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These rules have been repealed. However, rules 5321 - 5323 still apply to the VPharm 5400 rules.

Vermont Health Access Plan

5300 Vermont Health Access Plan (10/01/2007, 07-24)

The General Assembly of the State of Vermont, in enacting Act 14 (1995), created a health security trust fund for the purpose of providing expanded access to health care benefits for uninsured low-income Vermonters. This coverage is provided under the Vermont Health Access Plan for the uninsured (VHAP).

Access is expanded by an approved waiver from the Health Care Financing Administration (HCFA) that eliminates the Medicaid categorical test and the resource test for individuals age 18 or over. Vermont's approved 1115 Research and Demonstration Medicaid Waiver also authorizes the Agency of Human Services to require enrollment in managed care as a condition of eligibility for this new coverage group and to limit the covered services provided to VHAP beneficiaries. Additional provisions of the Medicaid program are waived. (Refer to rules 4100, Purpose-Medicaid Program and rule 4102,Vermont Health Access Plan). If an individual has access to an employer-sponsored-insurance (ESI) plan, enrollment in the ESI plan with premium assistance is a condition of eligibility for VHAP if the plan is approved and available, and the department determines that enrollment will be cost-effective. (rule 5911.1).

The policies that follow implement the Vermont Health Access Plan (VHAP) program, including the requirements for eligibility and, if required, for enrollment in managed health care plans. The requirement to enroll in a managed health care plan is subject to plan availability and capacity.

5301 Beneficiary Fraud (07/01/2007, 06-05)

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 ESD 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.

Eligibility

5310 Eligibility (10/01/2007, 07-24)

An individual must meet all of the following requirements (rules 5311–5331) to be found eligible for this program.

Age

5311 Age (10/01/2007, 07-24)

An individual age 18 or over meets the age requirement.

INTERPRETIVE MEMO

[X] VHAP Rule Interpretation **[ ] VHAP Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 5312 Date of this Memo 08/01/2008 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

UPDATE:

Individuals who qualify for, but are not enrolled in Medicare

Individuals who qualify for, but are not enrolled in full Medicare (e.g. Medicare Part A and Part B OR Medicare Part C) are ineligible for VHAP. An individual who enrolls in Medicare is eligible for VHAP from the enrollment date through the day before the Medicare start date.

Current insurance ending in the future for a reason meeting the exception criteria

Insured individuals who are otherwise eligible for VHAP may enroll in the program if:

- insurance coverage will end for a reason that qualifies for an exception to the waiting period;
- the application is received within 60 days of the insurance end date;
- any premium that is required is paid; and
- the individual's insurance remains the primary payer of claims incurred prior to the end date.

Prior coverage through another public entity

Vermont residents who have terminated prior coverage that was sponsored by another public entity are exempt from the twelve-month waiting period.

Multiple insurance losses within a 12 month period

In cases where an individual has multiple private, employer-sponsored or college insurance losses within a 12 month period, the most recent loss reason supersedes all prior loss reasons.

5312 Uninsured (05/01/2010, 10-02)

Individuals are considered "uninsured" and meet this requirement if they are not eligible for Medicare and have no other insurance that includes both hospital and physician services, and did not have such insurance within the 12 months prior to the month of application, unless they meet one of the exceptions specified below.

A. An individual with household income, after allowable deductions, at or below 75 percent of the federal poverty guideline for households of the same size;

B. An individual who lost private insurance or employer-sponsored coverage during the prior 12 months for the following reasons:

1. The individual's coverage ended because of:

a. Loss of employment, including a reduction in hours that results in ineligibility for employer-sponsored coverage, unless the employer has terminated its employees or reduced their coverage for the primary purpose of discontinuing employer-sponsored coverage and establishing their eligibility for Catamount Health;

b. death of the principal insurance policyholder;

c. Divorce or dissolution of a civil union;

d. No longer receiving coverage as a dependent under the plan of a parent or caretaker relative; or

e. no longer receiving COBRA, VIPER, or other state continuation coverage; or

2. College- or university-sponsored health insurance became unavailable to the individual because the individual graduated, took a leave of absence, decreased enrollment below a threshold set for continued coverage, or otherwise terminated studies. However, students under the age of 23 enrolled in a program of an institution of higher education are not eligible for coverage, if they:

a. Have elected not to purchase health insurance covering both hospital and physician services offered by their educational institution; or

b. Are eligible for coverage through the policy held by their parents, but their parents have elected not to purchase this coverage.

C. An individual who lost private insurance or employer-sponsored coverage during the prior 12 months for the following reasons:

1. The individual's coverage ended because of:

a. Loss of employment, including a reduction in hours that results in ineligibility for employer-sponsored coverage, unless the employer has terminated its employees or reduced their coverage for the primary purpose of discontinuing employer-sponsored coverage and establishing their eligibility for Catamount Health;

b. Death of the principal insurance policyholder;

c. Divorce of dissolution of a civil union;

d. No longer receiving coverage as a dependent under the plan of a parent or caretaker relative; or

e. No longer receiving COBRA, VIPER, or other state continuation coverage; or

2. College- or university-sponsored health insurance became unavailable to the individual because the individual graduated, took a leave of absence, decreased enrollment below a threshold set for continued coverage, or otherwise terminated studies. However, students under the age of 23 enrolled in a program of an institution of higher education are not eligible for coverage, if they:

a. Have elected not to purchase health insurance covering both hospital and physician services offered by their educational institution; or

b. Are eligible for coverage through the policy held by their parents, but their parents have elected not to purchase this coverage.

D. The individual lost health insurance as a result of domestic violence. The individual shall provide the agency of human services with satisfactory documentation of the domestic violence. The documentation may include a sworn statement from the individual attesting to the abuse, law enforcement or court records, or other documentation from an attorney or legal advisor, member of the clergy, or health care provider, as defined in section 9402 of Title 18. Information relating to the domestic violence, including the individual's statement and corroborating evidence, provided to the agency shall not be disclosed by the agency unless the individual has signed a consent to disclose form. In the event the agency is legally required to release this information without consent of the individual, the agency shall notify the individual at the time the notice or request for release of information is received by the agency and prior to releasing the requested information.

NOTE: This subdivision shall take effect upon issuance by the Centers for Medicare and Medicaid Services of approval of an amendment to the Global Commitment for Health Medicaid Section 1115 Waiver allowing for a domestic violence exception to the Catamount Health premium assistance waiting period.

E. Notwithstanding any other provision of law, when an individual is enrolled in Catamount Health solely under the high deductible standard outlined in 8 V.S.A. § 4080f(a)(9), the individual shall not be eligible for the Vermont health access plan for the 12-month period following the date of enrollment in Catamount Health.

