

STATE OF VERMONT
 AGENCY OF HUMAN SERVICES

P A T H

Department of Prevention, Assistance, Transition, and Health Access

BULLETIN NO.: 03-10

FROM: Patricia House, Commissioner
 for the Secretary

DATE: June 18, 2003

SUBJECT: Health Care Assistance Program Changes Mandated by H. 464 (2003), Making Appropriations for the Support of Government

CHANGES ADOPTED EFFECTIVE 7/1/03

INSTRUCTIONS

- Maintain Manual - See instructions below.**
- Proposed Regulation - Retain bulletin and attachments until you receive Manual Maintenance Bulletin: _____**
- Information or Instructions - Retain until _____**

MANUAL REFERENCE(S):

M100	M142.1	3204.3	4002.3
M102.1	M150	3204.5	4002.4
M103.2	M150.1	3300	4002.6
M103.3	M670	3302.5	4003.1
		3305	
		3402.5	

To sustain Vermont's public health care assistance programs, the budget act of 2004 of the Vermont General Assembly mandates immediate cost-saving measures for health care programs administered by the department. These actions require amendments to the rules governing these programs. This bulletin contains those changes.

This bulletin makes the following changes:

- extends indefinitely the suspension of eyewear coverage for adults;
- eliminates the 6-month guaranteed period for beneficiaries enrolled in the managed care delivery system in the VHAP and Medicaid programs;
- increases existing program fees for Working People with Disabilities;

- increases existing program fees for Dr. Dynasaur, including children covered under the State Children's Health Insurance Program (SCHIP);
- establishes hospital copayments for adult beneficiaries enrolled in managed care; and
- increases the inpatient hospital copayment for adult beneficiaries receiving Medicaid under the fee-for-service delivery system.

The legislation also requires two changes to a beneficiary's right to appeal. The rule eliminates continued benefits for participants who appeal a reduction or elimination of benefits mandated by federal or state law when the change affects some or all beneficiaries in a program (a mass change). It also requires a beneficiary to pay the program fee as billed by the department in order for coverage to continue while any appeal is pending, even if the amount of the program fee is the subject of the appeal. In each circumstance, beneficiaries who prevail on appeal will be reimbursed by the department for out-of-pocket covered costs or overpaid program fees.

Expedited Rulemaking Process

The Vermont legislature authorized PATH to adopt these rules using an expedited rulemaking process ensuring implementation by July 1, 2003. These rules will be effective when filed with the secretary of state's office, and will have the full force and effect of rules adopted under the regular rulemaking process at 3 V.S.A. §843. They remain in effect until December 31, 2003 or until amended by a subsequent rule adopted under the provisions of Section 152a of H. 464, the 2004 Budget Act.

Specific Changes to Existing Rules

Eyewear Coverage M103.2 , M150.1 , M670 , 3300 , 3305 , 4003.1	Continues indefinitely the suspension of eyewear coverage for adults that began in July 2002. Eyewear includes eyeglass frames and lenses, contacts, and special lenses.
6-Month Guaranteed Coverage Period M100, 4002.32	Eliminates the 6-month guaranteed period for beneficiaries enrolled in the managed care delivery system in the Medicaid and VHAP programs. Page M100 P.3 addressed only this guaranteed period and was deleted.
Program Fee Increases M102.1	Increases the program fees in the Working People with Disabilities program and the Dr. Dynasaur program, including children covered under SCHIP. Corrects an error in the rule that omitted the program fee for pregnant women in the Dr. Dynasaur program with income between 185% and 200% FPL; as H. 464 makes changes to these specific program fees, there is an opportunity to accurately align this coverage group to existing law. The following chart summarizes the changes:

Net Income	Other Insurance	Eligibility Category	Monthly Program Fee		Quarterly Program Fee	
			<u>Old</u>	<u>New</u>	<u>Old</u>	<u>New</u>
more than 185% but no more than 200% FPL	with or without other insurance	pregnant women	\$20	\$25	\$60	\$75
more than 185% FPL but no more than 225% FPL	with or without other insurance	children under 18	\$20	\$25	\$60	\$75
		working people with disabilities	\$20	\$50	\$60	\$150
more than 225% FPL but no more than 300% FPL	with other insurance	children under 18	\$24	\$35	\$72	\$105
	without other insurance		\$50	\$70	\$150	\$210
more than 225% FPL but no more than 250% FPL	with other insurance	working people with disabilities	\$24	\$60	\$72	\$180
	without other insurance		\$50	\$75	\$150	\$225

