

STATE OF VERMONT  
AGENCY OF HUMAN SERVICES

# P A T H

## Department of Prevention, Assistance, Transition, and Health Access

**BULLETIN NO.: 02-33F**

**FROM:** Eileen I. Elliott, Commissioner  
for the Secretary

**DATE:** 1/17/03

**SUBJECT:** Medicaid Requirement to Enroll in Private  
Health Insurance Plans and General Exclusions  
from Medicaid Coverage.

**CHANGES ADOPTED EFFECTIVE** 2/1/03

### INSTRUCTIONS

**Maintain Manual - See instructions below.**

**Proposed Regulation - Retain bulletin  
and attachments until you receive  
Manual Maintenance Bulletin: \_\_\_\_\_**

**Information or Instructions - Retain  
until \_\_\_\_\_**

**MANUAL REFERENCE(S):**

TOC M100                    M158  
M129                        M158.1  
M152.1

This rule formalizes through rule-making the authority granted the Department of Prevention, Assistance, Transition, and Health Access (PATH) under federal law Title XIX Section 1906 of the Social Security Act, to require Medicaid beneficiaries to enroll in private health insurance plans. It also clarifies and adds certain general exclusions from Medicaid coverage.

### ***Required Enrollment in Private Health Insurance Plans***

Under this rule, the department's authority to require enrollment in private health insurance plans as a condition of initial and continuing Medicaid eligibility is established when the department pays the premiums for such private coverage. The department shall not require beneficiaries to enroll in individual plans unless they have been enrolled in a plan for which the department has been paying the premiums since July 1, 2000. The department may, however, require enrollment in group plans (8 V.S.A. section 4079) when it is likely to be cost-effective and in the department's best interest. This rule also clarifies that beneficiaries required to enroll in private insurance plans are entitled to all Medicaid covered services.

### ***General Exclusions from Medicaid Coverage***

This rule clarifies that items and services ordered by an individual not enrolled as a Medicaid provider are excluded from Medicaid coverage, clarifying an existing provision that excludes items and services ordered for legal or administrative purposes. It also clarifies that Medicaid beneficiaries must follow the rules of their primary insurers. It adds provisions excluding health insurance premiums, preliminary services leading to non-covered services, and repair of non-covered items from coverage.

In addition, this rule specifies the conditions under which medical care provided in a foreign country is covered as provided by Medicare regulations (42 C.F.R. 424 Subpart H), which prohibit payment for emergency inpatient hospital care and related ambulance and physicians services provided in a foreign country except under certain conditions.

### ***Specific Changes to Rule Pages***

- M129 Clarifies that beneficiaries are required to cooperate by enrolling or remaining enrolled in a health insurance plan if required by the department to maintain Medicaid eligibility and changes “recipient” to “beneficiary”.
- M152.1 Clarifies or adds exclusions from Medicaid coverage.
- M158 Clarifies that Medicaid beneficiaries are required to follow the rules of their primary insurers. Changes “recipient” to “beneficiary.”
- M158.1 Specifies the conditions under which the department shall require beneficiaries to enroll or remain enrolled in a private group health insurance plan. Clarifies that the department shall pay the premiums and the beneficiary is entitled to all Medicaid covered services.

A public hearing was held on November 18, 2002, at 9:00 a.m., in the Agency of Human Services Secretary’s Conference Room, State Office Complex, Waterbury, Vermont. There were no attendees at that hearing.

Written comments were accepted until 4:30 p.m., on November 25, 2002. Two submissions of written comments were received and are summarized below.

#### Comments received

**Comment:** One commenter stated general support for bulletin 02-33, because it clarified existing regulations.

**Response:** The department agrees, but notes the bulletin did include some changes to existing rules.

**Comment:** One commenter requested that language from WAM 2365.31 be added to M129.21, and that it include a reference to Reach Up regulations.

**Response:** That sub-section, M129.21, is not a subject of this bulletin. The section was simply reformatted for ease of reading--not substantially changed. The commenter's suggestion is noted, however, and will be considered if and when that section of rule is revised.

**Comment:** One commenter suggested that the standard for Medicaid payment for private health insurance premiums be not only the Department's best interest, but also the beneficiary's best interest.