F. Prior Enrollment in a Health-Care Program

No waiting period is imposed because of the loss of:

1. Medicaid;

2. VHAP;

3. Dr. Dynasaur;

4. VHAP-ESIA;

5. Catamount-ESIA;

6. Catamount Health with or without premium assistance, or

Uninsured

7. 7. Prior state administered coverage under Title XIX or Title XXI of the Social Security Act by another public entity.

INTERPRETIVE MEMO

[X] VHAP Rule Interpretation **[ ] VHAP Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 5313 **Date of this Memo** 05/17/1999 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: Must an individual reside in Vermont for 12 months before applying for benefits from the VHAP Program?

ANSWER: No. We have changed the eligibility criteria for state residence in response to the United States Supreme Court decision, Saenz v. Roe (May 17, 1999). Applicants applying for benefits from VHAP must reside in Vermont at the time of application. This change eliminates the former 12-month residency requirement.

Citizenship and Identity

5313 Citizenship and Identity (01/01/2007, 06-48)

The rules for citizenship and identity are in rules 4170 – 4176.

5314 Residence (01/01/2007, 06-48)

An individual must be a resident of Vermont to meet the residence requirement.

5315 Living Arrangement (01/01/2007, 06-48)

An individual meets the living arrangement requirement unless: he/she is expected to remain for over 30 days in a long-term care facility such as a nursing home, a freestanding psychiatric facility, or an ICF/MR facility; is enrolled in a home and community-based waiver program; is receiving services from a hospice program; or is living in a correctional facility, including a juvenile facility.

An individual living in an alcohol treatment facility or a drug treatment facility is eligible for VHAP.

5316 Student Status (05/15/1996, 96-18)

A. Applicability

To be eligible for VHAP, a student must meet the requirements of section b. below unless he/she is exempt from these requirements based on at least one of the following criteria:

1. 50 years old or older,
2. disabled,
3. attending high school,
4. participating in an on-the-job training program,
5. enrolled full time in a school or training program, excluding post-secondary institutions of higher education, or
6. enrolled less than half time in a post-secondary institution of higher education.

If a claimed disability is not evident to the department, verification may be required. Appropriate verification may consist of receipt of temporary or permanent disability benefits issued by governmental or private sources or of a statement from a physician or licensed or certified psychologist.

High school and on-the-job training programs are not considered institutions of higher education. A person is considered a participant in an on-the-job training program only while being trained by the employer. When a person is no longer being trained by the employer, he/she is no longer exempt from the requirements of section B. below.

NOTE: See the rule 5312, Uninsured or Underinsured, and rule 5314, Residence, for additional restrictions on the coverage of students.

B. Eligibility Requirements

1. To be eligible to participate in the VHAP program, any student not exempt under section a. above shall meet at least one of the following criteria:

   a. Is employed for a minimum of 20 hours per week and receives cash payment for such employment or is self-employed for a minimum of 20 hours per week with weekly earnings at least equal to the Federal minimum wage multiplied by 20 hours.

   b. Participates in a state-financed or federally financed work-study program during the regular school year. To qualify under this provision, a student must be approved for a work-study program at the time of application and must anticipate starting a job within two months after the date of application. A student meets this criterion until the student stops working. If a student stops working because funding for the work study runs out, the student shall continue to meet this criterion for no more than two months.

   c. Is responsible for the care of a dependent household member under the age of 18.

   d. Is assigned to or placed in an institution of higher education through or in compliance with the requirements of:

      i. A program under the Job Training Partnership Act of 1974 (29 U. S. C. 1501, et seq.),

ii. A program under section 236 of the Trade Act of 1974 (19 U. S. C. 2296), or

iii. A program for the purpose of employment and training operated by a state or local government.

2. The enrollment status of a student shall begin on the first day of the school term of the institution of higher education. Such school enrollment shall be deemed to continue through normal periods of class attendance, vacation and recess unless the student graduates, is suspended or expelled, drops out, or does not intend to register for the next normal school term (excluding summer school).

5317 Other Eligibility Requirements (01/01/2009, 08-20)

An individual must, if required of him/her:

A. assign rights to any medical support and other payments for medical care,

B. cooperate with the department in establishing paternity, and

C. enroll in a group health plan if it includes both hospital and physician services and if the department has determined this would be cost-effective to the state. The department would pay all cost-sharing obligations associated with the group health plan, including premiums, deductibles and coinsurance. The individual remains in the VHAP program with no change in the level of benefits.

D. take all necessary steps to obtain any annuities, pensions, retirement, disability benefits or other income to which he or she may be entitled, unless he or she can show good cause for not doing so. Annuities, pensions, retirement and disability benefits include, but are not limited to, veterans' compensation and pensions; Old Age, Survivors, and Disability Insurance (OASDI) benefits; railroad retirement benefits; and unemployment compensation. Individuals are not required to apply for cash assistance programs such as SSI/AABD or Reach Up.

5320 Financial Need (01/01/2009, 08-20)

An individual must be a member of a VHAP group with countable income under the applicable income test to meet this requirement.

A VHAP group includes all of the following individuals if living in the same home:

A. the VHAP applicant and his or her spouse;

B. children under age 21 of the applicant or spouse;

C. siblings under age 21, including halfsiblings and stepsiblings, of B.;

D. parents, including a stepparent and adoptive parents of C., and

E. children of any children in B. and C., and

F. unborn children of any of the above.

The VHAP group shall not include any individual eligible for and receiving SSI/AABD benefits. In addition, the income of all SSI/AABD recipients living in the household shall not be considered in determining whether the VHAP group passes the income test for VHAP.

The VHAP group shall not include any individual eligible for and receiving Reach Up benefits. In addition, the income (including the Reach Up assistance payment) of all Reach Up participants living in the household shall not be considered in determining whether the VHAP group passes the income test for VHAP.

5321 Income (05/01/2010, 10-02)

Countable income is all earned and unearned income, as defined in this section, less all allowed deductions. Income in the month of application (or review) and future months is estimated based on income in the calendar month prior to the month of application (or review) unless changes have occurred or are expected to occur and this income does not accurately reflect ongoing income. If changes are expected to occur, an estimate of income based on current information should be used.

To determine countable monthly income, average weekly income is multiplied by 4.3 and average biweekly income is multiplied by 2.15.

A. Lump Sum Receipts

Lump sum benefits that would have been counted as income if received on time, such as social security benefits and unemployment compensation, shall be added to all other countable income of an applicant for or recipient of VHAP and counted only in the month of receipt.

Windfall lump sums such as insurance payments and money received from the sale of a resource (including the sale of an excluded resource) are not counted.

An insurance payment or similar third party payment that is received for a specific purpose, such as the payment of medical bills or funeral costs, and is used for the stated purpose is excluded. Payments not used for the stated purpose are counted as income in the month received.