Hospital Copayments

[M103.2](#), [M103.3](#),
[M150.1](#)

Increases hospital copayments in the Medicaid program. These copayments do not apply to children, pregnant women, or residents of nursing homes. They apply only to beneficiaries age 18 or older receiving SSI-related Medicaid and beneficiaries 21 or older receiving ANFC-related Medicaid.

For coverage groups in the managed care delivery system, a \$3.00 copayment is established for each outpatient visit, and a \$75.00 copayment for each inpatient admission.

For coverage groups in the fee-for-service delivery system, the copayment for outpatient visits remains at \$3.00, and the copayment for each inpatient admission increases from \$50.00 to \$75.00.

Appeal Rights

[M143](#), [3204.3](#),
[3302.5](#), [3402.5](#),
[4002.6](#)

Eliminates the provision that a beneficiary's coverage continues while an appeal of a mass change is pending. When a state or federal law requires reduction or elimination of a benefit for some or all beneficiaries (a mass change), that benefit will not continue as is while the appeal is pending. If the beneficiary prevails in the appeal, the department will refund any out-of-pocket costs for covered services during the period of non-coverage.

Requires the beneficiary to pay the billed program fee for benefits to continue while any appeal is pending, even if the beneficiary is appealing the amount of the program fee. The department will repay any overpaid program fees if the beneficiary prevails in the appeal.

Vertical lines in the left margin indicate significant changes. Dotted lines at the left indicate changes to clarify, rearrange, correct references, etc., without changing 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 by removing and inserting the following pages.

Manual Maintenance

<u>Remove</u>		<u>Insert</u>	
M100 P.3	(98-11F)	Nothing	
M102.1	(00-14)	M102.1	(03-10)
M103.2 P.3	(01-18F)	M103.2 P.3	(03-10)
M103.3 P.7	(01-18F)	M103.3 P.7	(03-10)
M142.1 P.2	(99-33)	M142.1 P.2	(03-10)
M150	(01-18F)	M150	(03-10)
M150.1	(01-18)	M150.1 P.2	(03-10)
M150.1 P.2	(91-31)	Nothing	
M670	(02-22F)	M670	(03-10)
3204.3 P.2	(97-4F)	3204.3 P.2	(03-10)
Nothing		3204.5	(03-10)
3300	(99-12)	3300	(03-10)
3302.5	(96-4F)	3302.5	(03-10)
3305 P.2	(02-22F)	3305 P.2	(03-10)
3402.5	(02-18)	3402.5	(03-10)
4002.3	(96-45F)	4002.3	(03-10)
4002.31 P.2	(96-45F)	4002.31 P.2	(03-10)
4002.32 P.2	(96-45F)	Nothing	
4002.4	(96-45F)	4002.4	(03-10)
4002.7	(96-45F)	4002.6 P.2	(03-10)
4003.1	(02-35)	4003.1	(03-10)

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M102.1

M102 Eligibility Process

M102.1 Program Fees

Certain Medicaid assistance groups are required to pay a monthly program fee, which is collected quarterly, to remain Medicaid-eligible. The amount of the program fee depends on the net income of the assistance group and the existence of other insurance that includes both hospital and physician coverage. Failure to pay the program fee shall result in termination of Medicaid eligibility.

The following table presents the required program fees:

Net Income	Other Insurance	Eligibility Category	Monthly Program Fee per Assistance Group	Quarterly Program Fee per Assistance Group
185% FPL or less	with or without other insurance	<ul style="list-style-type: none"> • pregnant women • children under 18 • working people with disabilities 	none	none
more than 185% but no more than 200% FPL	with or without other insurance	pregnant women	\$25	\$75
more than 185% but no more than 225% FPL	with or without other insurance	children under 18	\$25	\$75
		working people with disabilities	\$50	\$150
more than 225% FPL but no more than 300% FPL	with other insurance	children under 18	\$35	\$105
	without other insurance		\$70	\$210
more than 225% FPL but no more than 250% FPL	with other insurance	working people with disabilities	\$60	\$180
	without other insurance		\$75	\$225

When a single household is made up of more than one assistance group required to pay a program fee, the household is required to pay only one program fee, the highest fee applicable to an assistance group included within the household.

