

STATE OF VERMONT  
AGENCY OF HUMAN SERVICES

# DCF

## Department for Children and Families

**BULLETIN NO.:** 04-21

**FROM:** Betsy Forrest, Deputy Commissioner  
Economic Services Division

**DATE:** August 17, 2004

**SUBJECT:** Premium Rule Technical Amendments

**CHANGES ADOPTED EFFECTIVE:** 8/1/04

### 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):

<a href="#">M102</a>	<a href="#">2602</a>	<a href="#">3202</a>	<a href="#">3302.3</a>	<a href="#">4001.91</a>
<a href="#">M102.1</a>	<a href="#">2620</a>	<a href="#">3203</a>	<a href="#">3303.1</a>	<a href="#">4002</a>
<a href="#">M112</a>	<a href="#">2802</a>	<a href="#">3204</a>		<a href="#">4003.1</a>
<a href="#">M113</a>	<a href="#">2820</a>			
<a href="#">M150-M150.2</a>				
<a href="#">M302.26</a>				

This bulletin updates health care premium rules as authorized by Act 66 (2003), the Joint Legislative Committee on Administrative Rules (LCAR), and Act 122 (2004). Through this filing, the department has not changed any content of the rules approved by the LCAR on October 23, 2003. This bulletin removes italics from text for the parts of the rules that have now been implemented. It also changes the footnote references on some rule pages to correspond to when these rule provisions will be fully implemented.

### *Background*

Last year, the budget act of 2004 initiated several measures to sustain Vermont's public health care assistance programs. One initiative required the department of Prevention, Assistance, Transition and Health Access (PATH) (now, Department for Children and Families (DCF)) to implement a process for collecting premiums for certain coverage groups. (Act 66, §147). As explained more fully below, the department promulgated rules for this process.

This year, the budget act of 2005 amended the premium requirements of the budget act of 2004. These amendments have codified the department's phase-in of the premium process. (Act 122, §§ 129, 129a, 130).

Currently, the implementation of the premium process has four Phases: Phase One (from July 1, 2003 to January 1, 2004); Phase Two (from January 1, 2004 to August 1, 2004); Phase Three (from August 1, 2004 until further legislative direction is received); and Phase Four (following receipt of further legislative direction).

In compliance with section 130a(b) of Act 122, the department presented this bulletin to the Medical Care Advisory Committee (MCAC) on July 7, 2004. Although generally supportive of delaying full implementation of the premium system, the MCAC expressed concerns about the department's delay in implementing the provisions in the rules concerning medical incapacity and about the rulemaking process for premiums. Both concerns are addressed below.

### ***Medical incapacity***

The enabling legislation contemplates that medical incapacity will establish a basis for granting eligibility for past periods of coverage for VScript and VHAP-Pharmacy. It also provides that VHAP applicants who establish that medical incapacity prevented them from paying a premium timely, will be eligible for VHAP-limited when reinstated.

Although the premium rules include these provisions, the department has not implemented them yet. Full implementation of the medical incapacity provisions for VScript and VHAP-Pharmacy requires a mechanism by which to accept payments for past periods of coverage. This function will only be available in Phase Four, when the remaining billing components are activated. Full implementation of the medical incapacity provisions for VHAP-Limited are not needed until Phase Four because all individuals who are reinstated following nonpayment of premium currently receive VHAP-limited.

The department is looking into the feasibility of implementing some aspects of the medical incapacity provisions for the pharmacy coverage groups separately from the billing components to avoid delaying their implementation any longer than necessary.

### ***Rulemaking Process***

Bulletin 03-17 issued effective December 1, 2003, contained rules related to full implementation of the premium process as required by Act 66. On October 23, 2003, these rules were submitted to LCAR for review and were approved. By then, the department recognized the need to implement the premium process in phases. LCAR approved the phase-in approach. At that time, Phase Two was expected to end April 1, 2004, when full implementation would occur. The provisions in the rules that were delayed until full implementation were italicized<sup>1</sup> and LCAR authorized the department to convert the italics on these provisions to regular text upon full implementation of the premium process, without additional formal rulemaking.

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<sup>1</sup> Members of the advocacy community had requested that the department's rules in 03-17 reflect the parts of the rules being delayed.

On May 20, 2004, the Legislature approved the phased-in approach and authorized the extension of Phase Two, delaying full premium implementation until August 1, 2004. (Act 122, §130) One week later, on May 27, 2004, the Medicaid Advisory Board (now, Medical Care Advisory Committee (MCAC)) expressed concern about the premium rules being implemented on August 1, 2004. In its view, moving from the old to the new premium system and requiring beneficiaries to pay two bills in the transition month would be likely to confuse beneficiaries resulting in nonpayment and loss of coverage.