B. Unearned Income

Unearned income includes, but is not limited to, the following:

Income from pension and benefit programs, such as social security, railroad retirement, veteran's pension or compensation, unemployment compensation, and employer or individual private pension plans or annuities.

Interest and dividends.

Child support payments (see rule 5322 W for the exclusion of the first $50) and alimony payments.

Income from capital investments in which the individual is not actively engaged in managerial effort.

Time payments on mortgages or notes resulting from a casual sale (i.e., a sale not related to self-employment) of real (stationary or fixed) property or personal property.

Voluntary contributions from others.

Unearned income does not include the following:

Infrequent or irregular voluntary cash contributions or gifts, such as Christmas, birthday, or graduation presents, received from friends or relatives.

In-kind income.

Five percent of a VA monthly award that is retained by a guardian.

C. Earned Income

Earned income includes all wages, salary, commissions or profit from activities in which the individual is engaged as an employee or a self-employed person, including, but not limited to, active management of capital investments (e.g., rental property).

Earned income is defined as income prior to any deductions for income taxes, FICA, insurance or any other deductions voluntary or involuntary except that, in determining earned income for self-employed individuals, business expenses are deducted first.

Earnings over a period of time, for which settlement is made at one given time, are also included (e.g., sale of farm crops, livestock, poultry). Monthly income is determined by dividing the settlement by the number of months in which it was earned.

Earned income does not include in-kind income.

The following items are deducted from gross earned income in the sequence listed:

1. Business expenses (self-employment only)
2. Standard employment expense deduction
3. Dependent care expenses

D. Business Expenses

Items such as personal business and entertainment expenses, personal transportation, purchase of capital equipment, depreciation, and payment on the principal of loans for capital assets or durable goods are not allowable business expenses.

Business expenses, which are deducted from gross receipts to determine adjusted gross earned income, are limited to operating costs necessary to produce cash receipts, such as:

1. Office or shop rental; taxes on farm or business property;
2. Hired help;
3. Interest on business loans; and
4. Cost of materials, stock, and inventory, livestock for resale required for the production of this income.

Tax returns and business records are considered appropriate sources of accurate figures for farm and business receipts and expenses.

The income of a VHAP group owning or operating a commercial boarding house shall be treated as any other business income. A commercial boarding house is defined as an establishment licensed as a commercial enterprise that offers meals and lodging for compensation. In areas without licensing requirements, a commercial boarding house shall be defined as a commercial establishment that offers meals and lodging with the intention of making a profit.

No computation is required for foster homes furnishing boarding care to children in custody of, and placed by, the Family Services Division (FSD). Department board rates are established to cover expenses only, with no profit available; therefore, no earned income is considered available from this source.

For a VHAP group that is not a commercial boarding house, the business expense of furnishing room and board, alone or as part of custodial care, shall be allowed, provided that the amount shall not exceed the payment the VHAP group receives from the roomer/boarder for lodging/meals. (See the Medicaid Procedures Manual at P-2420 D2 for the table of standard business expense deductions for homes providing room or board on a non-commercial basis.)

E. Standard Employment Expense Deduction

The standard employment expense deduction is the first $90.00 earned per month after deduction of business expenses, where applicable.

The standard employment expense deduction is applied separately to the gross countable earned income of each individual in the VHAP group who is employed or self-employed.

F. Dependent Care Expenses

Dependent care expenses necessary to enable the individual to retain his or her employment or accept employment will be deducted up to a maximum of $175.00 per month for the care of each member of the VHAP group who is an incapacitated adult or a child age two years or older, and up to a maximum of $200 per month for the care of each child under two years of age who is a member of the VHAP group.

Dependent care expenses for the care of a child are not deducted unless the child requiring care is a member of the VHAP group or is not a member of the VHAP group solely because he/she is an SSI/AABD or a Reach up recipient and is:

1. under age 13; or

2. at least age 13 but younger than age 21 and physically or mentally incapable of caring for himself or herself, as verified by the written report of a physician or licensed psychologist; or

3. at least age 13 but younger than age 21 and under court supervision.

Dependent care expenses will be allowed as paid up to the maximum. If a recipient's dependent care expenses are below the maximum, transportation to and from the dependent care facility may be deducted as part of the expense up to the maximum for both dependent care and transportation.

Payments for dependent care provided by a member of the same VHAP group, by the child's parent (biological, adoptive, or stepparent) or legal guardian, or the incapacitated adult's spouse do not qualify as necessary dependent care expenses under this policy.

The provider of care must be at least 16 years of age. A deduction for dependent care expenses for care of a child can be allowed only when neither parent is available and able to provide the necessary care. A deduction for dependent care expenses for care of an incapacitated adult can only be allowed when the incapacitated adult's spouse (where applicable) is either unavailable, or available but unable to provide the necessary care because he/she is incapacitated. Incapacity shall be determined in accordance with the process used to determine whether a parent applying for or receiving Reach up is incapacitated (see rule 2235.3). This process shall give appropriate consideration to the treating physician's opinion. A spouse is considered unavailable if he/she is employed during the time care is required.

If dependent care is required for reasons other than employment (e.g., protective services child care or care for training purposes), the client shall be referred to FSD.

INTERPRETIVE MEMO

[X] VHAP Rule Interpretation **[ ] VHAP Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 5322 **Date of this Memo** 05/16/1996 **Page** 1 of 1

This Memo: [ ] is New [X] Replaces one dated 02/22/1996

QUESTION: Number 16 states that payments to the household for the care of foster children are excluded.

ANSWER: Yes. The portion of the foster care payment for supervision and care is excluded. The portion of the payment for room and board is counted as income less any allowed business expenses.

INTERPRETIVE MEMO

[X] VHAP Rule Interpretation **[ ] VHAP Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 5322 **Date of this Memo** 05/16/1996 **Page** 1 of 1

This Memo: [ ] is New [X] Replaces one dated 03/01/1996

QUESTION: Are there any other examples of excluded income at rule 5322?

ANSWER: Yes, as follows:

A. Aid granted for a specific purpose, such as vocational rehabilitation, including incentive allowances paid by the Division of Vocational Rehabilitation to an active VHAP recipient.

B. Aid for items or services not included in the limited benefit coverage package, such as special training for a child through a private agency, eyeglasses, and dental care.

C. General Assistance

INTERPRETIVE MEMO

[X] VHAP Rule Interpretation **[ ] VHAP Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 5322 Date of this Memo 01/01/2010 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

UPDATE:

Wages paid by the Census Bureau for temporary employment are excluded.

INTERPRETIVE MEMO

[X] VHAP Rule Interpretation **[ ] VHAP Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 5322 Date of this Memo 02/01/2010 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

UPDATE:

Any income received from a home equity conversion plan is excluded in the month of receipt. If the income is retained after the month of receipt, count it as a resource beginning the month after receipt.

