STATE OF VERMONT
AGENCY OF HUMAN SERVICES

DCF

Department for Children and Families

BULLETIN NO.: 12-08E

FROM: Richard Giddings, Deputy Commissioner
Economic Services Division

DATE: June 21, 2012

SUBJECT: State Fiscal Year 2013 Expedited Cost Sharing Changes

CHANGES ADOPTED EFFECTIVE 8/1/2012

INSTRUCTIONS

__X__ **Maintain Manual - See instructions below.**
____ **Proposed Regulation - Retain bulletin and attachments until you receive Manual Maintenance _____**
____ **Information or Instructions - Retain until_____**

MANUAL REFERENCE(S):

4161 C.2 5330 B

These expedited rule changes are being implemented as directed by Act 162 (H.781, the Big Bill) of the 2011-2012 Legislative Session, An Act Making Appropriations for the Support of Government.

LEGISLATION

Sec. E.307 33 V.S.A. § 2073 is amended to read:

§ 2073. VPHARM ASSISTANCE PROGRAM

(d)(1) An individual shall contribute a co-payment of $1.00 for prescriptions where the cost-sharing amount required by Medicare Part D is less than $30.00, and a co-payment of $2.00 for prescriptions where the cost-sharing amount required by Medicare Part D is $30.00 or more. A pharmacy may not refuse to dispense a prescription to an individual who does not provide the co-payment.

Sec. E.307.1 33 V.S.A. § 2074(c) is amended to read:

(c) Benefits under VermontRx shall be subject to payment of a premium and co-payment amounts by the recipient in accordance with the provisions of this section.

(4) A recipient shall contribute a co-payment of $1.00 for prescriptions costing less than $30.00, and a co-payment of $2.00 for prescriptions costing $30.00 or more. A pharmacy may not refuse to dispense a prescription to an individual who does not provide the co-payment.

Sec. E.307.2 VHAP AND MEDICAID CO-PAYS

(a) The following co-payments for individuals enrolled in the VHAP and Medicaid programs are hereby authorized and set by the general assembly, pursuant to 33 V.S.A. § 1901(b), and may be promulgated in rules by the secretary of human services or designee, in accordance with 33 V.S.A. § 1901(a)(1), and are effective upon adoption of rules pursuant to Sec. E.307.10 of this act:

(1) co-payments that apply to prescriptions and durable medical equipment/supplies: enrolled individuals shall contribute a co-payment of not more than $1.00 for prescriptions or durable medical equipment/supplies costing less than $30.00, a co-payment of $2.00 for prescriptions or durable medical equipment/supplies costing $30.00 or more but less than $50.00, and a co-payment of $3.00 for prescriptions or durable medical equipment/supplies costing $50.00 or more;

(2) co-payments that apply to hospital outpatient services: not more than $3.00 per hospital visit;

(3) co-payments that apply to hospital emergency room services: for individuals enrolled in VHAP, $25.00 per hospital visit;

(4) co-payments that apply to hospital inpatient stays: for individuals enrolled in Medicaid, the $75.00 co-payment for inpatient hospital stays is eliminated.

The intent of these changes is to ensure that individuals continue to have affordable access to coverage and bring copayment obligations into alignment across eligibility groups.

SUMMARY OF RULE CHANGES

The specific rule changes are as follows:

- elimination of the Medicaid $75.00 inpatient admission co-pay;

- implementation of a $3.00 co-pay for the VHAP population for outpatient hospital services (thus aligning with copayment requirements for individuals enrolled in traditional Medicaid eligibility groups);

- implementation of a $3.00 co-pay for the VHAP waiver expansion population for prescriptions costing $50.00 or more (thus aligning copayment requirements with copayment individuals enrolled in traditional Medicaid eligibility groups); and

- implementation of nominal co-pay requirements for Durable Medical Equipment (DME) and medical supplies for both traditional Medicaid and VHAP.

LEGISLATIVE AUTHORITY FOR EXPEDITED RULES

Sec. E.307.10 EXPEDITED RULES

(a) Notwithstanding any contrary provision in 3 V.S.A. chapter 25, and in order to implement Sec. E.307.2(a) (VHAP and Medicaid co-pays) of this act, the agency of human services may adopt expedited rules in accordance with this section. Expedited rules under this section shall have the full force and effect of rules adopted under 3 V.S.A. chapter 25.

(b) Notwithstanding 3 V.S.A. chapter 25 and Sec. F4 of No. 146 of the Acts of the 2009 Adj. Sess. (2010), the agency shall:

(1) Adopt the expedited rule without prefiling or filing in proposed or final proposed form, and adopt the expedited rule after whatever notice and hearing that the agency finds to be practicable under the circumstances. The agency shall make reasonable efforts to ensure that expedited rules are known to persons who may be affected by them. These efforts may occur prior to passage of this act and also shall occur on adoption of the rules by the agency.

(2) File expedited rules adopted under this section with the secretary of state and with the legislative committee on administrative rules. The legislative committee on administrative rules shall distribute copies of expedited rules to the appropriate standing committees.

(3) Ensure that expedited rules adopted under this section shall include as much of the information required for the filing of a proposed rule as is practicable under the circumstances.

(c) On a majority vote of the entire committee, the committee may object under this subsection if an expedited rule is:

(1) beyond the authority of the agency;
(2) contrary to the intent of the legislature; or
(3) arbitrary.