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M103.2 P.3

M103 Benefit Delivery Systems

M103.2 Managed Health Care Plan System (Continued)

B. Wrap-Around Benefits

Medicaid beneficiaries enrolled in managed health care plans are eligible to receive additional services as defined in the State Plan and by regulation that are not included in the managed health care plan package. Some of these services do not require a referral from the beneficiary's primary care provider and are reimbursed on a fee-for-service basis. Examples of these services are:

- transportation services (M755);
- dental care for children under age 21 (M620) and limited dental services for adults up to the annual benefit maximum (M621);
- eyeglasses for children under age 21 furnished through the department's sole source contractor (M670);
- chiropractic services (M640);
- family planning services (defined as those services that either prevent or delay pregnancy);
- personal care services (M740); and
- prescription drugs and over-the-counter drugs prescribed by a physician for a specific disease or medical condition (M810-M812).

C. Cost Sharing

Medicaid beneficiaries age 21 and older who are enrolled in a managed health care plan, unless they are exempted under M150.1, are subject to the following copayment requirements.

1. \$3.00 for each dental visit.
2. \$75.00 for the first day of an inpatient hospital stay in a general hospital.
3. \$3.00 per day per hospital for hospital outpatient services unless the individual is also covered by Medicare. An individual covered by Medicare has no copayment requirement for outpatient services.
4. Prescriptions:
 - \$1.00 for each prescription, original or refill, having a usual and customary charge of \$29.99 or less;
 - \$2.00 for each prescription, original or refill, having a usual and customary charge of more than \$30.00 but less than \$50.00;
 - \$3.00 for each prescription, original or refill, having a usual and customary charge of \$50.00 or more.

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M103.3 P.7

M103 Benefit Delivery Systems

M103.3 Primary Care Case Management Program

D. Self-Referral Services (Continued)

- chiropractic services (M640);
- maternity/prenatal (M510, M600);
- family planning services (defined as those services that either prevent or delay pregnancy);
and
- personal care services (M740).

E. Cost Sharing

Medicaid beneficiaries age 21 and older enrolled in the PCCM, unless they are exempted under M150.1, are subject to the following copayment requirements.

1. \$3.00 for each dental visit.
2. \$75.00 for the first day of an inpatient hospital stay in a general hospital.
3. \$3.00 per day per hospital for hospital outpatient services unless the individual is also covered by Medicare. An individual covered by Medicare has no copayment requirement for outpatient services.
4. Prescriptions:
 - \$1.00 for each prescription, original or refill, having a usual and customary charge of \$29.99 or less;
 - \$2.00 for each prescription, original or refill, having a usual and customary charge of \$30.00 or more but less than \$50.00;
 - \$3.00 for each prescription, original or refill, having a usual and customary charge of \$50.00 or more.

F. Enrollment

1. Choice of Primary Care Provider (PCP)

A benefits counselor will assist beneficiaries in making an informed decision among the choices described in M103, Options 5 and 6.

The benefits counselor will initiate a follow-up contact with an individual who has failed to notify the benefits counselor of his or her decision and will provide additional information if requested to do so. If two or more PCCM PCPs are available and no choice has been made within 30 days of being contacted, the benefits counselor will assign the individual to a PCP using a state-approved algorithm.

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M142.1 P.2

M142.1 Disability Determination Appeal (Continued)

- (2) Department Disability Decision - if the state's disability determination agent has made a Medicaid disability determination under the circumstances specified in Determination of Disability or Blindness, the decision may be appealed to the Human Services Board.

