FINAL PROPOSED RULE # 22-P14

Final Proposed Filing - Coversheet

Instructions:

In accordance with Title 3 Chapter 25 of the Vermont Statutes Annotated and the "Rule on Rulemaking" adopted by the Office of the Secretary of State, this filing will be considered complete upon filing and acceptance of these forms with the Office of the Secretary of State, and the Legislative Committee on Administrative Rules.

All forms shall be submitted at the Office of the Secretary of State, no later than 3:30 pm on the last scheduled day of the work week.

The data provided in text areas of these forms will be used to generate a notice of rulemaking in the portal of "Proposed Rule Postings" online, and the newspapers of record if the rule is marked for publication. Publication of notices will be charged back to the promulgating agency.

PLEASE REMOVE ANY COVERSHEET OR FORM NOT REQUIRED WITH THE CURRENT FILING BEFORE DELIVERY!

Certification Statement: As the adopting Authority of this rule (see 3 V.S.A. § 801 (b) (11) for a definition), I approve the contents of this filing entitled:

Health Benefits Eligibility and Enrollment Rule, General Provisions and Definitions (Part 1)

/s/ Todd Daloz , on 10/12/22
(signature) (date)

Printed Name and Title:
Todd Daloz, Deputy Secretary, Agency of Human Services

RECEIVED BY: _____

- ☐ Coversheet
- ☐ Adopting Page
- ☐ Economic Impact Analysis
- ☐ Environmental Impact Analysis
- ☐ Strategy for Maximizing Public Input
- ☐ Scientific Information Statement (if applicable)
- ☐ Incorporated by Reference Statement (if applicable)
- ☐ Clean text of the rule (Amended text without annotation)
- ☐ Annotated text (Clearly marking changes from previous rule)
- ☐ ICAR Minutes
- ☐ Copy of Comments
- ☐ Responsiveness Summary

State of Vermont
Agency of Human Services
280 State Drive
Waterbury, VT 05671-1000
www.humanservices.vermont.gov

Jenney Samuelson, Secretary
[phone] 802-241-0440
[fax] 802-241-0450

MEMORANDUM

To: Jim Condos, Secretary of State, Vermont Secretary of State Office
Sen. Mark A. MacDonald, Chair, Legislative Committee on Administrative Rules (LCAR)

From: Adaline Strumolo, Deputy Commissioner, Department of Vermont Health Access

Cc: Todd Daloz, Deputy Secretary, Agency of Human Services
Charlene Dindo, Committee Assistant, Legislative Committee on Administrative Rules
Louise Corliss, APA Coordinator, Secretary of State's Office

Date: October 18, 2022

Re: Agency of Human Services Final Proposed Rule Filing

Enclosed are the final proposed rule filings for the following Health Benefits Eligibility and Enrollment (HBEE) rule parts:

Amended:

- 22P014 HBEE Part One – General Provisions and Definitions
- 22P015 HBEE Part Two – Eligibility Standards
- 22P016 HBEE Part Three – Nonfinancial Eligibility Requirements
- 22P017 HBEE Part Five – Financial Methodologies
- 22P018 HBEE Part Seven – Eligibility and Enrollment Procedures

Public comments were received on HBEE Part Two and HBEE Part Three during the public comment period. No comments were received for the other parts. One general comment was received that was out of the scope of this rulemaking.

HBEE Part Two and HBEE Part Three were amended in response to comments from Vermont Legal Aid, Inc. (VLA). Please see the State's Responsiveness Summary and Summary of Technical Changes at the end of each rule package for the list of changes from the propose rule.

Changes are indicated in red and highlighted in grey in the annotated copy of the final proposed rule for HBEE Part Two and HBEE Part Three. No changes were made from the proposed rule in HBEE Part One, Part Five, and Part Seven.

If you have any questions, please contact Dani Fuoco, Policy Analyst, at 802-585-4265.

280 State Drive – Center Building
Waterbury, VT 05671-1000

OFFICE OF THE SECRETARY
TEL: (802) 241-0440
FAX: (802) 241-0450

JENNEY SAMUELSON
SECRETARY

TODD W. DALOZ
DEPUTY SECRETARY

STATE OF VERMONT
AGENCY OF HUMAN SERVICES

MEMORANDUM

TO: Jim Condos, Secretary of State

FROM: Jenney Samuelson, Secretary, Agency of Human Services

DATE: April 1, 2022

SUBJECT: Signatory Authority for Purposes of Authorizing Administrative Rules

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I hereby designate Deputy Secretary of Human Services Todd W. Daloz as signatory to fulfill the duties of the Secretary of the Agency of Human Services as the adopting authority for administrative rules as required by Vermont's Administrative Procedure Act, 3 V.S.A. § 801 et seq.

Cc: Todd W. Daloz

VERMONT

State of Vermont
Agency of Human Services
280 State Drive
Waterbury, VT 05671-1000
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[phone] 802-241-0440
[fax] 802-241-0450

Jenney Samuelson, Secretary

Date: October 18, 2022

Re: Summary of Changes from proposed to final proposed rule filing for Health Benefits Eligibility and Enrollment (HBEE) rules (GCR 22-029 through 22-033)

In addition to the changes being made in response to public comments (see responsiveness summary), additional changes are being made to correct technical and typographical errors.

The following is a list of these additional changes and the reasons for them. All changes being made in HBEE rule are identified in gray highlight in the annotated version of the final proposed rule being filed contemporaneously herewith.

The changes, in order by section number, are as follows:

PART TWO

Section 8.05(k)(6)(iii) – To align more closely with federal law at 42 CFR § 435.225(b), add "the" before "appropriate" on the first line of text; replace "medical care in the community" with "institutional level of care outside of a medical institution;" add "and" before "the" on the second line of text; add "estimated Medicaid" before "cost" on the second line of text; replace "of which" with "of such care" after "cost" on the second line of text; add "Medicaid" before "cost" on the third line of text; replace "medical care in an appropriate medical institution" with "appropriate institutional care."

