BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association.

September 12, 2017

VIA E-mail & U.S. Mail

Robin Chapman
Agency of Human Services
280 State Drive, Center Building
Waterbury, VT 05671-1201

Dear Ms. Chapman:

Blue Cross and Blue Shield of Vermont respectfully submits the following comment in response relating to Part Seven of the Health Benefits and Eligibility proposed rule.

Section 64(h): Conditions of eligibility and enrollment

This section, as it pertains to qualified health plans states: "timely payment of a premium is required as a condition of initial and ongoing enrollment." BCBSVT is concerned that this language does not clearly specify that in order for initial coverage to be effectuated, the initial premium payment must be received by Vermont Health Connect (VHC). As you know, VHC has had some challenges collecting premiums for coverage provided. This lack of supporting premium for coverage drives up overall costs for those VHC enrollees who are paying their premiums. Although this section provides that as a condition of initial enrollment, premium must be paid, we suggest adding language like the following to make it more explicit that an initial timely payment must be made before coverage will be effectuated: "Coverage shall not be effectuated until the initial payment of all premium due has been received by VHC. If the initial payment is not received timely, the coverage effective date may be changed or coverage may not be effectuated, depending on the enrollee's enrollment rights."

Please let me know if you have any questions.

Sincerely,

Rebecca C. Heintz
General Counsel & Privacy Officer

P.O. Box 186 • Montpelier, VT 05601-0186
Corporate Office (802)223-6131 • Subscriber Service (800)247-BLUE
www.bcbsvt.com

VERMONT LEGAL AID, INC.

264 NORTH WINOOSKI AVENUE
BURLINGTON, VERMONT 05401
802-863-5620 (VOICE AND TTY)
802-863-7152 FAX

By email to: robin.chapman@vermont.gov

September 12, 2017

Robin Chapman, Policy Analyst
State of Vermont
Agency of Human Services
280 State Drive, Center Building
Waterbury, VT 05671-1000

Re: Comments on Health Benefits Eligibility and Enrollment Rules Updates
Proposed GCR 17-043 through 17-049

Dear Ms. Chapman:

Thank you for the opportunity to comment on the updates to the Vermont Health Benefits Eligibility and Enrollment Rules.

GENERAL COMMENT

The Agency of Human Services (AHS) should harmonize procedures across all of the Vermont health benefits programs, to the extent this is prudent and possible. This effort should include notice requirements, time frames, benefit appeals, and eligibility appeals. We understand that there are different minimum requirements for different situations under federal law, and standard procedures may not be appropriate for every type of notice, grievance, or appeal. However, AHS could seek additional waiver authority to standardize these rules if it believed that to be necessary. A simplified system of rules would reduce consumer confusion and be easier to administer.

We support AHS's Health Care Administrative Rules (HCAR) project. This will bring Vermont's health program rules into a unified format, update outdated rules, and ensure that all of Vermont's health benefits programs have rules. We suggest that a broad systemic review of procedures be undertaken as part of the HCAR project. For example, when incorporating DVHA appeal rules into HCAR, AHS should consider whether the procedures can be harmonized with those under HBEE. Likewise, when HBEE rules are updated, AHS should consider the extent to which procedures differ from those in HCAR and other program rules, and harmonize as many of them as possible.

PART ONE

4.02(b) Right to nondiscrimination and equal treatment

Religion was removed from this section as a basis upon which AHS does not unlawfully discriminate. We assume this was a drafting error and recommend that the word "religion" be restored.

5.03 Navigator Program

With the expansion of the listed areas of expertise for navigators, we note the importance of training to ensure that all navigators fully understand and are able to meet the listed standards. We request that AHS collaborate with the HCA when it is developing and updating its standards for navigators. We also support a fully funded and robust Navigator program which will be able to provide in person help to Vermonters who need it.

PART FOUR

24.04(e)(1)(ii) Allocation to other family members

We support the proposed clarification that income allocation to a family member is only available when no community spouse is living in the home.

