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State/Territory Name: Vermont

State Plan Amendment (SPA) #: 14-001

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

Division of Medicaid and Children's Health Operations/Boston Regional Office

May 13, 2014

Douglas A. Racine, Secretary
Agency of Human Services
208 Hurricane Lane, Suite 103
Williston, VT 05495

Re: VT Title XIX FMAP State Plan Amendment, Transmittal #14-001

Dear Secretary Racine:

We have reviewed the proposed Federal Medical Assistance Payment (FMAP) State Plan Amendment (SPA), TN 14-001, which was submitted to the Centers for Medicare & Medicaid Services Boston Regional Office on February 27, 2014. This SPA describes the methodology used by the state for determining the appropriate FMAP rates, including the increased FMAP rates, available under the provisions of the Affordable Care Act applicable for the medical assistance expenditures under the Medicaid program associated with enrollees in the new adult group adopted by the state and described in 42 CFR 435.119.

Based on the information provided, the Medicaid SPA 14-001 is approved with an effective date of January 1, 2014. Attached are copies of the pages to be incorporated into your State Plan.

If you have any questions, please contact Lynn Wolfsfeld by phone at (410) 999-4004 or by email at Lynn.Wolfsfeld@cms.hhs.gov .

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

Enclosure

cc: Mark Larson, Commissioner
Lindsay Parker, DVHA Health Program Administrator, Policy Unit

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 14 - 001

2. STATE: VERMONT

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE(S)
JANUARY 1, 2014

5. TYPE OF PLAN MATERIAL *(CHECK ONE)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR §430.12(c)(ii)

7. FEDERAL BUDGET IMPACT:
a. FFY 2014 $ ~~49,200,000~~ $0.00
b. FFY 2015 $ ~~65,600,000~~ $0.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
SUPPLEMENT 18 TO ATT. 2.6-A

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

10. SUBJECT OF AMENDMENT: FMAP

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
SIGNATURE OF SECRETARY OF ADMINISTRATION
[redacted]

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
DOUGLAS A. RACINE

14. TITLE:
SECRETARY, AGENCY FOR HUMAN SERVICES

15. DATE SUBMITTED: 2/27/14

16. RETURN TO:

ASHLEY BERLINER

DEPARTMENT OF VERMONT HEALTH ACCESS
312 HURRICANE LANE, SUITE 201
WILLISTON, VT 05495

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 2/27/14

18. DATE APPROVED: 5/13/2014

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 1/1/14

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Richard R. McGreal

22. TITLE Associate Regional Administrator, Division of Medicaid and Children's Health Operations, Boston Regional Office

23. REMARKS VT approved the pen and ink change (4/29 email), as requested by CO, to change the federal budget impact estimates in Box 7 to $0.00 for each year. The budget impact estimates of $49.2M in FFY14 and $65.6M in FFY15 will be communicated to the MAGI eligibility component for tracking purposes.

State Plan Under Title XIX of the Social Security Act

State: Vermont

METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

The State will determine the appropriate FMAP rate for expenditures for individuals enrolled in the adult group described in 42 CFR 435.119 and receiving benefits in accordance with 42 CFR Part 440 Subpart C. The adult group FMAP methodology consists of two parts: an individual-based determination related to enrolled individuals, and as applicable, appropriate population-based adjustments.

Part 1 – Adult Group Individual Income-Based Determinations

For individuals eligible in the adult group, the state will make an individual income-based determination for purposes of the adult group FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan (Part 2) approved by CMS on 01/28/2014. In general, and subject to any adjustments described in this SPA, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available. The relevant MAGI-converted standards for each population group in the new adult group are described in Table 1.