5322 Excluded Income (05/15/1996, 96-18)

A. Any income received by a recipient of SSI/AABD or Reach Up living in the VHAP household.

B. All income to an undergraduate student (including parents or children in the VHAP group) from student grants, loans, or work study if:

1. such loans or grants are made under a program administered or insured by the U. S. Secretary of Education; or

2. the sponsor of the grant or loan precludes its use for maintenance purposes; or

3. the work/study program is administered by a college or university recognized by educational authorities and the undergraduate student is enrolled half time or more than half time, as defined in relation to the definition of full time used by the school.

Examples of excludable income sources are: federal Pell Grants, Vermont Student Assistance Corporation grants or loans, federal Supplemental Educational Opportunity Grants (SEOG), and federal College Work-Study Programs (CWSP).

That portion of any Veterans Administration Educational Assistance Program payment that is for the student and is actually used for tuition, books, fees, child care services or other expenses necessary for enrollment is also excluded.

C. Student financial assistance provided under Title IV of the Higher Education Act or Bureau of Indian Affairs Student Assistance programs.

Examples of programs in Title IV of the Higher Education Act include:

1. Federal Pell Grants.

2. Federal Supplemental Educational Opportunity Grants (SEOG).

3. State Student Incentive Grants (SSIG).

4. Federal College Work Study (CWSP).

5. Federal Perkins Loans. These are different from loans under the Carl D. Perkins Vocational and Applied Technology Education Act, which are not totally disregarded (see # 4).

6. Educational loans under the federal Family Educational Loan Program or the federal Direct Student Loans Program (Stafford or PLUS loans).

D. Student financial assistance provided under the Carl D. Perkins Vocational and Applied Technology Education Act when the assistance is made available to meet attendance costs. Attendance costs include:

1. tuition and fees normally assessed a student carrying the same academic workload as the applicant/recipient, as determined by the institution, including costs for rental or purchase of any equipment, materials, or supplies required of all students in the same course of study as the applicant/recipient; and

2. an allowance for books, supplies, transportation, dependent care and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution.

E. Reimbursements for expenses (such as child or dependent care, transportation, purchase or maintenance of clothing, and meals) attributable to participation in unpaid voluntary activities, including the value of meals provided during the course of these activities.

F. Payments made pursuant to a court order for support or alimony, an administrative order for support issued by the Human Services Board, or a contract between the Office of Child Support and noncustodial parent requiring the payment of support. This income exclusion is limited to payments actually made by a member of the VHAP group toward the support of a person outside the group. The payment amount is deducted first from the VHAP group's countable earned income, with any balance deducted from unearned income.

G. The value of 3SquaresVT benefits under the Food Stamp Act of 1977.

H. The value of foods donated by the U. S. Department of Agriculture (surplus commodities).

I. Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.

J. Earned income of a child under the age of 19 if such child is a full-time student or a part-time student who works less than full time. A child is a student if he or she is enrolled in a school, college, university, or a course of vocational or technical training designed to prepare him or her for gainful employment. Such educational institution shall determine whether the student is enrolled full time or part time. Full-time employment is work that involves 100 or more hours per month; less than full-time employment is work that involves fewer than 100 hours per month.

K. Monthly income of any child (see definition of child at J. above) from any program carried out under the Job Training Partnership Act (JTPA). This applies to earned or unearned income, except that, in the case of earned income, this disregard may not exceed six months per calendar year.

This income cannot be disregarded for adults.

The $10 per day allowance given to individuals in JTPA training is always disregarded as income for both children and adults.

L. Payments for support services and/or reimbursement for out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions and to persons serving in the Service Corps of Retired Executives and Active Corps of Executives or any other program under Titles II and III pursuant to Section 418 of P. L. 93-133.

M. Payments to individual volunteers under Title I of P. L. 93-133, Section 404(g); University Year For Action payments under P. L. 93-113, and P. L. 96-143; and Section 9 (VISTA) payments; unless determined by the Director of ACTION to be equivalent to or greater than the federal or state minimum wage.

N. The tax-exempt portions of payments made pursuant to P. L. 92-203 (Alaska Native Claims Settlement Act of 1973).

O. Payments distributed per capita to or held in trust for members of any Indian Tribe under P. L. 92-254 or P. L. 93-134, or P. L. 94-540.

P. Payments received for the care of foster children in the custody of, and placed by, the Family Services Division. The rate of payment is established to cover expenses only, with no profit available; therefore, no income is considered available from this source.

Q. Experimental Housing Allowance Program payments made under Annual Contributions Contracts entered into prior to January l, 1975, under the U. S. Housing Act of 1937, as amended.

R. Reach Up support services, either as reimbursements or advance payments to the individual for child care, transportation, work-related expenses, work-related supportive services, education, or training-related supportive services.

Excluded Income

S. Any benefits received under Title VII, Nutrition Program for the Elderly, of the Older American Act of 1965, as amended.

T. The value of supplemental food assistance received under the Child Nutrition Act of 1966, as amended, and the Special Food Service Program for children under the National School Lunch Act, as amended (P. L. 92-433 and P. L. 93-150).

U. Receipts distributed to members of certain Indian tribes referred to in Section 5 of P. L. 94-114, which became effective October 17, 1975.

V. Any income received from an emergency fuel supplement or energy allowance to assist with the cost of heating.

W. The first $50 in child support payments made by a noncustodial parent on behalf of a VHAP group member within each calendar month. When more than one noncustodial parent makes child support payments on behalf of a single VHAP group in the same calendar month, the maximum amount of child support to be disregarded in determining the VHAP group's eligibility is $50.

X. Payments to persons of Japanese or Aleut ancestry as restitution for injustices suffered during the Second World War.

Y. Federal Earned Income Tax Credit (EITC), whether received with each paycheck or as a refund (lump sum).

Z. Payments made from the Agent Orange Settlement Fund or any other fund established because of the Agent Orange product liability litigation.

AA. Payments made pursuant to the Radiation Exposure Compensation Act (P. L. 101-426).

AB. Payments made under Indian Trust Funds Acts (P. L. 97-458 and P. L. 98-64) and initial purchases made with such funds by the original recipient of the funds.

AC. Interest held in a trust or in restricted lands pursuant to section 8 of P. L. 93-134 and up to $2,000 annual income received from the lease or other uses of the individually owned trust or restricted lands.

AD. Distributions made under P. L. 100-241, which amended the Alaska Native Claims Settlement Act:

1. cash, including cash dividends on stock received from a Native Corporation, to the extent that it does not, in the aggregate, exceed $2000 per individual per calendar year; or

2. stock, including stock issued or distributed by a Native Corporation as a dividend or distribution of stock; or

3. a partnership interest; or

4. land or an interest in land, including land or an interest in land received from a Native Corporation as a dividend or distribution on stock; or

5. an interest in a settlement trust.