M143 Continued Benefits During Appeal

When a Medicaid recipient appeals a decision to end or reduce Medicaid coverage, he or she has the right, under certain conditions, to have benefits continue without change until the appeal is decided. However, continuation of benefits without change does not apply when the appeal is based on a reduction or elimination of a benefit required by federal or state law affecting some or all beneficiaries, or when the decision does not require the minimum advance notice (see Notice of Decision). To receive continued benefits a recipient must request a hearing before the effective date of the adverse action and continue to pay any required program fees throughout the appeal process. Recipients appealing the amount of their program fees shall pay at the billed amount until the dispute is resolved. If the last day before the adverse action date is on a weekend or holiday, the recipient has until the end of the first subsequent working day to request the hearing.

A recipient may choose to waive his or her right to continued benefits. If he or she does so and wins the appeal, any benefits due will be paid retroactively.

This Department is allowed to recover the value of any Medicaid benefits paid during the appeal period when the recipient withdraws the appeal before a fair hearing decision is made, or the reason for the appeal is an issue of law or policy and the Department's position is affirmed by the fair hearing decision

An issue of law or policy means that the person is questioning the legality of a law or rule rather than the facts used or Department's judgment in applying the rules to make the decision being appealed.

When a SSI/AABD recipient is determined "not disabled" by the Social Security Administration (SSA) and appeals this determination, his/her Medicaid coverage continues as long as his/her SSI/AABD benefits are continued (or could have been continued but the client chose not to receive them during the appeal period) pending a SSA decision on the appeal. When eligibility for SSI/AABD benefits is terminated following a determination of "not disabled", Medicaid coverage ends unless the individual applies and is found eligible for Medicaid on the basis of a categorical factor other than disability.

When a Medicaid recipient applies for SSI/AABD and is determined "not disabled" by the Social Security Administration (SSA) and files a timely appeal of this determination with the SSA, his/her Medicaid coverage continues until a final decision is made on the appeal provided the SSA's determination of "not disabled" is the only basis on which the individual might be found ineligible for Medicaid. If the Medicaid recipient continues to appeal unfavorable decisions by SSA, the "final decision" is the decision made by the SSA Appeals Council.

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M150

M150 Payment System

M150.1 Obligation of Recipients

Copayment from some recipients is required for certain services. The recipient copayment will be deducted from the amount computed to be the Medicaid payment for each service subject to copayment. Federal statutes (specifically, Section 1916 (c) of the Social Security Act) stipulate that "no provider participating under the State (Medicaid) plan may deny care of services to an individual eligible for (Medicaid)...on account of such individual's inability to pay (the copayment)." This subsection further provides, however, that these requirements "shall not extinguish the liability of the individual to whom the care or services were furnished for the payment of (the copayment)."

Copayment is never required for recipients who are:

- Patients in a participating long term care facility; or
- Under the age of 18; or
- Pregnant or in the 60-day post-pregnancy period.

Copayments are required for certain services as follows:

1. \$75 for the first day of an inpatient hospital stay in a general hospital.
2. \$3.00 per day per hospital for hospital outpatient services unless the individual is also covered by Medicare. An individual covered by Medicare has no copayment requirement for outpatient services.
3. Prescriptions as follows:
 - \$1.00 for each prescription, original or refill, having a usual and customary charge of \$29.99 or less,
 - \$2.00 for each prescription, original or refill, having a usual and customary charge of \$30.00 or more.
 - \$3.00 for each prescription, original or refill, having a usual and customary charge of \$50.00 or more.
4. \$3.00 per date of service per provider for dental services for recipients age 21 and older.

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M150.1 P.2

M150.1 Obligation of Recipients (Continued)

No copayments are required on the following services:

1. Services reimbursed by the Department of Mental Health and Mental Retardation and the Department of Health.
2. Emergency hospital services.
3. Services furnished to women related to pregnancy, including routine prenatal care, labor and delivery, routine postpartum care, and any complications of pregnancy, delivery, or the postpartum period. The postpartum period begins in the last day of pregnancy and extends to the last day of month that is 60 days later.
4. Home Health, hospice, and Home and Community Based Services for the Elderly and Disabled.
5. Services provided by other licensed practitioners. These include:
 - Podiatry
 - Chiropractic
 - Audiology
 - Psychological
 - Optometric and Optician
 - Nurse practitioner.
6. Services provided by rural health clinics and federally qualified health care facilities.
7. Independent laboratory.
8. X-ray interpretations performed by a physician who has no direct contact with the recipient.
9. Transportation including ambulance.
10. Medical supplies.
11. Durable Medical Equipment (DME) purchases and rental and nursing services.
12. Oxygen and respiratory equipment and supplies.
13. Family planning services.

