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Re: Comments on AHS Bulletin No. 14-04P

Dear Robin:

Thank you for the opportunity to comment on the proposed rules issued March 21, 2014 in Agency of Human Services Bulletin No. 14-04P.

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## **Big-picture issues**

### **Choices for Care eligibility criteria should not be changed**

The rules confuse Choices for Care (Vermont’s Long-Term Care Medicaid Program) and Medicaid for the Aged Blind and Disabled (MABD). They are distinct Medicaid coverage categories with their own financial and clinical eligibility criteria.

Although, in general, the same financial criteria apply to both programs, the clinical criteria are different and responsibility for making clinical or disability determinations rests with different departments within the Vermont Agency of Human Services (AHS). Eligibility for Choices for Care (CFC) is based on the need for institutional level of care under Medicaid. It is implemented in Vermont through the CFC regulations (the high and highest need criteria) and is an eligibility determination made by the Department of Disabilities, Aging and Independent Living (DAIL).

By equating CFC with MABD, this rule makes a significant policy change that is not related to the implementation of the exchange. We are concerned that this new policy will delay access to long term care by forcing some individuals to go through

what is often a lengthy Disability Determination Services (DDS) evaluation. Furthermore, this change will deny CFC services to individuals who need institutional level of care for less than a year.

We have raised these issues since August 2013, and met with AHS about it. AHS has still not offered any explanation why Vermont made major policy changes to long term care by burying them in these rules related to implementing the exchange.

### **The Vermont Health Connect system must not require gaps in coverage for individuals granted Special Enrollment Periods**

This is a very serious operational and policy problem. Vermont must make seamless coverage possible for people who qualify for a Special Enrollment Period, especially those with serious medical conditions. We discuss the problems and our proposed solutions below under section 71.03.

### **Notice requirements for Qualified Health Plan terminations must be clearly stated**

The notice requirements for the termination of Qualified Health Plans (QHPs) are inadequate. It is not clear in these proposed regulations that advance notice is always required before a QHP can be terminated. Advance notice of the termination of a benefit is a well-established and fundamental element of due process. The Office of the Health Care Advocate (HCA) has already seen one case where lack of clarity about advance notice of termination was a problem.

A general rule for advance notice of adverse actions is mentioned in 68.02(a), which says that “AHS will send a notice of adverse action at least 11 days before the date the adverse action is to take effect (date of action), except as permitted under paragraph (b) of this subsection.” However, the advance notice requirement is muddled in 76.00, which specifically addresses terminations of QHP coverage but says little about notice requirements for those particular adverse actions.

Section 76.00(a) states that “AHS will determine the form and manner in which coverage in a QHP may be terminated.” Termination can be initiated by AHS or a carrier. 76.00(b)(2). In each situation described in section 76.00(b)(2), the rule should say which entity is required to send the notice and how far in advance it must be sent.

There is no language in 76.00 about notice requirements, other than “reasonable notice is defined as at least fourteen days from the requested effective date of

termination,” in the section on effective dates of terminations. 76.00(d)(1)(i). This section seems to apply only to situations where an individual has requested termination and presumably means that the individual must give at least fourteen days’ notice to AHS or the QHP issuer to cancel coverage. Please confirm this interpretation.

That an individual is required to give at least fourteen days of advance notice in order to terminate coverage, but AHS and the issuers have no notice requirements before termination is patently unfair. New language should be added to address this serious gap. We make specific suggestions below, in 76.00(b)(2) and 64.06.

Also, please clarify whether coverage can ever terminate in the middle of a month. This is important for evaluating the likely effect of different advance notice periods. Mid-month termination does not appear to be prohibited by the rules. However, under section 73.06 it appears that changes are generally implemented on the first of a month.

### **A system should be created to quickly implement federal changes**

Due to the incompleteness of the federal Affordable Care Act regulations, the chaotic nature of 2014’s open enrollment period, and the continued technological challenges facing the exchanges, federal agencies have repeatedly issued re-interpretations and exceptions to the federal rules for 2014 and beyond. This pattern could continue into the next year or two. AHS needs to create a system whereby it can quickly implement changes in federal law. Of particular importance are changes that ameliorate unfairness and hardship caused by prior federal rules or guidance. AHS needs a way to immediately help people when federal agencies relax or change the rules.

The system could be akin to the former AHS system of “PP&D” interpretive memoranda, or the bulletins that the Department of Vermont Health Access and the Department of Financial Regulation issue periodically. We suggest AHS issue numbered Guidance Bulletins. These bulletins could be issued for changes that are either temporary allowances from federal agencies to relax certain rules, or important changes that should become effective immediately. For the latter changes, AHS could simultaneously pursue rulemaking.

A formal, public system of guidance bulletins would be more transparent, reliable and readily available to applicants, advocates, navigators, and other assistors than the current somewhat confused method of communicating changes. Navigators and other interested parties could better keep track of changes if there were a series of

numbered, published guidance bulletins initially sent out by email and then posted online.

Two examples of recent federal guidance that need to be addressed quickly are:

Retroactive Premium Tax Credits and Cost Sharing Reductions

AHS should implement the option of granting retroactive Premium Tax Credit (PTC) payments and Cost Sharing Reductions (CSR) in certain circumstances. See, 45 C.F.R. § 155.545(c); *CMS Bulletin to Marketplaces on Availability of Retroactive Advance Payments of the PTC and CSRs in 2014 Due to Exceptional Circumstances*, February 27, 2014, <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/retroactive-advance-payments-ptc-csrs-02-27-14.pdf>.

This federal guidance allows retroactive QHP coverage and retroactive subsidies for individuals who did not receive timely eligibility decisions during 2014 open enrollment, due to technical problems experienced by an exchange. This guidance should be implemented immediately.

Premium Tax Credits and Special Enrollment Periods for domestic violence victims

This is a second example of when immediate guidance should be issued by AHS. The IRS issued guidance on March 26, 2014 providing that domestic violence victims who use the “married filing separately” filing status can qualify for Premium Tax Credits (PTC) in the Marketplace in 2014. Notice 14-23, <http://www.irs.gov/pub/irs-drop/n-14-23.pdf>. The notice indicates that a proposed rule will be forthcoming.

In a related development, guidance from the Centers for Medicare & Medicaid Services (CMS) created a special enrollment period through May 31, 2014 for domestic violence victims who thought they were ineligible for PTC because of the joint tax return requirement. See, <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/complex-cases-SEP-3-26-2014.pdf>. The SEP appears to be under the authority of 45 C.F.R. § 155.420(d)(9), which would require State Based Marketplaces to affirmatively adopt it.

