

P A T H

Department of Prevention, Assistance, Transition, and Health Access

FROM Eileen I. Elliott, Commissioner
for the Secretary

BULLETIN NO. 02-10F

DATE 6/28/02

SUBJECT General Assistance Payments for Medical Care
General Assistance Burials at Public Expense

CHANGES ADOPTED EFFECTIVE 7/1/02

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) BY CURRENT PAGE NUMBERS

In the appropriations bill for state fiscal year 2003, the legislature authorized the Department of Prevention, Assistance, Transition, and Health Access (department) to adopt rules necessary to establish procedures to limit general assistance (GA) payment for medical and dental care to those required to treat emergency medical needs and establish cremation as the preferred arrangement for GA burials at public expense.

The changes to existing department policy in this rule include:

- clarification of the definition of an emergency medical need;
- establishment of the requirement that pharmacists comply with the department's pharmacy best practices and cost control program (Pharmacy Benefit Management - PBM);
- substitution of references to a list of prescription drug classifications not covered by GA for existing descriptions of covered and noncovered drugs;
- reorganization and rewriting of existing policy governing GA payment for medical and dental care to improve clarity and comprehensibility without changing the intent of the policy;
- clarification of term "burial" to mean either cremation or interment;
- establishment of cremation as the preferred burial arrangement when family has not requested alternative arrangement;
- explanation of allowable costs associated with cremation; and
- modification of existing rule for purposes of clarity without affecting substantive content.

Definition of Emergency Medical Need (2602.3)

The department adds a definition of emergency medical need that is based on and consistent with the definition set forth in federal Medicaid rules (42 CFR 460.100). This definition replaces less clear language in existing policy that consists only of examples of such needs.

Pharmacy Best Practices and Cost Control Program and Noncovered Drugs (2622)

The rule formally extends the department's best practices and cost control program for its health care assistance programs to prescription drugs paid by GA. Under this program, Vermont's pharmacy benefit manager, First Health, must approve payment for certain prescription drugs, which may be contingent upon substitution of a generic equivalent or other program requirements.

First Health also administers the list of prescribed drugs not covered by GA referenced in the rule. The department's eligibility workers continue to determine financial eligibility for persons applying for GA payment for a prescription. Once an applicant is determined financially eligible, the pharmacist will be able to provide the drug to the applicant and receive payment for it, provided that the requirements administered by Vermont's pharmacy benefit manager had been met and the drug is not on the list of drugs not covered by GA.

The department, with the assistance of a panel of physicians, has determined that none of the drugs in the drug classifications included in its noncovered list is ever used to treat emergency medical needs, as defined in GA policy at 2602.3. Applicants with prescriptions for drugs in these classifications are not eligible for GA because they do not have an emergency medical need.

Eligibility workers will authorize GA payment for a prescription drug in a classification not included in the noncovered list, whether or not it has been prescribed to address an emergency medical need. If any drug in a given classification might be appropriately prescribed to address an emergency medical need, GA payment may be made for all drugs in the classification, even if the likelihood of an emergency medical need is small. The department decided not to propose a case-by-case determination of emergency medical need for GA applicants requesting payment for a prescribed drug because of the burden it would place on GA applicants, eligibility staff, clinical staff, physicians, and pharmacists as well as the application processing delay it would inevitably introduce into the GA program, a program designed to deal with emergencies.

Because the requirements of the Generic Drug Bill (1977), which requires substitution of generic drugs for brand name drugs in certain situations, are included in the requirements of the department's pharmacy best practices and cost control program, existing references to compliance with the requirements of the Generic Drug Bill have been eliminated.

Cremation as Preferred Burial Arrangement (2641)

The rule clarifies that the two alternatives for burials at public expense are cremation and interment and establishes cremation as the preferred arrangement when the decedent or the decedent's family has not expressly requested the alternative arrangement. The department has also modified the rule to clearly specify the allowable costs of cremation.

Reorganization and Rewriting of Existing Policy Related to the Proposed Changes

In the rule, the department has also updated obsolete references to its Medicaid Division, now called the Office of Vermont Health Access (OVHA), eliminated unnecessary repetition, and simplified existing language to clarify its policy related to GA provided to applicants with emergency needs due to catastrophic situations, focusing on emergency medical needs. In addition, the department has updated obsolete references to the Department of Social Welfare, now called the Department of Prevention, Assistance, Transition, and Health Access (PATH), made minor stylistic changes, and simplified existing language to clarify its policy related to GA burials. These changes clarify policy, but are not intended to change its meaning.

Specific Changes and Additions to Policy Pages

After the final proposed rule was made available for public comment and before the rule was filed with the Joint Legislative Committee on Administrative Rules the department made some changes to the rule. These changes are indicated below as occurring *“Since the proposed rule was made available for public comment.”*

After filing the final proposed rule and before the hearing of the Joint Legislative Committee on Administrative Rules, all who commented on the rule were invited to meet with department representatives to discuss ongoing concerns. The meeting was held on June 19, 2002, via teleconference with representatives from the Office of Health Care Ombudsman, Vermont Legal Aid, Community of Vermont Elders (COVE), and Vermont Ombudsman Project. Several changes to the rule were made in response to concerns raised by the commenters. All changes that have been made since the filing of the final proposed rule are indicated below as occurring *“Since the last filing and with the approval of the Joint Legislative Committee on Administrative Rules.”*

Sections Changed

Table of Contents 2600 Updated 2602-2603 and 2620.1-2629 to reflect changes in organization of the rules.

2600 (C)(4) Clarified that eligibility for payment of medical services or items is based on criteria at 2602.

Since the proposed rule was made available for public comment, all obsolete references to “ANFC” on page 2600 P.2 have been replaced with “Reach Up.”

