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1.00 General Provisions

The Agency of Human Services (AHS) is the adopting authority for the Immigrant Health Insurance Plan administrative rule. The Immigrant Health Insurance Plan was enacted by the Vermont General Assembly in Act 48 of 2021 and is codified in state statute at 33 V.S.A. chapter 19, subchapter 9.

The Immigrant Health Insurance Plan was created to establish Dr. Dynasaur-like coverage for certain Vermont residents (children under 19 years of age and pregnant individuals) who have an immigration status for which Medicaid coverage is not available, including migrant workers who are employed in seasonal occupations in Vermont, and who are otherwise uninsured.[1]

This Immigrant Health Insurance Plan rule refers to other Agency of Human Services' administrative rules in some sections to best align the Immigrant Health Insurance Plan with the Dr. Dynasaur program. There are two bodies of rules referenced:

Health Benefits Eligibility and Enrollment (HBEE) Rules – The HBEE rules provide the eligibility standards for Medicaid and other health care programs in Vermont.

Health Care Administrative Rules (HCAR) – HCAR is the collection of regulations adopted by the Agency of Human Services that govern the administration of Vermont Medicaid, including general provisions, eligibility, benefit delivery, covered services, reimbursement, specialized services, beneficiary rights, and provider responsibilities.[2]

Current HCAR and HBEE adopted rules can be found on the Agency of Human Services' website.

[1] "Dr. Dynasaur," as defined at HBEE § 3.00, is the collection of programs that provide health benefits to children under age 19 in the group defined in HBEE § 7.03(a)(3) and pregnant women in the group defined in HBEE § 7.03(a)(2).
[2] This is the definition of "HCAR" in HCAR § 1.101.

2.00 Definitions

As used in this rule, the following terms are used as defined below:

Alternate reporter means a person who is authorized to receive original notices or copies of notices on behalf on an individual.

Applicant means an individual seeking eligibility for Immigrant Health Insurance Plan health benefits for themselves through an application submission.

Application means a non-Medicaid application for Immigrant Health Insurance Plan health benefits, submitted by or on behalf of an applicant to determine eligibility, or, for an individual who applies for the Immigrant Health Insurance Plan by completing an application for Vermont Medicaid and being approved for Medicaid coverage of emergency medical conditions only (pursuant to HBEE § 17.02(d)), it means the Vermont Medicaid application.

Application date means the day the application is received by AHS, if it is received on a business day; or the first business day after the application is received, if it is received on a day other than a business day.

Assister Program means the professionals who are trained and certified by the Department of Vermont Health Access to help Vermont residents enroll and maintain health coverage through Vermont's state-based health insurance marketplace, Medicaid, or other state health care programs.

Authorized representative means a person or entity designated by an individual to act responsibly in assisting the individual with their application, renewal of eligibility and other ongoing communications.

Case record means the permanent collection of documents and information required to process eligibility.

Categorical eligibility criteria means the age or pregnancy status that an individual must have to be eligible for the Immigrant Health Insurance Plan.

Child means an individual under 19 years of age.

Electronic account means an electronic file that includes all information collected and generated regarding each individual's health benefit eligibility, including all required documents and information collected or generated as part of the State fair hearing process conducted with regard to health benefits eligibility and enrollment.

Eligibility decision or determination means an approval, denial, or termination of eligibility.

Eligible means the status of an individual determined to meet all financial, nonfinancial, and categorical requirements for a health benefits program.

Enrollee means an individual who has been approved for benefits under the Immigrant Health Insurance Plan.

Federal poverty level (FPL) means the poverty guidelines most recently published in the Federal Register by the Secretary of HHS under the authority of 42 USC § 9902(2), as in effect for the applicable period of time used to determine an individual's income eligibility for health benefits.

Human Services Board means AHS's fair hearings entity for Immigrant Health Insurance Plan appeals.

In an institution refers to an individual who is admitted to live in an institution and receive treatment or services provided there.

Individual means an applicant or enrollee for Immigrant Health Insurance Plan health benefits.

Institution means, for purposes of Section 5.00 of this rule, the same as the definition of institution and medical institution in 42 CFR § 435.1010. For purposes of an out of state placement in an institution, the term also includes foster care homes, as set forth in 45 CFR § 1355.20, that provide food, shelter and supportive services to one or more persons unrelated to the proprietor. For purposes of subsection 6.03 of this rule, institution means an establishment that furnishes food, shelter, and some treatment or services to four or more individuals unrelated to the proprietor.

Interpreter means a person who orally translates for an individual who has limited English proficiency or an impairment.

Limited English proficiency means an ineffective ability to communicate in the English language for individuals who do not speak English as their primary language and may be entitled to language assistance with respect to a particular type of service, benefit or encounter.

Long-term services and supports means services and supports provided to individuals of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the individual to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting, including medically complex nursing care or assistance with activities of daily living (such as eating, bathing, dressing, preparing meals, and managing medication).

Medicaid means the medical assistance provided under the State Plan approved under Title XIX of the Social Security Act, and the terms and conditions of the Global Commitment to Health Waiver, as approved by the Centers for Medicare & Medicaid Services, that are administered by AHS in Vermont.

Medicaid applicants means an individual seeking eligibility for health benefits authorized in Title XIX of the Social Security Act for themselves through an application submission.

Medicaid enrollees means an individual who has been approved and is currently receiving health benefits authorized in Title XIX of the Social Security Act.

Minimum Essential Coverage means health coverage under government-sponsored programs, employer-sponsored plans that meet specific criteria, grandfathered health plans, individual health plans, and certain other health-benefits coverage as provided in 42 C.F.R. § 435.4.

Modified Adjusted Gross Income (MAGI) has the same meaning as defined in HBEE § 28.02(b) for Medicaid applicants and enrollees.

MAGI-based income is defined in subsection 6.02(b) of this rule.

Plain language means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because the language is concise, well-organized, and follows other best practices of plain language writing.