On July 7, 2004, the department responded to MCAC's concerns by further delaying full implementation of the premium process until the Legislature has an opportunity to decide whether it supports waiving a payment in the transition month.

Additional technical changes for premium implementation will be issued as solutions for the medical incapacity provisions are identified as well as when legislative approval is received for Phase Four.

**Manual Maintenance**

**Medicaid Rules**

<b><u>Remove</u></b>		<b><u>Insert</u></b>	
M102	(03-17)	M102	(04-21)
M102.1	(03-17)	M102.1	(04-21)
M111	(03-17)	M111	(04-21)
M113	(03-17)	M113	(04-21)
M150	(03-17)	M150	(04-21)
M150.1 P.2	(03-17)	M150.1 P.2	(04-21)
M150.1 P.3	(03-17)	M150.1 P.3	(04-21)
M200.24 P.2	(03-17)	Nothing	-
M302.26	(03-17)	M302.26	(04-21)

**General Assistance Rules**

2602	(03-17)	2602	(04-21)
2620	(03-17)	2620	(04-21)

**Emergency Assistance Rules**

2801 P.3	NOTHING	2801 P.3	(04-21)
2820	(03-01)	2820	(04-21)

**VScript Rules**

3202	(03-17)	3202	(04-21)
3203	(03-17)	3203	(04-21)
3204	(03-17)	3204	(04-21)
3204.3	(03-17)	3204.3	(04-21)
3204.3 P.2	(03-17)	3204.3 P.2	(04-21)

**VHAP-Pharmacy Rules**

3302.3	(03-17)	3302.3	(04-21)
3302.3 P.2	(03-17)	3302.3 P.2	(04-21)
3303.1 P.2	(03-17)	3303.1 P.2	(04-21)

**VHAP Rules**

4001.91	(03-17)	4001.91	(04-21)
4002.3 P.2	(03-17)	4002.3 P.2	(04-21)
4002.31 P.2	(03-17)	4002.31 P.2	(04-21)

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M102

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**M102**     Eligibility and Enrollment Process

The eligibility and enrollment process includes the steps an individual requesting health care assistance and the department must take to determine an individual's eligibility for and enrollment in health care assistance programs.

Eligible means the department has decided the individual meets all the eligibility criteria specific to the coverage group such as age, residency, and income level.

Enrolled means *the department has received full payment of required premiums for the individual who has been determined to meet all eligibility criteria specific to the coverage group. Enrolled individuals are health care assistance beneficiaries. Coverage begins the first day of the month after receipt of any required premiums, unless retroactive coverage provisions apply as in rule M113.*

The person (or group) must:

- apply for health care assistance,
- give necessary facts about their (or their family's) situation for the eligibility tests, and
- pay any required premium by the due date.

The department must:

- accept all health care assistance applications and premium payments,
- compare the facts of the individual's situation to the health care assistance eligibility rules,
- make decisions on initial and continuing eligibility for health care assistance,
- notify the individual of its decisions, and
- keep records of decisions and the facts used to make them.

Rules and time limits for these steps are given in M110-M149.

***Italicized text on this page will be effective upon full implementation of the premium provisions of Act 66 (2003) and Act 122 (2004).***

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M102.1

M102 Eligibility and Enrollment ProcessM102.1 Premiums

Certain health care assistance groups are required to pay a monthly premium as a condition of *initial and* continuing coverage. The amount of the premium depends on the net income of the assistance group on the most recent approved version of eligibility on the case record at the time the bill is generated, and for some coverage groups, the existence of other insurance that includes both hospital and physician coverage.

Failure to pay the full premium by the last day of the month shall result in disenrollment.

The premium payment system is described in M150 through M150.2.

***Italicized* text on this page will be effective upon full implementation of the premium provisions of Act 66 (2003) and Act 122 (2004).**

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M111

M110-M119     ApplicationM111     Application Requirement

Any individual who wants Medicaid must file a Medicaid application with the department except: An individual who has applied at a Social Security Office for supplemental security income.

If an individual granted SSI/AABD also wants retroactive Medicaid coverage before the start of the cash assistance grant, he/she must file a separate application for retroactive Medicaid coverage and be found eligible based on criteria other than receiving cash assistance.

Filing an application means taking or mailing a signed Medicaid application form to a department office, preferably the district office responsible for the town where the applicant lives. Department offices give Medicaid application forms to any individual who asks for one. Medicaid providers, referring agencies and other locations serving the public may also keep supplies of application forms.

An application form must be signed by individuals applying for Medicaid or by their authorized representative.

M112     Reapplication and Reenrollment

Any individual who has applied before for Medicaid and is not now eligible for coverage may reapply at any time.

