STATE OF VERMONT
AGENCY OF HUMAN SERVICES

DCF

Department for Children and Families

BULLETIN NO.: 14-02E

FROM: Richard Giddings, Deputy Commissioner
Economic Services Division

DATE: March 31, 2014

SUBJECT: Health Benefits Eligibility and Enrollment Amendment #3

CHANGES ADOPTED EFFECTIVE March 31, 2014

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):

4100	5300	5900
4200	5500	HBEE
4300	5600	
4400	5700	

Bulletin 14-02E and the related emergency rule, Health Benefits Eligibility and Enrollment (HBEE) Amendment #3, are effective March 31, 2014. HBEE Amendment #3 supersedes, in its entirety, HBEE Amendment #2 (B-13-46E) that was effective January 1, 2014.

HBEE Amendment #2 superseded HBEE Amendment #1 (B-13-36E) that was effective October 1, 2013. HBEE Amendment #1 modified the original HBEE rule (B-13-12F).

HBEE Amendment #3 implements the provisions of the federal Patient Protection and Affordable Care Act, 42 U.S.C. Sec. 18001, and Vermont Act Nos. 48 of 2011, 171 of 2012 and 79 of 2013. It incorporates federal guidance issued too late in 2013 for incorporation into HBEE Amendment #2, and makes changes, technical corrections and clarifications to language in that rule.

Which Health Care Rules are in Effect

The chart below, **Specific Changes to Rule Sections,** summarizes the status of health care rules 4100-4400 and 5300-5900 including which remain in effect and which are repealed.

Description of Changes

Below is a description, by part and section number, of the changes that HBEE Amendment #3 makes to HBEE Amendment #2. HBEE Amendment #3 can also be viewed in its entirety at http://dcf.vermont.gov/esd/rules.

Emergency Rulemaking Process

The Department filed HBEE Amendment #3 with the Office of the Secretary of State and the Legislative Committee on Administrative Rules to be effective March 31, 2014. HBEE Amendment #3 is referred to as Rule 14-E03 by the Secretary of State.

The Department will post the emergency rule on the DCF website at http://dcf.vermont.gov/esd/rules and notify advocates and members of the public about the rule on March 31, 2014.

To get more information about the Administrative Procedures Act and the rules applicable to state rulemaking, go to the website of the Office of the Secretary of State at http://vermont-archives.org/aparules/ or call Louise Corliss at 802-828-2863

For information on upcoming hearings before the Legislative Committee on Administrative Rules go to the website of the Vermont Legislature at http://www.leg.state.vt.us/Committee01.cfm or call 802-828-5760.

Manual Maintenance

Health Care Rules

Remove	**Insert**
HBEE Amendment #2 (B-13-46E)	HBEE Amendment #3 (B-14-02E)

Specific Changes to Rule Sections

Section	Description of Change
4100	Repealed on 12/31/13 and replaced with the HBEE rule on 1/1/14.
4200	Repealed on 12/31/13 and replaced with the HBEE rule on 1/1/14.
4300	Repeal on 12/31/14. For new enrollees, repeal became effective and was replaced with the HBEE rule on 1/1/14. The HBEE rule will become effective for individuals enrolled on or before 12/31/13 as they reach their annual review date throughout 2014.
4400	Repealed on 12/31/13 and replaced with the HBEE rule on 1/1/14.
5300	Repeal on 3/31/14 for individuals enrolled on or before 12/31/13 and choosing to remain enrolled (for new applicants after 12/31/13, repeal became effective 1/1/14), except: Retain 5321-5323 for VPharm (5400) and HVP (5700) eligibility
5400	Remains in place until a point prior to 12/31/15 when information technology support is available; beneficiaries will then convert to the HBEE rule.
5500	Repealed on 12/31/13.
5600	Repealed on 12/31/13.
5700	Remains in place until a point prior to 12/31/15 when information technology support is available; beneficiaries will then convert to the HBEE rule
5900	Repeal on 3/31/14 for individuals enrolled on or before 12/31/13 and choosing to remain enrolled (for new applicants after 12/31/13, repeal became effective 1/1/14).