Pregnant person means an individual during pregnancy and the post partum period. The post partum period shall have the same meaning as defined in HBEE § 7.03(a)(2) for Medicaid applicants and enrollees.

Quality control means a system of continuing review to measure the accuracy of eligibility decisions. It is also the name of the AHS unit that is responsible for administering quality control measures.

Redetermination means to determine eligibility following a change of circumstance, or to determine eligibility as a result of a State fair hearing request before the request is sent to the Human Services Board.

Renew means to determine eligibility again at a specified periodic interval (e.g., annual renewal of eligibility).

Third party means any person, entity, or program that is or may be responsible to pay all or part of the expenditure for another person's medical benefits.

Uninsured means to lack minimum essential coverage including under government sponsored programs (e.g., Medicaid, Medicare), employer sponsored plans, individual health plans, and other health benefits coverage (e.g., Refugee Medical Assistance).

3.00 Rights and responsibilities, authorized representatives, accessibility and nondiscrimination, AHS assistance, case records, privacy, quality control, and fraud

3.01 Rights of applicants and enrollees

(a) **Notice of rights and responsibilities**. AHS will provide individuals with information about their rights and responsibilities at the time of their application and subsequent reviews of eligibility.

(b) **Right to nondiscrimination and equal treatment.** AHS will not unlawfully discriminate on the basis of race, color, religion, national origin, disability, age, sex, gender identity, or sexual orientation in the administration of the Immigrant Health Insurance Plan.

(c) **Right to confidentiality.**

(1) AHS will not make any information regarding applicants and enrollees of the Immigrant Health Insurance Plan available to the United States government.

(2) All applications submitted and records received or created concerning any applicant for or enrollee of the Immigrant Health Insurance Plan:

(i) Are protected in accordance with federal and state laws regarding confidentiality, privacy, disclosure, and personally identifiable information, and

(ii) Will be made available only to persons authorized by AHS, by the State of Vermont, or by the United States government for purposes directly connected with the administration of the Immigrant Health Insurance Plan or as otherwise required by law.

(A) "Purposes directly connected with the administration of the Immigrant Health Insurance Plan" includes establishing eligibility, determining the amount of medical assistance, providing services to the individual, conducting or assisting with an investigation or prosecution, and civil or criminal proceedings, or audits, related to the administration of the Immigrant Health Insurance Plan.

(d) **Right to timely eligibility decision on application.** Applicants for the Immigrant Health Insurance Plan have the right to the timely decision on their application, as defined in subsection 7.02(h) of this rule.

(e) **Right to information**. Individuals who inquire about the Immigrant Health Insurance Plan have the right to receive information about eligibility, services, and the rights and responsibilities of program enrollees.

(f) **Right to apply**. Any person, individually or through an authorized representative or legal representative, has the right, and will be afforded the opportunity without delay, to apply for Immigrant Health Insurance Plan.

(g) **Right to be assisted by others.**

(1) The individual has the right to be:

(i) represented by a legal representative, and

(ii) accompanied and represented by an authorized representative during the eligibility or appeal processes.

(2) Upon request by the individual, copies of all eligibility notices and all documents related to the eligibility or appeal process will be provided to the individual's authorized or legal representative.

(h) **Right to inspect the case file**. An individual has the right to inspect information in their case file and contest the accuracy of the information.

(i) **Right to appeal.** An individual has right to appeal, as provided in Section 9.00 of this rule.

(j) **Right to interpreter services.** Individuals will be informed of the availability of interpreter services. Unless the individual chooses to provide their own interpreter services, AHS will provide telephonic or other interpreter services whenever:

(1) The individual who is seeking assistance has limited English proficiency or sensory impairment (for example, a seeing or hearing disability) and requests interpreter services, or

(2) AHS determines that such services are necessary.

(k) **Right to program information**. Upon request, an individual has a right to accessible information on eligibility requirements, covered health care services, the rights and responsibilities of applicants and enrollees, and the appeals processes.

(l) **Right to information about Medicaid application.** An individual who reports to AHS that they are pregnant has the right to be informed that, if they apply for and are determined eligible for Medicaid (including pursuant to HBEE § 17.02(d)) their child will be deemed to have applied and been determined eligible for Medicaid effective as of the date of birth, provided the child's

mother was eligible for and received covered services under Medicaid on that date (regardless of whether payment for services for the mother is limited to those defined in HBEE § 17.02(d)), and that the child will remain eligible for Medicaid until they reach age one regardless of changes in circumstances (except if the child dies or ceases to be resident of the state or the child's representative requests a voluntary termination of the child's eligibility).

3.02 Responsibilities of applicants and enrollees

(a) **Responsibility to cooperate.** An individual must cooperate in providing information necessary to establish and maintain their eligibility and must comply with all relevant laws. Failure to cooperate may result in an application being denied or eligibility being terminated because AHS is not able to determine eligibility due to the individual's failure to cooperate.

(b) **Responsibility to report changes.** An individual must report changes that may affect eligibility. Such changes include, but are not limited to, contact information, immigration status, income, household members, third-party liability, and coverage by other health insurance. An enrollee must report such changes to AHS within 10 days of learning of the change.

3.03 Authorized Representatives

(a) **Rules that govern authorized representatives.** The same rights, responsibilities, and procedures as those set forth in HBEE §5.02 for Medicaid applicants and enrollees apply to Immigrant Health Insurance Plan and extend to its applicants and enrollees.

3.04 Accessibility, Americans with Disabilities Act, and nondiscrimination

(a) **Accessibility requirements**

(1) **Plain language.** AHS will provide information and communications, including program information, applications, and notices, in plain language as defined at Section 2.00 of this rule, and in a manner that is accessible and timely.

(2) **Individuals living with disabilities.** Individuals living with disabilities will be provided with, among other things, accessible websites and auxiliary aids and services at no cost to the individual, in accordance with the Americans with Disabilities Act and § 504 of the Rehabilitation Act.