The Department is not responsible for copayments a provider may collect in error or a recipient makes on a service that is not paid for by Medicaid.

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M670

M670 Eyeglasses and Vision Care Services

M670.1 Definition

Eyeglasses and vision care services are those services requiring the application of theories, principles and procedures related to vision and vision disorders for the purpose of diagnosis and treatment, including lenses, frames, other aids to vision, and therapeutic drugs. This definition is consistent with the federal definition of services found at 42 CFR §440.60(a), 440.120(d), and 441.30.

M670.2 Eligibility for Care

Coverage of eyewear is limited to beneficiaries under the age of 21. Vision care services are provided to beneficiaries of any age.

M670.3 Covered Services

Eyeglasses and vision care services that have been pre-approved for coverage are limited to:

- one comprehensive visual analysis and one interim eye exam within a two-year period;
- diagnostic visits and tests;
- dispensing fees (all dispensing fees for beneficiaries age 21 and older are suspended indefinitely);
- a prescription for frames and lenses every two years (all frames and lenses for beneficiaries age 21 and older are suspended indefinitely);
- contact and special lenses, when medically necessary and with prior approval (all lenses for beneficiaries age 21 and older are suspended indefinitely); and
- other aids to vision, such as closed circuit television, when the beneficiary is legally blind and when providing the aid to vision would foster independence by improving at least one activity of daily living (ADL or IADL).

M670.4 Conditions for Coverage

Coverage is limited to one pair of glasses every two years per beneficiary. Earlier replacement is limited to the following circumstances.

When eyeglasses (frames or lenses) have been lost, broken beyond repair, or scratched to the extent that visual acuity is compromised. (Dispensing providers will make the decision about being broken beyond repair or visual acuity being compromised.)

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3204.3 P.2

3204.3 Period of Eligibility (Continued)

If VScript eligibility begins on or after July 1 but no later than December 31, VScript coverage continues through June 30 of the next year. If VScript eligibility begins on or after January 1 but no later than June 30, VScript coverage continues through June 30 of the following year. Individuals must file a new application and be found eligible for VScript in order for coverage to continue beyond these dates.

Once eligible for VScript, coverage continues through June 30 unless the individual is closed at the end of the month following a notice mailed at least 11 days before the termination date because he/she:

- establishes residence outside of Vermont;
- becomes eligible for full or partial coverage of prescription drugs under another plan of assistance or insurance;
- is incarcerated;
- voluntarily withdraws;
- is found to have been ineligible on the date coverage began;
- is no longer in contact with the Health Access Eligibility Unit, a Department of Social Welfare district office or the Office of Vermont Health Access and has no known address;
- dies.

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

3204.4 Payment Methodology

A pharmacy shall dispense a drug to an eligible recipient upon payment of the required co-payment. The pharmacy shall collect the remainder of the charge for the drug from the Department.

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3204.5

3204.5 Right to Appeal

Any applicant/recipient has the right to appeal any decision of the Department relating to their VScript Program participation and coverage, and to 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 made. A request for a hearing is defined as a clear expression, oral or written, that the applicant/recipient wishes to appeal a decision.

When the appeal is based on a reduction or elimination of a benefit required by federal or state law which affects some or all beneficiaries, that benefit does not continue while the appeal is pending.

If a change in the co-payment requirement is necessary, a notice of this change must be mailed to the recipient at least 10 days before the effective date of the adverse action.

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3300

3300 Introduction

Legislative Act 14, authorizing and supporting the Vermont Health Access Plan, was adopted by the Vermont General Assembly and signed into law by the Governor on April 12, 1995. The Vermont Health Access Plan extends a pharmacy benefit and vision care services to low-income disabled and elderly Vermonters to assist them to purchase the prescription medicines that maintain their health and prevent unnecessary health problems. Vision care services do not include eyewear.

