslie; Green, Devon; Strumolo, Adaline; Kennedy, Alice; Cruz, Robert (CMS/CMCHO); Chapman, Robin
Subject: RE: LTC Medicaid question - Can CMS provide Vermont with a quick response?

The state asked whether the determination that the person satisfies the clinical level-of-care requirement for long-term care services obviate the need for the person to also have "category" for Medicaid - either as being aged, blind or disabled or as being a parent/caretaker relative, pregnant woman or newly-eligible adult (under 42 CFR 435.119)? The answer is no.

Under the state plan, level of care cannot be the sole basis for Medicaid eligibility. To be eligible for Medicaid an individual must be eligible under an eligibility group that is defined under the Social Security Act and the state covers under its approved Medicaid state plan. Individuals must meet the definition of a group which includes a categorical , financial criteria and other non-financial criteria.

Additionally, there are no expansion groups under the 1115 waiver that permits VT to cover individuals without a category.

Therefore, to be eligible for Medicaid an individual must meet all eligibility criteria of a specific eligibility group that the state is covering under its Medicaid plan.

Jackie Wilder

From: Coffey, Gene (CMS/CMCS) [mailto:Gene.Coffey@cms.hhs.gov]
Sent: Tuesday, July 01, 2014 9:25 AM
To: Parker, Lindsay; Corddry, Mary C. (CMS/CMCS)
Cc: Wilder, Jacqueline (CMS/CMCS); Wolfsfeld, Lynn (CMS/CMCHO); Hickman, Selina; McLemore, Linda; Wisdom, Leslie; Green, Devon; Strumolo, Adaline; Kennedy, Alice; Cruz, Robert (CMS/CMCHO); Chapman, Robin
Subject: RE: LTC Medicaid question - Can CMS provide Vermont with a quick response?

Lindsay,

Jackie Wilder will be e-mailing you the feedback to your question at some point this morning. You'll be hearing from her at some point soon. Thanks.

Gene

From: Parker, Lindsay [Lindsay.Parker@state.vt.us]
Sent: Friday, June 27, 2014 2:49 PM
To: Corddry, Mary C. (CMS/CMCS); Coffey, Gene (CMS/CMCS)
Cc: Wilder, Jacqueline (CMS/CMCS); Wolfsfeld, Lynn (CMS/CMCHO); Hickman, Selina; McLemore, Linda; Wisdom, Leslie; Green, Devon; Strumolo, Adaline; Kennedy, Alice; Cruz, Robert (CMS/CMCHO); Chapman, Robin
Subject: RE: LTC Medicaid question - Can CMS provide Vermont with a quick response?

Hi Gene and Jackie,

Thank you, again, for your time on Friday afternoon to discuss the categorical requirements for Long-Term Care Medicaid eligibility. We very much appreciate your willingness to follow up with a response in writing, and specific to Vermont, to the below question. Please let us know if we can provide any further clarification on the issue or question posed.

- The state has been in discussions with one of its community partners (Vermont Legal Aid) about the categorical requirements for Long-Term Care Medicaid eligibility. The issue that needs to be resolved is whether there is a need for someone to have "category" (that is, be aged, blind, disabled, pregnant, a parent/caretaker relative, or an adult under 65) if the state has determined that the person meets the clinical level-of-care criteria for long-term care services. Said another way, does the determination that the person satisfies the clinical level-of-care requirement for long-term care services obviate the need for the person to also have "category" for Medicaid - either as being aged, blind or disabled or as being a parent/caretaker relative, pregnant woman or newly-eligible adult (under 42 CFR 435.119)?

As discussed, attached please find Vermont's Choices for Care 1115 Wavier Renewal Application. Section 4, page 36 (of 54), outlines the provisions of the Social Security Act that Vermont has waived.

We very much look forward to your response, by Tuesday, July 1 if possible.

Thank you,
Lindsay

Lindsay Parker, MPH
Department of Vermont Health Access
[p] 802-879-5639

Email correspondence with Mary Corddry, CMS:
(Yellow highlight added for emphasis)

From: Corddry, Mary C. (CMS/CMCS) [mailto:Mary.Corddry@cms.hhs.gov]
Sent: Tuesday, June 24, 2014 3:58 PM
To: Chapman, Robin; Coffey, Gene (CMS/CMCS)
Cc: Wilder, Jacqueline (CMS/CMCS)
Subject: RE: LTC Medicaid question - Can CMS provide Vermont with a quick response?

Each individual is enrolled in Medicaid based on being approved as meeting the requirements for a particular eligibility group, defined in the Social Security Act and covered based on the state's approved Medicaid state plan. Some groups require an individual to meet an institutional level of care, in addition to other requirements. The requirements depend on VT's Medicaid state plan requirements for the particular eligibility group for which an individual is approved. Gene and Jackie can say more.

Mary

From: Chapman, Robin [mailto:Robin.Chapman@state.vt.us]
Sent: Tuesday, June 24, 2014 2:43 PM
To: Coffey, Gene (CMS/CMCS); Corddry, Mary C. (CMS/CMCS)
Cc: Green, Devon; McLemore, Linda; Gekas, Cassandra; Wisdom, Leslie; 'Betsy Forrest (bforrest@phpg.com)'; Bell, Stephanie G. (CMS/CMCS); Hickman, Selina; Strumolo, Adaline; Kennedy, Alice

Subject: LTC Medicaid question - Can CMS provide Vermont with a quick response?
Importance: High

Good afternoon,

AnneMarie Costello gave us your names as folks that might be able to provide the State of Vermont with a quick resolution on an Long-Term Care Medicaid matter. Vermont is in the middle of state rulemaking to implement the Affordable Care Act and we go before the state's legislative committee Thursday morning. If at all possible, it would really be helpful if we had CMS's input on this issue before that meeting. Here's the issue:

The state has been in discussions with one of its community partners (Vermont Legal Aid) about the categorical requirements for Long-Term Care Medicaid eligibility. The issue that needs to be resolved is whether there is a need for someone to have "category" (that is, be aged, blind, disabled, pregnant, a parent/caretaker relative, or an adult under 65) if the state has determined that the person meets the clinical level-of-care criteria for long-term care services. Said another way, does the determination that the person satisfies the clinical level-of-care requirement for long-term care services obviate the need for the person to also have "category" for Medicaid - either as being aged, blind or disabled or as being a parent/caretaker relative, pregnant woman or newly-eligible adult (under 42 CFR 435.119)?

Thank you so much for your time on this matter. If anything isn't clear or if there are any questions we can answer before you respond to the issue, please don't hesitate to contact me.

Sincerely,

Robin Chapman, Esquire
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DCF – Economic Services Division
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802-279-3996 (cell)
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