To reapply, the individual (or group) must file a new up-to-date signed application form with the department. An authorized representative may act for the individual or group when needed.

When an individual has been disenrolled from coverage solely for non-payment of a premium, if the department receives and processes the payment on the next business day following the last day of the month the premium was due, the coverage group will be automatically reenrolled without a new application and without a break in benefits.

If the department receives and processes the payment after the first business day after the month the premium was due, but within the first month after closure, the coverage group will be automatically reenrolled *for the next month with a one month break in coverage*. Beneficiaries must submit a new application, however, if any change in a coverage group's circumstances affects its eligibility or a review of the case is scheduled for the current month or the following month.

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M113

M110-M119     ApplicationM113     Retroactive Application

Medicaid may be granted retroactively for up to three calendar months before the month of application provided all eligibility criteria were met during the retroactive period *and any premiums required for those months have been received by the department*. A woman is not eligible for the 60-day post-pregnancy period (i.e., when no other categorical criterion is met) if she was granted retroactively after her pregnancy has ended.

An authorized representative may apply for retroactive coverage on behalf of an individual who dies before he or she can apply for Medicaid.

Payments for Medicare cost sharing for individuals who are Qualified Medicare Beneficiaries (QMBs) and not otherwise eligible for Medicaid are first made in the month following the month QMB eligibility is determined. There is no retroactive QMB coverage.

Payments for Medicare cost sharing for the other Medicare cost-sharing groups can be paid for allowed Medicare costs incurred prior to the month of application provided all eligibility criteria were met during the three month retroactive period.

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M150

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M150     Payment System

The Vermont legislature instituted a premium-based payment system for most health care assistance programs with the 2004 Appropriations Act, Act 66 of 2003. This legislation also unified the method of billing and the premium collection system for all coverage groups.

M150.1   Cost Sharing RequirementsA.   Definitions

- (1) *Medical incapacity means a serious physical or mental infirmity to the health of the adult beneficiary or beneficiaries responsible for paying the premium that prevented the adult beneficiary or beneficiaries from paying the premium timely, as verified in a physician's certificate furnished to the department. Notice by telephone or otherwise by the physician that such certificate will be forthcoming will have the effect of receipt, providing the certificate is in fact received within seven days.*
- (2) *Physician's certificate means a written statement on a form supplied by the department signed by a duly licensed physician certifying that an adult beneficiary suffered from medical incapacity that prevented the beneficiary from paying the premium timely. If the medical incapacity is expected to continue or recur, the department will encourage beneficiaries to designate an authorized representative to receive and pay future bills for as long as the anticipated duration of the condition.*
- (3) “Premium” means a nonrefundable charge as a condition of *initial and* ongoing enrollment received in full by the department from applicants.
- (4) “Received” or “received and processed” means the department has posted the full premium payment and logged the transaction on the applicable case record on the department’s computer system, thereby ensuring the information is available to authorized staff.

***Italicized text on this page will be effective upon full implementation of the premium provisions of Act 66 (2003) and Act 122 (2004).***

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M150.1 P.2

M150 Payment SystemM150.1 Cost Sharing Requirements (Continued)B. Premium

This section describes the general premium rules and process. Additional rules applicable to the specific coverage groups subject to these premium rules vary, and are described in the following sections: Dr. Dynasaur (M302.26 and M302.27), VHAP (4000), VHAP-Pharmacy (3300), and VScript (3200).

*Coverage always begins on the first day of a month and only after the full premium has been received. Beneficiaries must pay the full monthly premium before coverage will begin, even if the department finds them eligible in all other respects before the first day of the next month. Applicants for Dr. Dynasaur may also be granted coverage during the months of application and billing provided all eligibility criteria were met during those months and the department has received and processed any premiums required for those months. They may also be granted retroactive coverage provided the requirements specified in M113 are met.*

The department's premium billing cycle is designed to make it as easy as possible for beneficiaries to maintain their monthly premium payments and avoid loss of coverage. The department's automated premium collection and distribution system manages the receipt and processing on the day of receipt of premiums if paid according to the billing directions.

The department will:

- send premium bills at least 25 days before the last day of the month, which is the date that coverage will end if the department does not receive the payment;
- mail beneficiaries a notice of impending closure at least 11 days before coverage ends for nonpayment of a premium;
- reinstate coverage without a break in benefits if the department receives the payment by the last day of the month, or the first business day following the last day of the month in which the due date falls.

When households with more than one coverage group make a partial payment of a bill that includes more than one premium, the payment will be applied as payment of one or more premiums in full rather than as a partial payment of all of the billed premiums. Beneficiaries who want to choose which premium to pay must call the Member Services number on the bill to record that designation on the case record.