2602 Rewrote and reorganized the section to improve clarity; moved some language about health care coverage from 2620 and some about other resources for vision care assistance from 2624; incorporated policy from PP&D memo facing page 2602.

Since the last filing and with the approval of the Joint Legislative Committee on Administrative Rules, subsection 4 has been eliminated and language from current rule has been added back in second to last paragraph.

2602.1 Created new subsection of 2602 for the definition of catastrophic situation; rewrote and reorganized the section to improve clarity.

Since the proposed rule was made available for public comment, a typographical error has been corrected by changing 2601.2 to 2602.2 in item number 4.

2602.2 Created new subsection of 2602 for the definition of constructive eviction; rewrote and reorganized the section to improve clarity without changing the substance; incorporated policy from PP&D memos facing page 2602.

Since the proposed rule was made available for public comment, the last sentence in the second paragraph has been modified to clarify its application to the department.

2602.3 Created new subsection of 2602 for the definition of emergency medical need; replaced language describing emergency medical need with definition; clarified that the determination of emergency medical need for medical care other than dental services and pharmaceuticals is made by OVHA; moved language from 2623 about the determination of emergency medical need for dental services is made by the health department; rewrote and reorganized the section to improve clarity.

Since the proposed rule was made available for public comment, subsection designations have been added for clarity.

Since the last filing and with the approval of the Joint Legislative Committee on Administrative Rules, page 2602.3 has been restructured by moving paragraph about prior authorization to follow subsection A and by changing order of subsections B and C; an introductory paragraph has been added.

Since the last filing and with the approval of the Joint Legislative Committee on Administrative Rules, the reference to Medicaid has been replaced with a reference to the pharmacy best practices and cost control program in subsection D and the term pharmaceuticals has been changed to prescription drugs for consistency with other parts of the rule.

2603 Moved some language about applicants coming to Vermont for medical care from 2620; renamed 2603; rewrote section to improve clarity.

2604 Revised section to make it gender-neutral; rewrote section to improve clarity.

Since the proposed rule was made available for public comment, a typographical error has been corrected by changing 3104 to 2104.

2620 Replaced specifications of payment limitations and requirements in 2620-2624 with language that aligns GA payment limitations and requirements with those specified for Medicaid; moved language about applications and application dates from 2622-2624; rewrote sections to improve clarity.

Since the last filing and with the approval of the Joint Legislative Committee on Administrative Rules, parenthetical information has been added to explain reasons for section references and the sentence “Medical care not covered by Medicaid is not covered by GA” has been removed.

2620.1 Moved language about balance billing from 2620.2, which is eliminated, to 2620.1; incorporated policy from PP&D memo facing page 2620.

Since the proposed rule was made available for public comment, a typographical error has been corrected by changing 2622 to 2627 and the last paragraph on balance billing has been modified to clarify the department's obligation.

Since the last filing and with the approval of the Joint Legislative Committee on Administrative Rules, proposed language incorporating information on balance billing in the PP&D memo facing page 2620 has been removed.

2621 Added list of services not covered by Medicaid; rewrote section to improve clarity.

Since the last filing and with the approval of the Joint Legislative Committee on Administrative Rules, the language "because they are not covered by Medicaid" has been removed.

2622 Rewrote section to improve clarity.

2623 Added list of services not covered by Medicaid; rewrote section to improve clarity.

Since the last filing and with the approval of the Joint Legislative Committee on Administrative Rules, the section language has been replaced with following: "Eyeglass frames or lenses meeting an emergency medical need are covered only if purchased through the department's authorized supplier."

2624 Added requirement for providers to comply with the pharmacy best practices and cost control program (PBM); eliminated reference to the Generic Drug Bill; replaced language about covered and noncovered drugs with language about noncovered drug classifications, rewrote section to improve clarity.

Since the proposed rule was made available for public comment, the language “including over-the-counter drugs prescribed by a physician” has been added to first sentence to clarify that prescribed drugs includes over-the-counter drugs prescribed by a physician.

Since the proposed rule was made available for public comment, the content of the last two sentences in the second paragraph has been clarified by substituting the following language: “As long as the drug is covered under Medicaid, GA payment shall be made for drugs in classifications other than those on the not-covered list even if the likelihood of an emergency is small or the drug has not been prescribed to address an emergency need.”

Since the last filing and with the approval of the Joint Legislative Committee on Administrative Rules, the reference to Medicaid has been replaced with a reference to the pharmacy best practices and cost control program.

2625 Added definition of medical supplies; rewrote section to improve clarity.

Since the last filing and with the approval of the Joint Legislative Committee on Administrative Rules, the list of specific medical supplies not covered has been removed.

2626 Added definition of durable medical equipment; added lists of services not covered by Medicaid; rewrote section to improve clarity.

Since the last filing and with the approval of the Joint Legislative Committee on Administrative Rules, the language “and the community” that was in the existing rule and removed in the proposed rule has been replaced and the second paragraph on equipment not covered by Medicaid has been removed.

2627 Eliminated criteria for covering ambulance services, which duplicate language in Medicaid policy; included language about services not covered by Medicaid.

Since the last filing and with the approval of the Joint Legislative Committee on Administrative Rules, the section has been revised to read: “Ambulance services that meet the definition of a medical emergency need may be covered. Transportation of a hospital inpatient to another facility for outpatient services is never a covered ambulance service because it is not an emergency medical need.