Table 1: Adult Group Eligibility Standards and FMAP Methodology Features

Covered Populations Within New Adult Group		Applicable Population Adjustment			
Population Group	**Relevant Population Group Income Standard** For each population group, indicate the lower of: • The reference in the MAGI Conversion Plan (Part 2) to the relevant income standard and the appropriate cross-reference, or • 133% FPL. If a population group was not covered as of 12/1/09, enter "Not covered".	**Resource Proxy**	**Enrollment Cap**	**Special Circumstances**	**Other Adjustments**
		Enter "Y" (Yes), "N" (No), or "NA" in the appropriate column to indicate if the population adjustment will apply to each population group. Provide additional information in corresponding attachments.			
A	B	C	D	E	F
Parents/Caretaker Relatives	Attachment A, Column C, Line 1 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.	No	No	No	No
Disabled Persons, non-institutionalized	Attachment A, Column C, Line 2 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.	No	No	No	No
Disabled Persons, institutionalized	Attachment A, Column C, Line 3 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.	No	No	No	No
Children Age 19 or 20	Attachment A, Column C, Line 4 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.	No	No	No	No
Childless Adults	Attachment A, Column C, Line 5 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.	No	No	No	No

Part 2 – Population-based Adjustments to the Newly Eligible Population Based on Resource Test, Enrollment Cap or Special Circumstances

A. Optional Resource Criteria Proxy Adjustment (42 CFR 433.206(d))

1. The state:

   ☐ Applies a resource proxy adjustment to a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

   ■ Does NOT apply a resource proxy adjustment (Skip items 2 through 3 and go to Section B).

   Table 1 indicates the group or groups for which the state applies a resource proxy adjustment to the expenditures applicable for individuals eligible and enrolled under 42 CFR 435.119. A resource proxy adjustment is only permitted for a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

   The effective date(s) for application of the resource proxy adjustment is specified and described in Attachment B.

2. Data source used for resource proxy adjustments:

   The state:

   ☐ Applies existing state data from periods before January 1, 2014.

   ☐ Applies data obtained through a post-eligibility statistically valid sample of individuals.

   Data used in resource proxy adjustments is described in Attachment B.

3. Resource Proxy Methodology: Attachment B describes the sampling approach or other methodology used for calculating the adjustment.

B. Enrollment Cap Adjustment (42 CFR 433.206(e))

1. ☐ An enrollment cap adjustment is applied by the state (complete items 2 through 4).

   ■ An enrollment cap adjustment is not applied by the state (skip items 2 through 4 and go to Section C).

2. Attachment C describes any enrollment caps authorized in section 1115 demonstrations as of December 1, 2009 that are applicable to populations that the state covers in the eligibility group described at 42 CFR 435.119 and received full benefits, benchmark benefits, or benchmark equivalent benefits as determined by CMS. The enrollment cap or caps are as specified in the applicable section 1115 demonstration special terms and conditions as confirmed by CMS, or in alternative authorized cap or caps as confirmed by CMS. Attach CMS correspondence confirming the applicable enrollment cap(s).

3. The state applies a combined enrollment cap adjustment for purposes of claiming FMAP in the adult group:

   ☐ Yes. The combined enrollment cap adjustment is described in Attachment C

   ☐ No.

4. Enrollment Cap Methodology: Attachment C describes the methodology for calculating the enrollment cap adjustment, including the use of combined enrollment caps, if applicable.

C. Special Circumstances (42 CFR 433.206(g)) and Other Adjustments to the Adult Group FMAP Methodology

1. The state:

   ☐ Applies a special circumstances adjustment(s).

   ■ Does not apply a special circumstances adjustment.

2. The state:

   ☐ Applies additional adjustment(s) to the adult group FMAP methodology (complete item 3).

   ■ Does not apply any additional adjustment(s) to the adult group FMAP methodology (skip item 3 and go to Part 3).

3. Attachment D describes the special circumstances and other proxy adjustment(s) that are applied, including the population groups to which the adjustments apply and the methodology for calculating the adjustments.