(3) **Individuals with limited English proficiency.** For individuals with limited English proficiency, language services will be provided at no cost to the individual, including:

(i) Oral interpretation,

(ii) Written translations,

(iii) Taglines in non-English languages indicating the availability of language services, and

(iv) Website translations.

(4) Individuals will be informed of the availability of the services described in this paragraph and how they may access such services.

(b) **Americans with Disabilities Act**

(1) **Reasonable Accommodation for persons living with disabilities.** As required by the Americans with Disabilities Act, AHS will make reasonable accommodations and modifications to its policies, practices, or procedures, when necessary to provide access to Immigrant Health Insurance Plan, as determined by the appropriate commissioner or their designee, or when necessary to avoid discrimination on the basis of disability. An individual may appeal the commissioner's determination to the appropriate entity within AHS.

(c) **Non-discrimination.** In the administration of the Immigrant Health Insurance Plan, AHS will comply with all applicable non-discrimination statutes and will not discriminate on the basis of race, color, national origin, disability, age, sex, gender identify or sexual orientation.

3.05 AHS assistance (including call center, website, and one on one assistance) and outreach and education

(a) **In general.** AHS will provide assistance to any individual seeking help with the application or renewal process or an appeal, in person or over the telephone, and in a manner that is accessible to individuals with disabilities and those who are limited English proficient.

Eligibility and enrollment assistance that meets the accessibility standards in this section is provided, and referrals are made to assistance programs in the state when available and appropriate. These functions include assistance provided directly to any individual seeking help with the application or renewal process.

(b) **Assistance available**

(1) **Call center.** A toll-free call center will be provided to serve the needs of all applicants for and enrollees in health benefits.

(2) **Internet website**. AHS will maintain an internet webpage that meets the accessibility requirements at section 3.04(a) of this rule that provides information to applicants and enrollees regarding Immigrant Health Insurance Plan including eligibility requirements, available health benefits, rights and responsibilities of applicants and enrollees, information about the Assister Program, and the toll-free telephone number of the call center.

(3) **One on one assistance**. The Assister Program will provide one on one assistance to individuals in understanding their health care coverage options, and in enrolling in and maintaining health care coverage. They will assist an individual in the application processes and in reporting changes. The requirements of HBEE § 5.03 through § 5.05 apply to and are extended to the Immigrant Health Insurance Plan.

(c) **Outreach and education.** AHS will conduct outreach and educational activities that meet the standards outlined in subsection 3.04(a) of this rule.

3.06 Case records

(a) Case records of applicants and enrollees must comply with the requirements of HBEE § 4.04 to the same extent the requirements apply to Medicaid applicants and enrollees.

3.07 Quality control review

(a) AHS will conduct independent reviews of eligibility facts in a sampling of Immigrant Health Insurance Plan cases. These reviews ensure that program rules are clear and consistently applied and that individuals understand program requirements and provide correct information in support of their application for Immigrant Health Insurance Plan. AHS will periodically review a sample of active enrollees to review eligibility determinations, and a sample of negative actions (e.g., denials, terminations) to review the accuracy of the action.

(b) When there is a discrepancy between the eligibility facts, as discovered in a review, and those contained in the case record, AHS will conduct an eligibility review and take action to correct errors.

3.08 Fraud

(a) A person commits fraud in Vermont if they:

(1) "[K]nowingly fails, by false statement, misrepresentation, impersonation, or other fraudulent means, to disclose a material fact used in making a determination as to the qualifications of that person to receive aid or benefits under a state or federally funded assistance program, or who knowingly fails to disclose a change in circumstances in order to obtain or continue to receive under a program aid or benefits to which he or she is not entitled or in an amount larger than that to which he or she is entitled, or who knowingly aids and abets another person in the commission of any such act . . . ;"[3] or

(2) "[K]nowingly uses, transfers, acquires, traffics, alters, forges, or possesses, or who knowingly attempts to use, transfer, acquire, traffic, alter, forge, or possess, or who knowingly aids and abets another person in the use, transfer, acquisition, traffic,

[3] 33 VSA § 141(a).

alteration, forgery, or possession of a . . . certificate of eligibility for medical services, or State health care program identification card in a manner not authorized by law . . . ."[4]

(b) **Legal consequences**. An individual who commits fraud may be prosecuted under Vermont law. If convicted, the individual may be fined or imprisoned or both. Action may also be taken to recover the value of benefits paid in error due to fraud.

(c) **AHS's responsibilities**. When AHS suspects that fraud has been committed, it has authority to investigate the case, and, if appropriate, refer the case to State's Attorney or Attorney General for a decision on whether or not to prosecute. Any investigation of a case of suspected fraud is pursued with the same regard for confidentiality and protection of the legal and other rights of the individual as with a determination of eligibility. The final decision regarding referral to a law enforcement agency shall be the responsibility of the Commissioner or their designee.

(d) **Suspected fraud.** The following criteria will be used to evaluate cases of suspected fraud to determine whether they should be referred to a law enforcement agency:

(1) Does the act committed appear to be a deliberately fraudulent one?

(2) Was the omission or incorrect representation an error or result of the individual's misunderstanding of eligibility requirements or the responsibility to provide information?

(3) Did the act result from AHS omission, neglect, or error in securing or recording information?

(4) Did the individual receive prior warning from a state employee that the same or similar conduct was improper?

3.09 Privacy and security of personally identifiable information

(a) When personally-identifiable information is collected or created for the purposes of determining eligibility and coverage of services, such information will be used or disclosed only to the extent such information is necessary to administer health care program functions in accordance with federal and state laws.

(b) **Requirements of AHS.** AHS responsibilities for establishing and implementing privacy and security standards for Immigrant Health Insurance Plan are the same as those at HBEE § 4.08(b) for Medicaid applicants and enrollees. AHS will not make any information regarding applicants for and enrollees in the Immigrant Health Insurance Plan available to the United States government.

[4] 33 VSA § 141(b).