The policies which follow describe this pharmacy program, which is called VHAP-Pharmacy.

3301 Eligibility

An individual must meet all of the following requirements (3301.1 - 3301.74) to be found eligible for this program.

3301.1 Age

An individual qualifying on the basis of age must be at least 65 years of age on the date the application is filed.

3301.2 Disability

An individual qualifying on the basis of disability must be receiving disability benefits from Social Security (OASDI) or have Medicare coverage. Individuals in receipt of Railroad disability benefits must have Medicare coverage in order to be considered disabled.

3301.3 Uninsured

An individual meets the uninsured requirement if he/she does not have any plan, including VHAP-Limited, which pays or reimburses, either in whole or in part, with the exception of VScript or Medicare, his/her prescription drug expenses.

3301.4 Citizenship

An individual meets the citizenship requirement if he/she meets one of these two criteria:

- (1) He/she is a native-born or naturalized U.S. citizen. For purposes of qualifying as a United States citizen, the United States, as defined in the Immigration and Nationality Act, includes the 50 States, the District of Columbia, Puerto Rico, Guam, Virgin Islands, and the Northern Mariana Islands. Nationals from American Samoa or Swain's Island also are regarded as United States citizens for purposes of VHAP-Pharmacy.

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3302.5

3302 Eligibility Process

3302.5 Application for Other Benefits

Individuals who wish to apply for traditional Medicaid or other benefits available through the Department of Social Welfare must file an application as required under those programs.

3302.6 Right to Appeal

Applicants and recipients shall be provided by the department with notices whenever an individual is found ineligible for the VHAP-Pharmacy program or when the services they may receive under the VHAP-Pharmacy program are reduced or discontinued. The notice shall include a statement of the intended action, the reason for the action and an explanation of the individual's right to request a fair hearing before the Human Services Board.

A request for a fair hearing must be made within 90 days of the date the notice of the decision being appealed was mailed.

Coverage in the VHAP-Pharmacy program benefits continue during the appeal period provided the beneficiary has requested a hearing before the effective date of the change. A beneficiary who waives his or her right to continued benefits will be reimbursed by the department for out-of-pocket expenses for covered services provided during the appeal process in any case in which the Human Services Board reverses the decision. When the appeal is based on a reduction or elimination of a benefit required by federal or state law which affects some or all beneficiaries, that benefit does not continue while the appeal is pending.

3302.7 Recipient Fraud Investigation

A person, who knowingly gives false or misleading information or holds back needed information in order to obtain VHAP-Pharmacy benefits may be prosecuted for fraud under Vermont law or federal law or both. If convicted, the individual may be fined or imprisoned or both.

When the Department of Social Welfare learns that fraud may have been committed, it will investigate the case with respect for confidentiality and the legal rights of the recipient. If appropriate, the case will be referred to the State's Attorney or Attorney General for a decision on whether or not to prosecute.

3303 Payment Conditions

3303.1 Cost Sharing

A co-payment is required from all recipients for each prescription or covered diabetic supply, original or refill. The recipient co-payment will be deducted from the amount computed to be the VHAP-Pharmacy payment.

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3305 P.2

3305 Benefit Coverage (Continued)

- insulin and other diabetic supplies, including:
 - glucose strips and tablets, and
 - needles and syringes;
- one comprehensive visual analysis and one interim eye exam within a two-year period, and
- diagnostic visits and tests.

Exclusions

No benefits are provided for:

- refills beyond the original and five refills per script up to one year maximum;
- multi-vitamins;
- hair replacement therapies;
- drugs, and contraceptive medications, devices or supplies for which there is no prescription;
- drugs for the sole purpose of fertility; and
- over-the-counter drugs and medicinals.

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3402.5

3402 Eligibility Process

3402.5 Requirement to Report Changes

Applicants and beneficiaries must report changes in income and household composition within 10 days after learning of the change. They must also notify the department within 10 days after they:

- become eligible for insurance or other assistance covering prescription drugs;
- no longer meet state residency requirements (3401.3);
- are incarcerated; or
- have a change of address.

