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Re: Response to comments received from the public for the Health Benefits Eligibility & Enrollment (HBEE) Rule Update ([Proposed GCR 22-029 to 22-033](#))

A summary of the comments received on the proposed HBEE rule and the Agency of Human Services' responses to those comments is as follows:

General Comment

Comment: On behalf of stakeholders, my family member included, I'd like the committee to allow a comprehensive service system that allows contracted supports which are not available at any designated agencies to follow this law. Currently, ABA providers must operate at a fiscal loss when providing a contracted service under HCAR rule of \$30.11 cap. This is discriminatory in use of federal funding. I'd appreciate a chance to discuss this issue further.

Response: The agency appreciates this comment and the concern raised by the commenter. While the commenter's concern speaks to an issue that is outside the scope of this rulemaking effort, the agency will take the concern into consideration.

Comments by Rule Sections

PART TWO

8.05(k)(6) Disabled child in home care (DCHC, Katie Beckett)

Comment 1 from Vermont Legal Aid:

Vermont Legal Aid (VLA) states, "We urge DVHA to delete 8.05 (6)(1)(A and B)." VLA's full comments are part of the final proposed rulemaking filing. VLA opposes proposed 8.05(k)(6)(i)(A)-(B), including for the following reasons:

- *"Requiring eligibility tied to modern standards of admissions for institutions that do not exist in Vermont will make it almost impossible to [sic] for children to be found eligible for Katie Beckett Medicaid."*

- “... to require proof that ‘without the receipt of institutional level of care in the home, the individual would be required to continue to reside in an institution,’ as described in (6)(i)(B)(II), is another standard that is impossible to meet.”
- “DVHA needs to use the institutional standard of 1965.”

Response:

The proposed amendments to the rule at 8.05(k)(6) are not intended to change the current legal standard for eligibility for the optional Medicaid category, Disabled Child in Home Care (DCHC or the “Katie Beckett provision”), including the federal requirement that the individual require an institutional level of care.¹ The intent of the proposed changes is to (1) improve clarity of the institutional level of care eligibility requirement, (2) indicate that Vermont Medicaid may use a standardized medical assessment tool to determine level of care in the future, (3) align the rule with current operations and federal law regarding the frequency of reviews of clinical eligibility, and (4) make technical changes to align the rule with federal law.

While the agency’s proposed changes were not intended to change the legal standard for meeting institutional level of care, the agency is revising 8.05(k)(6)(i), including due to the commenter’s feedback. Specifically, the agency has revised 8.05(k)(6)(i)(A)-(B) in two ways:

- Removed the references to federal regulations at 8.05(k)(6)(i)(A). This change aligns the rule more closely with the corresponding federal regulation, 42 CFR 435.225; and
- Removed 8.05(k)(6)(i)(B)(II) as recommended by the commenter.

The only remaining changes from those proposed to 8.05(k)(6)(i)(A)-(B) are (1) final proposed 8.05(k)(6)(i)(A)(I) newly defines “medical institution” by aligning the definition with federal law, 42 CFR 435.225(b)(1), which states that to qualify for this Medicaid category, a disabled child must require care in a hospital, SNF [skilled nursing facility], or an ICF [intermediate care facility], and (2) final proposed 8.05(k)(6)(i)(A)(II) aligns with 42 CFR 435.225(a) and clarifies that a disabled child must be living in the home to qualify for DCHC.

¹ Explanation of why this Medicaid category is referred to as the “Katie Beckett provision:” At five months old Katie Beckett contracted a devastating brain infection. She suffered paralysis that left her hospitalized on a ventilator for three years. Katie’s middle-class family had a million dollars of health insurance, but that was soon exhausted. While she was institutionalized, Medicaid paid for her medical care but when she improved enough to live with her family, her Medicaid was terminated. Katie required professional nurses to meet her needs at home, but Medicaid would not cover it because her family’s income was too high. Under the law, Medicaid would only pay for Katie’s care if she remained in an institutional setting. Katie’s family faced a dilemma, whether to leave her in the hospital or bring her home where there was a lack of certainty about the care that would be provided to her.

In 1981, President Ronald Reagan heard about Katie’s dilemma and personally intervened. President Reagan created the Katie Beckett Waiver. The waiver allowed Katie, and children like her who required an institutional level of care, but could safely receive this care at home, to receive their care at home while retaining their Medicaid coverage, regardless of their parents’ income. Katie grew up to be an accomplished motivational speaker and was a champion for people with disabilities until her death in her 30s. In 1982, Congress expanded what had been accomplished by the Katie Beckett Waiver by creating a new state plan option in Medicaid pursuant to Section 134 of the Tax Equity and Fiscal Responsibility Act (TEFRA), sometimes referred to as “the Katie Beckett provision.”