PART THREE

Section 17.03(c)(6) – To improve clarity, change "the" to "their" on the first line of text; to align with revisions being made in Section 3.00 (to definition of "pregnant woman") and Section 7.03(a)(2), delete "60-day" on the first line of text

Section 18.03(b) – To align with revisions being made in Section 3.00 (to definition of "pregnant woman") and Section 7.03(a)(2), change "60-day" to "post partum" on the fourth line of text; to improve clarity, add "," after "period" on the fourth line of text; to improve clarity, add "," after "delivery" on the fifth line of text

1. TITLE OF RULE FILING:
Health Benefits Eligibility and Enrollment Rule, General Provisions and Definitions (Part 1)

2. PROPOSED NUMBER ASSIGNED BY THE SECRETARY OF STATE
22P 014

3. ADOPTING AGENCY:
Agency of Human Services (AHS)

4. PRIMARY CONTACT PERSON:
(A PERSON WHO IS ABLE TO ANSWER QUESTIONS ABOUT THE CONTENT OF THE RULE).

Name: Danielle Fuoco

Agency: Agency of Human Services

Mailing Address: 280 State Drive, Center Building, Waterbury, Vermont 05671-1000

Telephone: (802)585-4265 Fax: (802)241-0450

E-Mail: danielle.fuoco@vermont.gov

Web URL *(WHERE THE RULE WILL BE POSTED)*:
https://humanservices.vermont.gov/rules-policies/health-care-rules

5. SECONDARY CONTACT PERSON:
(A SPECIFIC PERSON FROM WHOM COPIES OF FILINGS MAY BE REQUESTED OR WHO MAY ANSWER QUESTIONS ABOUT FORMS SUBMITTED FOR FILING IF DIFFERENT FROM THE PRIMARY CONTACT PERSON).

Name: Jessica Ploesser

Agency: Agency of Human Services

Mailing Address: 280 State Drive, NOB 1 South, Waterbury, VT 05671

Telephone: (802)241-0454 Fax: (802)241-0450

E-Mail: jessica.ploesser@vermont.gov

6. RECORDS EXEMPTION INCLUDED WITHIN RULE:
(DOES THE RULE CONTAIN ANY PROVISION DESIGNATING INFORMATION AS CONFIDENTIAL; LIMITING ITS PUBLIC RELEASE; OR OTHERWISE, EXEMPTING IT FROM INSPECTION AND COPYING?) No

IF YES, CITE THE STATUTORY AUTHORITY FOR THE EXEMPTION:

N/A

PLEASE SUMMARIZE THE REASON FOR THE EXEMPTION:

N/A

7. LEGAL AUTHORITY / ENABLING LEGISLATION:

(THE SPECIFIC STATUTORY OR LEGAL CITATION FROM SESSION LAW INDICATING WHO THE ADOPTING ENTITY IS AND THUS WHO THE SIGNATORY SHOULD BE. THIS SHOULD BE A SPECIFIC CITATION NOT A CHAPTER CITATION).

3 V.S.A. 801(b)(11); 33 V.S.A. 1901(a)(1) and 1810

8. EXPLANATION OF HOW THE RULE IS WITHIN THE AUTHORITY OF THE AGENCY:
This rule amends an existing rule on eligibility and enrollment in the State of Vermont's health benefit programs. AHS's authority to adopt rules as identified above includes, by necessity, the authority to amend the rules to ensure continued alignment with federal and state guidance and law.

9. THE FILING HAS CHANGED SINCE THE FILING OF THE PROPOSED RULE.

10. THE AGENCY HAS INCLUDED WITH THIS FILING A LETTER EXPLAINING IN DETAIL WHAT CHANGES WERE MADE, CITING CHAPTER AND SECTION WHERE APPLICABLE.

11. SUBSTANTIAL ARGUMENTS AND CONSIDERATIONS WERE RAISED FOR OR AGAINST THE ORIGINAL PROPOSAL.

12. THE AGENCY HAS INCLUDED COPIES OF ALL WRITTEN SUBMISSIONS AND SYNOPSES OF ORAL COMMENTS RECEIVED.

13. THE AGENCY HAS INCLUDED A LETTER EXPLAINING IN DETAIL THE REASONS FOR THE AGENCY'S DECISION TO REJECT OR ADOPT THEM.

14. CONCISE SUMMARY (**150 WORDS OR LESS**):

This proposed rulemaking amends Parts 1, 2, 3, 5, and 7 of the 8-part Health Benefits Eligibility and Enrollment (HBEE) rule. Substantive revisions include: codifying the annual open enrollment period for qualified health plans from November 1 - January 15; adding a new income-based special enrollment period for qualified health plans that allows ongoing enrollment for those at or below 200% of the Federal Poverty Level (FPL); extending the Medicaid postpartum period for pregnant women from 60 days to 12 months; adding Compacts of Free Association (COFA) migrants as qualified non-citizens eligible for Medicaid and exempt from the 5-year bar; adding a reference to a standardized eligibility tool for Katie Beckett Medicaid; and expanding Medicaid eligibility for former

foster care children to include children aging out of foster care in another state. In response to comment, the rule also addresses the ACA's "family glitch" regarding affordability of employer coverage.

15. EXPLANATION OF WHY THE RULE IS NECESSARY:

The changes align HBEE with federal and state guidance and law, provide clarification, correct information, improve clarity, and make technical corrections. Substantive revisions include those listed in the concise summary above.

16. EXPLANATION OF HOW THE RULE IS NOT ARBITRARY:

The rules are required to implement state and federal health care guidance and laws. Additionally, the rules are within the authority of the Secretary, are within the expertise of AHS, and are based on relevant factors including consideration of how the rules affect the people and entities listed below.

17. LIST OF PEOPLE, ENTERPRISES AND GOVERNMENT ENTITIES AFFECTED BY THIS RULE:

Medicaid applicants/enrollees;

Individuals who wish to purchase health coverage including those who apply for premium and cost-sharing assistance;

Health insurance issuers;

Eligibility and enrollment assisters, including agents and brokers;

Health care providers;

Health law, policy and related advocacy and community-based organizations and groups including the Office of the Health Care Advocate;

Agency of Human Services including its departments; and Department of Financial Regulation.

18. BRIEF SUMMARY OF ECONOMIC IMPACT (150 WORDS OR LESS):

AHS anticipates that some of the proposed changes to HBEE will have an economic impact on the State's budget, beginning in SFY2023. The estimated gross annualized budget impact of expanding postpartum Medicaid coverage for pregnant women from 60 days to 12 months is ~$2 million and accounted for in AHS's FY2023 budget. The estimated gross annualized budget impact of expanding Medicaid coverage to

children who age out of foster care in any state is $52,700. There is no anticipated impact from the addition of COFA migrants.