AE. Payments made pursuant to the Maine Indian Claims Settlement Act of 1980 to a member of the Passamaquoddy Indian Tribe, the Penobscot Nation, or the Houlton Band of Maliseet Indians.

AF. Payments made to a member of the Aroostook Band of Micmacs pursuant to the Aroostook Band of Micmacs Settlement Act.

AG. Financial assistance paid through the Disaster Relief Act of 1974 as amended by P. L. 100-707 in 1988 and provided as major disaster and emergency assistance. This disaster coverage is intended

Excluded Income

to provide relief to people living or working in an area severely struck by natural or man-made disaster. The disaster must have been so severe as to cause the President to designate a Federal Disaster Zone. Additional relief provided under these circumstances by states, local governments and disaster assistance organizations is also excluded.

AH. Bona fide loans.

5323 Countable Income (05/15/1996, 96-18)

Complete the following steps to determine countable income:

A. Constitute the VHAP group according to the definition included in the Financial Need (rule 5320).

B. Determine the combined countable income for the VHAP group, as constituted in step A. above.

C. Compare the result to the applicable income test for the VHAP group size, as constituted at step A. above.

All otherwise eligible individuals in a VHAP group who pass the income test are income-eligible for the VHAP program.

Individuals potentially eligible for traditional Medicaid, such as pregnant women and children, have their eligibility determined under those rules but are considered members of the VHAP group for purposes of determining the VHAP group size and countable income.

INTERPRETIVE MEMO

[X] VHAP Rule Interpretation **[ ] VHAP Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 5324 Date of this Memo 06/01/2009 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

Caretaker relatives of dependent children are eligible for VHAP if the group income is less than or equal to 185% FPL. This higher income test applies to, but is not limited to, those caring for children who receive SSI or Reach Up benefits. If the household includes two caretaker relatives, the 185% income test applies to both adults.

5324 Income Test (05/01/2010, 10-02)

Individuals with group income less than 150 percent of the federal poverty level (FPL) are eligible for VHAP, as long as none of the conditions that result in a reduced income test apply. These conditions are described in paragraph three below.

Uninsured parents and caretaker relatives having dependent children in their households and group income less than 185 percent of the federal poverty level (FPL) are eligible for VHAP. This higher income test applies to those caring for children. If the household includes two caretaker relatives, the 185% income test applies to both adults.

Current poverty levels are at P-2420.

The income maximums (P-2420) are updated 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 ESD's income maximum, ESD will issue a second increase on April 1.

5330 Cost-Sharing Requirements (08/01/2012, 12-08)

A. Premium

Beneficiaries meet this requirement when they have paid any required premium as specified in rules 4160 - 4162. The amount of the premium for each beneficiary increases according to VHAP income maximums (P-2420) based on the federal poverty level (FPL) as shown in the following chart:

VHAP Premiums

Income Maximums	Monthly Premium per Beneficiary
0 - 50% FPL	$ 0
> 50% but ≤ 75% FPL	$7.00
> 75% but ≤ 100% FPL	$25.00
> 100% but ≤ 150% FPL	$33.00
> 150% but ≤ 185% FPL	$49.00

B. Co-Payment

There is a co-payment requirement of $25 per hospital emergency room visit, as defined in rule 7101.3.

There is a $3 copayment per day per hospital for hospital outpatient services.

Beneficiaries in households with income at or greater than 100% of the federal poverty guideline (see Medicaid Procedures P-2420 B) shall contribute a copayment of $1 for prescriptions costing less than $30, a copyament of $2 for prescriptions costing $30 or more but less than $50, and a copayment of $3 for prescriptions costing $50 or more.

In addition, all beneficiaries shall contribute a copayment of $1 durable medical equipment/supplies costing less than $30, a copayment of $2 for durable medical equipment supplies costing $30 or more but less than $50, and a copayment of $3 for durable medical equipment/supplies costing $50 or more.

A pharmacy may not refuse to dispense a prescription to a beneficiary who does not provide the copayment.

5340 Application (09/07/1996, 96-45)

An individual must file a signed application for VHAP with the Health Access Eligibility Unit or an Economic Services Division district office and provide information about his/her situation relevant to the tests for eligibility (rule 5310). Applications are date-stamped to assure that earlier applications are acted upon first.

An applicant must furnish his/her social security number or apply for a social security number unless he/she is a member of a religious organization that objects to the use of a social security number. An applicant who substantiates membership in such a religious organization shall be given an alternate identification number.

Verification of the information provided is not generally required of the applicant or recipient unless it is questionable, verification is outstanding for another benefit program, or the applicant or recipient has refused to provide a social security number because of a religious objection. Social security numbers are used to verify information through tape matches. Clients are notified on the application form of the verification actions the department may take, including the use of verification obtained for other department programs, randomly selected quality control reviews, and the penalties for fraudulent reporting of their situation.

5341 Application Decision (09/07/1996, 96-45)

An eligibility decision must be made within 30 days of the date the application is received by either office. An applicant who meets other eligibility criteria in rule 5310 but cannot be accepted into the VHAP program due to the cap on expenditures or enrollment (rule 5324) shall have his/her application held for 90 days. If an opening becomes available during this 90-day period, he/she will be accepted into the program and referred to the benefits counselor, if appropriate. Individuals whose applications have been held will be referred ahead of individuals who filed an application on a later date.

An applicant will be sent a notice regarding the action being taken on his/her application. An applicant who is denied will be sent a denial notice that includes the reason for the denial and the applicant's appeal rights. An applicant whose application is being held will be sent a notice explaining the reason for this action. Notices will be mailed during the 90-day period to provide clients with an update of their status. If a client is not accepted into the program at the end of the 90-day period, a denial notice will be sent along with a new application for the VHAP program.

Applicants will be given information about the traditional Medicaid program at the time of application and at the time of review.

INTERPRETIVE MEMO

[X] VHAP Rule Interpretation **[ ] VHAP Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 5342 Date of this Memo 12/01/2009 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

UPDATE:

Individuals whose most recent closure was for a reason other than failure to pay a premium are entitled to VHAP-Limited. This is true even if they closed for failure to pay within the prior 12 months.

5342 Eligibility Period and Enrollment (05/01/2010, 10-02)

A. Eligibility

The VHAP eligibility criteria are described in rules 5311 – 5331.

B. Enrollment

If all eligibility criteria are met, the individual shall be enrolled in the VHAP program on the first day of the month after the department has received and processed the premium.