Part 3 – One-Time Transitions of Previously Covered Populations into the New Adult Group

A. Transitioning Previous Section 1115 and State Plan Populations to the New Adult Group

☒ Individuals previously eligible for Medicaid coverage through a section 1115 demonstration program or a mandatory or optional state plan eligibility category will be transitioned to the new adult group described in 42 CFR 435.119 in accordance with a CMS-approved transition plan and/or a section 1902(e)(14)(A) waiver. For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to new adult group, the adult group FMAP methodology is applied pursuant to and as described in Attachment E, and where applicable, is subject to any special circumstances or other adjustments described in Attachment D.

☐ The state does not have any relevant populations requiring such transitions.

Part 4 - Applicability of Special FMAP Rates

A. Expansion State Designation

The state:

☐ Does NOT meet the definition of expansion state in 42 CFR 433.204(b). (Skip section B and go to Part 5)

☒ Meets the definition of expansion state as defined in 42 CFR 433.204(b), determined in accordance with the CMS letter confirming expansion state status, dated 06/18/2013.

B. Qualification for Temporary 2.2 Percentage Point Increase in FMAP.

The state:

☐ Does NOT qualify for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).

☒ Qualifies for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7), determined in accordance with the CMS letter confirming eligibility for the temporary FMAP increase, dated 06/18/2013. The state will not claim any federal funding for individuals determined eligible under 42 CFR 435.119 at the FMAP rate described in 42 CFR 433.10(c)(6).

Part 5 - State Attestations

The State attests to the following:

A. The application of the adult group FMAP methodology will not affect the timing or approval of any individual's eligibility for Medicaid.

B. The application of the adult group FMAP methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

ATTACHMENTS

Not all of the attachments indicated below will apply to all states; some attachments may describe methodologies for multiple population groups within the new adult group. Indicate those of the following attachments which are included with this SPA:

- ■ Attachment A – Conversion Plan Standards Referenced in Table 1
- ☐ Attachment B – Resource Criteria Proxy Methodology
- ☐ Attachment C – Enrollment Cap Methodology
- ☐ Attachment D – Special Circumstances Adjustment and Other Adjustments to the Adult Group FMAP Methodology
- ■ Attachment E – Transition Methodologies

Attachment A. Most Recent Updated Summary Information for Part 2 of the Modified Adjusted Gross Income (MAGI) Conversion Plan*

Summary Information for Part 2 of Modified Adjusted Gross Income (MAGI) Conversion Plan

OFFICIAL

VERMONT

1/6/2014

	Population Group	Net standard as of 12/1/09	Converted standard for FMAP claiming	Same as converted eligibilty standard? (yes, no, or n/a)	Source of information in Column C (New SIPP conversion or Part 1 of approved state MAGI conversion plan)	Data source for Conversion (SIPP or state data)
	A	B	C	D	E	F
Conversions for FMAP Claiming Purposes						
1	**Parents/Caretaker Relatives** FPL %	185%	195%	yes	Part 1 of approved state MAGI conversion plan	SIPP
2	**Noninstitutionalized Disabled Persons** Dollar standards Single Couple	 * *	 $956 $956	no	new SIPP conversion	SIPP
3	**Institutionalized Disabled Persons** SSI FBR%	300%	300%	n/a	ABD conversion template	n/a
4	**Children Age 19-20** Dollar standards by family size 1 2 3 4 add-on	 * * * * n/a	 $997 $1,021 $1,229 $1,383 n/a	no	new SIPP conversion	SIPP
5	**Childless Adults** FPL % (VHAP)	150%	157%	yes	Part 1 of approved state MAGI conversion plan	SIPP

n/a: Not applicable.

* Converted standards are a weighted average of separate standards for inside and outside Chittenden County.

***The numbers in this summary chart will be updated automatically in the case of modification in the CMS approved MAGI Conversion Plan.**

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Attachment E: Transition Methodologies

Vermont is an expansion state with no newly eligibles, and as such will be claiming enhanced FMAP only for non-pregnant, childless adults in the new adult group.

