S.262, Miscellaneous Medicaid Bill

Testimony from Ashley Berliner, DVHA, Director of Healthcare Policy,
provided to the House Committee on Health Care, April 4th, 2018:

Section 1: Medicaid for Working People with Disabilities

Background
The MWPD program allows workers with disabilities whose income is less than 250% FPL to be eligible for Medicaid.

As a result of Act 51 in 2015, eligibility enhancements were made to the MWPD program. VT received CMS approval this year, and enhancements will be operationalized effective 1/1/18.

Proposed change
Incorporates the 2015 eligibility enhancements into the statute that defines the MWPD program (33 V.S.A. § 1902).

Purpose of Statutory Change
To comply with state law and align state statute, state operations, and VT Medicaid rules.

Fiscal Impact
None. There is no fiscal impact of the conforming change in S.262 related to Medicaid for Working People with Disabilities, and the fiscal component of this change was evaluated and considered when passed in 2015.

Section 2: Delay Implementation of MAGI Calculations until IE

Background
Vermont statute requires eligibility determinations be based on MAGI methodology for Vpharm and Healthy Vermonters beginning January 1, 2019.

MAGI determinations are not possible in the State's current Access system, and the new IE system must be operational in order to implement the MAGI methodology for these programs.

Proposed change
Delays the implementation of using MAGI for VPharm and Healthy Vermonters until the IE system is operational.

Purpose of Statutory Change
To comply with state law and reflect current technology restraints.

Fiscal Impact
None.

Section 2a: Dr. Dynasaur FPL Correction

Background
In 2014, an amendment to 33 V.S.A. § 1901(c) updated the Dr. Dynasaur premium threshold from 185% of the FPL to 195% FPL. The conversion to MAGI, as required by the ACA, changed the effective level for premiums to 195% FPL.

Proposed change
Amends statute to change Dr. Dynasaur FPL from 185% to 195%.

Purpose of Statutory Change
Technical change to ensure alignment between state statute, state operations, and VT Medicaid rules.

Fiscal
None. This change to FPL has been implemented since 1/1/14.

Section 3: Amend Timeline for Medicaid Provider Tax Appeals

Background
DVHA collects taxes from Medicaid-enrolled providers. Pursuant to 33 V.S.A. § 1958, a provider may appeal the assessment, and DVHA must hold a hearing within 20 days of receiving the request for reconsideration.

Proposed change
Amends the hearing date timeline so that DVHA must hold the hearing within 90 days of receiving the request, rather than 20 days.

Purpose of Statutory Change
To alleviate the current time pressure facing DVHA and providers to find, examine, and prepare to present all of the evidence and witnesses that may be advantageous/necessary for this type of appeal.

Facilitate the parties' meaningful engagement in the discovery process and provide a greater opportunity to reach mutual agreements and/or stipulated agreements.

Fiscal Impact
None.

Section 4: Change Collection Date for Ambulance Provider Tax

Background

As of 2017, DVHA collects provider taxes from ambulance agencies on an annual basis. Pursuant to 33 V.S.A. § 1959, ambulance agencies must remit the assessment to DVHA annually on March 31st.

Proposed change
Changes the ambulance agencies' tax collection date from March 31st to June 1st to accommodate the provide community and logistical issues, and to align with 2017 timelines.

Purpose of Statutory Change
Alleviates the need for DVHA to annually permit a collective variance from the date stated under 33 V.S.A. § 1959.

Facilitate continuity and predictability in the ambulance provider community.

Fiscal Impact
None.

Section 5: Grant DVHA Authority to Verify Asset Information

Background
Federal law has always required the verification of assets to determine eligibility for Medicaid Long Term Care (LTC) and Medicaid for the Aged, Blind, and Disabled (MABD). Existing statute provides authority for DCF to verify bank information, but that authority was erroneously not replicated when Medicaid eligibility determinations were moved from DCF to DVHA in 2016.

Proposed change
Amends statute to grant DVHA authority to verify asset information with banking institutions (currently removed from bill) and government agencies. This authority mirrors the authority already granted to DCF under state statute.

Purpose of Statutory Change
This change is to comply with the federal requirements that Medicaid verify income information and use an electronic AVS.

Fiscal Impact
None, unless the legislature would like to voluntarily provide payment to banks for responding to Medicaid's request. This is not a federal requirement.

Section 5d: Strengthen "Notice to Creditors" Requirement

Background
Federal law mandates that states recover monies from estates where Long Term Care (LTC) claims were paid by Medicaid. Probate courts allow 4 months for creditors to claim against an estate.

In Vermont, DVHA is noticed of probate estates via the Department of Taxes, which receives the information from the Probate Courts.

This notice is not sufficiently timely and/or is often incomplete, resulting in the State being prohibited from recouping Medicaid payments.

Proposed change
Amends statute to require Probate Courts to notify DVHA directly of new probate estates.

Purpose of Statutory Change
To better comply with Federal law. DVHA will have timely notice of probate estates and be able to recoup more LTC Medicaid funds from probate estates before the closure of the 4-month notice period, as required by law.

Fiscal Impact
With timely noticing, DVHA will likely be eligible to recoup more LTC Medicaid funds from probate estates.

NEW: Section 6: Medicaid Applications; Asset Verification

6a. Background
Vermont Legal Aid requested statutory language require specific Medicaid notices around AVS.

DVHA shares the value of a Medicaid notice written in plain, accessible language, but does not support the modification to Section 5, as proposed. Until IE, there are significant IT constraints around modifications to the MABD and LTC Medicaid applications. These constraints make it impossible to agree to the proposed language above without first examining the operational feasibility of such changes to the application. DVHA will begin to explore the operationalization of these changes, but the timeline necessary will not be such that will accommodate DVHA's support of the proposed language at this time.