Changes related to Qualified Health Plan enrollment are not expected to have an economic impact except insofar as any opportunity to encourage enrollment and maintain VT's low uninsured rate is fiscally positive for VT.

Other changes in Parts 1, 2, 3, 5, & 7 align the rule with federal and state guidance and law, provide clarification, correct information, improve clarity, and make technical corrections. These changes do not carry a specific economic impact on any person or entity.

19. A HEARING WAS HELD.

20. HEARING INFORMATION

(THE FIRST HEARING SHALL BE NO SOONER THAN 30 DAYS FOLLOWING THE POSTING OF NOTICES ONLINE).

IF THIS FORM IS INSUFFICIENT TO LIST THE INFORMATION FOR EACH HEARING, PLEASE ATTACH A SEPARATE SHEET TO COMPLETE THE HEARING INFORMATION.

Date: 8/17/2022

Time: 02:00 PM

Street Address: Cherry A Conference Room

Waterbury State Office Complex, 280 State Drive, Waterbury, VT

OR Virtual Hearing - Phone or Microsoft Teams

Call in (audio only)

(802) 522-8456; Conference ID: 738063547#

For Teams Link, view Public Notice in Global Commitment Register on AHS website.

Zip Code: 05671

Date:

Time: AM

Street Address:

Zip Code:

Date:

Time: AM

Street Address:

Zip Code:

Date:
Time: AM
Street Address:
Zip Code:

21. DEADLINE FOR COMMENT (NO EARLIER THAN 7 DAYS FOLLOWING LAST HEARING):

8/24/2022

KEYWORDS (PLEASE PROVIDE AT LEAST 3 KEYWORDS OR PHRASES TO AID IN THE SEARCHABILITY OF THE RULE NOTICE ONLINE).

HBEE
Health Benefits Eligibility and Enrollment
Vermont Health Connect
Exchange
Medicaid
QHP
Qualified Health Plan
Health Benefit
Pregnant
Foster Care
Special Enrollment Period
SEP
Annual Open Enrollment Period
AOEP
Post partum

Adopting Page

Instructions:

This form must accompany each filing made during the rulemaking process:

Note: To satisfy the requirement for an annotated text, an agency must submit the entire rule in annotated form with proposed and final proposed filings. Filing an annotated paragraph or page of a larger rule is not sufficient. Annotation must clearly show the changes to the rule.

When possible, the agency shall file the annotated text, using the appropriate page or pages from the Code of Vermont Rules as a basis for the annotated version. New rules need not be accompanied by an annotated text.

1. TITLE OF RULE FILING:
   Health Benefits Eligibility and Enrollment Rule, General Provisions and Definitions (Part 1)
2. ADOPTING AGENCY:
   Agency of Human Services (AHS)
3. TYPE OF FILING (*PLEASE CHOOSE THE TYPE OF FILING FROM THE DROPDOWN MENU BASED ON THE DEFINITIONS PROVIDED BELOW*):
   - **AMENDMENT** - Any change to an already existing rule, even if it is a complete rewrite of the rule, it is considered an amendment if the rule is replaced with other text.
   - **NEW RULE** - A rule that did not previously exist even under a different name.
   - **REPEAL** - The removal of a rule in its entirety, without replacing it with other text.

   This filing is **AN AMENDMENT OF AN EXISTING RULE** .

4. LAST ADOPTED (*PLEASE PROVIDE THE SOS LOG#, TITLE AND EFFECTIVE DATE OF THE LAST ADOPTION FOR THE EXISTING RULE*):

   Part 1 - General Provisions and Definitions, SOS # 21P005, effective 10/1/2021; Part 2 - Eligibility Standards, SOS # 18P044, effective 1/15/2019; Part 3 - Nonfinancial Eligibility Requirements, SOS # 18P045, effective 1/15/2019; Part 5 - Financial Methodologies,

SOS # 21P006, effective 10/1/2021; Part 7 - Eligibility and Enrollment Procedures, SOS # 21P007, effective 10/1/2021.

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Kristin L. Clouser, Secretary

INTERAGENCY COMMITTEE ON ADMINISTRATIVE RULES (ICAR) MINUTES

Meeting Date/Location: June 13, 2022, virtually via Microsoft Teams
Members Present: Chair Douglas Farnham, Brendan Atwood, Jared Adler, Jennifer Mojo, Diane Sherman, Mike Obuchowski and Donna Russo-Savage
Members Absent: John Kessler and Diane Bothfeld
Minutes By: Melissa Mazza-Paquette

- 2:01 p.m. meeting called to order, welcome and introductions.
- Committee discussion on process improvements is scheduled for the August meeting to allow for participation from all members.
- Review and approval of minutes from the May 9, 2022 meeting.
- No additions/deletions to agenda. Agenda approved as drafted.
- Note: An emergency rule titled 'Vital Records Emergency Rule', provided by the Agency of Human Services, Department of Health, was supported by ICAR Chair Farnham on May 16, 2022. This rulemaking implements a process for individuals to amend the marker on their birth certificate to reflect the individual's gender identity. Specifically, it does the following: 1) Defines the term "non-binary" to describe the additional gender identities that may be reflected on a birth certificate. 2) Creates a process for registrants to file their Affidavit of Gender Identity with the Department.
- One public comment made by Venn [Saint Wilder].
- Presentation of Proposed Rules on pages 2-10 to follow.
  1. 2021 Vermont Plumbing Rules, Department of Public Safety & Plumbers Examining Board, page 2
  2. Vital Records Rule, Agency of Human Services, Department of Health, page 3
  3. Rule 4.600 Definition of Electric Transmission Facility in 30 V.S.A. § 248, Public Utility Commission, page 4
  4. Health Benefits Eligibility and Enrollment Rule, General Provisions and Definitions (Part 1), Agency of Human Services, page 5
  5. Health Benefits Eligibility and Enrollment Rule, Eligibility Standards (Part 2), Agency of Human Services, page 6
  6. Health Benefits Eligibility and Enrollment Rule, Nonfinancial Eligibility Requirements (Part 3), Agency of Human Services, page 7
  7. Health Benefits Eligibility and Enrollment Rule, Financial Methodologies (Part 5), Agency of Human Services, page 8
  8. Health Benefits Eligibility and Enrollment Rule, Eligibility-and-Enrollment Procedures (Part 7), Agency of Human Services, page 9
  9. Administrative Rules of the Board of Nursing, Secretary of State, Office of Professional Regulation, page 10
- Next scheduled meeting is Monday, July 11, 2022 at 2:00 p.m.
- 3:25 p.m. meeting was paused for a 15-minute break
- Add discussion of strike-all rules for transparency at a future meeting as time allows.
- 3:50 p.m. meeting adjourned.