Vermont's 1115 waiver demonstration groups cover non-pregnant, childless adults, some of whom have current incomes below 133% FPL. Specifically, those programs are the Vermont Health Access Plan (VHAP), the Employer-sponsored insurance premium assistance program (ESIA), and the Catamount Health premium assistance program (CHAP). The non-MAGI income limits for these groups in effect as of December 1, 2009, were as follows:

- VHAP: 150% FPL for childless adults and 185% for parents
- ESIA: 300% FPL
- CHAP: 300% FPL

As of January 1, 2014, adults in these programs with income at or below the 133% threshold for the adult group have been assigned a Medicaid category code; non-pregnant, childless adults, as a subgroup, will be identifiable by this code. Adults who have been assigned a Medicaid category code are being held temporarily in the legacy system, ACCESS, and will be transitioned to the new eligibility system, OneGate, at the time of their first annual review in 2014, at which point a full determination of their eligibility based on MAGI methodologies, including the use of the streamlined application form and verification through electronic data sources, will be completed. Vermont estimates that approximately 32,000 individuals enrolled in 1115 expansion groups were assigned Medicaid category codes as a result of this transition. A portion of these individuals are parents and therefore not eligible for enhanced FMAP claims.

A more detailed description of the transition plan for all groups under the state plan and the 1115 waiver is contained in our approved transition matrix (attached).

In addition to the transition matrix, Vermont has requested and received several waivers under 1902(e)(14)(A) authority to augment its transition plan. They are as follows:

- Annual redeterminations scheduled for January through March 2014 for Individuals eligible for Medicaid as of 12/31/13 and subject to MAGI methodologies in 2014 were rescheduled for the months of April through December 2014.
- Individuals enrolled in Medicaid as of 12/31/13 and subject to MAGI methodologies in 2014 will have income increases disregarded until their first annual redetermination in 2014.
- Adults under age 65 enrolled in an 1115 expansion group as of 12/31/13 and whose income is at or below 133% were transitioned to the new adult group without a formal redetermination of eligibility based on MAGI methodologies.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Children and Adults Health Programs Group

JAN 2 8 2014

Mark Larson
Commissioner
State of Vermont, Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495

OFFICIAL

Dear Mr. Larson:

Thank you for submitting Part 2 of your state's Modified Adjusted Gross Income (MAGI) Conversion Plan for FMAP claiming. This letter is to notify you that the Centers for Medicare & Medicaid Services (CMS) is formally approving Part 2 (conversions for FMAP claiming) of your conversion plan. **[Attached please find the Summary Information Table that accompanied your conversion results that will be incorporated by reference into your Conversion Plan.]**

A state covering the new adult group in its Medicaid program (under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act) must include and submit Part 2 of the MAGI Conversion Plan (as approved with this letter) as "Attachment A" to its submission of the FMAP claiming methodology state plan amendment ("FMAP SPA") which is associated with such new adult group. Furthermore, the converted income standards contained in Part 2 of the MAGI Conversion Plan must also be appropriately identified and referenced in Table 1 of Part 1 of the FMAP SPA.

The FMAP SPA template and associated instructions can be found on Medicaid.gov at:

FMAP SPA Template:
www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/FMAP-Claiming-SPA-Template.pdf

Instructions for FMAP SPA Template:
www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/FMAP-Claiming-SPA-Instructions.pdf

The FMAP SPA should be submitted to your regional office SPA intake mailbox.

If there are any questions or you wish to discuss the Conversion Plan, please contact Stephanie Kaminsky at Stephanie.Kaminsky@cms.hhs.gov or SHADAC at 612 486-2439 or fmaphelp@shadac.org

CMS staff are available to work with you regarding the development and/or submission of the FMAP SPA. If there are any questions or you wish to discuss the FMAP SPA, please contact your regional office.