**Response:** Federal law allows the state the discretion to pay premiums and other cost-sharing obligations only when it is "cost-effective". That discretion will only be exercised when it is in the best interest of the state. It is hard to imagine when paying the premium would not be in the interest of the beneficiary.

**Comment:** One commenter expressed concern about the circumstances in which care and services are provided in a foreign country. She asked why Vermont Medicaid wouldn't pay if a beneficiary were, for example, to need emergency care after being injured in a car accident when in Montreal. She further wondered why this regulation was following conditions set out in a federal Medicare regulation.

**Response:** As a general rule Medicaid policy follows Medicare policy. The department intends to follow Medicare policy in this matter and adopted Medicare policy rather than create confusion by trying to say the same thing with different words. This rule change attempts to clarify the intent of the rule by adopting Medicare policy.

**Comment:** One commenter expressed opposition to the state ever purchasing private health care insurance for Medicaid beneficiaries because it would drive up the cost of private health insurance. The commenter added that Medicaid beneficiaries frequently miss appointments, greatly increasing the practice's "chair costs." He felt the rule would unfairly attempt to circumvent health care practitioner's reluctance to accept Medicaid patients, because now they would be coming in with private health insurance.

**Response:** This rule proposes to decrease, not increase the number of beneficiaries enrolled in private health insurance at the department's expense. The practice does reduce the cost to the state and federal government.

Two comments were not germane to the proposed rule. They were:

**Comment:** One commenter said that far too many people are being granted Medicaid, and doctors are refusing to accept it because the reimbursement is so low.

**Comment:** One commenter asserted that the Vermont should provide eye examinations only once every 2 years to Medicaid recipients, at a reimbursement rate equal to what providers receive through "Vision Service Plan" (currently \$60.00 per visit). One pair of glasses should be provided every 2 years, and if they are lost, then Medicaid recipients should go without.

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

**Manual Holders:** Please maintain manuals assigned to you as follows.

**Manual Maintenance**

<b><u>Remove</u></b>		<b><u>Medicaid Rules</u></b>		<b><u>Insert</u></b>	
TOC P.1 (M100-M199)	(99-15)			TOC P.1 (M100-M199)	(02-33)
TOC P.2 (M100-M199)	(98-11F)			TOC P.2 (M100-M199)	(02-33)
M129	(93-19)			M129	(02-33)
M129.2	(88-8)			M129.21	(02-33)
M152.1	(83-14)			M152.1	(02-33)
M158	(88-8)			M158	(02-33)

M100-M199 Medicaid Eligibility and Payment

M100 General Description – Medicaid Program

M101 Purpose – Medicaid Program

M101.1 Purpose – Vermont Health Access Plan

M102 Eligibility Process

M102.1 Program Fees

M103 Benefit Delivery Systems

M103.1 Fee-For-Service System

M103.2 Managed Health Care Plan System

M103.3 Primary Care Case Management Program

M104 Authorized Representative

M105 Case Records

M106 Prior Authorization

M106.1 Background

M106.2 Criteria for Services Requiring Prior Authorization

M106.3 Prior Authorization Determination

M106.4 Waiver of Prior Authorization

M106.5 Prior Authorization Process

M107 Medical Necessity

M108 Procedure for Requesting Coverage of a Service or Item

M110 Application

M111 Application Requirement

M112 Re-application

M113 Retroactive Application

M114 Date of Application

M115 Choice of Category

M116 VHAP Program

M120 Initial Eligibility

M121 Application Decisions

M122 Decision Time Limits

M123 Application Forms

M124 Interview

M125 Social Security Numbers

M126 Verification (Proof)

M127 Collateral Sources

M128 Requirement to Apply for Annuities, Pensions, etc.