(d) When objection is made under subsection (c) of this section, on majority vote of the entire committee, the committee may file the objection in certified form with the secretary of state. The objection shall contain a concise statement of the committee's reasons for its action. The secretary shall affix to each objection a certification of its filing and as soon as practicable transmit a copy to the agency. After a committee objection is filed with the secretary under this subsection, to the extent that the objection covers a rule or portion of a rule, the burden of proof thereafter shall be on the agency in any action for judicial review or for enforcement of the rule to establish that the part objected to is within the authority delegated to the agency, is consistent with the intent of the legislature, and is not arbitrary. If the agency fails to meet its burden of proof, the court shall declare the whole or portion of the rule objected to invalid. The failure of the committee to object to a rule is not an implied legislative authorization of its substantive or procedural lawfulness.

Specific Changes to Rule Sections:

Section	Description of Change
4161 C.2.	Eliminate reference to SSI Medicaid beneficiaries; eliminate reference to "ANFC related"; eliminate reference to $75.00 for first day of inpatient hospital stay; add copayments for durable medical equipment/supplies in the same amounts as prescription co pays; minor adjustments to co pays for prescriptions
5330 B.	Add $3.00 co pay for hospital out patient services; add copayment for durable medical equipment/supplies in the same amounts as prescription co pays; add 3.00 co pay for prescriptions and durable medical equipment/supplies costing $50.00 or more; minor adjustments to prescription co pays.

Responses to Public Comments

A public hearing was held on June 4, 2012, from 10:00 a.m. to 12:00 noon at the Department of Vermont Health Access (DVHA) Conference Room, 289 Hurricane Lane, Williston, Vermont. There were no attendees at the public hearing.

Written comments were to be submitted no later than 12:00, noon, on Monday, June 4, to Greg Needle, DVHA, 312 Hurricane Lane, Suite 201, Williston, Vermont, 05495, or via email to: greg.needle@state.vt.us, or by Fax: (802) 879-8224. No written comments were received.

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To get more information about the Administrative Procedures Act and the Rules applicable to state rule making go to the website of the Department of the Vermont Secretary of State at: http://vermont-archives.org/aparules/index.htm or call Louise Corliss at 828-2863. [General information, not specific rule content information]

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For information on upcoming hearing before the Legislative Committee on Administrative rules go to the website of the Vermont Legislature at: http://www.leg.state.vt.us/schedules/schedule2.cfm or call 828-5760.

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Vertical lines in the left margin indicate significant changes. Dotted lines at the left indicate changes to clarify, rearrange, correct references, etc., without changing content.

Manual Maintenance

Medicaid Rules

Remove		**Insert**	
4161 C	(11-30)	4161 C	(12-08E)
5330 B	(09-17)	5330 B	(12-08E)

Cost Sharing

C. Copayments

Copayments from some beneficiaries are required for certain services. Copayments will be deducted from the Medicaid payment for each service subject to copayment. Section 1916(c) of the Social Security Act requires that "no provider participating under the State (Medicaid) plan may deny care of services to an individual eligible for (Medicaid) . . . on account of such individual's inability to pay (the copayment)." This subsection further provides, however, that these requirements "shall not extinguish the liability of the individual to whom the care or services were furnished for the payment of (the copayment)."

1. Copayments are never required from beneficiaries who are:

   a. long-term care beneficiaries; or
   b. Medicaid beneficiaries under age 21; or
   c. pregnant or in the 60-day post-pregnancy period.

2. Copayments are required for these services:

   a. $3.00 per day per hospital for hospital outpatient services unless the individual is also covered by Medicare. An individual covered by Medicare has no copayment requirement for outpatient services.

   b. Prescriptions and durable medical equipment/supplies for recipients age 21 and older as follows:

      i. $1.00 for each prescription, original or refill, or durable medical equipment/supplies having a usual and customary charge of less than $30.00.

      ii. $2.00 for each prescription, original or refill, or durable medical equipment/supplies having a usual and customary charge of $30.00 but less than $50.00.

      iii. $3.00 for each prescription, original or refill, or durable medical equipment/supplies having a usual and customary charge of $50.00 or more.

   c. $3.00 per date of service per provider for dental services for recipients age 21 and older.

5330 Cost-Sharing Requirements
Premium

Beneficiaries meet this requirement when they have paid any required premium as specified in rules 4160 - 4162. The amount of the premium for each beneficiary increases according to VHAP income maximums (P-2420) based on the federal poverty level (FPL) as shown in the following chart:

Income Maximums	Monthly Premium per Beneficiary
0 - 50% FPL	$ 0
> 50% but ≤ 75% FPL	$7.00
> 75% but ≤ 100% FPL	$25.00
> 100% but ≤ 150% FPL	$33.00
> 150% but ≤ 185% FPL	$49.00

B. Co-Payment

There is a co-payment requirement of $25.00 per hospital emergency room visit, as defined in rule 7101.3.

There is a $3.00 copayment per day per hospital for hospital outpatient services.

Beneficiaries in households with income at or greater than 100% of the federal poverty guideline (see Medicaid Procedures P-2420 B) shall contribute a co-payment of $1.00 for prescriptions costing less than $30.00, a copayment of $2.00 for prescriptions costing 30.00, or more but less than $50.00, and a copayment of $3.00 for prescriptions costing $50.00 or more.

In addition, all beneficiaries shall contribute a co-payment of $1.00 for durable medical equipment/supplies costing less than $30.00, a copayment of $2.00 for durable medical equipment/supplies costing 30.00, or more but less than $50.00, and a copayment of $3.00 for durable medical equipment /supplies costing $50.00 or more.

A pharmacy may not refuse to dispense a prescription to a beneficiary who does not provide the co-payment.