Sincerely,

[redacted]

Eliot Fishman
Director

Enclosures

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Health-Care Programs Transition Plan			
Health-Care Group	**Transition Methodology**	**Notes**	**CMS Questions**
MAGI-related Medicaid: • Children • Parents & Caretaker Relatives • Pregnant Women • Adults < 65	Hold everyone harmless until March 31, 2014, or their review date, whichever is later. At review date, apply MAGI rules. All incorporated into MAGI by December 31, 2014 Updated 6/18/13: If income is less than 133% FPL, bump reviews for each of the last 3 months of 2013 by adding 6 months to each month of review. Example: October 2013 reviews would be bumped to April 2014. This takes this population beyond the "hold harmless period". If income less than 133% FPL, bump reviews for each of the first 3 months of 2014 by adding 6 months to each month of review. Example: January reviews are bumped to July 2014. By September 2014, we will have completed the review cycle.	**Applicable federal guidance:** "In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid coverage to begin on or before December 31, 2013, application of the financial methodologies set forth in this section will not be applied until March 31, 2014 or the next regularly-scheduled renewal of eligibility for such individual under § 435.916 of this part, whichever is later." 42 CFR § 435.603(a)(3). **Assumptions:** All in these groups will be eligible for MAGI-related Medicaid, as of January 1, 2014: ▪ Medicaid will go up to 133% ▪ Income calculation under MAGI would yield slightly higher FPL than same incomes calculated under current methodology. **Options:** If the proposed approach is not adopted, only alternative is to run parallel eligibility systems for 15 months. For obvious reasons, this would be highly undesirable. **Issues:** Need to figure out how to handle favorable change reports (*e.g.*, change that would cause premium reduction) received during hold-harmless period.	▪ Does CMS support proposed bumping of reviews? ▪ Does CMS support Vermont's interpretation of the rule prohibiting application of MAGI methodologies to ongoing eligibility for current enrollees and Vermont's proposed hold-harmless strategy for meeting this requirement? ▪ Does CMS agree with Vermont's proposal to delay implementation of the following new annual-review protocols until after first review? o Renewal on basis of available info. 435.916(a)(2). o Prepopulated renewal form 435.916(a)(3) (limited info would be available). ▪ Does CMS see any other issues with the proposed approach that must be addressed to permit implementation? DG3: Prepopulated review form: will not be used during the transition phases as described on the left because we are considering this population "new" to VHC. We will not have data integration until after 1/1/14 so bulk loading the population in the new system will not be possible. We will use the prepopulated review form at first review in VHC.

Health-Care Programs Transition Plan			
Health-Care Group	**Transition Methodology**	**Notes**	**CMS Questions**
Transitional Medicaid	If the program sunsets by end of 2013, apply provisions of 42 CFR §§ 435.112 and 435.115, as modified by NPRM.	None.	• Do the Extended Eligibility provisions in CMS's most recent eligibility NPRM mean that anyone enrolled in TM on 12/31/13 would be provided with an unconditional 4-month extension of coverage, followed by an eligibility renewal at the conclusion of the extended period of eligibility? • Will there be guidance as to how states should proceed in the event that TM does not sunset on 12/31/13? • Does CMS see any other issues with the proposed approach that must be addressed to permit implementation?
Traditional Medicaid: • SSI-Related Groups (inc. SSI-Related Medically Needy) • Medicare Savings Program • Long-Term Care • Breast and Cervical Cancer Treatment • Foster Children • Refugee Medical Assistance	No changes. These programs will remain in our legacy system to be moved over during 2014 as part of the Integrated Eligibility (IE) project.	None.	None.