We further support the addition of a reference to the community spouse resource allocation (CSRA) minimum. This clarifies the applicable standard. However, we do not believe the rule should refer readers to the Vermont Medicaid Procedures Manual. Rather, the federal CSRA regulations should be referenced directly. (42 CFR §§ 435.725, 435.735, and 435.832.) This could be done in a footnote rather than in the text, for clarity.

PART FIVE

29.08(e)(1)(F)(i) Excluded trusts; in general

We support the proposed change to this section. The change expands the special needs trust (SNT) resource exclusion to include a SNT created by a disabled individual after 12/16/16.

29.08(i)(3)(ii)(E) Independent living contracts; exclusion

This provision caps payments for care and services under an Independent Living Contract (ILC) at Choices for Care (CFC) payment rates. AHS should ensure that these caps allow caregivers to make a livable wage.

29.10(e) Determining countable resources for individuals requesting Medicaid coverage of long term care services and supports under MABD who have spouses

We do not believe the rule should refer readers to the Vermont Medicaid Procedures Manual for the community spouse resource allocation (CSRA) maximum. Rather, the federal CSRA

regulations should be referenced directly. (42 CFR §§ 435.725, 435.735, and 435.832.) This could be done in a footnote rather than in the text, for clarity.

29.14 (g)(1)(i) & (h)(1)(i) Long-term care individuals

We support the proposed changes to these sections. The updated language recognizes that the provisions apply to a broader range of family members than just dependent children.

PART SEVEN

60.00 Computing the premium-assistance amount

In general, this section of the rules should better include and explain the availability of Vermont Premium Assistance (VPA). It is only mentioned briefly in § 60.07. A sentence or two should be added to explain VPA generally. New § 61.01(b) could be created for this purpose, or the language could be added to § 61.01.

Also, we note that Vermont Health Connect uses the term Vermont Premium Assistance in its consumer communications. That term should be used in the HBEE rules as well, rather than "Vermont Premium Reduction" (in § 60.07 currently). The statute refers to "premium assistance." 33 V.S.A. § 1812(a)(1).

To footnote 68, a citation should be added to the Vermont financial assistance authority, 33 V.S.A. § 1812.

60.01 In general

The second sentence should be revised to read, "A tax filer's federal premium assistance credit amount for a benefit year is the sum of the premium-assistance amounts determined under § 60.04 for all coverage months for individuals in the tax filer's household." § 60.04 only includes federal assistance.

60.04 Premium assistance amount

The text in § 60.04 should be clarified to explain that it refers to federal premium subsidies only. Alternately, the title of this section could be changed to "Federal premium assistance amount."

60.07 Applicable percentage

The examples in § 60.07(d) should incorporate VPA. Alternately, the introductory text should clarify that the examples only include federal assistance calculations.

60.03(d) Appeals of coverage eligibility

We support the addition of this provision, which gives consumers 120 days to pay premiums if the consumer enrolls in retroactive coverage pursuant to an appeal decision. Most consumers do not have the funds available to pay multiple months of premiums immediately.

61.00(c) Normal maximum time for determining eligibility

This rule should be clarified to state when an application will be considered "based on a person's disability." (§ 61.00(c)(1)). Which programs does AHS consider to fall under that provision? Recently a dispute arose regarding a Vermont consumer's application for the Medicare Savings Programs.

We believe that the plain language of the rule should control, as it is directly from the federal regulation cited. The 90-day time frame should not apply to an applicant 65 years or older applying for Medicare Savings Programs, the VPharm pharmacy program, or Medicaid for Aged, Blind and Disabled. Once a consumer turns 65, eligibility for those programs are based on age, and should be processed in the normal 30-day time frame absent extenuating circumstances.

67.00 General notice standards

We support the wording changes made to this section; the new proposed language is clearer.

68.01(b)(1)(iii) Notice of Decision and Appeal Rights

We object to limiting this rule to decisions related to Medicaid eligibility. AHS should provide specific reasons supporting a decision to deny, reduce, suspend, or increase liability for beneficiaries enrolled in any health care program, including federal and state premium assistance. For consumers to fully understand AHS's decision and exercise their appeals rights, they must know the specific reasons for the decision.