- 2641 Added language to clarify that word “burial” can mean either cremation or interment.
- Incorporated paragraph on district director’s delegation authority into second paragraph.
- Added language that requires cremation in situations where the decedent or the decedent’s family has not expressly requested an alternative arrangement.
- Since the proposed rule was made available for public comment*, the obsolete term “director” has been replaced with “manager” in first line of second paragraph.
- 2643 Changed reference from Department of Social Welfare to Department of Prevention, Assistance, Transition, and Health Access
- Since the proposed rule was made available for public comment*, a typographic error has been corrected by changing 3101 to 2301.
- 2644.2 Added “cremation” to section title and made minor capitalization changes throughout section.
- Moved language about alternative containers for cremation to rule section 2644.2 (10).
- Removed language about authorization for cremation that is unrelated to costs and now covered in section 2641; added information on allowed costs of cremation.
- 2644.2 *Since the proposed rule was made available for public comment*, the language “religious service, and newspaper death notice” has been added to end of first paragraph to clear up inadvertent inconsistency with section 2647.
- Since the proposed rule was made available for public comment*, a sentence has been added to the end of paragraph #10 to clarify that the allowable expenses, consistent with those in paragraph #8, are limited to wholesale costs.
- 2647 Added cremation costs as specified expenses that require an invoice.
- Since the proposed rule was made available for public comment*, an obsolete reference to form DSW 206 GB has been changed to current form PATH 206 GB.

Since the proposed rule was made available for public comment, the department has modified the Drug Classification Not-Covered List that was provided to commenters with the draft rule. The following drug classifications have been removed from the list: C6N Niacin Preparations; L1A Antipsoriatic Agents, Systemic; M4E Lipotropics; and Q8H Ear Preparations, Local Anesthetics.

Summary of Written Comments and Department's Responses

Due to the expedited rulemaking schedule there was insufficient time to hold a public hearing. Written comments were received on June 13, 2002 from the following organizations: Office of Health Care Ombudsman, Vermont Medical Society, Vermont Legal Aid, Community of Vermont Elders (COVE), Vermont Coalition for Disability Rights, Vermont Ombudsman Project.

On June 19, 2002, representatives of the department met with commenters by teleconference in an attempt to resolve outstanding issues. All commenters were invited to participate but not all commenters' schedules could be accommodated. The following individuals participated in the meeting: Donna Sutton Fay (Office of Health Care Ombudsman), Trinka Kerr (Vermont Legal Aid), Brian Sawyer (COVE), and Jackie Majoros (Vermont Ombudsman Project).

Comment: Generally, commenters expressed concern about the proposed rule's alignment of GA payments for emergency medical needs with the limitations and requirements of the Medicaid program. They claim that section 2620 of the current rules specifically states that GA can cover medical services not covered by Medicaid and feel this change is too restrictive and inconsistent with the GA statute. They state that these changes will affect the ability of low-income individuals, some who have disabilities or who are elderly, to get the medically necessary services they rely on GA to provide.

Response: In consideration of the commenters' concerns about the overall application of Medicaid limitations to the GA medical emergency needs rule, the department has decided to remove the limitations that restrict coverage to Medicaid coverage, with the exception of the limitations as they apply to providers. Because the Budget Act requires the department to incorporate the features of the pharmacy best practices and cost control program into the GA medical rules, the features of that program limit GA payment for prescription drugs. The reference to Medicaid has been replaced with a reference to the pharmacy best practices and cost control program. The provision in section 2620 that limits GA payment to providers enrolled in the Medicaid program is the GA program's method of assuring the payments are to licensed providers.

Comment: One commenter requested that the department use the regular instead of the expedited rulemaking process because the commenter found that the GA medical changes to be substantial and the seven-day comment period too short for adequate consideration and comment. The commenter challenges the department's authority to use expedited rulemaking noting that section 152 of the Budget Act does not specifically apply to section 149(e) on the GA medical care changes. The commenter adds that because there were no projected savings for GA medical care in the department's materials prepared for the General Assembly's appropriations committees, there is no need to go through expedited rulemaking.

Response: The commenter is mistaken about the final version of the Budget Act. In the final version of the Budget Act, section 152 specifically references GA rule changes in section 149. The language of section 152 of the Budget Act authorizes expedited rulemaking to amend all GA rules pursuant to section 149, including GA medical. The only exception would be applicable to subsection 149(b), which specifically allows for the filing of the rules no later than October 1, 2002.

The materials prepared by the department for the General Assembly's appropriations committees included a spreadsheet on page 9 representing a savings of \$48,502 for GA medical emergency changes if the department had been able to make the change effective January 1, 2002 change. The intent throughout the legislative process was to initiate these changes as soon as possible through the expedited rulemaking process as reflected in the Budget Act.

Comment: The commenter states that requiring applicants to demonstrate an emergency medical need is a higher test than medical necessity and the standard is incorrect because it is not in accordance with the GA statute.

Response: The proposed rule does not change the current standard for the GA program. According to current department regulations that have been in force for decades, the General Assistance program provides assistance to eligible individuals and families "*to meet emergency needs only.*" WAM 2600(A) (emphasis added). This proposed rule, pursuant to the requirements in section 149(e) of the Budget Act, establishes the procedures necessary to limit general assistance payment for medical and dental services and items to those required to treat an emergency medical need.

Comment: The commenter states that limiting GA coverage to services and items that are covered by Medicaid is a significant substantive change to the GA regulations and that there is no statutory authority for requiring GA to track Medicaid. The commenter also cites the GA statute where it specifies, "Eligibility standards for general assistance as established by the commissioner need not be the same as those applicable to the department's categorical assistance programs."

Response: While there is no statutory requirement that GA track Medicaid, the department is not prohibited from using Medicaid standards in the GA program. The reference to the GA statute on eligibility is not relevant to this rule, as the proposed changes do not address eligibility; instead they address benefits available under the program. In addition, as previously stated the language that limited coverage to Medicaid covered items and services has been eliminated from the rule.