3.10 Use of standards and protocols for electronic transactions.

(a) The requirements for HIPAA administrative simplification at HBEE § 4.09(a) apply to the Immigrant Health Insurance Plan.

4.00 Eligibility Standards

4.01 In general

(a) To qualify for benefits under the Immigrant Health Insurance Plan, an individual must meet the nonfinancial, categorical, and financial eligibility criteria outlined in this rule.

4.02 Nonfinancial criteria

(a) An individual must meet the nonfinancial criteria described in Section 5.00 of this rule.

4.03 Categorical and financial criteria

(a) **Coverage groups and income standards.** The individual must meet the categorical and financial criteria for at least one of the following coverage groups:

(1) **Child**

(i) A child is an individual who is under 19 years of age, with a MAGI-based income that is at or below 312% of the Federal Poverty Level (FPL) for the applicable family size.

(ii) For a hospitalized child who turns 19, coverage will be provided to an individual eligible and enrolled under this sub clause until the end of an inpatient stay for which inpatient services are furnished, if the individual:

(A) Was receiving inpatient services covered by the Immigrant Health Insurance Plan or Medicaid pursuant to HBEE § 17.02(d) on the date the individual is no longer eligible under this sub clause, based on the individual's age; and

(B) Would remain eligible but for attaining such age.

(2) **Pregnant Person**

(i) A pregnant person, as defined in Section 2.00 of this rule, with a MAGI-based income that is at or below 208% of the FPL for the applicable family size.

(ii) **Continuous eligibility**. An eligible pregnant person who would lose eligibility because of a change in household income is deemed to continue to be eligible through the pregnancy and the postpartum period without regard to the change in income.

5.00 Nonfinancial Eligibility Requirements

5.01 Immigration status requirement

(a) Individuals are eligible for the Immigrant Health Insurance Plan only if they have an immigration status for which Medicaid coverage is not available pursuant to HBEE § 17.00. This includes persons who are not lawfully residing in the United States, including persons who entered the country without the permission of the United State government.

(b) Citizens and nationals of the United States, as defined at HBEE § 17.01(a) through (c), are not eligible for the Immigrant Health Insurance Plan.

5.02 Incarceration in a correctional facility

(a) An individual who is incarcerated is ineligible for the Immigrant Health Insurance Plan. Incarceration begins on the date of admission to the correctional facility and ends when the individual moves out of the facility.

5.03 Residency requirement

(a) An individual must be a resident of Vermont to be eligible for the Immigrant Health Insurance Plan, and must be a Vermont resident at the time that a medical service is provided in order for it the service to be covered by the Immigrant Health Insurance Plan.

(b) **Who is a Vermont resident.** A resident of Vermont is an individual who meets the requirements of subsection 5.03(g) or 5.03(h) of this rule.

(c) **Incapability of indicating intent.** An individual is considered incapable of indicating intent regarding residency for the Immigrant Health Insurance Plan based on the standards set forth in HBEE § 21.02 for Medicaid applicants and enrollees.

(d) **Individuals placed by a state in an out of state institution.** For applicants and enrollees who were placed by a state in an out of state institution, residency is determined by HBEE § 21.04 to the same extent that it applies to Medicaid applicant and enrollees.

(e) **Prohibitions.** AHS will not:

(1) Deny Immigrant Health Insurance Plan eligibility because an individual has not resided in Vermont for a specified period.

(2) Deny Immigrant Health Insurance Plan eligibility to an individual in an institution who satisfies the residency rules set forth in this section, on the grounds that the individual did not establish residency in Vermont before entering an institution.

(3) Deny or terminate Immigrant Health Insurance Plan eligibility to an individual due to their temporary absence from the state, as defined in subsection 5.03(f) of this rule, if the person intends to return to Vermont when the purpose of the absence has been accomplished.

(f) **Temporary absences from the state.** Temporary absences from Vermont do not interrupt or end Vermont residence. An absence is considered temporary if an individual leaves the state with the intent to return when the purpose of the absence has been accomplished, such as absences for visiting others or obtaining necessary medical care. Temporary absence does not include when an individual moves to another state to work or to seek employment.

(g) **Residency requirements for individuals 19 years old or older.**

(1) **Individuals 19 years old or older who are not living in an institution.** The state of residence for an individual 19 years old or older who is not living in an institution, is as follows:

(i) For individuals who are capable of indicating intent regarding residency, they are a resident of the state in which they are living and:

(A) intend to reside, including without a fixed address, or

(B) have entered the state with a job commitment or are seeking employment (whether or not currently employed), including migrant workers who are employed in seasonal occupations in the state.

(ii) For individuals who are incapable of indicating intent regarding residency, the state of residence is where the individual is living.

(2) **Individuals 19 years old or older who are living in an institution.** The state of residency for an individual 19 years old or older who lives in an institution, is determined by HBEE § 21.06(c)-(e).

(h) **Residency requirements for individuals under 19 years old.**

(1) **Individual under 19 years old who are not living in an institution.** The state of residence for an individual under 19 years old who is not living in an institution is as follows:

(i) If the individual is capable of indicating intent regarding residency and is emancipated from their parents, is married, or is at least 18 years old, the state of residence is determined in accordance with subsection 5.03(g) of this rule.

(ii) For other individuals, the state of residence is the state in which the individual is living and:

(A) intends to reside, including without a fixed address, or

(B) is the state of residency of the parent or caretaker with whom the individual lives.

(2) **Individuals under 19 years old who are living in an institution.** The state of residency for an individual under 19 years old, who lives in an institution, who is not married and is not emancipated, is determined by HBEE § 21.08(c).

5.04 Assignment of rights and cooperation requirements

(a) The assignment of rights to third party payments for medical care to AHS is a condition of Immigrant Health Insurance Plan eligibility. If an individual has the legal authority to do so, they must also assign such rights of any other individual who is also applying for or enrolled in the Immigrant Health Insurance Plan. The exceptions to this rule are set forth in HBEE § 18.02(b).