Once enrolled, coverage continues until the scheduled eligibility review unless beneficiaries are disenrolled from the program following a notice mailed at least 11 days before the termination date because they:

1. have a change in income that results in income over the applicable income test;
2. have a change in the household size that results in income over the income test for the new household size;
3. lose eligibility as a student;
4. are incarcerated;
5. are 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;
6. acquire insurance that includes both 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;
7. become eligible for Medicare coverage regardless of enrollment;
8. move out-of-state;
9. voluntarily disenroll from the program;
10. are found to have been ineligible on the date coverage began;
11. are no longer in contact with the department and have no known address;
12. fail to provide verification requested for another program if it pertains to an eligibility factor for the VHAP program;
13. fail to pay any required premiums; or
14. die.

The notice will inform beneficiaries of their appeal rights and provide them with information about other health care assistance, including how and where to apply.

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

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.

5342.1 VHAP-Limited Coverage (05/01/2010, 10-02)

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 rules 4160-4162. 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 eligibility or coverage is cancelled or closed in whole or in part due to nonpayment of the premium and the individual attempts to reenroll within twelve months, VHAP-Limited coverage will be provided only if the individual meets one of the six exceptions listed below.

A. The individual or spouse had employer-sponsored insurance that terminated because of:

   1. loss of employment;

   2. death of the principal insurance policyholder;

   3. divorce or dissolution of a civil union;

   4. no longer qualifying as a dependent under the plan of a parent or caretaker relative; or

   5. no longer receiving COBRA, VIPER or other state continuation coverage.

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:

   1. have elected not to purchase health insurance covering both hospital and physician services offered by their educational institution; or

   2. are eligible for coverage through the policy held by their parents, but their parents have elected not to purchase this coverage.

C. The individuals 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 rule 4161, 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.

F. The individual lost health insurance as a result of domestic violence. The individual shall provide the agency of human services with satisfactory documentation of the domestic violence. The documentation may include a sworn statement from the individual attesting to the abuse, law enforcement or court records, or other documentation from an attorney or legal advisor, member of the clergy, or health care provider, as defined in section 9402 of Title 18.

Information relating to the domestic violence, including the individual's statement and corroborating evidence, provided to the agency shall not be disclosed by the agency unless the individual has signed a consent to disclose form. In the event the agency is legally required to release this information without consent of the individual, the agency shall notify the individual at the time the notice or request for release of information is received by the agency and prior to releasing the requested information.

5342.2 VHAP Managed Health Care (04/01/2005, 05-09)

If all eligibility criteria (rules 5311 - 5331) 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.

Identification Document

5343 Identification Document (04/01/2005, 05-09)

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

5344 Application for Medicaid (12/01/2003, 03-17)

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 spenddown for Medicaid may use VHAP premiums and cost sharing to meet their spenddown. 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, depending on their income, of any premium requirements. 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.

5345 Right to Appeal (07/01/2007, 06-05)

Applicants and beneficiaries shall be provided by the department with notices whenever an individual is found ineligible for the VHAP program or when the services they may receive under the VHAP program are denied, 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 an internal managed care organization (MCO) appeal and a fair hearing before the Human Services Board. Appeals regarding denials of eligibility will not be entitled to an internal MCO appeal.

Regarding eligibility issues, 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 or that he/she wants an opportunity to present his/her case to a higher authority.

Regarding issues of coverage, a beneficiary may utilize the internal MCO appeal process (rule 7110.2) while a fair hearing is pending or before a fair hearing is requested (rule 7110.3). Fair hearings or MCO appeals must be filed within 90 days of the date the notice of action was mailed by the MCO, or if no mailing, within 90 days after the action occurred. A request for a fair hearing challenging an MCO appeal decision must be made within ninety (90) days of the date the original notice of the MCO decision being appealed was made, or within thirty (30) days of the date the notice of the MCO decision being appealed was mailed.

When beneficiaries appeal a decision to end or reduce VHAP coverage, they have the right, under certain conditions, to have benefits continue without change until the appeal or fair hearing is decided provided the beneficiary has requested an appeal before the effective date of the change and has paid in full any required premiums (see rule 7110.2). Beneficiaries appealing the amount of their premiums shall pay at the billed amount in order for coverage to continue until the dispute is resolved. Beneficiaries who appeal the amount of their premium and win will be reimbursed by the ESD for any premium amounts overpaid.

Continuation of benefits without change does not apply when the appeal is based solely 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 rule 4150).

Beneficiaries who request a hearing after the effective date of termination will not receive continued benefits but will be reimbursed for out-of-pocket expenses provided during the appeal period in any case in which the MCO or Human Services Board reverses the decision.

Beneficiaries may waive their right to continued benefits. If they do so and are successful on an appeal, benefits will be paid retroactively.

VHAP beneficiaries also have the right to file grievances using the provisions of the Global Commitment for Health 1115 waiver internal grievance process. Beneficiaries (or duly appointed representatives) may file grievances orally or in writing. The grievance provisions are found at rule 7110.5.

See rule 5352.2 for rights to appeal managed health care decisions or disenrollment from a plan.

5350 Benefit Delivery (01/02/2003, 02-35)

While enrollment in a managed health care plan will be mandatory for VHAP participants, covered services for eligible beneficiaries may be provided using a fee-for-service payment system until adequate managed care capacity is developed.

As managed care capacity becomes available in a given area, VHAP participants will be transferred into available managed care slots.

For beneficiaries required to enroll in managed health care plans, no payment will be made for services obtained outside the plan except for covered services designated as wrap-around services. (See rule 5351)

INTERPRETIVE MEMO

[X] VHAP Rule Interpretation **[ ] VHAP Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 5351 **Date of this Memo** 07/15/2009 **Page** 1 of 1

This Memo: [X] is New [ ] Replaces one dated _____

QUESTION: Who is affected by the rule as it related to a 90–day supply?

ANSWER: The rule applies to persons using the selected maintenance drug classes when they are eligible under Medicaid, VHAP-Pharmacy, VScript or VScript Expanded when Medicaid, VHAP-Pharmacy, VScript or VScript Expanded is their primary coverage. This means that the rule does not apply to persons who are on Medicare or covered by private insurance. the list of maintenance drugs requiring a 90–day fill is on the OVHA webpage: http://ovha.vermont.gov/for-providers/pharmacy-programs-bulletins-alerts.

QUESTION: What happens when a physician or medical professional licenses to prescribe drugs in Vermont wants to request an exception to the 90–day supply policy?

ANSWER: When a pharmacy submits a claim for payment for a drug in a selected 90 day supply class, the claim will deny unless there is an exception authorization on file. The prescriber should request an exception when he/she believes in his/her clinical and professional judgement there is an extenuating circumstance to justify an exception. A request must be patient and drug specific. To facilitate the request, the prescriber should submit the Exception to Required 90 Day Maintenance Medication Fill form found on the web page of the Office of Vermont Health Access at: http://ovha.vermont.gov/for-providers/pharmacy-prior-authorization-request-forms using the instructions found on the form.