DESCRIPTION OF CHANGES

PART ONE

Section 3.00 - Revisions to existing provisions

Replace "MABD" with "Medicaid" in the following definitions:

Community spouse

Hospice services

Institutionalized individual

PART TWO

Section 7.00

a. 7.03(a)(2)(i) - revision to existing provision

Repeat definition of pregnant woman from Section 3.00

b. 7.03(a)(2)(ii) – new provision

Insert new provision to explain retroactive eligibility for this coverage group

c. 7.03(a)(2)(iii) – revision to existing provision

Renumber former (ii) as (iii)

Section 12.00

12.02(b) – revision to existing footnote

Insert "be" between "to" and "considered"

PART FOUR

Section 24.00 – Revisions to existing provisions

Replace "MABD" with "Medicaid" throughout section

Section 25.00 – Revisions to existing provisions

Replace "MABD" with "Medicaid" throughout section

PART FIVE

Section 30.00 - Revisions to existing provisions

Replace "MABD" with "Medicaid" in the following subsections:

30.00(a)(1)

30.01(b)(2)

30.01(c)(2)

30.01(d)

30.01(g)

30.02(c)(2)

30.02(c)(3)

30.04(a)(1)

30.05(c)(1)

30.05(c)(2)

PART SIX

Before Section 31.00 Definitions

Add statement at the beginning of Part Six that explains that the rules under Part Six do not apply to coverage in qualified health plans for which small employers and their employees enroll directly through issuers during the limited transition period when such enrollment is permissible

Section 32.00(f)

In paragraph (1), clarify that VHC will in the first instance contact the employer and attempt to resolve the inconsistency and that VHC will not issue written notice unless it has made the reasonable effort

Section 33.00(g)

Correct typographical error removing "the" before VHC

Section 42.00(b)

Change language to reflect that late initial enrollment results in retroactively effectuated coverage not a delay, and distinguish between effect on enrollees and effect on providers

Section 44.00

a. 44.00(a)

Rephrase awkwardly worded modifier

b. 44.00((b)

Clarify language

Section 50.00(d)

Clarify that late payment and intent to terminate notice may not necessarily be issued on the 22nd of the month when payment is not received by the 21st; remove requirement to notify employees of late payment and intent to terminate notice

PART SEVEN

Section 52.00

Section 52.02(a)(6) – revision to existing provision

Revise subsection to clarify that a single, streamlined application will be used for MAGI-based Medicaid by inserting the word "MAGI-based" in front of "Medicaid" and by creating a separate sentence to explain the use of a supplemental form (or alternative application) for non-MAGI based Medicaid categories

Section 54.00

54.05(c) - revision to existing provision

To be consistent with other provisions, insert the word "paragraphs" between "in" and "(a)(1)(i)" and replace "§ 54.05" with "subsection"

Section 56.00

56.09(a)(1)(i) – revision to existing provision

Correct cross-reference by replacing "(a)(3)" with "(a)(1)(iii)"

Section 57.00

57.00(a) – revision to footnote

Narrow cross-reference to federal regulation by replacing "155.300" with "155.300(d)"

Section 62.00

62.00 – revision to existing provision

Replace "MABD" with "Medicaid"

Section 64.00

a. 64.01(d)(2)(ii) – revision to existing provision

   Re-word subsection to clarify that an adjustment to the premium amount will be made even if the premium bill has already been paid (adjustments are not just made when the premium payment is outstanding)

b. 64.01(e)(3) – revision to existing provision

   Replace "of" with "or" at end of second line

c. 64.01(j) – revision to existing provision

   Remove cross-reference to § 64.12 (§ 64.12 was deleted)

d. 64.01(l) – revision to existing provision

   Revise second sentence to make it clear that AHS will bill the individual for the premium that is applicable to the retroactive island by inserting the words "premium applicable to the" in front of "Dr. Dynasaur;" revise last sentence to make it clear that it is the premium payment that is subject to allocation by inserting the word "Premium" at the beginning of the sentence.

e. 64.04(a) – revision to existing provision

   Insert appropriate punctuation to end of text

f. 64.06 – revision to existing provision

   Revise subsection to include a one month grace period for an individual enrolled in a QHP without APTC (revision included a change to the subsection's title, renumbering of paragraphs, and deletion of former paragraph (b))

g. 64.07(a) – revision to existing provision

Correct cross-reference to § 64.06 in light of changes made to that subsection (see above)

h. 64.08(a) – revision to existing provision

Remove the words ", and has been," at the end of the first line of text to clarify that the requirement that a past-due premium be paid applies to the premium payer not the individual

i. 64.13 – revision to existing provision

Revise subsection to state that, pending the outcome of an appeal, an individual must pay the premium amount that was in effect prior to the decision that resulted in the appeal (revision included adding a new paragraph to state the state's recovery rights if an individual withdraws their appeal or the appeal decision is in the state's favor)