M129 Pursuit of Medical Support, Third-Party Medical Payments and Private Health Insurance

M129.1 Assignment of Rights to Support and Payments

M129.2 Cooperation in Obtaining Support Payments

M129.2.1 Good Cause for Noncooperation

M129.3 Enrollment in a Health Insurance Plan

M130	Continuing Eligibility
M131	Eligibility Review Requirement
M132	Review Frequency
M133	Review Decisions
M134	Quality Control Review
M135	Beneficiary Fraud Investigation
M140	Notice and Appeal
M141	Notice of Decision
M142	Right to Appeal
M142.1	Disability Determination Appeal
M143	Continued Benefits During Appeal
M144	Fair Hearing Rules
M150	Payment Systems
M150.1	Obligation of Beneficiaries
M150.2	Obligation of the Department
M151	Eligibility Expenses
M152	Medical Services
M152.1	General Exclusions
M153	Beneficiary Identification
M154	Provider Responsibility
M155	Violations of Provider Responsibility
M155.1	Definitions
M155.2	Grounds for Sanctioning Providers
M155.3	Sanctions
M155.4	Imposition and Extent of Sanctions
M155.41	Imposition of Sanctions
M155.42	Scope of Sanctions
M155.43	Notice of Sanctions
M155.5	Provider Information Program
M155.6	Right of Appeal
M155.7	Withholding Payment for Provider Fraud or Willful Misrepresentation
M156	No Reassignment of Claims to Benefits
M157	Utilization Control
M157.1	Beneficiary Abuse
M157.2	Provider Abuse
M158	Third-Party Liability
M158.1	Health Insurance Premiums
M159	Recovery
M160	Health Care Improvement Trust Fund

2/1/03

Bulletin No. 02-33

M129

M129 Pursuit of Medical Support, Third-Party Medical Payments and Private Health Insurance

As a condition of initial and continuing eligibility, all Medicaid applicants and beneficiaries must meet the requirements related to the pursuit of medical support, third-party payments and the requirement to enroll or remain enrolled in a group health insurance plan, as detailed in M129.1-M129.3 below.

M129.1 Assignment of Rights to Support and Payments

Medicaid applicants and beneficiaries with the legal authority to do so must assign their rights to medical support and third-party payments for medical care to the department, with the exceptions noted below. If they have the legal authority to do so, they must also assign the rights of any other Medicaid applicants and beneficiaries to such support and payments to the department.

No assignment is required for Medicare payments or cash payments from the Department of Veterans Affairs for aid and attendance.

M129.2 Cooperation in Obtaining Support and Payments

Medicaid applicants and beneficiaries must cooperate with the department in obtaining medical support and third-party payments for medical care unless the department has granted them a good cause waiver for not cooperating (M129.21). To meet this requirement, the department may require an individual to:

- provide information or evidence relevant and essential to obtain such support or payments;
- appear as a witness in court or at another proceeding;
- provide information or attest to lack of information under penalty of perjury; or
- take any other reasonable steps necessary for establishing parentage or securing medical support or third-party payments.

The department shall exempt an unmarried pregnant woman with income under 200 percent of the federal poverty level from the requirement to cooperate in establishing paternity or obtaining medical support and payments from, or derived from, the father of the child she expects to deliver or from the father of any of her children born out-of-wedlock. She shall remain exempt through the end of the calendar month in which the 60-day period beginning with the date of her delivery ends.

2/1/03

Bulletin No. 02-33

M129.21

M129.21 Good Cause for Noncooperation

Medicaid applicants and beneficiaries may request a waiver of the cooperation requirement from the department. Those to whom the department has granted a good cause waiver for noncooperation are eligible for Medicaid, provided that all other program requirements are met. The department shall grant such waivers when either of the following circumstances has been substantiated to the department's satisfaction:

1. Compliance with the cooperation requirement is reasonably anticipated to result in physical or emotional harm to the individual responsible for cooperating or the person for whom medical support or third-party payments are sought. Emotional harm means an emotional impairment that substantially affects an individual's functioning.
2. Compliance with the cooperation requirement would entail pursuit of medical support for a child:
  - conceived as a result of incest or rape from the father of that child;
  - for whom adoption proceedings are pending; or
  - for whom adoptive placement is under active consideration.

Individuals requesting waivers of the cooperation requirement bear the primary responsibility for providing the documentation the department deems necessary to substantiate their claims of good cause. The department shall consider an individual who has requested a good cause waiver and submitted the required documentation to be eligible for Medicaid while a decision on the request is pending.