## **Vermont should adopt federal options to expand Medicaid coverage and prevent gaps in coverage**

AHS should pursue two options provided by HHS in May 2013 guidance: Strategy 3, enrolling individuals into Medicaid based on Supplemental Nutrition Assistance Program (SNAP) eligibility; and Strategy 5, adopting 12 months of continuous eligibility (without regard to changes in circumstances) for adults through the Medicaid section 1115 waiver authority. *Facilitating Medicaid and CHIP Enrollment and Renewal in 2014*, Center for Medicaid & CHIP Services, SHO #13-003, ACA #26, May 17, 2013, available at <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-003.pdf>

In particular, continuous 12 month eligibility for adult Medicaid beneficiaries would significantly address the problem of income fluctuation and resulting “churn”. We have not seen this problem yet in Vermont Health Connect (VHC), as the focus has been on initial enrollment, but we expect to see these cases shortly. In our experience, low income workers frequently have changes in their income. Under the current eligibility rules, a family could potentially transition between Medicaid for Children and Adults (MCA) and a QHP with subsidies multiple times per year. These transitions will disrupt access to health care and gaps in coverage may occur. The provider network may change each time a family transitions between programs. Churning will be financially difficult as well, since the family will have to meet a new deductible each time they enroll in a new QHP.

## **Part One**

### **2.02(b) Medicaid eligibility**

This section requires additional clarification. Is the §1115 waiver referenced in this section the Global Commitment waiver, the Choices for Care waiver or both? This provision implies that the 1115 waiver is a separate eligibility category. Is that the case? If not, how do the §1115 waivers interface with the three eligibility groups listed in this section?

### **3.00 Definitions**

#### Application

The last phrase should be deleted. AHS should not use an entirely separate application form for non-MAGI-based Medicaid, even though it may be permitted under federal regulations. AHS should commit to maximum implementation of the

“single streamlined application” and “no wrong door” ideals of health care reform. A single streamlined application for all programs will ensure that AHS fulfills its duties to gather additional information about non-MAGI-based eligibility and to make an eligibility determination on all possible bases under sections 58.01(a)(2) and (c).

#### Application date

Revise definition to clarify the application date of an applicant who is ultimately found eligible for non-MAGI-based Medicaid, who initially applied for Medicaid using the single streamlined application. We believe the application date should be the date the individual submitted the streamlined application, even if other forms were subsequently required.

#### 3.00 Hospice Services

This section defines hospice services as a long term care service. This is a change from the existing rules which list Hospice and Long Term Care as distinct Medicaid services. See sections 7402 and 7601. Defining hospice as a long term care service is inconsistent with existing rules. Also, we ask that you clarify the legal basis for sections (b) and (c).

#### Long-term care; Long-term care services

The definitions of long-term care and long-term care services are confusing as drafted and inconsistent with one another and with other applicable regulations and policies. The previous definitions under rule 4201 did not have a separate definition for “long term care services” so adding that additional definition creates confusion. What is the purpose of adding an additional definition for “long term care services” in these rules? The proposed federal rule cited in support of this section has not been finalized. 78 Fed. Reg. 4593, 4692 (proposing an amendment to 42 C.F.R. § 435.603(j)(4)) (Jan. 22, 2013).

The definition of long term care services here conflicts with the existing DVHA rule for coverage of Long-Term Care Services, 7601. We request that the additional definition for long term care services be deleted.

#### **4.04 Case records**

Case records must include all information relevant to the individual’s case. The proposed definition is too narrow. For example, phone logs and notes regarding voicemail messages or phone calls are often important for determining whether an individual attempted to notify AHS of a change in circumstance.

## **5.01 Assistance offered through AHS**

Stronger language is needed regarding AHS's affirmative obligation to assist people in applying for benefits. Eligibility and enrollment assistance should be provided to all applicants and recipients who need it, and not just individuals with disabilities or limited English proficiency. Many English-speaking Vermonters without disabilities will need in-person and on-call assistance to enroll and maintain eligibility. The State has an affirmative obligation to provide this assistance. DCF should not be turning away people who show up in district offices seeking help filling out health care applications. The HCA has seen a couple of instances where this has happened. The policy should be that no one who wants help is turned away. This is consistent with a "no wrong door" philosophy.

This assistance may be required for AHS to gather and collect the necessary information to perform the proper application screening as specified in section 58.01(a). This section should also cross reference section 52.02 on application filing, to make it clear that AHS will accept applications from someone acting on behalf of an incapacitated individual, and that AHS has an affirmative duty to assist that person in the application, under the duties to the applicant as set out here. AHS's obligation to advise applicants about their options is well established in Vermont, including from *Lavigne v. Department of Social Welfare*, 19 Vt. 114, 423 A. 2d 842 (1980).

## **Part Two**

### **7.03(a)(6) and (7) Transitional Medicaid**

These sections refer to what is currently called Transitional Medicaid in Vermont. Recent federal legislation extended Transitional Medicaid through March 31, 2015 (see § 202 of the "Protecting Access to Medicare Act of 2014," or [Pub. L 113-93](#)).

Just prior to filing these comments we learned that AHS plans to change these sections because of the TMA program's recent one year extension. We have not yet seen the proposed language. We expect to continue to talk to AHS in order to clarify how the program will work.

Here are the comments we had written prior to the news that the sections are going to be rewritten:

We had hoped that Vermont would continue Transitional Medicaid as it now operates. The program allows a parent or caretaker relative who has been on Reach Up, but has new or increased earnings, to continue on Medicaid for up to an additional 36 months if the household income is below 185% FPL and certain other requirements are met. This reduces the so-called benefits cliff and encourages families on Reach Up to work. See, Medicaid ANFC Rule 4312.1 Eligible Except for Earnings.

Unfortunately, sections 7.03(a)(6) and (7) of the HBEE rule are taken directly from federal proposed rules that do not make sense, and they bear no relation to Vermont's Transitional Medicaid program. The income limits in sections 7.03(a)(6)(iii) and 7.03(a)(7)(iii) appear to fully nullify the provisions, because the income limits are not higher than the regular MCA eligibility level for the applicable individuals. This is baffling. We do not see how anyone could be eligible under these sections.

The relevant proposed federal rules have not been finalized. (42 C.F.R. §§ 435.112, 435.115, NPRM, 78 FR 4593, Jan 22, 2013.) These sections should either be deleted from the Vermont rules, or they should be changed to accurately reflect the current Transitional Medicaid program. If these rules are retained unchanged, please explain to whom they might apply.

Tracking the proposed federal regulation word for word (42 C.F.R. §435.112, NPRM, 78 FR 4593), §7.03(a)(6)(i)(B) states that "If Transitional Medical Assistance under §1925 of the Act *is not available* or applicable, extended eligibility must be provide in accordance with this subclause, if applicable." (emphasis added) Vermont currently offers Transitional Medicaid, so we are assuming that it *is available*. Since the sub-clause mentioned in the proposed federal and state rules provides for only four months of Transitional Medicaid, rather than Vermont's current 36 months of Transitional Medicaid, we ask that the State continue this more generous program rather than defaulting to the stingier federal option.

Section 7.03(a)(6)(ii)(B)(II)(ii) discusses when eligibility for a parent or other caretaker relative is lost due to "increased hours from a parent's employment resulting in the parent no longer having a 'dependent child,' as defined at §3.00 living in his or her home." It is not clear how this would occur. We realize this is word for word from the proposed federal regulation, but it doesn't really make sense. Under the definition of 'dependent child' in §3.00, increased earnings would have no effect on whether a child continues to be dependent. AHS may be intending

a different definition of “dependent child” than that stated in §3.00, in which case that needs to be explained and a reference cited.