Proposed Rule: Health Benefits Eligibility and Enrollment Rule, General Provisions and Definitions (Part 1), Agency of Human Services

Presented By: Robin Chapman and Addie Strumolo

Motion made to accept the rule by Donna Russo-Savage, seconded by Jared Adler, and passed unanimously except for Brendan Atwood who abstained, with the following recommendations:

1. Proposed Filing Coversheet, #12: Spell out acronym 'QHP' and include acronym in parenthesis as it's the first time being used in the filing.
2. Public Input Maximization Plan, #12: Specify entities (not individuals) included in the 'Representatives of Vermont's Health Insurance Industry' and 'Health law, policy and related advocacy and community-based organizations and groups.'.

Economic Impact Analysis

Instructions:

In completing the economic impact analysis, an agency analyzes and evaluates the anticipated costs and benefits to be expected from adoption of the rule; estimates the costs and benefits for each category of people enterprises and government entities affected by the rule; compares alternatives to adopting the rule; and explains their analysis concluding that rulemaking is the most appropriate method of achieving the regulatory purpose. If no impacts are anticipated, please specify "No impact anticipated" in the field.

Rules affecting or regulating schools or school districts must include cost implications to local school districts and taxpayers in the impact statement, a clear statement of associated costs, and consideration of alternatives to the rule to reduce or ameliorate costs to local school districts while still achieving the objectives of the rule (see 3 V.S.A. § 832b for details).

Rules affecting small businesses (excluding impacts incidental to the purchase and payment of goods and services by the State or an agency thereof), must include ways that a business can reduce the cost or burden of compliance or an explanation of why the agency determines that such evaluation isn't appropriate, and an evaluation of creative, innovative or flexible methods of compliance that would not significantly impair the effectiveness of the rule or increase the risk to the health, safety, or welfare of the public or those affected by the rule.

1. TITLE OF RULE FILING:

   Health Benefits Eligibility and Enrollment Rule, General Provisions and Definitions (Part 1)

2. ADOPTING AGENCY:

   Agency of Human Services (AHS)

3. CATEGORY OF AFFECTED PARTIES:

   LIST CATEGORIES OF PEOPLE, ENTERPRISES, AND GOVERNMENTAL ENTITIES POTENTIALLY AFFECTED BY THE ADOPTION OF THIS RULE AND THE ESTIMATED COSTS AND BENEFITS ANTICIPATED:

   Categories of people, enterprises, and governmental entities that may be affected by these rules:

   Medicaid applicants/enrollees;

Individuals who wish to purchase health coverage including those who apply for premium and cost-sharing assistance;

Health insurance issuers (including standalone dental issuers);

Eligibility and enrollment assisters, including agents and brokers;

Health care providers;

Health law, policy and related advocacy and community-based organizations and groups including the Office of the Health Care Advocate;

Agency of Human Services including its departments; and Department of Financial Regulation.

Anticipated costs and benefits of this rule:

The Agency of Human Services anticipates that some of the proposed changes to HBEE will have an economic impact on the State's gross annualized budget, beginning in fiscal year 2023. The estimated gross annualized budget impact of expanding postpartum Medicaid coverage for pregnant women from 60 days to 12 months is expected to be approximately $2 million and is accounted for in AHS's FY2023 budget. The estimated gross annualized budget impact of expanding Medicaid coverage to children who age out of foster care in any state is $52,700. There is no anticipated economic impact from the addition of Compacts of Free Association (COFA) migrants at this time, as this population is not currently present in Vermont Medicaid.

An extended open enrollment period for qualified health plans (QHP) could result in increased QHP enrollment which would have a financial impact on health insurance issuers. However, this rulemaking codifies current practice, and AHS does not expect it to result in a meaningful difference in enrollment.

Allowing for a continuous enrollment opportunity through the income-based special enrollment period

could result in increased enrollment as well as upward rate pressure due to adverse selection (signing up for health insurance when utilization is expected). However, AHS consulted with the QHP issuers on this point and neither indicated a need to increase rates in anticipation of this enrollment opportunity. Instead, they strongly support this policy change to encourage continuous coverage.

Households accessing this special enrollment period will be eligible for federal and state subsidies. The federal government may pay out more in federal subsidies because of the special enrollment period. However, there is unlikely to be a fiscal impact on the State. AHS expects that most households enrolling through this special enrollment period will have previously been covered by Vermont Medicaid. Therefore, any increase in state subsidy expenditures would be offset by Medicaid savings.

Addressing the ACA's family glitch could result in more Vermonters becoming eligible for state and federal subsidies; however, AHS expects the population to be small and the subsidy costs to be borne primarily by the federal government.

Finally, any opportunity to encourage enrollment and maintain Vermont's low uninsured rate is fiscally positive for the State. It means less uncompensated care and a healthier risk pool to stabilize the insurance market.

The other changes in Parts 1, 2, 3, 5, and 7 align the rule with federal and state guidance and law, provide clarification, correct information, improve clarity, and make technical corrections. While these changes are made with a goal of reducing administrative burden on Vermonters and the State, they do not carry a specific economic impact on any person or entity.

4. IMPACT ON SCHOOLS:

INDICATE ANY IMPACT THAT THE RULE WILL HAVE ON PUBLIC EDUCATION, PUBLIC SCHOOLS, LOCAL SCHOOL DISTRICTS AND/OR TAXPAYERS CLEARLY STATING ANY ASSOCIATED COSTS:

No impact.

5. ALTERNATIVES: *CONSIDERATION OF ALTERNATIVES TO THE RULE TO REDUCE OR AMELIORATE COSTS TO LOCAL SCHOOL DISTRICTS WHILE STILL ACHIEVING THE OBJECTIVE OF THE RULE.*

   Not applicable.