The commenter's interpretation that level of care for DCHC should be determined by standards that existed in 1965 is contrary to federal law. The level of care standard for DCHC Medicaid has never been tied to the institutional level of care standard of 1965. The Medicaid program was first implemented in 1965, but it was not until 1981 that President Reagan created the Katie Beckett Waiver, and it was not until 1982 that Congress made a related state plan option available to states. There is nothing in federal law or CMS guidance that supports that the Medicaid agency should use the institutional level of care standard from 1965 in determining eligibility for DCHC. 42 CFR 435.225 states in full:

§ 435.225 Individuals under age 19 who would be eligible for Medicaid if they were in a medical institution.

(a) The agency may provide Medicaid to children 18 years of age or younger who qualify under section 1614(a) of the Act, who would be eligible for Medicaid if they were in a medical institution, and who are receiving, while living at home, medical care that would be provided in a medical institution.

(b) If the agency elects the option provided by [paragraph \(a\)](#) of this section, it must determine, in each case, that the following conditions are met:

(1) The child requires the level of care provided in a hospital, SNF, or ICF.

(2) It is appropriate to provide that level of care outside such an institution.

(3) The estimated Medicaid cost of care outside an institution is no higher than the estimated Medicaid cost of appropriate institutional care.

(c) The agency must specify in its State plan the method by which it determines the cost-effectiveness of caring for disabled children at home.

(55 Federal Register 48608, 11/21/90)

Finally, the commenter mentions the lack of certain medical institutions within Vermont; however, the existence of such institutions within Vermont's borders is not relevant to the legal requirements for DCHC Medicaid eligibility and is outside the scope of this rulemaking. The level of care analysis in DCHC is not a placement decision; it is solely to determine eligibility for this Medicaid category.

The agency agrees with the commenter that the DCHC Medicaid category is a critical category for some Vermont families. It is the only means for some disabled children who require an institutional level of care, but whose household income is too high to qualify for Dr. Dynasaur, to avoid institutionalization by the Medicaid agency paying for them to receive that level of care in their home.

Comment 2 from Vermont Legal Aid:

Vermont Legal Aid (VLA) states, “We urge DVHA to cut sections (A- C).” VLA’s full comments are part of the final proposed rulemaking filing. VLA opposes proposed 8.05(k)(6)(i)(A)-(C), including for the following reasons:

- “No information exists that supports the proposition that a standardized level of care tool is necessary or helpful for these eligibility determinations. It is unclear what problem DVHA is trying to solve by use of a standardized tool.”
- “We have not seen a pattern or ‘type’ of case that would be amenable to fitting into the standards of a tool. We have not seen a draft of any tool, so it is hard to envision how the diverse experiences of a small number of medically needy children can be standardized.”
- “There has been no community conversation or consensus on the value of a standardized tool, or the contents of a standardized tool.”

Response:

Vermont Medicaid plans to move to the use of a standardized tool to determine level of care for DCHC eligibility to ensure objective, accurate, and reliable decision making. Much of the care that Vermont Medicaid covers program wide is approved using standardized tools. Such tools are designed to be as objective as possible to achieve the highest “interrater reliability,” i.e., that two screeners would answer the same way for the same individual. This promotes best practices by ensuring proper and fair eligibility determinations and will provide greater consistency across Vermont Medicaid.

Presently, Vermont Medicaid is seeking to amend 8.06(k)(6) to indicate that it may designate a standardized assessment tool to determine whether an individual qualifies for an institutional level of care for DCHC. The proposed amendment does not require Vermont Medicaid to designate a tool, but does provide that if the agency designates one, that it must be used in all DCHC level of care decisions. Vermont Medicaid has not selected a standardized tool for deciding level of care in DCHC. The agency informed the commenter, prior to its submission of comments, that it would be seeking its and other stakeholder’s input on the standardized level of care tool prior to one being implemented.