(b) Cooperation includes identifying and providing information to assist in pursuing third parties who may be liable to pay for care and services provided by the Immigrant Health Insurance Plan, unless the individual has good cause for not cooperating. Good cause for noncooperation is defined in HBEE § 18.04.

5.05 Uninsured requirement

(a) **In general.** An individual must be uninsured to qualify for the Immigrant Health Insurance Plan.

(b) **Eligibility for government sponsored minimum essential coverage**. An individual who meets the eligibility criteria for government sponsored minimum essential coverage, including Medicaid, is considered insured for purposes of this rule and therefore ineligible for the Immigrant Health Insurance Plan.

5.06 Pursuit of potential unearned income requirement

(a) As a condition of Immigrant Health Insurance Plan eligibility, an individual is required to take all necessary steps to obtain unearned income to which they may be entitled (e.g., pensions, retirement, disability, unemployment compensation), unless they can show good cause for not doing so.

6.00 Financial Methodologies

The financial methodologies set forth in this section will be applied in determining the financial eligibility of all individuals for health benefits under the Immigrant Health Insurance Plan. Financial eligibility is determined based on household income, as defined in subsection 6.02 of this rule. Household composition is determined separately for each individual; see subsection 6.01 of this rule for details on household composition.

6.01 Household composition

(a) For purposes of household composition, the terms "child", "parent", and "sibling" include a natural or biological, adopted or step-child/parent/sibling.[5]

(b) The Immigrant Health Insurance Plan household consists of the individual and, if living with the individual:[6]

(1) The individual's spouse;

(2) The individual's children under the age of 19; and

(3) In the case of an individual under the age of 19, the individual's parents and siblings under the age of 19.

(c) **Special counting rule for pregnant person.** In the case of determining the family size of a pregnant person, or the family size of other individuals who have a pregnant person in their household, the pregnant person is counted as one person plus the number of children they are expected to deliver.

6.02 Household income

(a) Except as provided in subsection 6.02(c), household income for the Immigrant Health Insurance Plan is the sum of the MAGI-based income of every person included in the individual's household, as defined in subsection 6.01 of this rule.[7]

(b) MAGI-based income[8] means income calculated using the same financial methodologies used to determine MAGI, with the following exceptions:

[5] HBEE § 28.03(e)(1)
[6] HBEE § 28.03(e)(4)
[7] HBEE § 28.03(c)(1)
[8] This definition of MAGI-based income aligns with the definition at HBEE § 28.03(d)(1)-(2).

(1) An amount received as a lump sum is counted as income only in the month received unless otherwise required by federal law with respect to qualified lottery and gambling winnings of $80,000 or greater.

(2) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are excluded from income.

(c) **Income of children.** The MAGI-based income of a person who is included in the household of their natural, adopted, or step-parent, and is not expected to be required to file a federal tax return for the benefit year in which eligibility for the Immigrant Health Insurance Plan is being determined, is not included in the household income whether or not such person files a federal tax return.[9]

(d) **Five-percent disregard.**[10] In determining the eligibility of an individual for the Immigrant Health Insurance Plan under the eligibility group with the highest income standard under which the individual may be determined eligible, an amount equivalent to 5 percentage points of the FPL for the applicable family size is deducted from household income.

6.03 Budget period[11]

(a) Financial eligibility for applicants and new enrollees is based on current monthly household income and family size.

(b) For an enrollee who has been determined financially eligible for the Immigrant Health Insurance Plan using the financial methodologies set forth in this section, AHS will base financial eligibility on projected annual household income and family size for the remainder of the current calendar year.

[9] HBEE § 28.03(c)(2)(i)
[10] HBEE § 28.03(c)(4)
[11] HBEE § 28.03(g)

7.00 Eligibility and Enrollment Procedures

The Eligibility and Enrollment Procedures section of the Immigrant Health Insurance Plan rule sets forth the application processing and enrollment requirements for health benefits, including verification of eligibility factors and periodic renewals of eligibility.

7.01 Application

(a) An individual will be afforded the opportunity to apply for health benefits under the Immigrant Health Insurance Plan at any time. An individual can apply for health benefits under the Immigrant Health Insurance Plan in one of two ways:

(1) By completing an application for Vermont Medicaid and being approved for Medicaid coverage of emergency medical conditions only (pursuant to HBEE § 17.02(d)); or

(2) By completing a non-Medicaid application specific to the Immigrant Health Insurance Plan.

(b) A separate application for the Immigrant Health Insurance Plan is not required for an individual who is approved for Medicaid coverage of emergency medical conditions only (pursuant to HBEE § 17.02(d)) and who is otherwise categorically eligible for the Immigrant Health Insurance Plan.

(c) AHS may request that an individual enrolled in the Immigrant Health Insurance Plan complete a Medicaid application if they incur claims for emergency medical services or labor and delivery, provided the individual has not already completed a Medicaid application within the past 12 months.

(d) AHS will provide assistance to any individual seeking help with the application or renewal process, in the manner prescribed in subsection 3.05 of this rule.

(e) An application will be accepted from:

(1) The applicant;

(2) An adult who is in the applicant's household;

(3) An authorized representative; or

(4) If the applicant is a minor or incapacitated, someone acting responsibly for the applicant.[12]

[12] HBEE § 52.02(d)

(f) **Missing Information**[13]

(1) The applicant's eligibility for health benefits will not be determined before the applicant provides answers to all required questions on the application. If an incomplete application is received, the applicant will be sent a request for answers to all of the unanswered questions necessary to determine eligibility. The request will include a response due date, which will be no earlier than 15 days after the date the request is sent to the applicant.

(2) If a full response to the request is received on or before the due date, the eligibility process will be activated for determining:

(i) Coverage, based on the date the application was originally received; or

(ii) The need to request any corroborative information necessary to determine eligibility.