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M150.1 P.3

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M150     Payment SystemM150.1   Cost Sharing Requirements (Continued)

In the event the beneficiary has not made the designation, the department will apply the partial payment to the following coverage groups in the following order: (1) Dr. Dynasaur; (2) VHAP; (3) VHAP-Pharmacy; and (4) VScript. If there is more than one beneficiary in the same coverage group with the same premium amount, the department will apply the partial payment to the first beneficiary listed on the bill.

In the event of an overpayment, the department will retain and reflect it as a credit on the next premium bill. When coverage ends, to expedite a possible reinstatement if requested, the department will wait 30 days before reimbursing a beneficiary any credit remaining on the account. If coverage remains closed for 30 days, PATH will issue a refund within 10 business days thereafter. If it will be a financial hardship to apply an overpayment in this way, beneficiaries may request that the department reimburse the overpayment within 30 days.

The department will automatically reimburse a beneficiary the amount of a premium within 30 days from when coverage terminates before the month the premium pays for because the beneficiary:

- moves out of state;
- moves from a premium-based coverage group to a non-premium-based group;
- becomes ineligible because of an increase of income; or
- dies.

In addition to premiums, health care beneficiaries may also be responsible for copayments for some services, which are described below.

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M302.26

M302.26 Children Under 18 (Dr. Dynasaur)

Children under age 18 who would be eligible for ANFC-related Medicaid except that their income or resources exceed the maximums are categorically eligible for Dr. Dynasaur as long as their household income does not exceed 300 percent of the federal poverty level (FPL). There is no resource test under this provision.

Premiums as specified in M150-M150.2 are required for the following individuals within this coverage group. Individuals requesting Dr. Dynasaur with income above 185 percent of the FPL but no more than 225 percent are required to pay a monthly premium of \$25 per household before coverage will *begin or* continue. Those with incomes above 225 percent but no more than 300 percent of the FPL must pay a \$35 monthly premium if the family has other insurance that includes hospital and physician coverage and a \$70 monthly premium if the family has no insurance besides Dr. Dynasaur.

When a single household includes more than one individual eligible for Dr. Dynasaur coverage, the household must pay the highest applicable Dr. Dynasaur premium.

Children who are members of federally designated American Indian or Alaskan Native tribes, as designated by the federal Bureau of Indian Affairs do not have to pay a premium if their household income is more than 225% but less than or equal to 300% FPL and they have no other insurance. Abenaki is not a federally designated tribe. If other children in the household are beneficiaries but not members of a federally-designated tribe, then the household is still responsible for the premium.

Children qualifying for Medicaid under Dr. Dynasaur and the Disabled Child in Home Care (DCHC/Katie Beckett) coverage group (see M200.23(d)) may select which of the two sets of rules that they wish to have determine their eligibility. An applicant applying under the DCHC coverage group who is eligible under Dr. Dynasaur shall receive Dr. Dynasaur coverage while the application is pending.

To assist applicants in making a decision between the two coverage groups, the department will provide the applicant with the requirements specific to the two groups, including the service delivery systems used, the process for determining eligibility, the time for processing applications, and the cost-sharing requirements of beneficiaries in each group.

PATH updates its income maximums based on the FPL annually on January 1 using a methodology similar to the one employed by the federal government in setting the FPLs. In years when the actual FPL exceeds PATH's income maximum, PATH will issue a second increase on April 1.

***Italicized text on this page will be effective upon full implementation of the premium provisions of Act 66 (2003) and Act 122 (2004).***

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Bulletin No. 04-21

2602

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**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. Applicants seeking help for an emergency medical need shall not be eligible for GA to address that need if they have been denied or lost health insurance sponsored by the state or federal government for specified reasons (see 2602(4)).

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 and pursue or have explored and pursued all alternatives for addressing the need, such as family, credit or loans, private or community resources, and private or government-sponsored health insurance. Before the department will determine eligibility for GA payment for vision services or items, the applicant must pursue or have pursued assistance from the Vermont Association for the Blind, the Lions Club and other service organizations, school-related health programs, and other child development programs, if applicable.
4. If seeking assistance for a medical need, at the department's most recent eligibility determination they must not have been denied or lost government-sponsored health insurance that would have covered the current need because of either or both of the following reasons:
  - they failed to pay a premium for the government-sponsored health insurance, or
  - they failed to comply with any administrative eligibility requirement necessary to be covered by the government-sponsored health insurance.

For purposes of GA rules, premium is defined as it is defined in Vermont Medicaid rules. Premium means a nonrefundable charge that must be paid by an applicant or beneficiary as a condition of initial and ongoing enrollment for health insurance.

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.