6. IMPACT ON SMALL BUSINESSES:
   INDICATE ANY IMPACT THAT THE RULE WILL HAVE ON SMALL BUSINESSES (EXCLUDING IMPACTS INCIDENTAL TO THE PURCHASE AND PAYMENT OF GOODS AND SERVICES BY THE STATE OR AN AGENCY THEREOF):

   No impact.

7. SMALL BUSINESS COMPLIANCE: *EXPLAIN WAYS A BUSINESS CAN REDUCE THE COST/BURDEN OF COMPLIANCE OR AN EXPLANATION OF WHY THE AGENCY DETERMINES THAT SUCH EVALUATION ISN'T APPROPRIATE.*

   Not applicable.

8. COMPARISON:
   COMPARE THE IMPACT OF THE RULE WITH THE ECONOMIC IMPACT OF OTHER ALTERNATIVES TO THE RULE, INCLUDING NO RULE ON THE SUBJECT OR A RULE HAVING SEPARATE REQUIREMENTS FOR SMALL BUSINESS:
   There are no alternatives to the adoption of this rule. The rule is required to implement state and federal law.

9. SUFFICIENCY: *DESCRIBE HOW THE ANALYSIS WAS CONDUCTED, IDENTIFYING RELEVANT INTERNAL AND/OR EXTERNAL SOURCES OF INFORMATION USED.*
   AHS has analyzed and evaluated the anticipated costs and benefits to be expected from the adoption of these rules including considering the costs and benefits for each category of persons and entities described above. There are no alternatives to the adoption of this rule; it is necessary to ensure continued alignment with federal and state guidance and law on eligibility and enrollment in health benefits programs.

Environmental Impact Analysis

Instructions:

In completing the environmental impact analysis, an agency analyzes and evaluates the anticipated environmental impacts (positive or negative) to be expected from adoption of the rule; compares alternatives to adopting the rule; explains the sufficiency of the environmental impact analysis. If no impacts are anticipated, please specify "No impact anticipated" in the field.

Examples of Environmental Impacts include but are not limited to:

- Impacts on the emission of greenhouse gases
- Impacts on the discharge of pollutants to water
- Impacts on the arability of land
- Impacts on the climate
- Impacts on the flow of water
- Impacts on recreation
- Or other environmental impacts

1. TITLE OF RULE FILING:

   Health Benefits Eligibility and Enrollment Rule, General Provisions and Definitions (Part 1)

2. ADOPTING AGENCY:

   Agency of Human Services (AHS)

3. GREENHOUSE GAS: *EXPLAIN HOW THE RULE IMPACTS THE EMISSION OF GREENHOUSE GASES (E.G. TRANSPORTATION OF PEOPLE OR GOODS; BUILDING INFRASTRUCTURE; LAND USE AND DEVELOPMENT, WASTE GENERATION, ETC.):*
   No impact.

4. WATER: *EXPLAIN HOW THE RULE IMPACTS WATER (E.G. DISCHARGE / ELIMINATION OF POLLUTION INTO VERMONT WATERS, THE FLOW OF WATER IN THE STATE, WATER QUALITY ETC.):*
   No impact.

5. LAND: *EXPLAIN HOW THE RULE IMPACTS LAND (E.G. IMPACTS ON FORESTRY, AGRICULTURE ETC.):*
   No impact.

6. RECREATION: *EXPLAIN HOW THE RULE IMPACT RECREATION IN THE STATE:*
   No impact.

7. CLIMATE: *EXPLAIN HOW THE RULE IMPACTS THE CLIMATE IN THE STATE:*
   No impact.

8. OTHER: *EXPLAIN HOW THE RULE IMPACT OTHER ASPECTS OF VERMONT'S ENVIRONMENT:*
   No impact.

9. SUFFICIENCY: *DESCRIBE HOW THE ANALYSIS WAS CONDUCTED, IDENTIFYING RELEVANT INTERNAL AND/OR EXTERNAL SOURCES OF INFORMATION USED.*
   No impact.

Public Input Maximization Plan

Instructions:

Agencies are encouraged to hold hearings as part of their strategy to maximize the involvement of the public in the development of rules. Please complete the form below by describing the agency's strategy for maximizing public input (what it did do, or will do to maximize the involvement of the public).

This form must accompany each filing made during the rulemaking process:

1. TITLE OF RULE FILING:

   Health Benefits Eligibility and Enrollment Rule, General Provisions and Definitions (Part 1)

2. ADOPTING AGENCY:

   Agency of Human Services (AHS)

3. PLEASE DESCRIBE THE AGENCY'S STRATEGY TO MAXIMIZE PUBLIC INVOLVEMENT IN THE DEVELOPMENT OF THE PROPOSED RULE, LISTING THE STEPS THAT HAVE BEEN OR WILL BE TAKEN TO COMPLY WITH THAT STRATEGY:

   AHS consulted with key stakeholders on the development of policies in this rulemaking. The Medicaid post partum extension was supported by the General Assembly and advocacy groups including the Office of the Health Care Advocate. AHS worked with the Department of Financial Regulation on the Qualified Health Plan changes. The open enrollment period and income-based special enrollment period are both modeled on changes made by the federal government. AHS discussed the proposals with the General Assembly, Office of the Health Care Advocate/Vermont Legal Aid, Medicaid & Exchange Advisory Committee, and Qualified Health Plan issuers, and took their input in rule development. AHS notified the Medicaid and Exchange Advisory Committee of this rulemaking ahead of filing, including the estimated timeframe for filing and the proposed revisions to the rule.

Public Input

The proposed rule was posted on the AHS website for public comment, and a public hearing was held on August 17, 2022. No one attended the hearing. When the rule was filed with the Office of the Secretary of State, AHS provided notice and access to the rule, through the Global Commitment Register, to stakeholders and all persons who subscribe to the Global Commitment Register.

The public comment period ended August 24, 2022. Comments were received from Vermont Legal Aid on Part 2 and Part 3 of the HBEE rule. A general comment was also received on a topic outside the scope of the HBEE rule. Part 2 and Part 3 have been amended since the proposed filing. The comments received, responsiveness summary, and a list of technical changes are included with this filing. There are no changes to Parts 1, 5, and 7 since the proposed filing.

The Global Commitment Register is a database that provides notification of policy changes and clarifications of existing Medicaid policy, including rulemaking, under Vermont's 1115 Global Commitment to Health waiver. Anyone can subscribe to the Global Commitment Register. Subscribers receive email notification of the filing including hyperlinks to the documents posted on the Global Commitment Register and an explanation of how to be further involved in the rulemaking.