### **8.05(k) MABD for long-term care services**

These revised rules have deleted two important rules from the 4200s that governed long term care eligibility under CFC: 4201(k), the definition for waiver services, which specified that CFC applicants were not subject to a disability determination, and 4202.3 Long-Term Care Coverage Groups, which specified that CFC was a form of categorical eligibility under SSI-related Medicaid. This proposed rule is also inconsistent with current rule 7605 which states clearly that DAIL alone is responsible for establishing and determining clinical eligibility for individuals needing nursing home level of care. We strongly object to these changes, and request again that the clear provisions from the old rules that have been inexplicably dropped from these rules be restored.

If the prior language not restored, please clarify when, under the proposed rule, someone applying for CFC must be evaluated by DDS. Also, please explain AHS’s rationale for deleting former rule 4201(k).

#### 8.05(k)(3) and (4)

We object to these substantial revisions of the former rule, 4202.3 Long-Term Care Coverage Groups. There is no justification for making changes to long term care eligibility as part of these rules. Specifically, the additional resource test at section 8.05(k)(3)(iii) is confusing and ambiguous and should be deleted. There should be no change to the general principle governing resource eligibility for long term care. Further, the added language “Meets the MABD non-financial criteria” at section 8.05(k)(3)(iv) is misleading because it suggests that long term care requires a disability determination, and should also be deleted.

## **Part Three**

### **23.06(b)(7)(i)(C) Enumeration of possible hardship circumstances**

AHS should add “but not limited to” after the word “including” at the end of this phrase. This will ensure that navigators, beneficiaries, and others know that the list is non-exclusive. In addition to the general non-exclusive nature of the list, HHS has continued to announce additional hardship exemptions in guidance.

## **Part Four**

### **24.00 Patient share**

24.04(a): Allowable deductions from patient-share; Income deductions. The allowable deductions should include reasonable expenses related to the receipt of unearned income, withheld income that is not actually available to the individual, and court-ordered obligations. It is contrary to public policy to deny an individual the income to support an ex-spouse as ordered by a court. This further impoverishes the ex-spouse by denying them essential support. This provision should be expanded to include the following:

(9) Ordinary and necessary expenses of managing, maintaining or receiving the unearned income. For example, court costs, fees of a attorney, guardian, fiduciary, or other authorized representative;

(10) Federal and State offset of benefits for the recovery of an overpayment, support or other debt;

(11) Alimony, support, maintenance or other court-ordered payments.

### **25.03 Transfer penalty**

#### 25.03(c) transfers for less than fair market value

This general provision on transfers for less than fair market value should state the statutory presumption and cite the federal law. The following initial sentence should be added to this section: “There is a rebuttable presumption of ineligibility for transfers for less than fair-market value. 42 U.S.C. § 1396p(c)(1)(A) & (B).”

#### 25.03(c)(4) transfer penalty exception

To be consistent with federal law and Human Services Board precedent, this transfer penalty exemption should be reworded. It should say:

The transferor has made a satisfactory showing that the resources were transferred exclusively for a purpose other than for the individual to become or remain eligible for MABD for long-term care. 42 U.S.C. § 1396p(c)(2)(C)(ii). A signed statement by the transferor is not, by itself, a satisfactory showing. Examples of satisfactory evidence are documents showing that:....

The underlying federal statute asks for a “satisfactory showing” that the transfer was made for a purpose other than qualifying for benefits. 42 U.S.C.A. § 1396p(c)(2)(C). To the extent that “convincing evidence” is different from a

“satisfactory showing,” the requirement of “convincing evidence” is inconsistent with the governing statute.

Moreover, a transferor need only make a “satisfactory showing” of the reason for the transfer, even if that showing does not convince AHS. If AHS is unconvinced, the evidentiary burden shifts to AHS to produce evidence contradicting the transferor’s stated reason for the transfer. In F.H. 20,388, AHS was not satisfied by evidence that resources were transferred exclusively for a purpose other than becoming eligible for MASD. The applicant had presented undisputed evidence that he transferred assets purely for reasons other than qualifying for MABD for long-term care. He also presented documentary evidence that after making the transfer, he experienced a wholly unexpected and tragic accident when he fell down a cellarway onto a concrete floor. The fall created an unexpected need for long-term care.

Although this evidence did not document the purpose of the transfer “to AHS’s satisfaction,” the Human Services Board found that state and federal law required the denial of long-term care Medicaid to be reversed.

#### 25.03(c)(7) Transfer of excluded income or resources

The rule should remove the inconsistency that suggests that the transfer of an excluded resource other than the home could result in a penalty. There is no basis for such a rule, and the transfer of an excluded resource cannot be “for the purpose of qualifying for Medicaid” since the resource is already excluded. Therefore, revise to:

The transferor transferred excluded income or resources. Penalties are imposed for the transfer for less than fair market value of any asset considered by the SSA's SSI program to be countable ~~or excluded~~ or that result in the imposition of a penalty period under SSI. ~~For example, transfer of a home or of the proceeds of a loan are both subject to penalty.~~

#### Nominal gifts

Nominal gifts should be included in transfer penalty exemptions, as 25.03(c)(8):

A penalty period is not imposed for transfers totaling a nominal amount in any month. The average daily cost to a private patient of nursing facility services is considered nominal. See P-2420(D)(13).

#### 25.03(j)(1) jointly owned income or resources

The last sentence of this provision concerning transfers involving jointly owned income or resources established on or after January 1, 1994 should be reworded as:

The individual may rebut the presumption of ownership upon a satisfactory showing ~~by establishing to AHS's satisfaction~~ that the amount withdrawn was, in fact, the sole property of and contributed to the account by the other joint owner (or owners), and thus did not belong to the individual.

#### 25.05(c)(4) abuse or exploitation as undue hardship

Reported abuse or exploitation should constitute undue hardship. This rule currently sets unreasonably stringent standards that will be nearly impossible for abused or exploited applicants to meet. This provision should be changed to read:

Whether the individual was deprived of an asset by exploitation, fraud or misrepresentation. Such claims must be documented by police reports or civil or criminal action against the alleged perpetrator or substantiated by AHS or by a report to AHS for investigating abuse, neglect or exploitation.

## **Part Five**

### **28.03(e) Household composition**

The new method of household composition requires a major conceptual shift for those familiar with current Medicaid rules. AHS should include some introductory language about how the new system works. We suggest something along the lines of this addition:

28.03(e)(1)(iv) Household composition is determined separately for each individual seeking coverage. Individuals residing together may have different MCA household compositions.

Examples would be enormously helpful, including a mixed MABD/MCA household, and a child with a caretaker relative on Medicare. We propose adding a section 28.03(k) for examples. The examples suggested below are adapted from HHS examples shared with us by Robin Chapman in August 2013.