68.02(a) Advance Notice of Adverse Action decision

We object to limiting this rule to Medicaid enrollees only. Consumers who receive federal or state premium assistance should also get advance notice of an adverse action impacting their eligibility. Advance notice is particularly important for this group because the adverse action may trigger a Special Enrollment Period (SEP), and the consumer needs to be aware of when the 60 day SEP time period starts. Consumers whose APTC, VPA, or CSR is being reduced due to a redetermination should receive advance notice of the change.

QHP consumers already receive advance notice of one type of averse action: closure for nonpayment. We are not proposing that AHS send a separate adverse action notice for the closure of QHPs; those consumers receive grace period notices under section 64.06.

If the limitation is maintained in the final proposed rule, please clarify what is meant by "Medicaid" in this section. Does it include CHIP, VPharm, and Medicare Savings Programs?

71.03(d)(14) Special Enrollment Periods; pregnancy

The special enrollment period (SEP) for pregnancy should be available to current VHC enrollees as well as new enrollees. Access to prenatal care improves the health outcomes for both mother and baby, and reduces overall costs in the healthcare system. Many pregnancies are unplanned, and often a woman would have enrolled in more appropriate health insurance had she known she

would become pregnant. Currently, an enrollee who experiences complications in her pregnancy may not be able to afford appropriate care, particularly if she has a catastrophic plan.

The statute on which this SEP is based does not explicitly limit the SEP to new enrollees.

> "A registered carrier shall allow for the enrollment of a pregnant individual, and of any individual who is eligible for coverage under the terms of the health benefit plan because of a relationship to the pregnant individual, at any time after the commencement of the pregnancy. Coverage shall be effective as of the first of the month following the individual's selection of a health benefit plan." 33 V.S.A. § 1811(l).

We recognize that AHS has discretion to interpret the statute where the text and legislative intent are not clear. However, because of the strong public policy considerations, we believe the statute should be interpreted broadly to apply to both current and new enrollees.

73.05(b)(1)(iii) Data matching; tax filing

We support the addition of this section. It is appropriate and important to accept re-attestation of tax filing because nonfilter data received from the Internal Revenue Service (IRS) via the federal data hub can be out of date or inaccurate. According to the Treasury Inspector General for Tax Administration (TIGTA), for the 2016 enrollment period "the IRS erroneously notified the Exchanges that a required Tax Year 2014 return was not filed for 87,271 (25 percent) of the 342,450 individuals for whom the IRS sent notifications." *Affordable Care Act: Verification of Premium Tax Credit Claims During the 2016 Filing Season*, TIGTA Reference Number: 2017-43-022, p. 22 (Mar. 2, 2017). TIGTA also raised concerns about IRS delays in processing and uploading nonfilter data. *Id.* at 24.

77.00(e) Allocation of APTC and the Vermont Premium Reduction among policies

We support the revisions to this section. The allocation rule that AHS proposes is appropriate and simple to administer.

On an operational note, we appreciate that VHC is able to process enrollments with APTC and VPA for two tax families who wish to be covered by the same plan. This is necessary to allow adult children to remain on a parent's VHC plan until age 26. Most other exchanges have not developed that capability despite provision for it in the federal regulations.

PART EIGHT

80.07(d)(2) Expedited Administrative Appeals

Proposed § 80.07 addresses expedited administrative appeals. We support the expansion of this section to include all types of Medicaid. This is an important step towards harmonizing procedures across health programs.

Proposed § 80.07(d)(2)(i) establishes timelines within which hearing and notice of decision must occur for resolving expedited administrative appeals. The proposed rule establishes different timeframes for appeals involving MABD and Medicaid coverage of long-term care services and

supports (under both MCA and MABD), versus appeals not involving Medicaid coverage of long-term care services and supports. Specifically, AHS proposes 7 business days from the date of the request for appeals involving QHPs or MCA not involving coverage of long-term care services and supports. It proposes a resolution "as expeditiously as possible" for appeals involving MABD or Medicaid coverage of long-term care services and supports. We question the rationale for affording different levels of protection for different beneficiaries and recommend that expedited appeals for all beneficiaries be resolved within the 7 business day timeframe.