(3) If responses to all unanswered questions necessary for determining eligibility are not received by the response due date, the applicant will be notified that AHS is unable to determine their eligibility for Immigrant Health Insurance Plan benefits. The date that the incomplete application was received will not be used in any subsequent eligibility determinations.

(g) **Limits on Information**[14]

(1) An applicant will be required to provide only the information necessary to make an eligibility determination or for a purpose directly connected to the administration of health benefits programs.

(2) Information regarding immigration status will not be requested for an individual who is not seeking health benefits for themselves.

(h) **Signature Required on Application**[15]

(1) An initial application must be signed under penalty of perjury.

7.02 Attestation and verification

[13] HBEE § 52.02(e)
[14] HBEE § 52.02(f)
[15] HBEE § 52.02(h)

(a) AHS will verify or obtain information as described in subsection 7.02 before making a determination about an individual's eligibility for health benefits. AHS will abide by the confidentiality provisions described in subsection 3.01(c) of this rule.

(b) **Proof of identity**. An individual seeking health benefits under the Immigrant Health Insurance Plan must provide proof of identity. Evidence of identity that will be accepted can be found at HBEE § 54.07(d). AHS will also accept a valid, unexpired passport or consular identification card as proof of identity.

(c) **Proof of state residency.** An individual seeking health benefits under the Immigrant Health Insurance Plan must provide proof of Vermont residency. Proof of Vermont residency that will be accepted is as follows:

(1) Two pieces of mail with current name and street address (if mail is received at the street address)

(2) If mail is not received at the street address, provide any two of the following which show street address:

(i) Rental or lease agreements with the signatures of the owner/landlord and the tenant/resident

(ii) Home utility bills, including cellular phone bills (must list service address)

(iii) Vermont driver's license

(iv) Insurance documents, including medical, life, home, rental, and vehicle

(v) A property tax bill or statement with physical location

(3) If the individual resides with others and gets no mail at their street address, an affidavit signed, under penalty of perjury, certifying that the individual resides in Vermont at a specified street address may be submitted in addition to one of the documents listed at subsection 7.02(c)(2).

(4) If the individual seeking health benefits is a child, the name on the documents at subsection 7.02(c)(1)-(2) of this rule can be that of a parent or guardian with whom the child resides.

(d) **Proof of age**. An individual seeking health benefits under the Immigrant Health Insurance Plan must provide proof of age. This could include a date of birth on evidence of identity described at subsection 7.02(b) of this rule.

(e) **Documentary evidence**.[16] A photocopy, facsimile, scanned or other copy of a document will be accepted to the same extent as an original document under this subsection, unless information on the submitted document is inconsistent with other information available to AHS, or AHS otherwise has reason to question the validity of the document or the information on the document.

(f) **Self-attestation**. Unless information from an individual is not reasonably compatible with other information provided or otherwise available to AHS, attestation of information needed to determine the following eligibility requirements of an individual for health benefits will be accepted without requiring further information (including documentation) from the individual:

(1) Pregnancy;

(2) Family size;

(3) Immigration status; and

(4) Lack of access to minimum essential coverage

(g) **Income**

(1) An individual seeking health benefits under the Immigrant Health Insurance Plan must provide proof of income. Proof of income that will be accepted includes:

(i) 1040 federal or State tax return

(ii) Complete tax return including all forms and schedules, if self-employed

(iii) Wages and tax statement

(iv) Pay stub

(v) Signed letter from employer that contains a description of job, number of hours worked, salary or wages, employer's address, and employer's telephone number.

(vi) Bank or investment fund statement

(vii) Agricultural income certificate

(viii) Bookkeeping records

(ix) Self-employment ledger

[16] HBEE § 54.07(g)

(x) Business income and expense sheet

(xi) Most recent quarterly or year-to-date profit and loss statement

(2) An individual's attestation that their income is above the highest income standard under which they may be determined eligible will be accepted without further verification.

(h) **Exception for special circumstances.** AHS will provide an exception, on a case-by-case basis, to accept an individual's attestation as to information which cannot otherwise be verified, because such documentation:

(1) Does not exist; or

(2) Is not reasonably available.

(i) **Timely determination of eligibility.** An eligibility decision on an Immigrant Health Insurance Plan application will be made as soon as possible, but no later than 45 days after the application date.

7.03 Enrollment

(a) **Prospective enrollment.**[17] An individual approved for the Immigrant Health Insurance Plan will be enrolled in the plan on the first day of the month within which their application is received by AHS provided they are eligible for that month.

(b) **Retroactive eligibility.**[18] Retroactive eligibility is effective no earlier than the first day of the third month before the month an individual's application is received by AHS, regardless of whether the individual is alive when application is made, if the following conditions are met:

(1) Eligibility is determined separately for each of the three months;

(2) A medical need exists; and

(3) Elements of eligibility were met at some time during each month.

(c) **Eligibility redetermination during a benefit year**

[17] HBEE § 70.01(a)
[18] HBEE § 70.01(b)(1)

(1) AHS must redetermine the eligibility of an individual in the Immigrant Health Insurance Plan during the benefit year if it receives and verifies new information reported by the individual or otherwise identifies updated information that may affect eligibility.

(2) If a redetermination is made during a benefit year because of a change in the individual's circumstances and there is enough information available to renew eligibility with respect to all eligibility criteria, a new 12-month renewal period may begin.[19] AHS will promptly redetermine the individual's eligibility in accordance with program standards and notify the individual regarding the redetermination in accordance with the requirements specified in subsection 9.03 of this rule.

(d) **Eligibility renewal**.

(1) Eligibility of an individual in the Immigrant Health Insurance Plan will be renewed on an annual basis.

(2) AHS will provide the individual with:

(i) A form or application that is needed to renew eligibility;

(ii) At least 30 days from the date of the form or application to respond and provide any necessary information, and to sign the form or application; and

(iii) Notice in a timely manner of the decision concerning the renewal of eligibility in accordance with the requirements specified in subsection 9.03 of this rule.