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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) and payment of premiums for private or government-sponsored health insurance are not covered. For purposes of GA rules, premium is defined as it is defined in Vermont Medicaid rules. Premium means a nonrefundable charge that must be paid by an applicant or beneficiary as a condition of initial and ongoing enrollment for health insurance. 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 for reasons other than those specified in 2602 (4).

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 for reasons other than those specified in 2602 (4), 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.

2801 Definitions (Continued)

Transient An individual who does not intend to establish a permanent residence in Vermont.

2802 Eligibility Due to a Catastrophic Situation

Applicants with an emergency need attributable to a catastrophic situation (see below) may qualify for EA to address that need, provided that they meet the eligibility criteria in 2802-2804 and payment conditions in 2811-2820. Applicants seeking help for an emergency medical need shall not be eligible for EA to address that need if they have been denied or lost health insurance sponsored by the state or federal government for specified reasons (see 2802(4)).

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 (see below).
2. They must have exhausted all available income and resources.
3. They must explore and pursue or have explored and pursued all alternatives for addressing the need, such as family, credit or loans, private or community resources, and private or government-sponsored health insurance. Before the department will determine eligibility for EA payment for vision services or items, the applicant must pursue or have pursued assistance from the Vermont Association for the Blind, the Lions Club and other service organizations, school-related health programs, and other child development programs, if applicable.
4. If seeking assistance for a medical need, at the department's most recent eligibility determination they must not have been denied or lost government-sponsored health insurance that would have covered the current need because of either or both of the following reasons:
  - they failed to pay a premium for the government-sponsored health insurance, or
  - they failed to comply with any administrative eligibility requirement necessary to be covered by the government-sponsored health insurance.

For purposes of EA rules, premium is defined as it is defined in Vermont Medicaid rules. Premium means a nonrefundable charge that must be paid by an applicant or beneficiary as a condition of initial and ongoing enrollment for health insurance.

Eligibility workers shall explain to applicants that they are expected to take steps to avoid or resolve emergencies in the future without EA 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.

## 2820 Medical Care

Medical care is limited to the types of care described in General Assistance Rule sections 2620 through 2626 for events described in 2602. For purposes of the Emergency Assistance Program the type of medical care covered is limited to physician care, dental care, eye care, pharmacy care, and ambulance transportation. Other types of medical care (e.g., other transportation, visiting nurses, etc.) and payment of premiums for private or government-sponsored health insurance are not paid for under the EA program.

The following eligibility criteria must be met:

The applicant meets the criteria in 2802 (Catastrophic Situations).

The Medical Consultant in the Medicaid Division may be consulted by the Eligibility Specialist when the emergency nature of a need is questionable.

The Medical Consultant is also consulted when a medical need requires prior authorization as specified in sections 2611 through 2626.

The applicant is not eligible for Medicaid; or the expense cannot be covered by Medicaid.

The medical care is rendered in Vermont to an individual who has not entered Vermont for the purpose of obtaining medical care.

### 2820.1 Payment

A Department issued vendor must accompany provider bills.

Payment to providers may not exceed the amount set forth in the fee schedule used in the Vermont Medicaid Program.

The Medical Consultant in the Medicaid Division will review all questionable claims to confirm the emergency nature of the treatment and to establish that the amount charged is in accord with the usual and customary charge.

### 2820.2 Balance Billing

Vermont law (33 V.S.A. 6501-6508) prohibits charging or collecting from the recipient any amount in excess of the reasonable charge for the service. The reasonable charge for EA services is the Medicaid Fee Schedule.

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3202

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3202      Coverage

Individuals are enrolled in this program and receive assistance in purchasing covered drugs from participating pharmacies after meeting all eligibility criteria *and paying the required premium.*

The department's payment for covered pharmaceuticals shall be based upon current Medicaid payment and dispensing policies.

3202.1      Drugs

"Drug" means a drug that may not be dispensed unless prescribed by a licensed physician. A drug shall always be the lowest cost brand available to the pharmacist unless the physician writing the prescription specifies otherwise. The term includes insulin, an insulin syringe and an insulin needle. The term excludes:

- a drug determined less than effective under the federal Food, Drug and Cosmetics Act;
- a drug within therapeutic classifications primarily associated with the treatment of acute medical conditions; and
- a central nervous system agent other than:

- agents used for treatment of convulsive disorders;
  - nonsteroidal anti-inflammatory agents for arthritis; and
  - agents used primarily for control of psychotic conditions diagnosed under current classifications of the Diagnostic Statistical Manual.

Lists of covered and excluded drugs are maintained and periodically updated by the department and available upon request.

For beneficiaries whose VScript group income is greater than 175 percent but no greater than 225 percent of the federal poverty level coverage is limited to drugs dispensed by participating pharmacies of manufacturers that as a condition of participation in the program, have signed a rebate agreement with the commissioner.