#### 28.03(k) Examples

Example 1: Tax filer Mary is a working grandmother under 65 who claims her daughter Samantha, age 20 and a full-time student, and granddaughter Joy (Samantha's daughter), age 2, as tax dependents.

a) Mary earns \$4,500/month (\$54,000/year). Samantha earns \$300/month (\$3,600/year). There are no other sources of income. For 2014, IRS guidance establishes that tax dependents with more than \$6,200 per year of earned income must file federal income taxes.

b) Mary's MCA eligibility

1) Mary is a tax filer and she is not a tax dependent, so her MCA household is the same as her tax household. Mary's household is composed of Mary (tax filer), Samantha (tax dependent), and Joy (tax dependent).

2) Mary's household income is \$4,500/month. Samantha's income is not counted because Samantha is (1) the child or expected tax dependent of another member of the household and (2) not expected to be required to file a tax return. §28.03(c)(2)(i).

3) Mary's eligibility. \$4,500/month for a household of 3 is 276% FPL. This is over the MCA limit for adults. §7.03(a)(5). Mary is not eligible for MCA.

c) Samantha's MCA eligibility

1) Samantha's household composition. Samantha is claimed as a tax dependent, and none of the exceptions for tax dependents apply. Because none of the exceptions apply, Samantha's household is the same as the household of the tax filer who is claiming her as a dependent. Samantha's MCA household is composed of Mary (tax filer), Samantha (claimed dependent), and Joy (claimed dependent). Samantha's household income is the same as Mary's.

2) Samantha's eligibility. \$4,500/month for a household of 3 is 276% FPL. This is over the MCA limit for adults and also for parents and caretaker relatives. §7.03. Samantha is not eligible for MCA.

d) Joy's MCA eligibility

1) Joy's household composition. Joy is claimed as a tax dependent, but one of the exceptions for tax dependents applies. §28.03(e)(3)(i). Joy is being claimed by her grandmother. Under the nonfiler rules, Joy's MCA household is composed of herself and her mother, Samantha. §28.03(e)(4).

2) Joy's household income is \$300/month. Samantha's income counts here, because Samantha is not the child or expected tax dependent of another member of the household. §28.03(c)(1) & (2). Mary is not part of Joy's MCA household and therefore her income is not considered in determining Joy's eligibility for Medicaid.

3) Joy's eligibility. \$300/month for a household of 2 is 23% FPL. Joy is eligible for MCA. §7.03(a)(3).

Example 2: Alice is a 68 year old grandmother, applying for coverage for herself and her 12 year old grandson Bill, who lives with Alice. Alice receives Social Security retirement benefits. Alice is enrolled in Medicare. Bill receives Social Security Survivors benefits. Alice and Bill do not file taxes.

a) Alice's Social Security retirement benefits are \$850 per month. Bill receives \$500 per month in Social Security Survivors benefits. There are no other sources of income.

b) Alice's MCA eligibility

1) Alice is neither a tax payer, nor is she claimed as a tax dependent, so her household will be based on the non-filer rules. Alice's household is composed of only herself. §28.03(e)(4).

2) Alice's household income is \$850 per month. \$850 for a household of 1 is 89% FPL.

3) Alice is not eligible for MCA as an adult, because she is over 65 and because she is enrolled in Medicare. §7.03(a)(5). However, as Bill's caretaker relative, Alice may be eligible as medically needy. §7.03(a)(8). Alice's Medicare status is not relevant to her MCA eligibility determination as a medically needy caretaker relative.

c) Bill's MCA eligibility

1) Bill's household composition. Bill is neither a tax payer, nor is he claimed as a tax dependent, so his household will be based on the nonfiler rules. Bill's household is composed of only himself. §28.03(e)(4).

2) Bill's household income is \$500 per month. \$500 for a household of 1 is 52% FPL. Bill is eligible for MCA. §7.03(a)(3).

### **29.13(b)(1) Income exclusions**

Reasonable costs associated with accessing income should be excluded. The proposed language is too narrow. This provision should be changed to, “Reasonable and necessary expenses of acquiring, managing, maintaining or receiving the unearned income. For example, fees of a guardian, fiduciary, authorized representative or attorney and court costs may be deducted.”

### **Rule 29 terminology**

We continue to be confused by the change from “MABD for long term care” to “Medicaid for long term care” in these rules, and whether that change is intended to have any substantive meaning. If the change in terminology does change any aspect of eligibility for long term care, we request that be explained by the Department and justified. It is also confusing that the change was not made in Rule 29, which continues to refer to MABD for long term care. However, as long as our other comments are adopted, including restoring the critical provisions related to eligibility for CFC (4201(k) and 4202.3) and deleting the confusing addition of a separate definition for “Long Term Care Services”, we don’t oppose referring to long term care in these rules as generally “Medicaid for long term care services”.

The phrase “in the discretion of AHS” should be deleted from sections 29.09(d)(5)(ii), 29.09(d)(1), and 29.08(d)(2)(iii). These rules should specify AHS’s financial methodology for eligibility. That methodology must be clear and cannot be at the whim or discretion of AHS on a case by case basis.

## **Part Six**

### **41.00(d)(1) Employee Special Enrollment Rules**

We have the same comment here as below in 71.03. The existing rule is extremely harsh. Also, please clarify how it relates to the SEP provided in 40.00(g). As currently written, it appears that an individual who had previously elected COBRA could not enroll in SHOP insurance offered by his employer, if he became eligible for the new plan outside of open enrollment. Individuals should be permitted to drop COBRA coverage when in favor of a SHOP plan.

## **Part Seven**

### **52.02(a)(6) Application filing; MAGI-based Medicaid.**

We would delete the last phrase beginning with “or an appropriate”. As we explain above under section 3.00, we believe it is important that AHS not use an entirely separate application form for non-MAGI-based Medicaid. AHS should commit to maximum implementation of the “single streamlined application” and “no wrong door” ideals of health care reform.

### **Assistance with documentation and verification**

Section 54.07(f) provides, “AHS will assist individuals who need assistance to secure satisfactory documentary evidence of citizenship in a timely manner.” We would like to see that same language applied to all documentation and verification requests. Also, AHS has an affirmative duty to assist people with disabilities, including but not limited to documentation and verification requests.

### **57.00 Inconsistency procedures**

The Department has a long-standing and ongoing problem with processing Medicaid applications in a timely way, particularly for long term Medicaid. One of the major reasons for that failure to process applications in a timely manner is excessive and unduly burdensome verification requests. These rules substantially change the process for requesting verification from the applicant. This is part of the overall administrative simplification of application processing, which we support. However, we have significant concerns that the Department is not following these rules, and is continuing to request verification in violation of the process specified in 57.00(1) and (2). We would request that the Department immediately revise its procedures to comply with these rules.

Specifically, the Department may only request verification after providing an opportunity to explain the discrepancy first. Further, the Department is prohibited from denying an application for lack of verification, if the applicant responds to the verification request, even if the Department believes that the verification was inadequate in some way.

#### **57.00(c)(2)(ii)**

A sentence was added to this provision: “If, because of evidence submitted by the individual, one or more requests for additional evidence is necessary, such additional evidence must be submitted by the individual within the 90-day period that begins with the first verification request.”