Health-Care Programs Transition Plan			
Health-Care Group	**Transition Methodology**	**Notes**	**CMS Questions**
Medically-Needy AFDC Groups with Spenddowns	Beginning in August, 2013, limit spenddown periods to the number of months remaining in the year. For all individuals who meet spend-downs and are receiving benefits in December: • Review in December for January renewal, using MAGI rules. For all individuals who do not meet spenddown before December 31, 2013: • Transition according to the transition rules of whatever program they happen to be on at the end of December.	**Issues:** If 42 CFR § 435.603(a)(3) (MAGI start date for ongoing enrollees) applies to the medically needy who meet their spend-downs before the end of 2013, we might have to treat this group in the manner proposed above for MAGI-related Medicaid. This would mean holding them harmless and applying MAGI at next review. This is undesirable as it is: ▪ More expensive. ▪ Overinclusive: At least some in this group will be over income for Medicaid (*i.e.*, won't have yet met spenddown) during the 1st quarter of 2014. Some might never meet their spenddown before application of MAGI rules.	▪ Does CMS agree that 42 CFR § 435.603(a)(3) will not apply to this cohort, given the proposed implementation approach? ▪ Does CMS see any other issues with the proposed approach that must be addressed to permit implementation? ▪ Only ANFC-Related groups will be affected if we decide to reduce spenddown periods.We will also note that the decision on whether or not to ask for approval to end or not end this population is still under discussion. We are requesting your guidance. If we do not end them in December (meaning they are "eligible" at years' end, does that mean that they would or would not be included in the "hold harmless" condition that would be applied to all other Medicaid eligibles during January – March of 2014?

Health-Care Programs Transition Plan			
Health-Care Group	**Transition Methodology**	**Notes**	**CMS Questions**
VHAP	Transfer everyone under 133% to Medicaid by January 1, 2014. Updated 6/18/13: Assign everyone under 133% FPL a "MAGI" category code and leave in ACCESS until their newly assigned review date based on the anticipated "bumping" approval. If income is more than 133%,(except for spend-down population Transitional Medicaid pregnant women), move reviews to December 2013. These populations are in sunsetting programs that end 12/31/13 and thus, must be reviewed before the end of the year. Most of this population will be placed in a QHP; some with tax credits and cost sharing and some without. There will be no data integration between the new and old systems until after 1/1/14. This population will be sent the single-streamlined application at review. When the application is received, their eligibility will be processed in the VHC.	**Applicable Vermont Law:** "33 V.S.A. chapter 19, subchapter 3 (Vermont Health Access Plan; employer-sponsored insurance assistance) is repealed January 1, 2014, except that current enrollees may continue to receive transitional coverage by the department of Vermont health access as authorized by the Centers on Medicare and Medicaid Services." Act 171, § 41(h). "It is the intent of the general assembly that the transition from Catamount Health and the Vermont health access plan to the Vermont health benefit exchange should be accomplished in such a way that it minimizes the financial exposure of low income Vermonters, including the amounts of their premiums and out-of-pocket costs; ensures that health care providers receive compensation that is sufficient to enlist enough providers to ensure that health services are available to all Vermonters and are distributed equitably; and recognizes the need to limit the financial exposure of the state of Vermont." Act 171, § 35a(b). "Notwithstanding Sec. 41(h) of this act, repealing the Vermont health access plan and employer-sponsored insurance assistance, the department of Vermont health access may continue to provide employer-sponsored insurance assistance and coverage through the Vermont health access plan to eligible individuals beyond the date of repeal if the Vermont health benefit exchange is not operational by January 1, 2014 and the department of Vermont health access or a health insurer is unable to facilitate enrollment in health benefit plans through another mechanism, including paper enrollment. The department of Vermont health access shall maintain its authority to administer these programs until the exchange is able to enroll all qualified applicants who apply for coverage through the exchange." Act 171, § 41a(d). **Assumptions:**Many VHAP enrollees will be eligible for MAGI-related Medicaid, as of January 1, 2014: Medicaid will go up to 133% Income calculation under MAGI would yield slightly higher FPL than same incomes calculated under current methodology. 42 CFR § 435.603(a)(3) (MAGI start date for ongoing enrollees) does not apply to expansion populations. If this is incorrect, we would have to treat this group in the manner proposed above for MAGI-related Medicaid. This would mean converting them to Medicaid on January 1, 2014 and holding them harmless until MAGI is applied at next review.	▪ Does CMS agree that 42 CFR § 435.603(a)(3) will not apply to this cohort, given the proposed implementation approach? ▪ Requiring VHAP enrollees with incomes over 133% FPL to reapply in the last quarter of 2013, as well as conducting regularly scheduled renewals for those under 133% in this time frame will add to the substantial effort that will be required to stand up Vermont's Exchange, transition to a new eligibility system, and process new QHP/APTC/CSR applications. Can Vermont alleviate these pressures by bumping these reviews until later in 2014 and spreading them out over that year? ▪ Data integration between ACCESS and VHC is not possible for the October scope of work. ▪ Currently, when VHAP enrollees report a disqualifying increase in income or change in household composition, they are transitioned to CHAP. However, taking this action in 2013 will be disadvantageous to such enrollees, as the abbreviated coverage period reduces the likelihhod that they would meet their Catamount deductible prior to the extinguishment of the program on 12/31/13. They will also incur another coverage transition with the beginning of 2014, as they are moved into a QHP. To deal with these issues, can Vermont: o Hold harmless VHAP enrollees who report a disqualifying increase in income or change in household composition until after 1/1/14? o What is the process for asking for the authority to provide continuous eligibility for this group? ▪ Does CMS see any other issues with the proposed approach that must be addressed to permit implementation?