***Italicized text on this page will be effective upon full implementation of the premium provisions of Act 66 (2003) and Act 122 (2004).***

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3203

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3203 Cost Sharing Requirements

All VScript beneficiaries must pay monthly premiums as specified in M150 through M150.2 *to be enrolled in a VScript coverage group.*

The following premium amounts apply to VScript.

<u>VScript Group Income</u>	<u>Coverage Group</u>	<u>Monthly Program Fee, Per Individual</u>
> 150% ≤ 175% FPL	VScript	\$17
> 175% ≤ 225% FPL	VScript Expanded	\$35

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3204

3204 Process3204.1 Application

Between January 1 and June 15, applicants may complete the VScript application form provided in the state income tax return. The application form must be completed legibly and accurately with all questions answered fully, the rights and responsibilities statement read, proper signatures of applicant and applicant's spouse, dated, and submitted to the Department of Taxes on or before June 15. The Department of Taxes shall perform such income verification as is requested by the Secretary and transmit applications to the Department.

By signing/marking the rights and responsibilities statement on the application form, the applicant authorizes the Department to verify any information on the form, such as by contacting the Internal Revenue Service or the Social Security Administration.

Applicants may also access the VScript program anytime during the year by filing a VHAP-Pharmacy or Medicaid application. Applicants found ineligible for VHAP-Pharmacy or Medicaid shall have their eligibility determined for VScript and enrolled in VScript, *upon payment of the required premium* provided all other eligibility criteria are met.

Individuals have the responsibility to:

- notify the Department of a change of address;
- notify the Department whenever they become eligible for another plan of assistance or insurance;
- and
- notify the Department of a change in income or household size after an application has been submitted but before eligibility begins.

3204.2 Application Decision

An eligibility decision must be made within 30 days of the date the application is received by the Health Access Eligibility Unit or a Department of PATH district office. An applicant with countable income over the income test shall be denied and may reapply at any time.

Each applicant for the VScript program shall be given written notice of the decision on his/her application. All notice letters shall explain the decision and why it was made and how to appeal the decision if not satisfied.

The department will issue each enrolled beneficiary an identification card. This card shall contain the beneficiary's name and identification number. The identification card must be presented to a provider at the time of purchase. Replacement cards shall be issued by the department.

***Italicized text on this page will be effective upon full implementation of the premium provisions of Act 66 (2003) and Act 122 (2004).***

### 3204.3 Period of Eligibility and Enrollment

#### A. Eligibility

If VScript eligibility begins on or after July 1 but no later than December 31, VScript eligibility continues through June 30 of the next year. If VScript eligibility begins on or after January 1 but no later than June 30, VScript eligibility continues through June 30 of the following year.

A review of eligibility will be completed before the end of each certification period to assure uninterrupted coverage if the individual remains eligible, pays all required premiums and complies in a timely manner with review requirements. An individual who fails to pay required premiums or fails to comply in a timely manner with review requirements shall receive a termination notice mailed at least 11 days before the termination date.

Medicaid or VHAP-Pharmacy beneficiaries who lose eligibility in those programs will be enrolled in VScript *upon payment of required premium*, provided all other eligibility criteria are met.

#### B. Enrollment

Once eligibility for VScript is determined and *required premiums are received by the department*, according to rules specified at M150-M150.2 beneficiaries are enrolled *beginning on the first day of the month following receipt of full premium payment* through June 30 unless they are disenrolled at the end of the month following a notice mailed at least 11 days before the disenrollment date because they:

fail to pay required premiums;

establish residence outside of Vermont;

become eligible for full or partial coverage of prescription drugs under another plan of assistance or insurance;

are incarcerated;

voluntarily withdraw;

are found to have been ineligible on the date coverage began;

are no longer in contact with the department of PATH and have no known address; or

die.

Individuals are required to report any of the above changes, as applicable, and any change of address within 10 days of the change.

***Italicized text on this page will be effective upon full implementation of the premium provisions of Act 66 (2003) and Act 122 (2004).***

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### 3204.3 Period of Eligibility and Enrollment

#### B. Enrollment (Continued)

*If a beneficiary's coverage is terminated solely because of nonpayment of the premium, and the reason is medical incapacity, as specified in section M150.1(A)(1), the beneficiary or their representative may request coverage for the period between the day coverage ended and the last day of the month in which they request coverage. The department will provide this coverage if it has received verification of medical incapacity and all premiums due for the period of non-coverage. The beneficiary is responsible for all bills incurred during the period of non-coverage until the department receives the required verification and premium amounts due.*

*If the medical incapacity is expected to continue or recur, the department will encourage beneficiaries to designate an authorized representative to receive and pay future bills for as long as the anticipated duration of the condition (see Rule M104).*

### 3204.4 Payment Methodology

Participating pharmacies shall dispense a drug upon verification of a beneficiary's enrollment. The pharmacy shall collect the charge for the drug from the department.