This does not seem fair to beneficiaries. Applicants should not be subject to multiple and sequential verification requests. If AHS needs verification after following the process set out at 57.00(a) and (b), they can request it, but the request should be done once, in a timely fashion. AHS should then make an eligibility decision based on the applicant's response. The applicant can always submit additional evidence during an appeal, if AHS finds the applicant not eligible. We would prefer the additional sentence be removed.

57.00(c)(4)(ii)(B) & 57.00(c)(5)

We believe that an eligibility decision should always be made on the merits of the case, based on the information available to AHS.

The language to which we object does not appear to come directly from any federal regulation. We believe our proposed language, below, is consistent with the regulations at 42 CFR § 435.945(j), 42 CFR § 435.952, 45 CFR § 155.315, and 45 CFR § 155.320.

57.00(c)(4)(ii)(B) should be revised to read, "If AHS cannot determine... that the individual is ineligible for Medicaid, deny the application or disenroll the individual on the basis that the individual cannot be found ineligible for Medicaid."

57.00(c)(5) should be revised to read, "...if...the individual has not responded to a request for additional information, determine the individual's eligibility for Medicaid based on the information available, and notify the individual of such determination, including notice that AHS is unable to verify the attestation."

**58.01(a) MAGI screen**

Please clarify that under this rule, a MAGI screen is required for all health benefits applications.

**61.00(d) Timely determination of eligibility**

The new rules added an extenuating circumstance when the "individual delays providing needed verification or other information." While that is generally a reasonable concept, and was implied under the old rules and allowed under Federal regulations, the additional time to process the application should only apply when the AHS has made a timely request for verification. That request for verification would need to occur within the first week or so after the application; otherwise the delay is attributable to AHS. In the past, we have seen AHS send excessive verification requests for financial information late in the process that do not allow the applicant sufficient time to respond. Revise to:

An individual delays providing needed verification or other information in response to a timely request from AHS.

#### **64.01(j) Premium refunds**

It is categorically unjust to have a policy prohibiting refunds of all premium payments. Premiums that are not applied towards an individual's coverage should be refunded upon request from the beneficiary regardless of the scenario. The baseline should not be that premiums are non-refundable, with exceptions. It is entirely unreasonable for the state or an issuer to keep someone's money if it is not going towards past or future coverage. If it is going for future coverage, it must be for a reasonable period, e.g. a few months of advance payment, not years' worth.

The HCA has spoken with several Vermonters for whom this rule was a problem. Individuals called to cancel their VHC coverage shortly after enrolling, or mistakenly sent a check that was too large, and were denied refunds. In one instance the individual accidentally put the wrong check in the premium payment envelope. The check was for \$4,000 and not even made payable to VHC; the premium payment was supposed to be only \$48. VHC cashed the check and refused to refund it. Initially VHC told the beneficiary that the \$4,000 had to be applied to future premiums, which would have covered seven years! The HCA had to fight to get the money returned, which it finally was. This was an extreme example, but even shorter terms of involuntary advance payment could be a hardship, and are certainly unjust.

When a beneficiary's overpayment does result in hardship, the State should expedite the refund. If the individual can demonstrate the overpayment has created a hardship, the money should be refunded within one week.

The existing rule leads to inequitable results. In addition to lengthy mandatory advance payment, this rule, in conjunction with 70.02(c), could result in a partial payment being allocated to a month in which the individual has no coverage. Individuals should be entitled to refunds if they overpay.

This rule should be amended to allow refunds, and to allow the expedited issuance of refunds if the overpayment causes a hardship.

#### **64.03(b) QHP initial enrollment billing**

This section contains invoice and coverage effective dates for December 2013 and January 2014. It should be revised to include the relevant deadlines for the 2015 open enrollment period.

## **64.06 Grace periods**

We applaud AHS for making a one month grace period available for unsubsidized QHP beneficiaries. This is an improvement over the prior rule. However, AHS should extend the Advance Premium Tax Credit (APTC) grace period rule across all categories of VHC beneficiaries. This includes small businesses and individuals without APTC. A uniform grace period policy will be easier to administer on all sides, and easier for beneficiaries to understand. Medical providers and carriers will not need to keep track of whether someone with a QHP receives APTC.

For years, AHS has struggled with timely and accurate processing of applications and verification documents. If a beneficiary's payment is misplaced or misapplied, one month may not be enough time to sort things out. Or, if a beneficiary experiences a change in circumstances, VHC may need more time to determine whether the person now qualifies for subsidies. Especially where verification of income is required, we are concerned that VHC will not be able to complete its processing before the person's coverage is terminated.

Pending claims for an additional two months does not harm the carriers, since they don't pay claims unless the beneficiary catches up. Providers can also deny service while coverage is pending. Insurers are required to notify providers when coverage is pending.

### **64.06(b)(1) Notice of premium nonpayment**

AHS should add more detail to this section, to ensure that beneficiaries receive sufficient advance notice of their coverage termination date due to nonpayment. We suggest adding paragraph (i)(F) to read, "at least 11 days before the end of the first grace period month, the issuer will send a closure notice that coverage will end as of the end of that month if full payment is not made by the end of the grace period." Eleven days is the required period set for Dr. Dynasaur termination notices in 64.06(b)(2)(ii).

Second, it is possible that a beneficiary might dispute the fact of nonpayment. That appeal would presumably be to the HSB. Yet, these notices are being sent by the QHP issuers. Issuer notices under this section must advise beneficiaries of their right to appeal to AHS if they disagree with the allegation of nonpayment.

### **Reinstatement**

We request the enactment of reinstatement provisions for all beneficiaries. Currently, the rules lack any reinstatement rights.

An AHS proposal that we reviewed in October 2013 allowed small businesses limited reinstatement rights. Reinstatement was limited to twice per plan year, and was only be available during the one month period following the end of the grace period. In contrast, the federal SHOP allows unlimited reinstatement opportunities. CCIIO, REGTAP FAQ ID 1423, 4/14/14, available at <https://www.regtap.info/>.

This reinstatement proposal should be enacted for both small businesses and individuals. Uniformity makes for much easier administration and comprehension by all parties involved. Also, the goal of health care reform will be frustrated if some individual beneficiaries cannot get any health insurance until the next open enrollment period. AHS rules should be aimed at providing as much access to health insurance as possible.

As beneficiaries, providers, insurers, contractors, and AHS workers adjust to the new health care system, mistakes and glitches will occur. The rules need to have the flexibility to accommodate and address these bumps in the road without causing serious hardship and defeating the purpose of health care reform. At a minimum, AHS should adopt liberal grace period and reinstatement rules for the transition period. For example, the rules we propose could sunset after two years.

AHS should take care not to create a system where a minor mistake or a personal crisis causes irreversible hardship. The goals of Vermont health care reform will be best served by extending the APTC grace period rule to all QHP beneficiaries, and by allowing reasonable reinstatement opportunities for individuals as well as small businesses.