4. BEYOND GENERAL ADVERTISEMENTS, PLEASE LIST THE PEOPLE AND ORGANIZATIONS THAT HAVE BEEN OR WILL BE INVOLVED IN THE DEVELOPMENT OF THE PROPOSED RULE:

Agency of Human Services including its departments;

Agency of Administration;

Department of Financial Regulation;

Medicaid and Exchange Advisory Committee;

Representatives of Vermont's Health Insurance Industry, including the Qualified Health Plan issuers;

Health law, policy and related advocacy and community-based organizations and groups, including the Office of the Health Care Advocate at Vermont Legal Aid.

Comments on Rule 22P014
1557-Reg-Revision-QA-FINAL-2022.pdf

Hello, please Excuse my last submission as I was attempting to copy and paste this document.

On behalf of stakeholders, my family member included, I'd like the committee to allow a comprehensive service system that allows contracted supports which are not available at any designated agencies to follow this law. Currently, ABA providers must operate at a fiscal loss when providing a contracted service under HCAR rule of $30.11 cap. This is discriminatory in use of federal funding.

I'd appreciate a chance to discuss this issue further.
Thank you so much,
A parent of adult daughter with hcbs waiver

Submitted Electronically to:
Medicaid Policy Unit
AHS.MedicaidPolicy@vermont.gov

In re: GCR 22-029 to 22-033
Health Benefits Eligibility and Enrollment Rules Update

Dear Medicaid Policy Unit,

Thank you for the opportunity to comment on the proposed program changes to the Health Benefits Eligibility and Enrollment Rules.

The Office of the Health Care Advocate (HCA) and the Disability Law Project (DLP) at Vermont Legal Aid submit the following comments in response to the proposed HBEE changes:

Part Two:

Categorical Eligibility for Foster Children

The HCA and the DLP support the proposed changes in Rule 9.03(e) to expand categorical eligibility for foster children. The proposed rule expands eligibility for former foster children to include former foster children from other states. Under the current rule, this category had been limited to former foster children from Vermont. We strongly support this expansion.

We suggest some clarification to Rule 9.03 (e)(iii) that defines eligible former foster children. The rule currently reads,

"If the individual attained 18 years of age on or after January 1, 2023, . . ."

In approximately half the states in the country, foster care has been extended beyond age eighteen. (*See* Extending Foster Care Beyond 18 (ncsl.org)) The proposed rule should not be read in a limited way that would define this category to include only foster children who leave foster care at eighteen. It should be interpreted to also include foster children who leave foster after age eighteen.

Disabled Child Home Care Eligibility

The HCA and the DLP oppose the proposed eligibility changes to 8.05(k)(6) Disabled Child in Home Care (DCHC, Katie Beckett).

We have two concerns with this proposed rule change:

1. "Institutional level of care" is an evolving standard. In 1965 when the federal Medicaid program began, many children with serious medical conditions lived in institutions. Institutionalized medical services for children continued through 1981, when the Katie Beckett Medicaid Waiver was passed under President Ronald Reagan. It was through the advocacy of parents and Olmstead litigation that our medical system moved towards providing care so that children with serious medical conditions could live at home.

   The rule references skilled nursing facilities and intermediate care facilities as two of the three standards. Yet, Vermont does not have these institutions for children. Children are also explicitly excluded from the Choices for Care program which provides coverage for nursing facility care. Even when Vermont had an ICF-DD, this facility, too, had exclusion criteria for admission that made it inaccessible to children. It is better for children's development, and it is fiscally prudent for children to live at home, when medically advised. Vermont has worked hard to increase the amount of care that children can receive at home.

   Requiring eligibility tied to modern standards of admissions for institutions that do not exist in Vermont will make it almost impossible to for children to be found eligible for Katie Beckett Medicaid. Furthermore, to require proof that "without the receipt of institutional level of care in the home, the individual would be required to continue to reside in an institution," as described in (6)(i)(B)(II), is another standard that is impossible to meet.

   Parents have shared with us that they would rather lose everything they have, any savings, their jobs, and their homes, than send their child to an out of state institution, even if supports are inadequate at home. In other words, it is not without severe stress and financial burdens that parents can care for their medically needy children at home. It is financially better for the Vermont Medicaid program to have children receive medical care at home. To enable this to continue, DVHA needs to use the institutional standard of 1965.

   We urge DVHA to delete 8.05 (6)(1)(A and B).

2. No information exists that supports the proposition that a standardized level of care tool is necessary or helpful for these eligibility determinations. It is unclear what problem DVHA is trying to solve by use of a standardized tool. Proposing an as-yet-unidentified tool without any stakeholder input leads us to conclude that DVHA

believes too many children are mistakenly found eligible for Katie Beckett Medicaid.

In our experience, children are frequently found ineligible for coverage either on a first application or at a continuing eligibility review. We have seen no evidence given the regular stream of children and families with meritorious cases in need of assistance with denials and terminations that the current process for Katie Beckett eligibility is erroneously generous.

Furthermore, in representing dozens of children in appeals in Katie Beckett cases, the medical needs and interventions are extremely individualized. We have not seen a pattern or "type" of case that would be amenable to fitting into the standards of a tool. We have not seen a draft of any tool, so it is hard to envision how the diverse experiences of a
small number of medically needy children can be standardized.

We urge DVHA to not change the rule to require a tool. There has been no community conversation or consensus on the value of a standardized tool, or the contents of a standardized tool. It is possible that DVHA may find that no tool is either helpful or practical. Research and community engagement should precede any potential change to this rule.

We urge DVHA to cut sections (A-C).

Part Three

The HCA suggests that HBEE Rule 23.02 be amended to mirror the proposed federal rules that address the "family glitch." The Department of Treasury and the IRS have released proposed rules on this issue, and the HBEE rules should mirror the proposed federal rules. The proposed rules will change how affordability is calculated for family members when one member of the household has an offer of employer insurance.