Health-Care Programs Transition Plan			
Health-Care Group	**Transition Methodology**	**Notes**	**CMS Questions**
Catamount Health - Full-Pay	Program ends on 12/31/13. Apply for Medicaid/QHP through Exchange with a federal (& maybe state) premium assistance and cost-sharing subsidy in under 400% FPL during last quarter of 2013. The Catamount Health full pay group is not in our eligibility system and thus, will not need to apply 43 CFR 435.916(a)(2) and must apply for coverage through the VHC.	**Applicable Vermont law:** Act 171 indicates that this product will no longer meet the insurance requirements in state and federal law: "Eliminate Catamount Health Assistance in order to comply with the insurance provisions in this act and in the federal Affordable Care Act." Act 171, § 34(b)(4).	None.

Health-Care Programs Transition Plan			
Health-Care Group	**Transition Methodology**	**Notes**	**CMS Questions**
CHAP	Program ends on 12/31/13 **> 133%:** Apply for Medicaid/QHP through Exchange with a federal & state premium assistance and cost-sharing subsidy. during last quarter of 2013. If the individual has an employer plan, must take the employer plan unless it is unaffordable under federal standards. Starting on 10/1/13, process eligibility for new health benefits concurrently with CHAP application. Updated 6/18/13: Assign everyone under 133% FPL a "MAGI" category code and leave in ACCESS until their previously assigned review date. At their first review in the new system, this population will be sent the single-streamlined application. When the application is received, their eligibility will be processed in the VHC. If income is more than 133% FPL, move reviews to December 2013. These populations are in sunsetting programs that end 12/31/13 and thus, must be reviewed before the end of the year. Most of this population will be placed in a QHP; some with tax credits and cost sharing and some without.	**Applicable Vermont law:** "Eliminate Catamount Health Assistance in order to comply with the insurance provisions in this act and in the federal Affordable Care Act." Act 171, § 34(b)(4). *See also,* VHAP notes. **Assumptions:** CHAP enrollees with incomes ≤ 133% will qualify for Medicaid on January 1, 2014: ▪ Medicaid will go up to 133% ▪ Income calculation under MAGI would yield slightly higher FPL than same incomes calculated under current methodology. 42 CFR § 435.603(a)(3) (MAGI start date for ongoing enrollees) does not apply to this expansion population.	▪ Does CMS agree that 42 CFR § 435.603(a)(3) will not apply to this cohort, given the proposed implementation approach? ▪ There will be no data integration between the new and old systems until after 1/1/14. ▪ Does CMS see any other issues with the proposed approach that must be addressed to permit implementation?