M129.3 Enrollment in a Health Insurance Plan

The department may require a Medicaid applicant or beneficiary to enroll or remain enrolled in a group health insurance plan for which the department pays the premiums. Payment of group health insurance premiums shall be made only under the conditions specified in this section and in M158.1 and remain entirely at the department's discretion. Such payment of premiums shall not be considered an entitlement for any individual.

As a condition of continuing eligibility, the department may require beneficiaries to remain enrolled in individual health insurance plans, provided that they are enrolled in plans for which the department has been paying the premiums on a continuous basis since July 2000.

For the purposes of this section and M158.1, a group health insurance plan is a plan that meets the definition of a group health insurance plan specified in 8 V.S.A. §4079. An individual health insurance plan is a plan that does not meet that definition.

2/1/03

Bulletin No. 02-33

M152.1

M152.1 General Exclusions

No payment will be made for certain items and services including the following:

- A. Items and services not reasonable and necessary for the treatment or diagnosis of illness or injury, or to improve the functioning of a malformed body member.
- B. Items for which neither the beneficiary nor any other person or organization has a legal obligation to pay. This exclusion applies, for example, to X-rays or immunizations provided without charge to the general public by a health organization.
- C. Items and services furnished, paid for or authorized by an entity of the Federal Government.
- D. Care and services provided in a foreign country, except as provided in Medicare regulation 42 CFR 424 Subpart H, which allows payment for emergency inpatient hospital care and related ambulance and physicians services if the following conditions are met:
  - The beneficiary was present in the U.S. when the emergency arose, or was traveling to Alaska by the most direct route without delay, and
  - The foreign hospital is closer to, or more accessible from the site of the emergency than the nearest U.S. hospital equipped to deal with and available to treat the individual's illness or injury.
- E. Care and services ordered or prescribed by an immediate relative (see F) of the beneficiary.
- F. Care and services furnished by an immediate relative of the beneficiary or by a facility, such as a nursing home, of which an immediate relative is owner or principal stockholder. For purposes of this section, "immediate relative" includes spouse; natural parent, child, and sibling; adopted child and parent; stepparent, stepchild, stepbrother and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law and sister-in-law; grandparent and grandchild.
- G. Items and services to the extent that payment has been or can be expected to be made under worker's compensation.
- H. Items and services covered by private health insurances.
- I. Items and services ordered by an individual not enrolled as a Medicaid provider.
- J. Premiums for health insurance plans when the department has not required the beneficiary to enroll or remain enrolled.
- K. Preliminary procedures or treatments leading to a service that is not covered by Medicaid.
- L. Repair of items not covered by Medicaid.

2/1/03

Bulletin No. 02-33

M158

M158 Third Party Liability

Medicaid is the payer of last resort, after all third party medical resources have been applied. A third party is defined as one having an obligation to meet all or any portion of the medical expense incurred by the beneficiary for the time such service was delivered. Such obligation is not discharged by virtue of being undiscovered or undeveloped at the time a Medicaid claim is paid; it then becomes an issue of recovery (see Section M159). Medicaid beneficiaries are required to follow all rules of their third party insurance. Medicaid will not pay claims that have been denied by the third party insurer for failure to follow their rules. Some examples of third party medical resources are:

- Medicare;
- Health insurance, including health and accident but not that portion specifically designated for "income protection" which has been considered in determining beneficiary eligibility to participate in the Medicaid program;
- Medical coverage included in conjunction with other benefit or compensation programs such as military and veteran programs, and worker's compensation; and
- Liability for medical expenses as agreed or ordered in negligence suits, support settlements, trust funds, etc.

M158.1 Health Insurance Premiums

The commissioner may elect at any time to require an applicant or beneficiary to enroll, or remain enrolled, in a private health insurance plan, provided that such enrollment meets the conditions specified in this section and in M129.3 and, in the commissioner's judgment, is likely to be cost-effective and in the department's best interest. If enrollment is required, the department will pay the individual's share of the health insurance premium.

Once an individual has met this requirement by enrolling or remaining enrolled in a health insurance plan, Medicaid will cover the full array of Medicaid services and items, provided that the rules of their health insurance plan have been followed.