3402.6 Identification Document

The department shall provide each eligible Healthy Vermonters individual with an identification card. This identification card may be used only at participating pharmacies as defined at 3403.5.

3402.7 Application for Other Benefits

Individuals accepted into the Healthy Vermonters program may apply for the traditional Medicaid program or any other health care program at any time.

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

3402.8 Right to Appeal

The department will provide applicants and beneficiaries with notices whenever they are found ineligible for the Healthy Vermonters program or when the services they may receive under the Healthy Vermonters program are reduced or discontinued. The notice shall include a statement of the intended action, the reason for the action and an explanation of the individual's right to request a fair hearing before the Human Services Board.

A request for a fair hearing must be made within 90 days of the date the notice of the decision being appealed was mailed.

Coverage in the Healthy Vermonters program continues during the appeal period provided the beneficiary has requested a hearing before the effective date of the termination. A beneficiary who waives his or her right to continued benefits will be reimbursed by the department for out-of-pocket expenses for covered services provided during the appeal process in any case in which the Human Services Board reverses the decision. When the appeal is based on a reduction or elimination of a benefit required by federal or state law which affects some or all beneficiaries, that benefit does not continue while the appeal is pending.

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4002.3

4002 Eligibility Process

4002.3 Period of Eligibility

Effective dates of coverage and eligibility periods depend on the benefit delivery system, fee-for-service or managed health care, that applies to the individual. The rules under each system are described in the following sections.

4002.31 VHAP-Limited (Fee-for-Service) System

If all eligibility criteria (4001.1 - 4001.9) are met and no premium is required, the individual shall be accepted into the VHAP program effective the day eligibility is approved, or the first of the month following the day an opening in the program becomes available, if acceptance is delayed due to the cap on expenditures or enrollment. If all eligibility criteria (4001.1 - 4001.9) are met and a premium is required, the individual shall be accepted into the VHAP program by the first working day after the premium is received by the benefits counselor.

Once accepted into the VHAP program, coverage under the program continues until the scheduled review unless the individual is dropped from the program following a notice mailed at least 11 days before the termination date because he/she:

- has a change in income that results in income over the applicable income test;
- has a change in the household size that results in income over the income test for the new household size;
- loses eligibility as a student;
- is incarcerated;
- is admitted to a long-term care facility, such as a nursing home, a free-standing psychiatric facility or an ICF/MR facility for longer than 30 days;
- acquires insurance that includes hospital and physician coverage that has no disqualification period for a pre-existing condition, or has a disqualification period that has ended or that has lasted for one year or more;
- obtains Medicare coverage;
- moves out-of-state;
- voluntarily drops out of the program;
- is found to have been ineligible on the date coverage began;
- is no longer in contact with the Health Access Eligibility Unit, a Department of Social Welfare district office or the Office of Vermont Health Access and has no known address;
- fails to provide verification requested for another program if it pertains to an eligibility factor for the VHAP program;
- fails to pay timely any program fee required to maintain eligibility; or
- dies.

The notice will inform the recipient of his/her appeal rights and provide him/her with information about the traditional Medicaid program, including how and where to apply for the program.

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4002.31 P.2

4002 Eligibility Process

4002.3 Period of Eligibility

4002.31 VHAP-Limited (Fee-for-Service) System (Continued)

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

An individual who has been dropped 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 prior to the end of each certification period to assure uninterrupted coverage if the individual remains eligible and complies in a timely manner with review requirements and the payment of any required premium. An individual who fails to comply timely with review requirements and the payment of 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.

4002.32 Managed Health Care Plan System

If all eligibility criteria (4001.1 - 4001.91) are met and a choice of plan is made by the 15th of a month, the individual shall be enrolled in a managed health care plan no later than the 1st of the following month. If all eligibility criteria (4001.1 - 4001.91) are met or a choice of plan is made after the 15th of a month, enrollment in a managed health care plan begins the 1st of the second month.

For individuals joining an existing VHAP household, see 4003.21.

For the reasons an individual will be disenrolled from the plan, the notice requirements, requirements to report changes, procedure to follow to re-enroll, and procedures for review of eligibility, see 4002.31.