Comment: Two commenters state that the proposed rule's definition of emergency medical need is not relevant because it is derived from federal regulations that do not apply to the general Medicaid population and relate only to Programs for All-Inclusive Care for the Elderly (PACE). 42 CFR §460.100. The commenters recommend that the department should be consistent in its definition of an emergency medical need across all programs and should use its existing definition as contained in the VHAP and Medicaid regulations.

Response: In choosing an appropriate definition of medical emergency, the department sought a definition that represents a standard in the medical care community and one that would be appropriate to an emergency needs program, such as GA. The definition in the proposed rule meets these criteria. It is a standard used and recognized in the health care industry. The use of this definition is not limited to federal regulations applicable to PACE. The definition in the proposed rule is also substantially the same as the definition of medical emergency used for PATH's Primary Care Case Management Program, M103.3(13); federal regulations for Children's Health Insurance Programs (SCHIP), 42 C.F.R. § 457.10; and the federal regulations for the Medicare + Choice Program, 42 C.F.R. § 422.113(b)(1)(i).

Comment: Two commenters point out that the rule continues to refer to ANFC, even though this reference has been changed to Reach Up in other proposed regulations.

Response: The references to ANFC have been changed to Reach Up.

Comment: Two commenters took issue with the standard in section 2602(4) that requires reapplicants to demonstrate to the department's satisfaction that they have taken reasonable steps to prevent recurrence of an emergency need. The commenters feel the standard lacks clarity and specificity, it fails to provide guidance about how the determination will be made, and there is no timeframe in which recurring emergencies will be evaluated.

Response: This is not a new requirement; it is simply a clarification of the existing rule. The proposed language has been replaced with the language of the existing rule.

Comment: Two commenters noted a typographical error in 2602.1(4).

Response: The typographical error has been corrected.

Comment: Two commenters found section 2602.3 hard to follow and suggested assigning numbers or letters to the various sections for clarity. They suggest that the services covered in this definition section would be more appropriately placed in their respective sections.

Response: The information in the section begins with the general definition of an emergency medical need and it is followed by the more specific qualifications that apply to emergency medical needs for dental services, vision services and items, and pharmaceuticals. References to services are used to define the meaning and parameters for the specified emergency medical needs. The department agrees that restructuring the section and providing designations for the subsections may help to add clarity to the section. The section has been restructured. An introductory paragraph has been added and letters A through D now designate the subsections.

Comment: Two commenters state that the definition of dental services covered is too narrow and is narrower than the definition of an emergency medical need.

Response: The definition of covered dental services remains unchanged; it is the same as in the current rule at section 2623.

Comment: Two commenters found the definition of an emergency medical need for pharmacy coverage difficult to understand. They suggest that the department clarify the manner in which it determines which drugs will be covered. They also find the requirement that limits coverage of pharmaceuticals to only those drugs covered by Medicaid to be too narrow. As an alternative they suggest an individual assessment of each applicant's emergency need.

Response: The department agrees that the rule could be clearer in explaining the determination of which drugs will be covered. The language in section 2624 has been modified for clarity. The language limiting coverage to Medicaid has been replaced with new text that clarifies that the prescription coverage is subject to the requirements of the pharmacy best practices and cost control program.

Comment: Two commenters noted that hospital services should be covered in GA and that section 2620 of the proposed regulations state that hospital services are not covered, which is different from current GA regulations and the GA statute.

Response: This is not a change to the current GA rules, but rather a clarification. Section 2620 in the current GA rule specifies that medical care is limited to the types of care described in sections 2622 through 2626. Hospital care is not a type of care described in those sections. Hospitals maintain free care policies and provide care to individuals regardless of their ability to pay.

Comment: Two commenters noted that in section 2620.1 the department should deal with complaints from GA beneficiaries who are balance billed.

Response: The department has decided to withdraw the change and leave the language in section 2620.1 as it is in the current rule.

Comment: Two commenters suggest that since in the past, GA has paid for dentures it should continue to do so in emergency situations.

Response: The prohibition on payment for dentures is not a new change to GA rules. The GA program does not pay for dentures, current section 2623 specifically states that payment shall not be made for dentures.

Comment: Two commenters expressed concern with the determination of coverage of prescription drugs in the proposed rule. The commenters charge that the method used is arbitrary because instead of making an individual determination of whether the application presents an emergency need, the only consideration is whether the prescription drug needed is in a class of drugs predetermined to be covered. The commenters are also concerned that applicants will be denied assistance with no opportunity to demonstrate their emergency need.

Response: The procedure for determining coverage of prescription drugs to address an emergency medical need is not arbitrary. Section 149(e) of the Budget Act requires the department to establish a list of drug classifications for which general assistance payments are not made. The department, assisted by a panel of three physicians, determined the list of drug classifications that are not covered under GA. The physicians advised what drug classifications were appropriate for the not-covered list using the criterion that no drug in the classification is ever used to treat emergency medical needs.

Eligible individuals who need prescribed drugs that meet the requirements of the pharmacy best practices and cost control program and are not in a classification on the not-covered list will receive GA payment for the prescription. Payment will be provided even if the likelihood of an emergency is small or the drug has not been prescribed to address an emergency need. To simplify operational functions and reduce opportunity for error, the coverage for prescription drugs is broader than the proposed rule's general emergency medical need standard. Applicants who feel they have been erroneously denied prescribed drugs to meet a medical emergency may appeal the decision.

Comment: Two commenters want the department to continue to use current lists of drugs in the rule that are covered and to continue to use an exception process if applicants can demonstrate that their need for a noncovered drug is an emergency.

Response: There are no lists of covered drugs in the current rule; there are only lists of non-covered items. Current rules refer to allowed drugs as being drugs in the latest edition of an official drug compendia, and it is the same compendia referred to in the Medicaid rules at M810. The proposed rule removes language at 2625.1 (Allowable Drugs) that unnecessarily duplicates M800 – M810. Coverage for prescribed drugs under the proposed rule is so broad that an exception process is neither necessary nor warranted.