Proposed § 80.07(d)(2)(ii) purports to set an outside time limit of 21 days within which AHS must issue a written decision in expedited appeals. Proposed § 80.07(d)(2)(ii) makes reference to "the timeframe in [80.07(d)(2)](i)." However, as noted above, for appeals involving MABD or Medicaid coverage of long-term care services and supports, no timeframe is established in 80.07(d)(2)(i). Rather, expedited appeals involving MABD or Medicaid coverage of long-term care services and supports must only be resolved "as expeditiously as possible." Again, we recommend that expedited appeals for all beneficiaries be resolved within the 7 business day timeframe. As suggested in proposed § 80.07(d)(2)(ii), there may be an exception to the 7 day timeframe for "unusual circumstances."

Thank you for considering our comments. Please notify us when the responses to comments and the final proposed rule are available. If you have any questions, please contact Christine Speidel at cspeidel@vtlegalaid.org.

Sincerely,

Michael Benvenuto, Director, Senior Citizens Law Project
Nancy Breiden, Director, Disability Law Project
William Dysart, Senior Citizens Law Project
Mike Fisher, Chief, Office of the Health Care Advocate
Christine Speidel, Office of the Health Care Advocate
Marjorie Stinchcombe, Office of the Health Care Advocate

Comments Upon MWPD Rule Amendments

Aug. 23rd, 2017

Dear Ms. Chapman,

I would like to take the opportunity, during the public comment period, to remark on the rule amendments to the Medicaid for Working Persons with Disabilities (MWPD) program. I thank you and the Agency of Human Services (AHS) in advance for your consideration.

First of all, the 3 rule changes appear to be straightforward and in accordance with the MWPD provisions within Act 51 of the 2015 Vermont State legislative session and with AHS final policy as posted in the Global Commitment Register (GCR), effective 8/1/2016. As the lead advocate for these work incentive enhancements, I have no issues whatever with the language denoting the changes.

As for the one change legislated but disallowed by the Centers for Medicare and Medicaid Services (CMS) – the "reverse" spousal income disregard (i.e. disregarding the income of the MWPD beneficiary spouse for purposes of determining eligibility of the non-MWPD spouse for a Medicaid program), the denial appears to be solidly and soundly based. Because, as per Federal regulation, no disregards are allowed for MAGI Medicaid, nothing can be done at a state level to reverse that decision as it affects MAGI Medicaid. However, it is my understanding that, in the future, it may be possible to rework the relevant Medicaid State Plan Amendment (SPA) to more precisely define the income disregard parameters for non-MAGI Medicaid (e.g. Aged, Blind and Disabled Medicaid) prior to re-submission to CMS for approval. The more encompassing rationale for denial – the comparability rule – may be satisfied by such a refinement which would also preclude inadvertently extending the scope of the disregard well beyond the intent of Act 51. Of course, any refined rule amendment would apply to a smaller population than the original rule.

At this time, there exists some uncertainty regarding the issue of whether those former MWPD beneficiaries or potential beneficiaries now over 65 years of age can validly apply or re-apply for the MWPD program. A percentage of this population may have lost eligibility or been denied eligibility under the current rules but would not have under the proposed rules. Fairness seems to dictate that this population be allowed to apply/re-apply. Further, clarification is needed to generally explain whether re-application is allowed for this population after a break in employment and thus loss of eligibility for MWPD. Of course, Vermont's MWPD program is authorized by the Federal Balanced Budget Act (BBA) of 1997 which does not contain a termination age for Medicaid Buy-in (MBI) programs.

I applaud the efforts of AHS toward a thorough clarification of the issues stated above and look forward to a well-thought out response.

I am also pleased by proposed pro-active efforts by AHS to reach out to a targeted population of those, generally, who might have lost eligibility or been denied eligibility under the current rules but who would not have under the proposed new rules. Although it might not be technically feasible/possible to identify specific individuals, my understanding is that AHS will make every reasonable effort to publicize the new rules, including utilizing Department of Vocational Rehabilitation (DVR) benefit counselors, as

well as the collaboration of such entities as the Statewide Independent Living Council (SILC) and Vermont Center for Independent Living (VCIL). In addition, pertinent information will be posted on appropriate State Websites.