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4002 Eligibility Process

4002.4 Identification Document

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

4002.5 Application for Medicaid

Individuals who wish to apply for the Medicaid program must file an application as required under that program.

Applicant will be advised that retroactive benefits are only available through the traditional Medicaid program.

Individuals accepted into the VHAP program may apply for the traditional Medicaid program at any time. Individuals required to meet a spend-down for Medicaid may use VHAP premiums and cost sharing to meet their spend-down. Individuals who apply for Medicaid and request reimbursement are reimbursed for any cost-sharing expenses they paid during their participation in the VHAP program to the same extent as other traditional Medicaid recipients are reimbursed.

VHAP enrollees who become pregnant will be notified by the department that they are eligible for traditional Medicaid effective the first of the month in which they advised the department of this change in status. They will be notified that they are eligible for the traditional Medicaid benefits and have no premiums or copayment requirements during their pregnancy. They will also be notified that they are eligible for up to three months' retroactive benefits under the traditional Medicaid program if they were pregnant and have unpaid bills from that period. Individuals who request reimbursement are reimbursed for any cost-sharing expenses they paid during their participation in the VHAP program to the same extent as other traditional Medicaid recipients are reimbursed.

4002.6 Right to Appeal

Applicants and recipients shall be provided by the department with notices whenever an individual is found ineligible for the VHAP-Pharmacy program or when the services they may receive under the VHAP-Pharmacy program are reduced or discontinued. The notice shall include a statement of the intended action, the reason for the action and an explanation of the individual's right to request a fair hearing before the Human Services Board.

A request for a fair hearing must be made within 90 days of the date the notice of the decision being appealed was mailed.

Coverage in the VHAP program continues during the appeal period provided the beneficiary has requested a hearing before the effective date of the termination, and has continued to pay any required

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4002 Eligibility Process

4002.6 Right to Appeal (Continued)

program fees. Beneficiaries appealing the amount of their program fees shall pay at the billed amount until the dispute is resolved. A beneficiary who requests a hearing after the effective date of termination will be reimbursed by the department for out-of-pocket expenses for covered services provided during the appeal process in any case in which the Human Services Board reverses the decision.

When the appeal is based on a reduction or elimination of a benefit required by federal or state law which affects some or all beneficiaries, that benefit does not continue while the appeal is pending.

See 4003.24 for rights to appeal managed health care decisions or disenrollment from a plan.

4002.7 Recipient Fraud

An individual who knowingly gives false or misleading information or holds back needed information to obtain VHAP benefits may be prosecuted for fraud under Vermont law or federal law or both. If convicted, the individual may be fined or imprisoned or both.

When the department learns that fraud may have been committed, it will investigate the case with respect to confidentiality and the legal rights of the recipient. If appropriate, the case will be referred to the State's Attorney or Attorney General for a decision on whether or not to prosecute.

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4003.1

4003 Benefit Delivery Systems

4003.1 Benefits

A. Services Requiring Plan Referral (Continued)

- mental health and chemical dependency services;

NOTE: If a participating managed health care plan has a contract with an institution for mental diseases, services are limited to 30 days per episode and 60 days per calendar year.

- podiatry services;
- prescription drugs and over-the-counter drugs prescribed by a physician for specific disease or medical condition;
- over-the-counter and prescription smoking cessation with a limit of two treatment regimens per beneficiary per calendar year.

B. Self-Referral Services

In VHAP managed care the following services may be accessed by beneficiaries without a referral from their primary care provider.

- one routine annual gynecological exam and related diagnostic services (as specified by the plan);
- one mental health and chemical dependency visit (plans may determine the number of visits beyond the initial visit that can be provided before authorization is required from the plan's mental health and substance abuse in-take coordinator, or primary care physician); and
- one routine eye examination every 24 months.

C. Wrap-Around Benefits

In VHAP managed care, beneficiaries are eligible to receive additional services that are not included in the managed health care plan package. These services do not require a referral from the beneficiary's primary care provider and are reimbursed on a fee-for-service basis. The wrap-around services are:

- eyeglasses furnished through PATH's sole source contractor (coverage of all eyewear is suspended indefinitely);
- family planning services (defined as those services that either prevent or delay pregnancy).