Comment: Two commenters felt certain drugs on the noncovered list should be removed from the list because, from a layperson's view, they could be considered necessary and of an emergency nature. For example, the commenters cited needles for an insulin dependent diabetic, and eye irrigants and local eye anesthetics for someone with an eye injury.

Response: Needles for diabetics and hemophiliacs are covered; they are included in another classification that is not on the not-covered list. Outpatient treatments for eye injuries are available in classifications that are not on the not-covered list.

Comment: One commenter thought the list of noncovered drugs should be available beyond PATH's web site.

Response: The proposed rule specifically states that the department's list of drug classifications not covered by GA will be made available both at the website for the Office of Vermont Health Access and in paper form upon request. All district offices will have access to the list and can provide a copy to anyone who requests one.

Comment: Two commenters felt the medical supplies listed in section 2625 as not covered because they do not address an emergency medical need should be covered because GA currently covers them with prior authorization.

Response: The department has removed the referenced language in 2625.

Comment: Two commenters noted that the definition of durable medical equipment (DME) in section 2626 no longer contains the language regarding "use in the community" which is in the existing GA regulations and recommends that GA should continue to cover DME necessary for use in the community.

Response: The language "use in the community" has been added back into section 2626.

Comment: Two commenters objected to the removal of the current language regarding ambulance services and limiting it to as covered under Medicaid.

Response: The language limiting ambulance services to those covered under Medicaid has been eliminated.

Comment: Two commenters expressed concern that the proposed rules may unnecessarily restrict access to vision care under GA at the same time that vision care services are being eliminated from other public health programs.

Response: The proposed rule makes no change to limitation on vision care. In the current rule, vision care is limited to emergency eye care.

Comment: One commenter requested that the rule identify the panel of physicians that determined the classifications on the not-covered list and explain how physicians can request changes to the list in the future.

Response: The names of the doctors who served on the advisory panel determining the not-covered list are: Dr. Paul Jarris, Dr. Scott Strenio, and Dr. Frank Landry. The department does not feel that the GA rule is an appropriate place to list the names of the doctors who served on the panel. The department is currently considering how to develop a process to review the list that would be conducted by a panel or board of individuals knowledgeable about pharmaceuticals, such as the Drug Utilization Review Board. The process may involve opportunity for public comment and input from physicians.

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

Three dots at the bottom of a page after the last line of text and three dots at the top of the following page before the first line of text indicate that text has been moved.

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

Manual Maintenance

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TOC P.1 (2600)	(95-5F)	TOC P.1 (2600)	(02-10)
TOC P.2	(99-12)	TOC P.2	(02-10)
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PP&D Facing Page 2620 Dated 2/10/89		Nothing	
2620	(95-5F)	2620	(02-10F)
Nothing		2620.1	(02-10F)
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Bulletin No. 02-10

2600 P.2

2600 Eligibility Criteria (Continued)

not apply to an individual whose SSI eligibility has terminated because of the SSI 36-month time limit related to drug/alcohol disability. If the individual's SSI terminated prior to the 36-month time limit, the barrier may apply up to 36 months inclusive of the period of SSI receipt.

C. Except as specifically provided in 2602 (Catastrophic situations), GA shall be granted to applicant households only if all of the following six criteria are met:

1. Net income received during the 30-day period immediately prior to application, computed pursuant to 2608, is below the applicable Reach Up payment level for that size household in similar living arrangements.
2. No household members have been disqualified for Reach Up or Medicaid benefits because of their refusal to comply with a program eligibility requirement.

If a member of a GA applicant household has been disqualified for Reach Up or Medicaid benefits due to a refusal to comply, the duration of the disqualification period for GA will be a minimum of 30 days, or the length of the disqualification period for the other program, whichever is longer.

3. The household is actively pursuing all sources of potential income appropriate to their situation, such as, but not limited to: Reach Up, SSI, AABD, Medicaid, Food Stamps, Fuel Assistance, Unemployment or Worker's Compensation, Veterans Benefits, insurance payments, Railroad Retirement, pensions, Social Security, wages, and child support. Pursuit of potential income means initiating an application, request or complaint as appropriate prior to a subsequent GA grant, cooperating with requirements for a timely decision, and continuing to cooperate in meeting requirements to maintain such income on an ongoing basis thereafter.
4. There is an emergency need. If the emergency need is a need for medical services or items, the department shall determine eligibility according to the rules for catastrophic situations at 2602, even if the applicant meets the noncatastrophic income test at 2600.
5. The household has exhausted all available income and resources except that:
 - a. Applicants who have available resources (see 2601) less than their need shall have the amount of the resources deducted from the GA grant.
 - b. Single individuals age 62 or over, or in receipt of SSI/AABD or Social Security based on blindness or disability, may have up to \$1,500 of available resources disregarded. A married couple, either of which meets the above criteria, may have up to \$2,250 of available resources disregarded. Only resources in excess of these amounts will be counted as "available" in determining eligibility or benefits for such persons, excluding eligibility and benefits payable relating to burial expenses (2640 - 2647).

7/1/02

Bulletin No. 02-10F

2602

2602 Eligibility Due to a Catastrophic Situation

Applicants with an emergency need attributable to a catastrophic situation (2602.1) may qualify for GA to address that need, provided that they meet the eligibility criteria in 2602-2604 and payment conditions in 2611-2627. To qualify for such assistance, applicants must meet all of the following eligibility criteria:

1. They must have an emergency need attributable to a catastrophic situation, as defined in 2602.1.
2. They must have exhausted all available income and resources.
3. They must explore or have explored all alternatives for addressing the need, such as family, credit or loans, private or community resources, and private or government-sponsored health insurance.