#### **64.08 Lock-out period**

This rule generally requires that all outstanding premium balances for an individual's household be paid before an individual can reapply and receive premium-based Medicaid. This rule should include an exception for applicants who are children, applicants who are incapacitated, and for applicants who can show good cause why they should not be held responsible for the debts of the other household member.

#### **64.10, 64.11, & 64.13**

These three sections were changed to clarify that they only apply to Medicaid. As far as we can tell, there are no similar rule sections that apply to QHPs.

64.10 Medicaid premium payment balances: This section states that excess payments will be applied to the beneficiary's next bill. We see no reason to limit this rule to Medicaid beneficiaries.

64.11 Refund of prospective Medicaid premium payments: This section explains when prospective Medicaid premiums will be refunded. Prospective QHP premiums should also be refunded if the beneficiary is found to have no premium obligation. This can happen as a result of APTC. As we said above, we feel 64.01(j) on premium refunds should be changed. However, in the alternative 64.11 should be extended to QHP beneficiaries.

64.13 Appeal of Medicaid premium amount: The first paragraph of this section should also apply to QHPs. This states that a beneficiary must continue paying her premium at the original level for coverage during an appeal, if the beneficiary is appealing a premium increase or proposed termination of coverage. Section 82.00(g) allows for continuing QHP coverage, APTC, and CSR on appeal, but does not address the premium level. We assume the beneficiary must continue paying the premium in effect prior to the decision being appealed. This should be made explicit in the rules. The second paragraph of section 64.13 is not relevant to QHPs, since excess PTC is recovered on the beneficiary's federal tax return.

## **69.00 Corrective action**

This paragraph should be revised to address appeals of initial eligibility applications as well as redeterminations. When an initial Medicaid application is approved, corrective payments are made back to the date of application and sometimes earlier, not just back to the date of the incorrect adverse action. This rule should reflect that possibility.

## **71.03 Special Enrollment Periods**

The rules on effective dates must reasonably allow consumers to maintain seamless coverage

Vermont must make seamless coverage possible, especially for people with serious medical conditions. We believe there are two serious errors in AHS's current interpretation of the federal rules. Also, AHS should take advantage of a federal option for earlier effective dates.

Recently AHS informed navigators that an individual who is losing coverage, and therefore qualifies for a special enrollment period, cannot apply through Vermont Health Connect in anticipation of their loss of coverage. According to AHS, the

soonest a person can apply is the last day their existing coverage is in effect. Also, AHS has informed navigators that coverage is effective the first day of the month following the date the plan is selected.

The state's current interpretations regarding loss of Minimum Essential Coverage (MEC) mean that people who lose coverage in the middle of a month have no way to avoid a gap in coverage, and people who lose coverage at the end of a month have only one day to attempt to avoid a gap in coverage. So, for example, if an individual is losing coverage on May 31, they will experience a gap in coverage unless they successfully complete the VHC application and the QHP enrollment process, including premium payment, on May 31. This will be impossible for most people.

This situation is not acceptable and is not required. Section 71.03(b) should be modified to ensure there are no built-in gaps in coverage. Individuals must have a way to seamlessly get onto a QHP when their MEC ends. The HCA has seen multiple problems as a result of the current policy, often with individuals who are in need of medical care, and sometimes in dire need of that care.

*Individuals losing other minimum essential coverage must be allowed to apply with VHC up to 60 days before their coverage ends*

45 C.F.R. § 155.420(c) states that "a qualified individual or enrollee has 60 days from the date of a triggering event to select a QHP." We read the word "from" to mean "before or after." In the case of loss of employer coverage, § 155.420(d)(6)(iii) explicitly calls for allowing people to enroll as early as 60 days in advance of their loss of MEC: "The Exchange must permit an individual who is enrolled in an eligible employer-sponsored plan and will lose eligibility for qualifying coverage in an eligible employer-sponsored plan within the next 60 days to access this special enrollment period prior to the end of his or her existing coverage, although he or she is not eligible for advance payments of the premium tax credit until the end of his or her coverage in an eligible employer-sponsored plan." 45 C.F.R. § 155.420(d)(6)(iii). Vermont's current interpretation violates this provision.

Also, recently proposed regulations support our view of HHS's intent. *Patient Protection and Affordable Care Act: Exchange and Insurance Market Standards for 2015 and Beyond*, Proposed Rule, 79 Fed. Reg. 15808, 15838 (Mar. 21, 2014). <http://www.gpo.gov/fdsys/pkg/FR-2014-03-21/pdf/2014-06134.pdf>. See proposed § 155.420(c)(2) which addresses the situation of an individual who is going to lose MEC or whose eligibility for an employer sponsored plan is ending because the employer is ending or changing the available coverage. It says that a consumer has 120 days to select a QHP. The 120 days starts 60 days prior to the end of the

coverage. It specifically says the consumer has a right to select a QHP “prior to the end of his or her existing coverage or eligibility.” It goes on to say the consumer is not eligible for APTC until the end of the qualifying coverage. 79 Fed. Reg. at 15875.

*The special effective date for individuals who lost other minimum essential coverage is based on the date their coverage ended*

AHS now interprets 45 CFR § 155.420(b)(2)(ii)-(iii) to mean that the effective date of coverage when there is a loss of MEC is determined not by the triggering event, but by when plan selection is complete. We believe this interpretation is wrong.

Prompt enrollment is explicitly called for where a person is eligible for this SEP. See 78 FR 421160, 42263-64 (2013) (preamble discussion of effective dates of enrollment for SEPs). In the case of eligibility due to a marriage or loss of MEC, the Exchange must ensure that coverage is effective on the first day of the month following the event. 45 CFR § 155.420(b)(2)(ii)-(iii). The rules do not give the Exchange any discretion to delay the date of enrollment in a QHP. See, e.g., 77 FR 18310, 18393 (2012) (preamble to final rule on SEPs, noting that “in the case of marriage or in the case where a qualified individual loses minimum essential coverage, the Exchange must always ensure coverage is effective on the first day of the following month, consistent with HIPAA rules”).

We read the regulation to require retroactive coverage if necessary. This is something that insurance plans routinely provide in the COBRA and birth-of-child context.

In support of its interpretation, AHS cited a draft [federal marketplace operations policy manual](#). This document is not official guidance to state-based marketplaces. Additionally, the manual is just plain wrong about the SEP time (it states 30 days while the regulation provides 60 days). The statement in the FFM manual, "for marriage and loss of minimum essential coverage (MEC), coverage is effective the first day of the month following plan selection" is inconsistent with the federal regulation, which provides for coverage the first day after the month in which MEC is lost. The draft federal marketplace manual is not controlling or even persuasive as to SEP policy.

*AHS should work with QHP issuers to implement earlier effective dates for individuals who lose other MEC in the middle of a month*

Even under our interpretation of the federal regulations discussed above, individuals who lose MEC in the middle of a month will have a gap in coverage. However, federal regulations at 45 C.F.R. § 155.420(b)(3) allow an exchange to set

earlier effective dates for the SEPs in section 71.03(b)(2)(ii), if all participating QHP issuers agree. AHS should work with QHP issuers to implement this option. Ideally, consumers would be able to choose the day their coverage starts, including selecting the day after their qualifying event, all the way up to the normal coverage effective date.