QUESTION: Will the prescriber have to do anything to request a lesser day supply for the initial fill?

ANSWER: The prescriber does not have to do anything to request the initial supply. When the prescriber writes the new script the pharmacy will indicate it is a new script when submitting the claim for payment. That indication will exclude that first script from the requirement.

INTERPRETIVE MEMO

[X] VHAP Rule Interpretation **[ ] VHAP Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 5351 **Date of this Memo** 07/29/2002 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: Is there a change in policy regarding coverage of refraction exams?

ANSWER: Yes. All refraction exams are now covered when provided by a participating Ophthalmologist or Optometrist. No prior authorization is required.

5351 Benefits (01/15/2010, 09-17)

VHAP-Limited is an interim fee-for-service benefit package that covers a limited number of VHAP services until the beneficiary is enrolled in VHAP-Managed Care. The VHAP-Limited benefit package, including limitations and/or exclusions, is described in procedures found at P-4003.

The VHAP-Managed Care benefit package, including limitations and/or exclusions, is described in procedures found at P-4005. VHAP-Managed Care beneficiaries can access services through the following ways:

A. Services Requiring Plan Referral

In VHAP—managed care the following services must have a referral from the beneficiary's care provider:

1. inpatient hospital care;
2. outpatient services in a hospital or ambulatory surgical center;
3. non primary care physician services require referral from primary care provider;
4. maxillofacial surgery;
5. cornea, kidney, heart, heart-lung, liver and bone marrow transplants, including expenses related to providing the organ or doing a donor search;
6. home health care;
7. hospice services by a Medicare-certified hospice provider;
8. rehabilitative therapies (occupational therapy, physical therapy, and speech therapy), home infusion therapies, and nutrition therapy;
9. prenatal and maternity care;
10. ambulance services;
11. medical equipment and supplies;
12. skilled nursing facility services for up to 30 days length of stay per episode;
13. 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.

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

"Maintenance drug" means a drug approved by the FDA for continuous use and prescribed to treat a chronic condition for a prolonged period of time of 30 days or longer, and includes

INTERPRETIVE MEMO

[X] VHAP Rule Interpretation **[ ] VHAP Procedure Interpretation**

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Reference 5351.1 **Date of this Memo** 01/01/2006 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: If an individual is making a good faith effort to utilize the prescription drug plan's appeal process through the Independent Review Entity level, but the time frame has extended beyond 30 days, will the individual be deemed to have exhausted their appeal for purposes of being able to apply to OVHA for coverage of the drug?

ANSWER: Yes. The appeal process should continue while OVHA's decision is being made and while any coverage exists.

insulin, an insulin syringe and an insulin needle. It may not be dispensed unless prescribed by a duly licensed medical professional licensed by the state of Vermont to prescribe within the scope of his or her practice and enrolled in Vermont Medicaid.

Apart from the select drugs used for maintenance treatment described below, all other maintenance drugs must be prescribed and dispensed for not less than 30 days and not more than 90 days. Excluded from this requirement are drugs which the beneficiary takes or uses on an "as needed" basis or generally used to treat acute conditions. If there are extenuating circumstances in an individual case which, in the judgment of the prescriber, dictate a shorter prescribing period for these drugs, the supply may be for less than 30 days as long as the prescriber prepares in sufficient written detail a justification for the shorter period. The extenuating circumstance must be related to the health and/or safety of the beneficiary and not for convenience reasons. It is the responsibility of the pharmacy to maintain in the beneficiary's record the prescriber's justification of extenuating circumstances.

Select drugs used for maintenance treatment must be prescribed and dispensed in increments of 90-day supplies. The drug utilization review board shall make recommendations to the director on the drugs to be selected. This limit shall not apply when the beneficiary initially fills the prescription in order to provide an opportunity for the beneficiary to try the medication and for the prescriber to determine that it is appropriate for the beneficiary's medical needs. If there are extenuating circumstances in an individual case which, in the judgment of the prescriber, dictate a shorter prescribing period, an exception form that identifies the individual and the reason for the exception may be filed with the Department of Vermont Health Access.

Up to five refills are permitted if allowed by state and federal law.

B. Self-Referral Services

In VHAP—managed care the following services may be accessed by beneficiaries without a referral from a health care provider:

1. one routine annual gynecological exam and related diagnostic services (as specified by the plan).

2. 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).

3. one routine eye examination every 24 months.

4. chiropractic coverage for manipulation of the spine.

5. family planning services (defined as those services that either prevent or delay pregnancy).

6. emergency room services.

5351.1 Beneficiaries Eligible for VHAP and Medicare (01/01/2006, 05-24)

When a VHAP beneficiary becomes eligible for Medicare and thus ineligible for VHAP, there may be a brief period of time when the beneficiary is eligible for both programs before the effective date of the VHAP closure. In that case, VHAP becomes the secondary payer. VHAP pharmaceutical coverage for these beneficiaries is subject to the following rules.

Benefits

Beneficiaries who are entitled to Medicare benefits under Part D or enrolled in Medicare Part B, and who live in the service area of a Part D plan, are defined under Medicare rules at 42 CFR §423.30 as eligible for Part D. Vermont is included in the service area for several Part D plans. According to 42 CFR §423.906, Medicare is the primary payer for covered drugs for Part D eligible individuals. VHAP does not cover drugs in classes included in the Part D benefit.

Part D is administered either through a prescription drug plan (PDP) or as a component of Part C, Medicare managed care, in a Medicare Advantage – Prescription Drug benefit (MA-PD).

The only drug classes that VHAP covers for those enrolled in a drug plan, if they are not covered by the individuals PDP/MA-PD, are:

A. drugs for anorexia, weight loss, or weight gain (see rule 7502.3);

B. Single vitamins or minerals if the conditions described in rule 7502.4 are met;

C. over-the-counter prescription if the conditions described in rule 7502.5 are met;

D. barbiturates; and

E. benzodiazepines.

If a Part D eligible individual elects not to enroll in a PDP/MA-PD plan, or discontinues enrollment in such a plan, eligibility for VPharm will end.

When an individual appeals a denial of coverage of a drug under a Part D or Part C plan, and has exhausted the plans appeal process through the Independent Review Entity (IRE) decision level, or the plans transition processes as approved by the Centers for Medicare and Medicaid Services, the individual may apply to the Department of Vermont Health Access (DVHA) for coverage of the drug if it is included in the VHAP benefit (See P-4003 B9 or P-4004 B9). If the individual's prescriber documents medical necessity in a manner established by the director of DVHA, and the process for documentation conforms with the pharmacy best practice and cost control program established under subchapter 5 of chapter 19 of Title 33, the drug shall be covered.