The following public and private resources must be explored before eligibility for GA payment for vision services or items can be established: the Vermont Association for the Blind, the Lions Club and other service organizations, school-related health programs, and other child development programs.

Eligibility workers shall explain to applicants that they are expected to take steps to avoid or resolve emergencies in the future without GA and that they will be asked to demonstrate that they have done so if they reapply. This explanation shall be documented in the applicant's case record.

Subsequent applications must be evaluated in relation to the individual applicant's potential for having resolved the need within the time which has elapsed since the catastrophe to determine whether the need is now caused by the catastrophe or is a result of failure on the part of the applicant to explore potential resolution of the problem.

The department shall not apply an income test or resource exclusions in determining eligibility due to a catastrophic situation.

7/1/02

Bulletin No. 02-10

2602.1

2602.1 Definition of Catastrophic Situation

For the purposes of this section, catastrophic situations are limited to the following situations:

1. Death of a spouse or minor dependent child.
2. The presence of an emergency medical need, as defined at 2602.3.

The department shall determine the eligibility of an applicant for payment of medical services or items using the criteria for eligibility due to a catastrophic situation at 2602, even if the applicant meets the noncatastrophic income test at 2600.

3. A natural disaster such as a flood, fire, or hurricane.
4. A court-ordered eviction or constructive eviction, as defined at 2602.2, due to circumstances over which the applicant had no control.

A court-ordered eviction resulting from intentional, serious property damage caused by the applicant, other household members, or their guests; repeated instances of raucous and illegal behavior that seriously infringed on the rights of the landlord or other tenants of the landlord; or intentional and serious violation of a tenant agreement is not considered a catastrophic situation. Violation of a tenant agreement shall include nonpayment of rent if the tenant had sufficient income to pay the rent and did not use that income to cover other basic necessities or withhold the rent pursuant to efforts to correct substandard housing.

7/1/02

Bulletin No. 02-10

2602.2

2602.2 Definition of Constructive Eviction

Constructive eviction is defined as any disturbance caused by a landlord, or someone acting on the landlord's behalf, that makes the premises unfit for occupation. The motive for the disturbance, which may be inferred from the act, is the eviction of the occupant.

A situation in which the landlord has not provided heat, utilities, or water within a reasonable period of time and there is an agreement to furnish these items shall be considered a constructive eviction when the applicant is pursuing legal resolution of these offenses through the Vermont Department of Health or appropriate local officials, such as the local housing inspector or town health officer. The department shall not deny benefits to an individual in a constructive eviction situation because the individual chooses not to pursue legal action such as withholding rent, obtaining a court order, suing the landlord, or terminating the rental agreement.

Verifiable battering qualifies as a constructive eviction. Acceptable verification of battering includes:

- a relief-from-abuse restraining order;
- observable physical evidence of abuse;
- corroboration of physical abuse from police, hospitals, court officials, physicians, nurses, and other credible sources; and
- a determination of abuse by staff at a women's shelter.

2602.3 Definition of Emergency Medical Need

The general definition of emergency medical need in subsection A applies to all items and services except those related to vision, dental, and prescription drugs. The definitions of emergency medical need as applied to vision, dental, and prescription drugs are specified in subsections B through D.

A. Emergency Medical Need – General

An emergency medical need is defined as a need for a medical service or item attributable to a medical condition characterized by acute symptoms of sufficient severity, including but not limited to severe pain, such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in the following:

- serious jeopardy to the health of the participant;
- serious impairment to bodily functions; or
- serious dysfunction of the bodily organ or part.

Prior to issuing a vendor authorization for covered physician services, vision services and items, medical supplies, durable medical equipment, or ambulance services, eligibility workers shall obtain a determination from the Office of Vermont Health Access (OVHA) that such services or items address an emergency medical need (as defined in subsection A or B) or addressed such a need at the time the services or items were provided.

B. Emergency Medical Need –Vision

An emergency medical need is deemed to exist if and only if vision services or items for which GA payment is requested are covered by GA (2623) and necessary to:

- aid convalescence from eye surgery;
- prevent blindness or further deterioration of eyesight;
- avert risk of physical injury from normal living hazards, such as stairs and stoves; or
- allow an individual to continue education or employment.

C. Emergency Medical Need – Dental

An emergency medical need is deemed to exist if and only if dental services for which GA payment is requested are covered by GA (2622) and necessary to relieve pain, bleeding, or infection. The Division of Dental Services at the Vermont Department of Health shall determine whether dental services for which GA payment is requested addressed an emergency medical need at the time the dental services were provided.

D. Emergency Medical Need – Prescription Drugs

An emergency medical need is deemed to exist if and only if a prescribed drug for which GA payment is requested complies with the requirements of the pharmacy best practices and cost control program, and is not included in a classification on the department's list of noncovered drug classifications (2624).

7/1/02

Bulletin No. 02-10

2603

2603 Citizenship and Residence

To be eligible for GA, an applicant must be a U.S. citizen or a legal alien.

When a town service officer or district director has reason to believe that an applicant came into Vermont for the purpose of receiving GA or, in the case of applications for payment of medical services, receiving medical care, the town service officer or district director may find the applicant ineligible. (33 V.S.A. §2107) Such applicants, however, may be granted GA for transportation to the place they were living before coming to Vermont. (33 V.S.A. §2107)

2604 Applicant's Responsibility

Applicants are the primary source of information about their circumstances. Respect for their rights to privacy place responsibility on applicants to furnish complete and accurate information.

Pursuant to 33 VSA Section 2104 and 2105, all GA applications require investigation and recording of the circumstances of the person alleged to need GA to determine eligibility. Applicants must furnish information required as to physical condition, earnings or other income, ability of all members of their families to be employed, the cause of the person's condition, the ability and willingness of persons legally liable for their support to assist and other relevant data.