Proposed change
For Inclusion in session law:

(a) The Department of Vermont Health Access shall collaborate with the Office of the Health Care Advocate to ensure that applicants to and beneficiaries of the Medicaid Long-Term Care and Medicaid for the Aged, Blind, and Disabled programs receive notice written in plain and accessible language explaining the electronic asset verification system.

6b. Purpose of Statutory Change
To include a statement in the consent language that specifies the applicant's consent for DVHA to obtain information from their financial institutions.

Proposed change:
For Inclusion in session law:

(b) The Department of Vermont Health Access shall modify its application forms for the Medicaid Long-Term Care and Medicaid for the Aged, Blind, and Disabled programs as needed to enable applicants to authorize the Department ~~financial institutions~~ to obtain from financial institutions ~~disclose to the Department and its agents~~ information about the applicant's assets in order to verify the applicant's eligibility for the applicable program.

Section 7: Rulemaking for Section 5d.

NEW Section 8: EXCEPTIONS. Added by Legislative council.

Section 9: Eliminate Waiver Requirement for Maximum-out-of-Pocket

Background
Act 165 (2016) intended to provide DVHA with a method to preserve Vermont's pharmacy out-of-pocket maximum (Rx MOOP) within Bronze plans, and directed DVHA to apply for a federal waiver of actuarial value limitations in order to maintain the Rx MOOP while continuing to offer Bronze level QHPs.

Proposed change
Eliminates DVHA's obligation to pursue a waiver of federal MOOP requirements because there is no need for a waiver. QHP designs meet all federal and state requirements, including the Rx MOOP.

Purpose of Statutory Change
With this change, the State will not need to pursue a waiver because we now have flexibility to continue providing Bronze level plans that meet both state and federal prescription drug MOOP requirements.

Fiscal Impact
None.

Section 10: Bronze Enrollment Options

Background
Act 165 (2016) also established a stakeholder advisory group on bronze plan design and directed the group to make a recommendation regarding the continuation of the pharmacy out-of-pocket limit (Rx MOOP). On February 22, DVHA submitted to the Committees a report containing the advisory group's recommendation that the Rx MOOP remain in place along with the option of additional bronze plans that do not include the Rx MOOP.

Proposed change
Authorizes the continued availability of bronze plans without the Rx MOOP. It would be beneficial to act on this recommendation during this session due to the timing of the qualified health plan certification process: 2020 plan designs are finalized in January 2019.

Purpose of Statutory Change
Maintain an additional enrollment option for customers who don't benefit from the Rx MOOP. There has been considerable interest in these plans, including 3,300 current enrollees. Keeping these plan options promotes both stability and innovation in the QHP market.

Section 11(e)(3): Amend Human Services Board Fair Hearing Statute

Background
Recent federal Medicaid regulations require the Agency to enter a final order in a Medicaid appeal within an expedited time frame when taking the standard time would put the appellant's health at significant risk.

When the expedited standard is met, the Agency must enter a final order within 3 business days for Medicaid services appeals and 7 business days for Medicaid eligibility appeals.
Vermont's standard time frame requires the Board to enter orders in Medicaid appeals within 75 days.

Proposed change
Removes the requirement that the Board review and decide whether to adopt the findings of the hearing officer in expedited Medicaid appeals, and instead makes the hearing officer's findings and order the final HSB decision.

Purpose of Statutory Change
To comply with recent federal Medicaid regulations that require the Agency to enter a final order in a Medicaid appeal within an expedited time frame when taking the standard time would put the appellant's health at significant risk.

Without this, a quorum of the HSB would have to be on call to meet to review hearing officer's findings of fact and proposed orders within an extremely tight time frame, which is not feasible.

Fiscal Impact
None.

Section 11(h)(A)(1): Secretary Reversal

The Agency opposes the revision proposed by Vermont Legal Aid, but recognizes that the existing language could read more clearly. Therefore, DVHA proposed language in order to provide more clarity regarding the conditions for which the Secretary may reverse or modify a Board decision:

Section 11(i): Amend Human Services Board Fair Hearing Statute

Background
Human Services Board (HSB) statute grants individuals a broad right to a fair hearing, inclusive of covered services. New federal Medicaid regulations require DVHA to exhaust all covered services appeals through an internal process prior to proceeding with a Fair Hearing.

Proposed change
Amends the HSB statute to require individuals go through DVHA's Medicaid internal appeals process prior to appealing at the HSB.

Purpose of Statutory Change
This change is necessary to comply with the new federal requirements (42 CFR 438.402) effective January 1, 2018.

Fiscal Impact
None.

Section 12: Appeal of Medicaid Covered Service Decisions; Fair Hearing; Rule Making

Background
SHW added this provision to ensure that there is a warm handoff between the Human Services Board and DVHA.

Proposed change
Requires DVHA to adopt rules that establish a process to ensure there is no wrong door for beneficiaries to request an appeal on a Medicaid service decision.

NEW Section 13: Exchange Open Enrollment Extension

Section 14: Prescription Drug Price Disclosure Report – Remove Reporting Requirement

Background
State statute requires drug manufacturers to report average manufacturing price information quarterly to DVHA.

The information mandated to be reported is now available publicly, the data is not used programmatically, and the reporting requirement is an administrative burden on both manufacturers and the State.

Proposed change
Remove the reporting requirement on the Prescription Drug Price Disclosure Report.

Purpose of Statutory Change
The reported information is no longer used programmatically and is publicly available: https://data.medicaid.gov/browse?category=Drug+Pricing+and+Payment&limitTo=datasets

Fiscal Impact
None.