### 3204.5 Right to Appeal

Individuals who have applied for or received VScript may appeal any decision of the department relating to their coverage and may request a fair hearing before the Human Services Board.

A request for a fair hearing must be made within ninety (90) days of the date the notice of the decision being appealed was mailed. A request for a hearing is defined as a clear expression, oral or written, that the individual wishes to appeal a decision.

When beneficiaries appeal a decision to end or reduce VScript coverage, they have the right, under certain conditions, to have benefits continue without change until the appeal is decided provided the beneficiary has requested a hearing before the effective date of the change and has paid in full any required premiums. Beneficiaries appealing the amount of their premiums shall pay at the billed amount in order for coverage to continue until the dispute is resolved.

***Italicized text on this page will be effective upon full implementation of the premium provisions of Act 66 (2003) and Act 122 (2004).***

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3302.3

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3302     Eligibility Process

3302.3    Period of Eligibility and Enrollment

A.   Eligibility

Eligibility criteria are described in rules 3301.1 – 3301.74.

If VHAP-Pharmacy eligibility begins on or after July 1 but no later than December 31, eligibility continues through June 30 of the next year. If VHAP-Pharmacy eligibility begins on or after January 1 but no later than June 30, eligibility continues through June 30 of the following year.

A review of eligibility will be completed before the end of each certification period to assure uninterrupted coverage if the individual remains eligible, pays all required premiums, and complies in a timely manner with review requirements. An individual who fails to pay required premiums or fails to comply in a timely manner with review requirements shall receive a termination notice mailed at least 11 days before the termination date.

B.   Enrollment

Once eligibility for VHAP-Pharmacy is determined and *required premiums are received by the department*, according to the rules specified at M150-M150.2, beneficiaries are enrolled *beginning on the first day of the month following receipt of full premium payment* through June 30 unless they are disenrolled at the end of the month following a notice mailed at least 11 days before the disenrollment date. Disenrollment shall occur whenever beneficiaries:

- fail to pay the required premium;
- are incarcerated;
- become eligible for another plan of assistance or insurance that provides any payment or reimbursement of prescription costs;
- move out-of-state;
- voluntarily withdraw;
- are found to have been ineligible on the date coverage began;
- are no longer in contact with the Department and has no known address;
- die.

Individuals are required to report any of the above changes, as applicable, and any change of address within 10 days of the change.

***Italicized text on this page will be effective upon full implementation of the premium provisions of Act 66 (2003) and Act 122 (2004).***

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3302.3 P.2

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3302 Eligibility Process

3302.3 Period of Eligibility and Enrollment

B. Enrollment (Continued)

*If a beneficiary's coverage is terminated solely because of nonpayment of the premium, and the reason is medical incapacity, as specified in section M150.1(A)(1), the beneficiary or their representative may request coverage for the period between the day coverage ended and the last day of the month in which they request coverage. The department will provide this coverage if it has received verification of medical incapacity and all premiums due for the period of non-coverage. The beneficiary is responsible for all bills incurred during the period of non-coverage until the department receives the required verification and premium amounts due.*

*If the health condition related to this medical incapacity is expected to continue or recur, the department will encourage beneficiaries to designate an authorized representative to receive and pay future bills for as long as the anticipated duration of the condition.*

3302.4 Identification Document

Each individual in the household enrolled in VHAP-Pharmacy is provided with an identification card which includes the name and identification number.

3302.5 Application for Other Benefits

Individuals who wish to apply for traditional Medicaid or other benefits available through PATH must file an application as required under those programs.

***Italicized text on this page will be effective upon full implementation of the premium provisions of Act 66 (2003) and Act 122 (2004).***

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3303.1 P.2

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3303 Payment Conditions3303.1 Cost Sharing

The department requires all beneficiaries to pay a monthly premium of \$13 *to enroll* in the VHAP-Pharmacy program. The premium payment system applicable to VHAP-Pharmacy is described in M150 through M150.2.

3303.2 Lower of Price for Ingredients Plus Dispensing Fee or Charge

Payment for prescribed drugs, whether legend or over-the-counter items, will be made at the lower of the price for ingredients (see 3303.3) plus the dispensing fee on file or the provider's actual amount charged, which shall be the usual and customary charge to the general public.

3303.3 Price for Ingredients

Payment for the ingredients in covered prescriptions is made for two groups of drugs; multiple-source (i.e., therapeutically equivalent or generic drugs) and "other" drugs (i.e., brand name or drugs "other" than multiple-source).