(e) **Determination of ineligibility for Immigrant Health Insurance Plan benefits**

(1) Immigrant Health Insurance Plan benefits continue for all individuals until they are found to be ineligible. When an enrollee has done everything they were asked to do, benefits will not be closed even though a decision cannot be made within the required review frequency.[20]

(2) Individuals who are determined to be ineligible for benefits for any reason besides change in immigration status or state residency must be provided with information about applying for Medicaid pursuant to HBEE § 17.02(d) before benefits are closed.

(3) Individuals who are determined to be ineligible for benefits because of a change in immigration status must be advised that they may be eligible for Medicaid. Such individuals will receive benefits until the end of the calendar month following the month in which they are determined to be ineligible for the Immigrant Health Insurance Plan.

[19] HBEE § 73.03(a)
[20] HBEE § 75.03(c)

8.00 Covered Services

Individuals enrolled in the Immigrant Health Insurance Plan receive the same hospital, medical, dental, and prescription drug coverage as Medicaid enrollees as specified in the Vermont Medicaid State Plan, excluding long-term services and supports.

8.01 Conditions for Coverage

(a) Coverage for services for enrollees is subject to any service limitations, prior authorizations, and conditions for coverage described in either Chapter 4: Medicaid Covered Services of the Health Care Administrative Rules or Medicaid Covered Service Rules adopted by the Agency of Human Services that govern the scope of benefits available for Medicaid enrollees, except for the following rules:

(1) For rules governing eligibility and covered service appeals, please refer to Section 9.00 of this rule.

(2) The exception request process described in rule 7104 is not available to individuals enrolled in the Immigrant Health Insurance Plan.

(3) HCAR 4.106 – Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services is not applicable to the Immigrant Health Insurance Plan.

(b) There are no premiums, co-payments, or other form of cost-sharing for enrollees of the Immigrant Health Insurance Plan.

8.02 Additional Covered Service Provisions for Enrollees Under Age 21

(a) For enrollees under age 21, AHS will inform enrollees of the following:

(1) The benefits of preventive health care,
(2) Availability of screening and diagnostic testing services,
(3) How to access services, and
(4) The availability of transportation if necessary to access services.

(b) The Immigrant Health Insurance Plan covers medical, vision, dental, and hearing screenings according to a periodicity schedule that specifies screening services applicable at each stage of life, beginning with neonatal examination, up to age 21. Screenings are also covered on an interperiodic basis, as needed.

(c) Immigrant Health Insurance Plan covers medical screenings that include a comprehensive health and developmental history that assess for physical, mental and developmental health and substance use disorders, a comprehensive physical examination, appropriate immunizations and

laboratory tests (including lead blood level tests), and health education for both the enrollee and, where appropriate, their caregiver.

(d) Immigrant Health Insurance Plan covers diagnostic services without delay when a screening indicates a need for further evaluation.

(e) The medical necessity standard for all enrollees in the Immigrant Health Insurance Plan, including those under age 21, is the same as that for Medicaid enrollees age 21 and older pursuant to HCAR 4.101.

8.03 Non-Covered Services

(a) There is no coverage of long-term services and supports, as defined in Section 2.00 of this rule.

(b) Services that are only available under the Global Commitment to Health 1115 waiver and not available in the Vermont Medicaid State Plan are not covered.

8.04 Qualified Providers

(a) Providers of services to enrollees of the Immigrant Health Insurance Plan must be enrolled in Vermont Medicaid prior to delivery of services, except in the case of emergency services pursuant to HCAR 4.102.

(b) Providers of services to enrollees of the Immigrant Health Insurance Plan must abide by the same rights, responsibilities, and requirements as those that are applicable to Medicaid enrollees.

9.00 Immigrant Health Insurance Plan state fair hearing requests, internal appeals and grievances (services only), and notices

9.01 Eligibility State fair hearing requests

(a) **Definitions**

(1) **State fair hearing request**. A clear expression, orally or in writing, by an applicant or enrollee to have a decision by AHS affecting the individual's eligibility reviewed by the Human Services Board.

(2) **Human Services Board rules.** State fair hearing requests are processed in accordance with State fair hearing rules as adopted by the Human Services Board pursuant to 3 VSA § 3091(b).

(b) **Right to a State fair hearing.**

(1) AHS will grant an opportunity for a State fair hearing to any applicant or enrollee who requests it because AHS denies or terminates their eligibility, does not act timely on their application, or they are aggrieved by another AHS action that affects their eligibility.

(2) There is no right to a State fair hearing if the sole issue is a state or federal law requiring an automatic change adversely affecting some or all individuals. An individual retains the right to a State fair hearing in an appeal of the application of the law to the facts of an individual's case.

(3) AHS will provide every individual in writing with an explanation of their State fair hearing rights:

(i) At the time that the individual applies for the Immigrant Health Insurance Plan, and

(ii) At the time AHS sends a notice of decision that affects the individual's eligibility.

(c) **Request for a State fair hearing.**

(1) An applicant or enrollee may submit a State fair hearing request orally or in writing by contacting AHS or the Human Services Board. With the consent of the individual, a State fair hearing request may be submitted by an individual's authorized representative, legal counsel, or another person.

(2) An individual may submit a fair hearing request by telephone, mail, in person, or through the internet.

(3) An individual must request a State fair hearing within 90 days from the date that the notice of decision that is the issue of the appeal is sent by AHS to the individual.

(4) AHS will assist individuals with making a State fair hearing request, if requested.

(d) **AHS review prior to sending State fair hearing request to the Human Services Board.** Prior to referring an individual's request for a State fair hearing to the Human Services Board, AHS may take up to 15 days from receipt of the request to review the individual's appeal. If AHS determines, during its review, that the individual is entitled to relief, AHS will grant the individual relief and will send the individual a new notice of decision if eligibility is redetermined.