#### AHS should implement additional Special Enrollment Periods

States must provide the SEPs that are included in the federal regulations, but nothing prevents a state exchange from providing additional enrollment opportunities. *See, e.g., 78 FR 42159-42322* at 42264 (July 15, 2013) (“a state may establish additional special enrollment periods to supplement those described in this section as long as they are more consumer protective than those contained in this section and otherwise comply with applicable laws and regulations.”).

We have several suggestions for additional special enrollment periods that we believe VHC should implement. Some of our suggestions are included in the proposed federal rules published on March 21, 2014. We understand that AHS’s preference is to wait until proposed federal rules are finalized. However, waiting does not make sense here. As explained above, VHC has the authority to implement more generous SEPs than the federal marketplace. VHC should implement our proposed changes to SEPs and effective dates because it is the right thing to do, regardless of whether the federal proposed rule becomes finalized.

#### *Continuous open enrollment for lower income individuals*

Massachusetts grants a special enrollment period to any individual newly determined eligible for a ConnectorCare plan. 956 Code of Mass. Regs. 12.11(5)(b) (eff. Jan 1, 2014), available at [www.mahealthconnector.org](http://www.mahealthconnector.org). This effectively gives individuals under 300 percent of the federal poverty line a continuous enrollment period.

AHS should adopt an SEP for individuals who are determined newly eligible for a Vermont premium reduction. A continuous special enrollment period for this income group could be critical for many Vermonters this year, as they adjust to moving from VHAP and Catamount Health to QHPs. The income limit for receiving Catamount with premium assistance was 300% FPL. VHAP and Catamount did not have designated enrollment periods, and people frequently moved on and off the programs during the course of a year. It will be a rude shock to many this year to learn that they will have to wait until the next open enrollment if they fall off their QHP.

### *Non-marketplace plans that renew outside of VHC open enrollment*

AHS should create a SEP for people whose health plans renew outside of marketplace open enrollment. Consumers should have an option not to renew non-calendar year policies and instead to receive a special enrollment period in VHC. The HCA has already seen one situation where this was a problem for a consumer. The individual's grandfathered plan renewed outside of open enrollment, with a significant premium rate increase.

Affected individuals should be able to apply to VHC in advance and get coverage with no gap. Individuals should be able to report to VHC that they will not renew their plan up to 60 days before the renewal date. Also, consumers should have 60 days after their renewal date to enroll in a QHP. Coverage should be effective the day following the renewal date, unless the consumer elects a later effective date.

The federal marketplace implemented a similar SEP for individual market consumers on May 2, 2014. CCIIO, *Special Enrollment Periods and Hardship Exemptions for Persons Meeting Certain Criteria*, May 2, 2014, available online at <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/SEP-and-hardship-FAQ-5-1-2014.pdf>. Additionally, HHS proposes to include this SEP in a permanent rule change. *Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond*, Proposed Rule, 79 Fed. Reg. 15,808, 15,838 (Mar. 21, 2014).

### *Student health plans*

Historically student health plans have offered limited coverage in order to maintain low premium rates. An individual on a student health plan should be eligible for an SEP if they wish to disenroll from a student plan and get coverage through a QHP.

VHC's 4/1/14 navigator Q&A states: "We are awaiting clarification on whether a student can dis-enroll from a student plan mid-year and be eligible for a special enrollment period." Vermont does not need permission to create a new SEP for these students.

Furthermore, student health insurance plans are not subject to all ACA requirements. For example, they are not subject to the guaranteed availability and renewability requirements of the ACA. Carriers may also develop school specific community rates. See Vermont Department of Financial Regulation Insurance Bulletin No. 181, <http://www.dfr.vermont.gov/reg-bul-ord/student-health-insurance-plans>. A new section should be added allowing individuals on student health plans to disenroll and get an SEP to purchase a QHP.

## *COBRA*

COBRA coverage is very expensive. It can be much more expensive than a QHP, especially if the beneficiary qualifies for QHP subsidies. Consumers should be allowed to drop COBRA at any time and enroll in a QHP instead, as long as their COBRA premiums are paid through the date of coverage termination. The HCA has frequently heard from consumers who expected to be able to need COBRA for only a brief period because they thought they would find a new job quickly. When they don't find new employment, they often can't afford to continue their COBRA benefits. To be unable to get onto a QHP in those circumstances seems very harsh.

An individual with COBRA should be able to drop it at any time for either a subsidized or an unsubsidized QHP. The phrase, "and is otherwise newly eligible for APTC" should be deleted from section 71.03(e)(1).

As explained above, Vermont can make this change to the special enrollment periods even if the federal marketplace is not allowing individuals to have a SEP upon dropping COBRA.

### **70.02(c) Payment allocation**

This section should provide that partial payments cannot be applied to months prior to the start of coverage. It should not be possible for a beneficiary to pay for part of a month in which she has or had no coverage. Such a partial payment should be refunded, or applied to a future month's premium.

### **73.01 Eligibility redetermination during a benefit year; General requirement**

Language about seamless transitions should be added. In the Catamount Premium Assistance regulations, Section 5926 required that the state provide seamless coverage for individuals who experience changes in eligibility for DVHA programs. For example, if a family was on Dr. Dynasaur and Premium Assistance for Catamount Health (CHAP), and their income decreased, the state would "seamlessly" transition the parents onto VHAP after the income change was reported. This principle of seamless transition to other health benefit coverage should be more clearly incorporated into these rules and explicitly stated because it is such an important concept in a complicated system.

We suggest adding this language from the prior rule § 5926 on Seamless Coverage to §73.01:

From time to time, a beneficiary's changed circumstances may require a change from one health-care program to another. AHS will ensure that

individuals retain coverage during program transitions brought about by changed circumstances.

We understand that VHC is currently trying to avoid coverage gaps due to delays in redetermination through a process called “access to care.” (VHC 4/1/14 navigator Q&A) We applaud VHC for this, but we are concerned that the current rules do not require such efforts. The principle of seamless transitions should be acknowledged and clearly stated in the rules.

### **76.00 Termination of QHP coverage**

In section 76.00(b)(2), the numbering seems off. Paragraphs (ii), (iii), and (iv) should be (C), (D), and (E). They are all circumstances under which an individual’s QHP coverage may terminate.

As explained above, the termination provisions need more detail regarding advance notice to beneficiaries.

76.00(b)(2)(i)(A) should provide that AHS may initiate termination of coverage upon 30 days’ notice when an individual is no longer eligible for coverage in a QHP. Less than this gives the individual insufficient time to remedy the reason for the termination or to arrange for other health care coverage.

76.00(b)(2)(i)(B) should specify that the issuer may terminate coverage for nonpayment of premiums, upon notice to the beneficiary consistent with section 64.06.

76.00(b)(2)(ii) – (iv). These provisions all need to specify who will give notice to the beneficiary and how much time is required. We suggest 11 days’ notice, under the general standard in section 68.02.