- a. For multiple-source drugs, the price for ingredients will be the lowest of:
  1. an amount established as the upper limit derived from a listing issued by CMMS, formerly the Health Care Financing Administration, under the authority of Sec. 902(a)(30)(A) of the Social Security Act, or
  2. an amount established as the upper limit by the Office of Vermont Health Access, or
  3. the Average Wholesale Price (AWP).
- b. For "other" drugs, the price for ingredients will be 88.1 percent of the Average Wholesale Price (AWP less 11.9 percent).

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4001.91

4001.9 Cost-Sharing Requirements4001.91 Premium

Individuals meet this requirement when they have paid any required premium as specified in M150 - M150.2. The amount of the premium for each individual increases according to VHAP income maximums (P-2420) based on the federal poverty level (FPL) as shown in the following chart:

<u>Income Maximums</u>	<u>Monthly Premium per Individual</u>
0 - 50% FPL	\$ 0
> 50% but $\leq$ 75% FPL	\$10.00
> 75% but $\leq$ 100% FPL	\$35.00
> 100% but $\leq$ 150% FPL	\$45.00
> 150% but $\leq$ 185% FPL	\$65.00

4001.92 Copayment

There is a copayment requirement of \$25 per medically necessary hospital emergency room visit, as defined in M103.3(13) and (37).

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4002.3 P.2

4002 Eligibility Process4002.3 Period of Eligibility and Enrollment (Continued)

Individuals who have been disenrolled from the VHAP program must file a new application for the program before eligibility may be re-established.

A review of eligibility will be completed before the end of each certification period to assure uninterrupted coverage if the individual remains eligible, complies in a timely manner with review requirements, and pays any required premium by the due date. An individual who fails to comply timely with review requirements and paying any required premium shall receive a termination notice mailed at least 11 days before the termination date. A failure to comply timely may result in a gap in coverage.

4002.31 VHAP-Limited Coverage

Individuals applying for VHAP will receive limited coverage, as described in the Medicaid Procedures Manual section P-4003, at no cost between the date the department determines eligibility and the date full coverage begins. *Full coverage begins on the first day of the month after the department has processed the full premium payment as specified at M150-M150.2. Individuals who do not pay the full premium by the due date are responsible for all bills incurred during that limited coverage period. The notice of eligibility the department sends individuals describes the limited coverage and includes a warning that failure to pay the full premium by the due date will result in no coverage for any bills incurred since the date of eligibility. Individuals will also be notified of the requirement that they must choose a primary care provider by the premium due date, or one will be chosen for them by the department.*

*When an individual's coverage is cancelled in whole or in part due to nonpayment of the premium and the individual attempts to reenroll within twelve months, limited coverage will be provided only if the individual meets one of the five exceptions listed below.*

(A) *The individual or spouse had employer-sponsored insurance that terminated because of:*

*loss of employment;  
death of the principal insurance policyholder;  
divorce or dissolution of a civil union;  
no longer qualifying as a dependent under the plan of a parent or caretaker relative; or  
no longer qualifying for COBRA, VIPER or other state continuation coverage.*

***Italicized text on this page will be effective upon full implementation  
of the premium provisions of Act 66 (2003) and Act 122 (2004).***

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4002 Eligibility Process4002.31 VHAP-Limited Coverage (Continued)

(B) *The individual or spouse had university-sponsored insurance that terminated because they graduated, took a leave of absence, or otherwise terminated their studies. Students under the age of 23 enrolled in a program of an institution of higher education are not eligible for coverage, however, if they:*

*have elected not to purchase health insurance covering both hospital and physician services offered by their educational institution; or  
are eligible for coverage through the policy held by their parents, but their parents have elected not to purchase this coverage.*

(C) *The individual's household income dropped below 75% of FPL, after allowable deductions, for households of the same size.*

(D) *The individual established residence in another state for more than 30 days and subsequently returned to Vermont.*

(E) *The individual was medically incapacitated, as specified in section M150.1(A)(1), during the period when premium payments were due.*

*If the health condition related to this medical incapacity is expected to continue or recur, the department will encourage beneficiaries to designate an authorized representative to receive and pay future bills for as long as the anticipated duration of the condition.*

4002.32 VHAP Managed Health Care System

If all eligibility criteria (4001.1 - 4001.91) are met, individuals shall be enrolled in the managed health care system, with full VHAP coverage, no later than the first of the month *after the department has received and processed the full premium payment. If a choice of primary care provider is not made by the premium due date, a primary care provider will automatically be assigned.*

4002.4 Identification Document

Each individual in the household who is enrolled is provided with an identification card.

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