The Department retains the right to verify any or all information provided by applicants. To be eligible for consideration for assistance, applicants must agree to the requisite investigation of their circumstances.

7/1/02

Bulletin No. 02-10F

2620

2620 Medical Care

The types of medical care covered for applicants meeting the eligibility criteria in 2602, 2602.1, and 2602.3 for eligibility due to a catastrophic situation and the general eligibility criteria in 2603 and 2604 are limited to:

- physician services (as further limited in 2621),
- dental services, (as further limited in 2622),
- vision services and items (as further limited in 2623),
- prescription drugs (as specified in 2624),
- medical supplies (as defined and further limited in 2625),
- durable medical equipment (as defined and further limited in 2626), and
- ambulance transportation (as further limited in 2627).

Other types of medical care (e.g., hospital services, other transportation, visiting nurses) are not covered. Routine examinations and treatment are not covered by GA because they do not address emergency medical needs.

For applicants who are beneficiaries under Medicaid, VHAP or another government-sponsored health care coverage program, the prior authorization requirements for that program, if any, apply equally to coverage for medical care under GA. GA payment is limited to providers enrolled in the Medicaid program.

The department shall pay for medical care with GA only if application is made within the following time frames:

- before receipt of the care,
- up to 30 days after the original billing date for care received, or
- within 30 days from the notice date on denial of eligibility by Medicaid, VHAP, or other government-sponsored health care coverage.

When application is made within 30 days from the notice date on denial of eligibility by Medicaid, VHAP, or other government-sponsored health care coverage, the application date for health care coverage shall be considered the application date for GA, and the GA application shall cover the full period during which the application for health care coverage was pending.

The department shall determine the applicant's eligibility for GA payment of medical care based on the applicant's circumstances on the date of application, not on the date the care is received.

Requests for payment from providers of medical care shall not be considered applications for GA.

7/1/02

Bulletin No. 02-10F

2620.1

2620.1 Payment

Eligibility workers shall issue vendor authorizations to eligible applicants. Vendor authorizations issued by the department must accompany provider bills for medical services other than prescription drugs. No GA payments shall be made, however, unless the requirements set forth in 2620-2627 are also met.

Payment to providers may not exceed the amount set forth in the fee schedule used in the Vermont Medicaid Program. Vermont law (33 V.S.A. §6501-6508) prohibits balance billing, which is charging or collecting from the recipient any amount in excess of the reasonable charge for the service, defined as the amount in the fee schedule.

7/1/02

Bulletin No. 02-10F

2621

2621 Physician Services

The following physician services are not covered by GA:

- cosmetic surgery,
- experimental surgery,
- sterilization,
- fertility services,
- acupuncture, and
- massage therapy.

2622 Dental Services

Covered dental services to relieve pain, bleeding, and infection are limited to:

- examinations;
- diagnostic radiographs of the symptomatic area;
- sedative fillings;
- therapeutic pulpotomy;
- extraction of infected and symptomatic teeth;
- incision and drainage of abscess; and
- minor procedures for the emergency palliative treatment of dental pain.

No payment shall be made for replacement of missing teeth or dentures.

2623 Vision Services and Items

Eyeglass frames or lenses meeting an emergency medical need are covered only if purchased through the department's authorized supplier.

7/1/02

Bulletin No. 02-10F

2624

2624 Prescription Drugs

To receive GA payment for prescription drugs, including over-the-counter drugs prescribed by a physician, providers are required to comply with the requirements of the department's pharmacy best practices and cost control program, as implemented through its pharmacy benefit manager. The program, designed to reduce the cost of providing prescription drugs while maintaining high quality in prescription drug therapies, includes a preferred list of covered prescription drugs identifying preferred choices within therapeutic classes for particular diseases and conditions and utilization review procedures.

No payment shall be made for drugs in drug classifications not covered by GA. Such drug classifications are not covered because none of the drugs in those classifications is ever appropriately prescribed to address an emergency medical need (2602.3), in the department's judgment. GA payment shall be made for drugs in classifications other than those on the not-covered list, as long as they comply with the requirements of the pharmacy best practices and cost control program. These payments shall be made even if the likelihood of an emergency is small or the drug has not been prescribed to address an emergency need.

The department's list of drug classifications not covered by GA will be made available at the website for the Office of Vermont Health Access or in paper form upon request.

Payment shall not be authorized for items to be used in a hospital or nursing home.

2625 Medical Supplies

Medical supplies are nondurable items customarily used in conjunction with the care or treatment of a specific illness, injury, or disability.

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Bulletin No. 02-10F

2626

2626 Durable Medical Equipment

Durable medical equipment is equipment that arrests, alleviates, or retards a medical condition and is:

- used primarily and customarily to serve a medical purpose;
- able to withstand repeated use;
- generally not useful to a person in the absence of an illness, injury, or disability; and
- suitable for use in the home and in the community.

The following durable medical equipment is not covered by GA because it does not address emergency medical needs:

- air cleaners
- dehumidifiers
- patient lifts
- exercise equipment
- message devices
- speech teaching machines

The following durable items are not covered by GA to address an emergency medical need because they do not meet the definition of durable medical equipment:

- air conditioners
- heating plants
- elevators
- saunas
- bathroom scales
- car seats not designed specifically for medical purposes
- equipment prescribed for education or vocational purposes;
- toys
- whirlpool pumps

2627 Ambulance Services

Ambulance services for transporting a hospital inpatient to another facility for outpatient services are not covered by GA because they are not covered by Medicaid.