Under current regulations employer-based health insurance is defined as "affordable" if the coverage solely for the employee, and not for family members, meets the affordability requirements. That means that affordability is calculated based on what it would cost for the employee to purchase a self-only plan. If the cost of the employee only plan meets the current affordability test, the employee *and their family members* are not eligible for Advance Premium Tax Credit (APTC). This is called the "family glitch" because it makes family members ineligible for APTC, even though the cost of a *family plan* with the employer is not "affordable." The proposed rule change would allow for two separate calculations: one for the employee and the other for family members. Under the proposed federal rules, if the cost of covering family members were not affordable, they would be eligible for APTC. This

change addresses a long-standing problem and will allow more Vermonters to enroll in affordable coverage on Vermont Health Connect.

Thank you for the opportunity to comment. Please feel free to reach out should you have any questions.

Sincerely,

/s/ Marjorie Stinchcombe
Marjorie Stinchcombe
Helpline Director
Office of the Health Care Advocate
Vermont Legal Aid

/s/ Rachel Seelig
Rachel Seelig
Director
Disability Law Project
Vermont Legal Aid

/s/ Barb Prine
Barb Prine
Staff Attorney
Disability Law Project
Vermont Legal Aid

State of Vermont
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280 State Drive
Waterbury, VT 05671-1000
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Jenney Samuelson, *Secretary*
[phone] 802-241-0440
[fax] 802-241-0450

Date: October 18, 2022

Re: Response to comments received from the public for the Health Benefits Eligibility & Enrollment (HBEE) Rule Update (Proposed GCR 22-029 to 22-033)

A summary of the comments received on the proposed HBEE rule and the Agency of Human Services' responses to those comments is as follows:

General Comment

Comment: On behalf of stakeholders, my family member included, I'd like the committee to allow a comprehensive service system that allows contracted supports which are not available at any designated agencies to follow this law. Currently, ABA providers must operate at a fiscal loss when providing a contracted service under HCAR rule of $30.11 cap. This is discriminatory in use of federal funding. I'd appreciate a chance to discuss this issue further.

Response: The agency appreciates this comment and the concern raised by the commenter. While the commenter's concern speaks to an issue that is outside the scope of this rulemaking effort, the agency will take the concern into consideration.

Comments by Rule Sections

PART TWO

8.05(k)(6) Disabled child in home care (DCHC, Katie Beckett)

Comment 1 from Vermont Legal Aid:

Vermont Legal Aid (VLA) states, "We urge DVHA to delete 8.05 (6)(1)(A and B)." VLA's full comments are part of the final proposed rulemaking filing. VLA opposes proposed 8.05(k)(6)(i)(A)-(B), including for the following reasons:

- *"Requiring eligibility tied to modern standards of admissions for institutions that do not exist in Vermont will make it almost impossible to [sic] for children to be found eligible for Katie Beckett Medicaid."*

- *"... to require proof that 'without the receipt of institutional level of care in the home, the individual would be required to continue to reside in an institution,' as described in (6)(i)(B)(II), is another standard that is impossible to meet."*
- *"DVHA needs to use the institutional standard of 1965."*

Response:

The proposed amendments to the rule at 8.05(k)(6) are not intended to change the current legal standard for eligibility for the optional Medicaid category, Disabled Child in Home Care (DCHC or the "Katie Beckett provision"), including the federal requirement that the individual require an institutional level of care.[1] The intent of the proposed changes is to (1) improve clarity of the institutional level of care eligibility requirement, (2) indicate that Vermont Medicaid may use a standardized medical assessment tool to determine level of care in the future, (3) align the rule with current operations and federal law regarding the frequency of reviews of clinical eligibility, and (4) make technical changes to align the rule with federal law.

While the agency's proposed changes were not intended to change the legal standard for meeting institutional level of care, the agency is revising 8.05(k)(6)(i), including due to the commenter's feedback. Specifically, the agency has revised 8.05(k)(6)(i)(A)-(B) in two ways:

- Removed the references to federal regulations at 8.05(k)(6)(i)(A). This change aligns the rule more closely with the corresponding federal regulation, 42 CFR 435.225; and
- Removed 8.05(k)(6)(i)(B)(II) as recommended by the commenter.

The only remaining changes from those proposed to 8.05(k)(6)(i)(A)-(B) are (1) final proposed 8.05(k)(6)(i)(A)(I) newly defines "medical institution" by aligning the definition with federal law, 42 CFR 435.225(b)(1), which states that to qualify for this Medicaid category, a disabled child must require care in a hospital, SNF [skilled nursing facility], or an ICF [intermediate care facility], and (2) final proposed 8.05(k)(6)(i)(A)(II) aligns with 42 CFR 435.225(a) and clarifies that a disabled child must be living in the home to qualify for DCHC.

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[1] Explanation of why this Medicaid category is referred to as the "Katie Beckett provision:" At five months old Katie Beckett contracted a devastating brain infection. She suffered paralysis that left her hospitalized on a ventilator for three years. Katie's middle-class family had a million dollars of health insurance, but that was soon exhausted. While she was institutionalized, Medicaid paid for her medical care but when she improved enough to live with her family, her Medicaid was terminated. Katie required professional nurses to meet her needs at home, but Medicaid would not cover it because her family's income was too high. Under the law, Medicaid would only pay for Katie's care if she remained in an institutional setting. Katie's family faced a dilemma, whether to leave her in the hospital or bring her home where there was a lack of certainty about the care that would be provided to her.

In 1981, President Ronald Reagan heard about Katie's dilemma and personally intervened. President Reagan created the Katie Beckett Waiver. The waiver allowed Katie, and children like her who required an institutional level of care, but could safely receive this care at home, to receive their care at home while retaining their Medicaid coverage, regardless of their parents' income. Katie grew up to be an accomplished motivational speaker and was a champion for people with disabilities until her death in her 30s. In 1982, Congress expanded what had been accomplished by the Katie Beckett Waiver by creating a new state plan option in Medicaid pursuant to Section 134 of the Tax Equity and Fiscal Responsibility Act (TEFRA), sometimes referred to as "the Katie Beckett provision."

The commenter's interpretation that level of care for DCHC should be determined by standards that existed in 1965 is contrary to federal law. The level of care standard for DCHC Medicaid has never been tied to the institutional level of care standard of 1965. The Medicaid program was first implemented in 1965, but it was not until 1981 that President Reagan created the Katie Beckett Waiver, and it was not until 1982 that Congress made a related state plan option available to states. There is nothing in federal law or CMS guidance that supports that the Medicaid agency should use the institutional level of care standard from 1965 in determining eligibility for DCHC. 42 CFR 435.225 states in full:

§ 435.225 Individuals under age 19 who would be eligible for Medicaid if they were in a medical institution.