### **77.00 Administration of APTC and CSR**

VHC should implement the option of granting retroactive PTC and CSR in certain circumstances. See 45 C.F.R. § 155.545(c); *CMS Bulletin to Marketplaces on Availability of Retroactive Advance Payments of the PTC and CSRs in 2014 Due to Exceptional Circumstances*, February 27, 2014, available online at <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/retroactive-advance-payments-ptc-csrs-02-27-14.pdf>.

This federal guidance allows retroactive QHP coverage and retroactive subsidies for individuals who did not receive timely eligibility decisions during 2014 open

enrollment, due to technical problems experienced by an exchange. As we commented above, this guidance should be implemented immediately.

Even though this guidance pertains only to the 2014 open enrollment period, it should be noted in the rules at 77.00. The Vermont rules should say that AHS may provide retroactive coverage when authorized by federal law, and note this example.

## **Part Eight**

### **80.02(b) Requesting a fair hearing**

We disagree with the proposal to provide expedited appeals only in MAGI and QHP cases. We understand that this is all the federal rules currently require, but we believe Vermont should voluntarily extend the process to other Medicaid applicants. It seems counterproductive and unfair to have an expedited process that the elderly and disabled cannot use. As you know, in Vermont the exchange and the state Medicaid agency are both contained within AHS. There is generally no distinction in the Vermont rules between “exchange” cases and “non-exchange” cases. Differentiating between these cases here will likely confuse beneficiaries, authorized representatives, and providers. We strongly favor a unified application process for all applicants, including appeals. We believe this would further Vermont’s goal of maximizing health coverage.

Furthermore, section 58.01(a) appears to require AHS to perform a MAGI screen on all applications for health benefits, so AHS should be evaluating and making an MCA eligibility determination for all MABD applicants. Thus, applicants denied MABD would also have been denied MCA, blurring any clear distinction between applicants for purposes of considering an expedited appeal.

We understand that AHS has concerns regarding a lack of resources to handle additional appeals, especially in relation to the complexity of LTC decisions. We gather that AHS prefers to wait and see how the process works, and whether CMS will finalize a rule on Medicaid expedited appeals. We do not agree with that approach. All individuals should have the same rights to appeals for all Medicaid programs.

### **80.05(a) AHS Secretary review of fair hearing decisions**

Section 80.05(a)(1)(i)(A) should be stricken. The federal regulations at 42 CFR § 431.10(c)(3)(iii) limit the grounds for reversal of Medicaid fair hearing decisions to application of law or rule. The secretary should not be reversing based on a

difference of opinion about the facts before the HSB. Our prior comment is reproduced below.

The federal “single state agency” rule was significantly revised in July 2013 to allow delegation of certain appeals to the exchange. The Medicaid agency is permitted to review fair hearing decisions of the exchange, but the review is limited. The permissible scope of review is narrower than that set out in §80.05. 42 CFR §431.10(c)(3)(iii) states:

If authority to conduct fair hearings is delegated to the Exchange or Exchange appeals entity under paragraph (c)(1)(ii) of this section, the agency may establish a review process whereby the agency may review fair hearing decisions made under that delegation, but that review will be limited to the proper application of federal and state Medicaid law and regulations, including sub-regulatory guidance and written interpretive policies, and must be conducted by an impartial official not directly involved in the initial determination.

Therefore, the Secretary’s review must be limited to the proper application of Medicaid law. The rule should be changed to reflect this narrower scope.

### **80.06(b)(1) Implementation of appeal decisions**

This paragraph should be revised to include appeals of initial eligibility applications as well as redeterminations. When an initial Medicaid application is approved, corrective payments are made back to the date of application and sometimes earlier, not just back to the date of the incorrect adverse action. This rule should reflect that possibility.

### **80.07(a) Expedited appeals; in general**

We agree with the general framework, particularly placing the burden on AHS to gather the information necessary to decide the expedited appeal request.

There should be a way for applicants to contact the decision-maker at the first stage of their expedited appeal. Applicants will need to provide a medical provider’s contact information when they request the expedited appeal, or they will need to have their doctor fax information in.

### **80.07(c)(1) Denial of expedited appeal requests; Notice of denial of request**

The oral notice of eligibility for an expedited appeal should include all the same information as the written notice. This should include who DVHA spoke with, what evidence they relied on, and the HCA's phone number.

### **80.07(c)(2) Denial of expedited appeal requests; Content of written notice**

We have two comments on this section. First, the notice should include what evidence AHS gathered (e.g. who DVHA spoke with), and what evidence they relied on. The current language (“the reason for the denial”) is not specific enough. Applicants deciding whether to continue their appeal will want to know if DVHA spoke to a certain doctor, etc.

Second, sometimes DVHA will not be able to get enough information within two days. A doctor might be on vacation, for example. If a request for an expedited appeal is denied, the applicant should have some period of time (perhaps a week) to submit additional information and talk to the DVHA employee who made the decision. Meanwhile, the appeal should be sent to the HSB to be docketed as a regular appeal.

### **80.07(d)(3) Resolution of expedited appeals; Hearing**

We request that AHS incorporate the procedural rights set out in 45 C.F.R. § 155.535(d). Inter alia, this section gives the applicant the right to review his or her appeal record and the right to question or refute any testimony or evidence. These are important rights.

Also, we believe the rule should specify that the decision will be based on the evidence reviewed or noted at the hearing. This can include evidence gathered by AHS, if the applicant has a chance to review it and respond to it. The decision-maker could make a decision based on the available evidence if the applicant does not attend the hearing. But, the decision-maker should not be able to hold a hearing, subsequently gather additional information, and then make a decision without giving the applicant a chance to respond to the additional information.

We understand that AHS does not envision a truly contested hearing, in that the agency will not have a representative at the hearings, or be represented by counsel. Nevertheless, the applicant must have the ability to be fully involved in the process, and the process must be fair. The applicant should have the opportunity to respond to any evidence gathered by AHS, before a decision is made.

Additionally, we would strike the last sentence of this section, “hearing decisions have no precedential value.” We believe expedited appeal decisions should be treated like HSB decisions. They are confidential in that they are redacted, but they are available to the public and they are used as persuasive (if not controlling) authority in subsequent cases. Vermont has chosen to implement expedited appeals in an internal process, but this is not required by the federal rules, and indeed the federal rules (at 45 CFR Part 155, subpart F) do not distinguish between the appeals entity for fair hearings, and the appeals entity for expedited appeals. There is no legal basis for treating the decisions differently.

#### **80.07(d)(4) Resolution of expedited appeals; Notice of decision**

Rule 80.07(d)(4) says, “Written notice of the hearing decision is confidential and is not a public document.” What is the intent of this provision? As explained above, it seems to us that expedited hearing decisions should be treated like HSB decisions, i.e. available to the public in redacted form. We would strike, “and is not a public document.”

Thank you for considering our comments. Please feel free to contact us with any questions.

Sincerely,

Michael Benvenuto, Senior Citizens Law Project  
Trinka Kerr, Office of the Health Care Advocate  
Jackie Majoros, State Long Term Care Ombudsman  
Christine Speidel, Poverty Law Project