Section 65.00

65.02(a) – revision to existing provision

Replace "MABD" with "Medicaid"

Section 66.00

66.05 – revision to existing provision

Correct cross-reference by replacing "§§ 68.00 and 80.00" with "Part Eight of this rule"

Section 70.00

a. 70.01(b) – revision to footnote

Add cross-reference to CFR

b. 70.01(b)(2) – deletion

Delete second sentence (wording is awkward and concept is already covered in

§ 30.02(b)(2))

c. 70.01(c) – deletion

Delete subsection in its entirety to eliminate requirement that there be medical verification of a woman's pregnancy if she applies for retroactive eligibility under that coverage group (verification process of retroactive eligibility will align with verification process under § 55.01(d))

d. 70.02(c) – revision to existing provision

Revise provision to address the allocation of initial premium payments in the event that prior to the deadline for payment of the initial premium amount another month's premium becomes due

Section 75.00

a. 75.01(d) – revision to existing provision

To align with the rest of the text, replace "programs" with "program" (2 places)

b. 75.02(e)(2) – revision to existing provision

Insert "of this" (2 places)

PART EIGHT

Section 80.00

a. 80.02((b) – revision to existing provision

Add language at the beginning of the second paragraph to explain that requests for expedited appeals apply to appeals involving QHPs and MAGI-based Medicaid; to improve clarity, replace "if they request" with "by indicating"

b. 80.05(c)(2) - revision to existing provision

Between "HHS" and "entity," replace "appeal" with "appeals"

c. 80.06(b) – revision to existing provision

Add new paragraphs (i) and (ii) at (b)(2) to explain implementation of Medicaid decision if favorable to state (revision included renumbering of paragraphs)

d. 80.07 – revision to existing provision

Insert footnote at end of title cross referencing applicable federal regulation

e. 80.07(a) – new provision

Add language at beginning of provision to explain that requests for expedited appeals apply to appeals involving QHPs and MAGI-based Medicaid

f. 80.07(a) – revision to existing provision

Re-format provision by numbering paragraphs

g. 80.07(a)(1) – revision to existing provision

To align with language used in federal regulation, remove "emergent" on first line and insert "the individual has an immediate need for health services" on fourth line

h. 80.07(a)(2) – revision to existing provision

Insert "an individual's" between "reviewing" and "expedited" on first line and remove "expedited" at end of first sentence and second sentence

i. 80.07(a)(3) – revision to existing provision

Add language to clarify that this provision applies to the expedited appeal request and to the appeal, and that "necessary information" includes the opinion of the treating provider

j. 80.07(a)(4) – new provision

Move language formerly under paragraph (b) to this new provision so it is clear that it applies to both the requests for expedited appeals and to the appeals.

k. 80.07(b) – deletion

Delete last sentence (moved to 80.07(a)(4))

l. 80.07(c) – revision to existing provision

Re-format paragraph into numbered subparagraphs

m. 80.07(c)(1) – revision to existing provision

To clarify timeframe, insert "business" between "2" and "days;" to improve clarity, move sentence formerly at end of paragraph to this new subparagraph

n. 80.07(c)(2)(ii)(formerly 80.07(c)(2)) – revision to existing provision

Revise provision to clarify that the notice will advise the individual that the appeal will follow the standard timeframe

o. 80.07(d) – revision to existing provision

Re-format paragraph into numbered subparagraphs

p. 80.07(d)(1) – revision to existing provision

Add language to clarify the process and the content for the oral notification that approves an individual's expedited appeal request

q. 80.07(d)(2) – revision to existing provision

Replace "working" days with "business" days, and add language at the end of the first sentence to clarify timeframe for resolving the appeal

r. 80.07(d)(3) – new provision

Add new provision to explain the hearing

s. 80.07(d)(4) – revision to existing provision

To clarify timeframes, insert "business" between "2" and "days," add "of the hearing" after first reference to business days, and add "of the oral notification" after second reference to business days; insert sentence to explain that the written notice of the hearing decision is confidential and not a public document

Section 82.00

a. 82.00(a) – revision to existing provision

Revise subsection to state that, pending the outcome of a fair hearing, an individual must pay the premium amount that was in effect prior to the decision that resulted in the appeal

b. 82.00(d) – revision to existing provision

Delete last sentence since inconsistent with the rest of the provision