Health-Care Programs Transition Plan			
Health-Care Group	**Transition Methodology**	**Notes**	**CMS Questions**
ESIA	**≤ 133%:** Terminate new enrollment on 12/1/13 Transfer to Medicaid on January 1, 2014. Hold harmless does not apply, use MAGI rules starting with January reviews. Leave original ESIA review dates. **> 133%:** Continue to enroll newly eligible individuals until December, 2013 (Act 171 does not end the program until January 1, 2014.) Apply for Medicaid/QHP through Exchange during last quarter of 2013. If employer plan is unaffordable under federal standard, apply for a QHP with a federal & state premium assistance and cost-sharing subsidy. If employer drops coverage, individual applies for a QHP with a federal & state premium assistance and cost-sharing subsidy. Terminate program on January 1, 2014. Updated 6/18/13: Assign everyone under 133% FPL a "MAGI" category code and leave in ACCESS until their previously assigned review date. At their first review in the new system, this population will be sent the single-streamlined application. When the application is received, their eligibility will be processed in the VHC. If income is more than 133, move reviews to December 2013. These populations are in sunsetting programs that end 12/31/13 and thus, must be reviewed before the end of the year.	**Applicable Vermont law:** *See*, VHAP notes. **Assumptions:** Virtually all ESIA enrollees with incomes ≤ 133% will qualify for Medicaid on January 1, 2014: ▪ Medicaid will go up to 133% ▪ Income calculation under MAGI would yield slightly higher FPL than same incomes calculated under current methodology. 42 CFR § 435.603(a)(3) (MAGI start date for ongoing enrollees) does not apply to this expansion population.	▪ Does CMS agree that 42 CFR § 435.603(a)(3) will not apply to this cohort, given the proposed implementation approach? ▪ Does CMS see any other issues with the proposed approach that must be addressed to permit implementation? ▪ There will be no data integration between the new and old systems until after 1/1/14.

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VPharm	Continue to enroll newly-eligible through current system with current VHAP-based rules until new system is ready to accommodate this program (anticipated that transition will take place prior to end of 2014). Convert to MAGI-based methodologies upon transition of program to new system. Hold harmless does not apply. Convert to rolling reviews upon transition of program to new system.	**Applicable Vermont law:** "Sec. E.309 33 V.S.A. § 2072(c) is added to read: (c) If an individual becomes ineligible for assistance under this subchapter, the secretary shall terminate assistance to the individual. Sec. E.309.1 33 V.S.A. § 2077(a) is amended to read: (a) The programs established under this subchapter shall be designed to provide maximum access to program participants, to incorporate mechanisms that are easily understood and require minimum effort for applicants and health care providers, and to promote quality, efficiency, and effectiveness through cost controls and utilization review. Applications may be filed at any time and shall be reviewed annually. OVHA may contract with a fiscal agent for the purpose of processing claims and performing related functions required in the administration of the pharmaceutical programs established under this subchapter." Special Session, 2009, Act 001. "[H]as a household income, *when calculated in accordance with the rules adopted for the Vermont health access plan* under No. 14 of the Acts of 1995, as amended, no greater than 225 percent of the federal poverty level." 33 VSA § 2072(a)(3) (emphasis added). **Assumptions:** Act 001 of SS 2009 authorizes rolling reviews and the elimination of VPharm's hold-harmless provision. (This was the intent of the amendments.) 42 CFR § 435.603(a)(3) (MAGI start date for ongoing enrollees) does not apply to this expansion population.	• Does CMS agree that 42 CFR § 435.603(a)(3) will not apply to this cohort, given the proposed implementation approach? • Does CMS see any other issues with the proposed approach that must be addressed to permit implementation?

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VHAP-Pharmacy	Terminate program on January 1, 2014.	Few, if any, are enrolled in this program.	None.
VScript	Terminate program on January 1, 2014.	Few, if any, are enrolled in this program.	None.
Healthy Vermonters	Continue to enroll newly eligible through current system until December 31, 2013. Convert to MAGI-based methodologies on January 1, 2014.	None.	None.