Federal law gives Medicaid agencies flexibility in deciding whether to use a standardized tool and if so, which tool. As of 2015, standardized assessment tools were used by the District of Columbia and all 50 state Medicaid agencies in their Medicaid long term support and services (LTSS) programs, including to determine level of care.²

Vermont Medicaid has used standardized tools for many years, to determine service needs and eligibility for programs, including level of care. Historically, Vermont Medicaid used a “homegrown” tool to determine if level of care was met in DCHC cases, and, more recently, it has used criteria that functions as a tool and includes a multipage narrative that explains when level of care is met. The Department of Disabilities, Aging, and Independent Living (DAIL) uses a standardized tool to determine eligibility, including level of care, in the Choices for Care program, which allows individuals who require an institutional level of care to receive care in their home to avoid institutionalization. DAIL also uses standardized tools to determine eligibility and/or service needs for individuals applying for or enrolled in

² Medicaid and CHIP Payment and Access Commission (MACPAC) – Functional Assessments for Long-Term Services and Supports. <https://www.macpac.gov/wp-content/uploads/2016/06/Functional-Assessments-for-Long-Term-Services-and-Supports.pdf>. Accessed September 7, 2022.

the Traumatic Brain Injury Program, the Adult High Technology Program, and the Attendant Services Program.

Additionally, Vermont Medicaid uses a standardized tool to determine eligibility for services for children who are medically fragile, including those who need medically complex nursing services in the home. The Department of Vermont Health Access (DVHA) and the Department of Mental Health use InterQual standardized tools to determine both whether level of care is met in certain settings and whether a service authorization request for mental health, substance use disorder, behavioral health services, and medical services should be approved (e.g., inpatient hospitalization, inpatient psychiatric hospitalization; eating disorder treatment in inpatient, residential, PHP and IOP settings; Applied Behavioral Analysis; and psychiatry, across all ages). InterQual is a nationally recognized evidence-based platform that is used by health insurers, Medicaid agencies, and facilities nationwide.

In summary, the use of “tools” to make certain eligibility decision, including level of care, and service authorization decisions is widespread at Vermont Medicaid and at Medicaid agencies across the country. Such tools promote objective and fair decisions through the use of the proper administration of an appropriate assessment tool implemented by a trained person.

The agency is not amending proposed 8.05(k)(6)(i)(C) except to remove the proposed name of the standardized tool from the rule.

9.03(e) Former foster child

Comment: The HCA (Office of the Health Care Advocate at Vermont Legal Aid) and the DLP (Disability Law Project at Vermont Legal Aid) support the proposed changes in Rule 9.03(e) to expand categorical eligibility for foster children. The proposed rule expands eligibility for former foster children to include former foster children from other states. Under the current rule, this category had been limited to former foster children from Vermont. We strongly support this expansion.

We suggest some clarification to Rule 9.03 (e)(iii) that defines eligible former foster children. The rule currently reads,

“If the individual attained 18 years of age on or after January 1, 2023, . . .”

Response: The agency appreciates the commenters’ support of this expansion. The agency agrees with the commenters that clarification defining eligible former foster children would be helpful in light of the expansion of eligibility to include foster children from other states that have foster care extended beyond 18. The agency is adding text to the rule to make this clarification.

PART THREE

23.02 Affordable coverage for employer-sponsored MEC

Comment: The HCA (Office of the Health Care Advocate at Vermont Legal Aid) suggests that HBEE Rule 23.02 be amended to mirror the proposed federal rules that address the “family glitch.” The Department of Treasury and the IRS have released proposed rules on this issue, and the HBEE rules should mirror the proposed federal rules. The proposed rules will change how affordability is calculated for family members when one member of the household has an offer of employer insurance.

Under current regulations employer-based health insurance is defined as “affordable” if the coverage solely for the employee, and not for family members, meets the affordability requirements. That means that affordability is calculated based on what it would cost for the employee to purchase a self-only plan. If the cost of the employee only plan meets the current affordability test, the employee and their family members are not eligible for Advance Premium Tax Credit (APTC). This is called the “family glitch” because it makes family members ineligible for APTC, even though the cost of a family plan with the employer is not “affordable.” The proposed rule change would allow for two separate calculations: one for the employee and the other for family members. Under the proposed federal rules, if the cost of covering family members were not affordable, they would be eligible for APTC. This change addresses a long-standing problem and will allow more Vermonters to enroll in affordable coverage on Vermont Health Connect.

Response: The agency agrees with this comment. The agency is adding text to the rule at 23.02 to address the “family glitch” consistent with the rule proposed by the Internal Revenue Service (IRS) on April 7, 2022. The IRS has indicated that it will finalize this policy change prior to 2023. In revising this section of the rule, the agency is also simplifying the rule text by eliminating examples at (d), some of which are outdated under the family glitch change, and instead referring to the current illustrative examples provided by the IRS.