(e) **Judicial review of AHS final decision**. An applicant or enrollee may appeal a final order to the Vermont Supreme Court pursuant to Vermont Rule of Appellate Procedure 13.

(f) **Implementation of State fair hearing order**. AHS will promptly implement an order that is final and binding. If the order is favorable to the applicant or enrollee, eligibility will be reinstated to the date of the incorrect action that was taken by AHS. If the decision is favorable to AHS and results in an individual's ineligibility, AHS will terminate continued coverage on the last day of the month in which AHS acts to implement the order.

(g) **Maintaining eligibility pending State fair hearing.**

(1) If an applicant or enrollee appeals an AHS decision that denies or terminates their eligibility, does not act timely on their application, or is aggrieved by another AHS action that affects their eligibility, the individual has a right, under certain circumstances, to have their eligibility continue as it was before the decision that resulted in the appeal. This continued eligibility will continue until the State fair hearing is resolved, provided the individual submits the request for a State fair hearing before the effective date of the adverse action. If the last day before the adverse action goes into effect is on a weekend or State holiday, the individual has until the end of the first subsequent business day to request the State fair hearing. An individual may waive their right to continued Immigrant Health Insurance Plan coverage.

(2) There is no right to continued health care benefits without change when AHS's decision does not require the minimum advance notice, as described in subsection 9.03(c)(2), or if the sole issue is a state or federal law requiring an automatic change adversely affecting some or all individuals.

(h) **Recovery of value of continued Immigrant Health Insurance Plan benefits**. AHS may recover from the individual the value of any continued benefits paid during the State fair hearing process if the individual withdraws the State fair hearing request before a decision is made, or following a final disposition of the matter in favor of AHS.

9.02 Services appeals

(a) For rules that govern internal appeals, State fair hearings, and grievances on services covered by the Immigrant Health Insurance Plan, refer to Health Care Administrative Rule (HCAR) 8.100. Applicants and enrollees have the same rights and responsibilities regarding services internal appeals, State fair hearings, and grievances as those set forth in HCAR 8.100 for Medicaid applicants and enrollees except:

(1) There is no requirement that Immigrant Health Insurance Plan individuals exhaust the internal appeals process prior to requesting a State fair hearing.

(b) The following rules in HCAR 8.100 do not apply or have limited application, as indicated below, to Immigrant Health Insurance Plan applicants and enrollees:

(1) HCAR 8.100.3(b)(1)(E) - There is no requirement that a notice of adverse benefit determination provide information about the exhaustion requirement or when exhaustion is deemed.

(2) HCAR 8.100.4(g)(d) – Not applicable in its entirety.

(3) HCAR 8.100.4(g)(1)(B) – Not applicable in its entirety.

(4) HCAR 8.100.4(g)(2) – Not applicable in its entirety.

(5) HCAR 8.100.5(e) - Not applicable in its entirety.

(6) HCAR 8.100.5(l) - Not applicable in its entirety.

(7) HCAR 8.100.5(j)(1) – Modified to provide that:

(i) For individuals who file an internal appeal, the standard timeframe for final administrative action by AHS is 90 days from the date the internal appeal was filed, not including the days the individual took to subsequently file a request for a State fair hearing; and

(ii) For individuals who file a request for a State fair hearing without first having an internal appeal, the standard timeframe for final administrative action by AHS is 90 days from the date the State fair hearing request was filed.

9.03 General Notice Standards (eligibility and services)

(a) All notices that AHS is required to send will conform to the accessibility requirements set forth in subsection 3.04 of this rule.

(b) **Notices related to eligibility**. AHS will send a timely notice of decision when it makes a decision that affects eligibility. Notices of decision are generally sent in advance of the effective date of the change. Notices of decision that adversely affect an individual's eligibility (e.g., termination) will comply with notice requirements set forth at subsection 9.03(c) of this rule. Notices of decision concerning eligibility will contain clear statements of the following content, as applicable:

(1) AHS's decision, its basis, and the specific reasons supporting the decision,

(2) The effective date of the decision,

(3) If the decision is adverse, the state rule supporting the decision,

(4) If the decision is adverse, information about how to apply for Medicaid (including Medicaid pursuant to HBEE § 17.02(d))

(5) An explanation of the right to appeal, including the right to request a State fair hearing,

(6) A description of the methods by which an individual can request a State fair hearing,

(7) The timeframe in which AHS must enter a final administrative decision,

(8) Information about the individual's right to represent themself at a State fair hearing or use legal counsel, a friend, or another person as their spokesperson,

(9) In cases of a decision based on a change in law, an explanation of the limited circumstances in which a fair hearing may be granted,

(10) An explanation of when the individual's Immigrant Health Insurance Plan eligibility will continue pending a State fair hearing decision, and

(11) Contact information for AHS customer services.

(c) **Advance notice of Immigrant Health Insurance Plan adverse decisions concerning eligibility.**

(1) AHS will send a notice of decision that adversely affects eligibility (e.g., termination) at least 11 days before the date that the adverse action is to take effect except as described at subsection 9.03(c)(2) of this rule.

(2) Advance notice of an adverse action is not required in these circumstances:

(i) There is factual information confirming the death of an applicant or enrollee,

(ii) The enrollee has provided a clear, signed statement that they no longer wish to be enrolled,

(iii) The enrollee has been admitted to an institution where they are ineligible for the Immigrant Health Insurance Plan,

(iv) The enrollee's whereabouts are unknown, and the post office returns mail directed to the enrollee and does not indicate a forwarding address,

(v) AHS establishes the fact that the enrollee has been enrolled in Medicaid in Vermont or in another state.

(d) **Notices related to services**. For adverse benefit determinations concerning coverage of services, the content and timing of the notice will follow Heath Care Administrative Rule 8.100.3, except that HCAR 8.100.3(b)(1)(E) is replaced with the following:

(1) HCAR 8.100(b)(1)(E). An explanation of when there is a right to request a State fair hearing, including the option to request an internal appeal or go directly to a State fair hearing.