7/1/02

Bulletin No. 02-10

2641

2641 Burial Arrangements

For purposes of section 2640 through 2646 the word "burial" is used as a general term that can mean either cremation or interment.

The district manager or the manager's designee shall make the decision on eligibility and level of payment; and shall be responsible for making the burial arrangements in situations where no relative, friend, or interested person is available.

Unless the decedent or the decedent's family has expressly requested an alternative arrangement, the decedent's body shall be cremated.

It is not the policy of the department to make bodies available for the advancement of anatomical science in those instances when no family or friends are known. Autopsies are performed only under regulations of the State pathologist, who pays related expenses.

2642 Application

The district director will cooperate with the funeral director, other agencies and persons to obtain information to determine in a specific instance whether or not the department will be responsible for all or part of the payment of burial expenses.

2643 Eligibility Requirements

Eligibility for department financial participation in burial expenses shall be approved when all of the following requirements are met:

- A. The Department of Prevention, Assistance, Transition, and Health Access is responsible under the provision of 33 VSA § 2301;
- B. The deceased lacks sufficient resources to pay all of the total allowable burial expenses;
- C. The total allowable burial expenses do not exceed the prescribed maximums allowed herein.

Payment of burial expenses shall not be issued until a full accounting of total burial expenses, contributions and resources has been completed and the department has determined that the burial fulfills the requirements described in the section on "Provisions for Payment;" and payments made will not exceed the maximums prescribed in procedures section P-2690.

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Bulletin No. 02-10

2644.2

2644 Allowable Expenses

2644.2 Interment, Cremation, and Other Related Expenses

Payment for other burial expenses is limited to charges for the items or services listed below within the limits specified below or in procedures section P-2690. Any change in the dollar amount specified in Procedures P-2690 for the Burial Transportation Rate, the Religious Service Maximum or the Newspaper Death Notice Maximum which represents an increase relative to the dollar amount which immediately precedes the change shall be carried out via a procedures change. Any change in the dollar amount specified in Procedures P-2690 for the Burial Transportation Rate, the Religious Service Maximum or the Newspaper Death Notice Maximum which represents a decrease relative to the dollar amount which immediately precedes the change shall be accomplished only by following the Administrative Procedures Act process for regulatory changes. A copy of the invoice must be submitted for each item or service listed except transportation, religious service, and newspaper death notice.

1. Cemetery lot – Purchase of a cemetery lot, when one is not available without cost, is limited to the least expensive lot in the cemetery (not payable if deceased is cremated).
2. Interment – Standard cemetery charges for opening and closing a grave are allowed (not payable if deceased is cremated).
3. Temporary interment – The standard cemetery charge is allowed when weather conditions require temporary interment in a cemetery vault (not payable if deceased is cremated).
4. Grave liner - The actual cost for a concrete grave liner, or minimum outer enclosure required by the cemetery if grave liners are not available, is allowed. Set-up charges are also allowed. (No payment will be made if deceased is cremated).
5. Transportation – In or out-of-state transportation of the deceased by hearse is paid at the Burial Transportation Rate specified in Procedures P-2690, subject to limitations specified below. Only mileage accumulated while the deceased is actually present in the hearse may be counted.

Transportation, for the purpose of out-of-state burial of the body of a person who dies in Vermont, shall be paid at the lower of the Burial Transportation Rate or the cost of the least expensive alternative form of transportation available and shall only be paid if the cost of the least expensive form of transportation available does not exceed the cost of purchasing a burial lot in a local cemetery in Vermont.

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Bulletin No. 02-10

2644.2 P.2

2644 Allowable Expenses

2644.2 Interment, Cremation, and Other Related Expenses (Continued)

Vermont law authorizes the Department to pay for the burial of persons who are residents of Vermont but die out of state. Within this authority we can pay for transportation to return a body to Vermont, but only if there are no other resources available. Most other states have provisions for taking care of indigent persons who die in their states, just as Vermont does. Therefore, the availability of assistance from the state in which the Vermont resident dies which would cover all or part of transportation costs to Vermont must be explored before we can authorize reimbursement for transportation to Vermont.

6. Clothing - Necessary and suitable clothing at the least expensive cost is paid when clothing is not supplied or donated by a relative, friend, or charitable or religious organization.
7. Religious service - The lower of the actual charge for a religious service or the Religious Service Maximum specified in Procedures P-2690 is allowed when payment is not supplied or donated by a relative, friend or charitable or religious organization.
8. Casket - Cloth-covered, flat-top (or oval-top if a flat top casket is not available to the funeral director) not to exceed the wholesale cost. A casket less expensive than a flat-top may be used only if specifically requested by the family of the deceased.
9. Oversized Casket - When required due to the size of the deceased, the actual difference in cost from the casket provided under number 8 (above) may be allowed.
10. Cremation - The actual cost of cremation, an alternative container, and the cremation certificate (i.e. no interment expenses) may be allowed. Costs of a casket (see number 8 above) may be allowed only if there will be viewing during calling hours or services. If a member of the decedent's family requests an urn, the least expensive urn shall be allowed as a cost of cremation. The allowable expenses for an alternative container and urn shall not exceed the wholesale costs for those items.
11. Newspaper death notice - The lesser of the actual charge for the obituary or the Newspaper Death Notice maximum specified in Procedures P-2690 is allowed.

Department payment for an above-ground burial vault shall not be authorized. If a burial vault is used, the cost must be paid by contributions from relatives or friends.

7/1/02

Bulletin No. 02-10

2647

2647 Payment

Payment shall be authorized only when an itemized accounting of burial expenses is received at State Office on the appropriate billing form.

For all interment, cremation, and other related expenses except transportation, religious service, and newspaper death notices, an invoice is also required. The name and address of the newspaper and the clergy must be indicated on the PATH 260 GB when these expenses are billed without an invoice.