In summary, much thanks to the AHS "team" which has been diligently working to bring the legislated changes to fruition. I am hoping and trusting the remainder of the prescribed 6-month rule-making process proceeds accordingly in anticipation of the scheduled implementation date of January 1st, 2018.

Sincerely,

Sam Liss

Vice-President, Board of Directors; Chair, Program Committee, VCIL

Member, Former Chairperson, SILC

Member, State Rehabilitation Council (SRC)

86 Floyds Way
Pownal, VT 05261

August 9, 2017

Agency of Human Services
Waterbury State Office Complex
Conference Room – Cherry A-209
280 State Drive
Waterbury, Vermont 05671

RE: Public Comments regarding implementation of the Medicaid for Working Persons with Disabilities (MWPD) program updates

Dear AHS:

I have been waiting for this opportunity since 2001 when I first became eligible for SSDI. I am ecstatic to submit public comments in support of the above referenced program updates.

I first want to start out with a description of my scenario so that you understand my situation.

1. I am disabled.
2. I am working part-time (20 hrs/week).
3. I am not eligible for health insurance from my employer because I do not and cannot work enough hours.
4. I began receiving SSDI benefits in 2001.
5. I have been an amputee since age 11.
6. I wear a very expensive prosthesis.
7. I wear very expensive 5-ply wool prosthetic socks.
8. I am now a diabetic.
9. I wear diabetic shoes.
10. I take medications for diabetes that range in out of pocket costs from $0.00-$230. That is, of course, after I enter the donut hole. I just yesterday went to pick up my Trulicity medication and learned that I am now in the donut hole and my copay was $230. I did not buy it. I could not afford to buy it. Before I am in the donut hole my copay is $47. The copay may go up even higher before the end of the Medicare D calendar year as my escalation into the donut hole continues.
11. I also take pain medication as needed along with other medications to lower my cholesterol levels and my blood pressure to prevent a heart attack.
12. I cannot continue to work without my medications.
13. Without my medications, my health care needs will get more expensive.
14. I am married; we just celebrated our 40th Anniversary in June.

15. My husband is a Veteran. I thank God for that as he has been relying on the VA Healthcare system since he lost health insurance from his employer many years ago. His employer changed hands 3 times during his 29 years of employment. He lost and never regained his health insurance after the first sale of the business. He, too, is disabled. He currently has a 50% service-connected disability rating.
16. I am not eligible for VA medical benefits until my husband's disability rating reaches 100%.

My application for MWPD has been denied in the past. As you may know, it is a two-tier eligibility process. I passed the first income tier; however, I did not pass the second level tier due to having a spouse with income. Not to mention, I had some retirement savings at the time that was over the asset level. I do not have access to my retirement savings until I reach 59-1/2. I am age 57 now. The amount of my retirement funds will not sustain coverage of my medical out-of-pocket costs throughout the remainder of my lifetime.

I fully intend to reapply for MWPD after the changes are implemented. I want and need to continue working. I feel like the State of Vermont has been lackadaisical in developing, seeking, and implementing changes to the MWPD program that not only promote wellness for the disabled individual but support his/her effort to remain or become a tax payer. This is not a hand-out. It is a common-sense program change that is not only good for me but the State of VT too.

Thank you,

Tracy L. Dorman

Tracy L. Dorman

McLemore, Linda

From: Chapman, Robin
Sent: Friday, August 25, 2017 7:59 AM
To: Chapman, Robin
Subject: Comments on Rule 17P021/in re Navigator sections (5.03)

Good morning Robin,

I have read the AHS 17P021 and I am requesting that you revisit the Navigator Program. In particular pages 34 - 48.

I believe that this rule is out dated and needs to reflect current day needs.

I look forward to seeing some new language once this rule is reviewed.

Thank you

Navigator Gina O'Meara