At the beginning of coverage under Medicare Part D, when a VHAP-eligible individual has applied for and has attempted to enroll in a Part D or Part C plan and has not yet received coverage due to an operational problem with Medicare, or has otherwise not received coverage for the needed pharmaceutical, the necessary drugs will be covered, if DVHA finds that good cause and a hardship exist, until such time as the operational problem, good cause and hardship ends. The individual must have made every reasonable effort with CMS and the PDP, given the individual's circumstances, to obtain coverage. The intent of the good cause and hardship exception is remedial in nature and shall be interpreted accordingly. In general "good cause" shall include instances where the lack of coverage can not reasonably be considered the fault of the individual, and "hardship" shall include circumstances where alternative means for the coverage at issue are not reasonably available or will likely result in irreparable loss or serious harm to the individual. DVHA will make determinations of whether or not operational problems, good cause, or hardship exists for purposes of coverage.

5352 VHAP Managed Health Care Plan (10/19/1998, 98-23)

Subject to managed health care plan availability and capacity, individuals will be required to enroll in a managed health care plan. Under this system, a per-person payment for a defined array of services is made to the plan each month for each enrolled member.

Upon enrollment, managed health care plans shall provide their members with handbooks that include information such as the following:

- what services are covered and how to access those services;
- the procedures for changing primary care providers and specialty referrals;
- information on services that do not require a primary care provider referral;
- what services are covered as wrap-around services;
- appointment procedures and information on what to do in a medical emergency;
- information about member rights and responsibilities;
- information on how to register a complaint or file a formal grievance with the plan.

5352.1 Enrollment (09/07/1996, 96-45)

A. Choice of Managed Health Care Plans

A benefits counselor will help beneficiaries make an informed choice among available managed health care plans. The benefits counselor will initiate a follow-up contact with an individual who has failed to notify the benefits counselor of his or her choice of a plan and will provide additional information if requested to do so. If no choice has been made by within 30 days of being contacted, the benefits counselor will assign the individual to a plan using a state-approved algorithm.

All eligible members of a VHAP group are expected to select the same managed health care plan, except when it creates a hardship or a different plan is indicated for medical reasons. DVHA reserves the right to determine, in these specific cases, when enrollment in different managed health care plans is indicated.

Beneficiaries enrolled in managed health care plans will be required to select a primary care provider (PCP) from among the plan's network of providers. The benefits counselor will provide beneficiaries with information about each plan's provider network so that they may select a PCP at the time of enrollment or when contacted by the plan. A beneficiary who fails to select a PCP will have one assigned by the plan. Once assigned, individuals may make subsequent changes in their PCP with thirty days' notice to the managed health care plan. An individual's stated preference is contingent upon the availability of the chosen PCP.

B. Change of Managed Health Care Plan

Enrollees may change their choice of managed health care plan for any reason within 30 days of the effective date of coverage under a plan. Members may change plans once per year thereafter, and at other times for good cause. Good cause is limited to the following circumstances:

1. The individual notifies the department of a change in his or her place of residence and, as a result, is outside the service area of the plan.

2. The Department of Vermont Health Access has found that there is a rational and justifiable reason for determining that good cause exists, or, upon appeal, the Human Services Board finds good cause exists.

Managed health care plan changes will become effective on the first day of the following month, if all required actions have been completed on or before the 15th day of the prior month. Otherwise, the change shall become effective the first of the second month after all required actions are completed.

At least 30 days prior to the anniversary date, enrollees will receive a notice of their opportunity to renew their enrollment with their current managed health care plan or to choose another plan. Information about the plan options and assistance available in making a selection will be included in the notice.

C. Disenrollment

In rare instances it may become necessary to pursue disenrollment of individuals who are intentionally unresponsive to basic managed care expectations. The following may be disenrolled:

1. Individuals who pose a threat to plan employees or other members.

2. Individuals who regularly fail to arrive for scheduled appointments without canceling, despite documented aggressive outreach efforts by the managed health care plan.

3. Individuals who do not cooperate with treatment and have not made an affirmative decision to refuse treatment, despite documented aggressive outreach efforts by the plan.

Grounds for disenrollment does not include individuals who have cooperated with the plan in its effort to inform them fully of the treatment options and the consequences of their decisions regarding treatment and who have subsequently made an informed decision to refuse treatment.

Plan disenrollment requests must conform to criteria for disenrollment established by the Department of Vermont Health Access (DVHA). Managed health care plans must notify the affected member, or his or her designated representative, in writing, of a plan-initiated request for disenrollment. Only the DVHA may disenroll a member from a managed health care plan.

Individuals remain in the managed health care plan until DVHA decides to disenroll the individual. Individuals are notified of this decision in writing and of their right to request a fair hearing before the Human Services Board.

Individuals who are disenrolled will be considered for continued participation in VHAP only if enrollment caps for the program have not been reached.

D. New Enrollees

An individual not enrolled in a VHAP managed health care plan who joins a VHAP group will be enrolled in the head of household's managed health care plan. An individual already enrolled in a VHAP managed health care plan who joins another VHAP group will remain in his or her managed health care plan until the next review. Subsequent changes in managed health care plan enrollment may be made according to provisions under rule 5352.1 B.

5352.2 Appeals of Managed Health Care Decisions (09/07/1996, 96-45)

Beneficiaries enrolled in managed health care plans have the right to appeal medical care decisions made by the managed health care plans based on medical/clinical necessity determinations. Although medical/clinical determinations will be made by the medical director of the managed health care plan, ultimate authority on such determinations lies with the state.

Beneficiaries first must seek remedy of a medical care decision through the managed health care plan's formal grievance process. The managed health care plan may take up to 15 days to seek resolution of a complaint related to medical care and must address issues in less than 15 days if warranted by the patient's condition. Plans may take up to 30 days to seek resolution of a complaint not related to medical care.

The decision of the managed health care plan shall be in writing and shall be sent to the beneficiary and to the Department of Vermont Health Access.

If a beneficiary disagrees with the decision resulting from the managed health care plan's grievance process, he or she may request a fair hearing.

A managed health care plan must provide a service if determined medically/clinically necessary by the DVHA director.

5360 Medicaid Program (09/07/1996, 96-45F)

Individuals receiving health care assistance based on the rules of the VHAP program may apply for Medicaid at any time.

Individuals found eligible for Medicaid who have been enrolled in a managed health care plan under VHAP will remain in the managed health care plan and are eligible for wrap-around benefits covering services received in the month of application and up to three calendar months prior to the month of application under traditional Medicaid rules. Individuals are reimbursed for cost-sharing expenses paid during the time they were covered by the VHAP program to the same extent as other Medicaid recipients when requested.