(a) The agency may provide Medicaid to children 18 years of age or younger who qualify under section 1614(a) of the Act, who would be eligible for Medicaid if they were in a medical institution, and who are receiving, while living at home, medical care that would be provided in a medical institution.

(b) If the agency elects the option provided by paragraph (a) of this section, it must determine, in each case, that the following conditions are met:

(1) The child requires the level of care provided in a hospital, SNF, or ICF.

(2) It is appropriate to provide that level of care outside such an institution.

(3) The estimated Medicaid cost of care outside an institution is no higher than the estimated Medicaid cost of appropriate institutional care.

(c) The agency must specify in its State plan the method by which it determines the cost-effectiveness of caring for disabled children at home.

(55 Federal Register 48608, 11/21/90)

Finally, the commenter mentions the lack of certain medical institutions within Vermont; however, the existence of such institutions within Vermont's borders is not relevant to the legal requirements for DCHC Medicaid eligibility and is outside the scope of this rulemaking. The level of care analysis in DCHC is not a placement decision; it is solely to determine eligibility for this Medicaid category.

The agency agrees with the commenter that the DCHC Medicaid category is a critical category for some Vermont families. It is the only means for some disabled children who require an institutional level of care, but whose household income is too high to qualify for Dr. Dynasaur, to avoid institutionalization by the Medicaid agency paying for them to receive that level of care in their home.

Comment 2 from Vermont Legal Aid:

Vermont Legal Aid (VLA) states, "We urge DVHA to cut sections (A- C)." VLA's full comments are part of the final proposed rulemaking filing. VLA opposes proposed 8.05(k)(6)(i)(A)-(C), including for the following reasons:

- *"No information exists that supports the proposition that a standardized level of care tool is necessary or helpful for these eligibility determinations. It is unclear what problem DVHA is trying to solve by use of a standardized tool."*
- *"We have not seen a pattern or 'type' of case that would be amenable to fitting into the standards of a tool. We have not seen a draft of any tool, so it is hard to envision how the diverse experiences of a small number of medically needy children can be standardized."*
- *"There has been no community conversation or consensus on the value of a standardized tool, or the contents of a standardized tool."*

Response:

Vermont Medicaid plans to move to the use of a standardized tool to determine level of care for DCHC eligibility to ensure objective, accurate, and reliable decision making. Much of the care that Vermont Medicaid covers program wide is approved using standardized tools. Such tools are designed to be as objective as possible to achieve the highest "interrater reliability," i.e., that two screeners would answer the same way for the same individual. This promotes best practices by ensuring proper and fair eligibility determinations and will provide greater consistency across Vermont Medicaid.

Presently, Vermont Medicaid is seeking to amend 8.06(k)(6) to indicate that it may designate a standardized assessment tool to determine whether an individual qualifies for an institutional level of care for DCHC. The proposed amendment does not require Vermont Medicaid to designate a tool, but does provide that if the agency designates one, that it must be used in all DCHC level of care decisions. Vermont Medicaid has not selected a standardized tool for deciding level of care in DCHC. The agency informed the commenter, prior to its submission of comments, that it would be seeking its and other stakeholder's input on the standardized level of care tool prior to one being implemented.

Federal law gives Medicaid agencies flexibility in deciding whether to use a standardized tool and if so, which tool. As of 2015, standardized assessment tools were used by the District of Columbia and all 50 state Medicaid agencies in their Medicaid long term support and services (LTSS) programs, including to determine level of care.[2]

Vermont Medicaid has used standardized tools for many years, to determine service needs and eligibility for programs, including level of care. Historically, Vermont Medicaid used a "homegrown" tool to determine if level of care was met in DCHC cases, and, more recently, it has used criteria that functions as a tool and includes a multipage narrative that explains when level of care is met. The Department of Disabilities, Aging, and Independent Living (DAIL) uses a standardized tool to determine eligibility, including level of care, in the Choices for Care program, which allows individuals who require an institutional level of care to receive care in their home to avoid institutionalization. DAIL also uses standardized tools to determine eligibility and/or service needs for individuals applying for or enrolled in

[2] Medicaid and CHIP Payment and Access Commission (MACPAC) – Functional Assessments for Long-Term Services and Supports. https://www.macpac.gov/wp-content/uploads/2016/06/Functional-Assessments-for-Long-Term-Services-and-Supports.pdf. Accessed September 7, 2022.

the Traumatic Brain Injury Program, the Adult High Technology Program, and the Attendant Services Program.

Additionally, Vermont Medicaid uses a standardized tool to determine eligibility for services for children who are medically fragile, including those who need medically complex nursing services in the home. The Department of Vermont Health Access (DVHA) and the Department of Mental Health use InterQual standardized tools to determine both whether level of care is met in certain settings and whether a service authorization request for mental health, substance use disorder, behavioral health services, and medical services should be approved (e.g., inpatient hospitalization, inpatient psychiatric hospitalization; eating disorder treatment in inpatient, residential, PHP and IOP settings; Applied Behavioral Analysis; and psychiatry, across all ages). InterQual is a nationally recognized evidence-based platform that is used by health insurers, Medicaid agencies, and facilities nationwide.

In summary, the use of "tools" to make certain eligibility decision, including level of care, and service authorization decisions is widespread at Vermont Medicaid and at Medicaid agencies across the country. Such tools promote objective and fair decisions through the use of the proper administration of an appropriate assessment tool implemented by a trained person.

The agency is not amending proposed 8.05(k)(6)(i)(C) except to remove the proposed name of the standardized tool from the rule.

9.03(e) Former foster child

Comment: The HCA (Office of the Health Care Advocate at Vermont Legal Aid) and the DLP (Disability Law Project at Vermont Legal Aid) support the proposed changes in Rule 9.03(e) to expand categorical eligibility for foster children. The proposed rule expands eligibility for former foster children to include former foster children from other states. Under the current rule, this category had been limited to former foster children from Vermont. We strongly support this expansion.

We suggest some clarification to Rule 9.03 (e)(iii) that defines eligible former foster children. The rule currently reads,

"If the individual attained 18 years of age on or after January 1, 2023, . . ."

Response: The agency appreciates the commenters' support of this expansion. The agency agrees with the commenters that clarification defining eligible former foster children would be helpful in light of the expansion of eligibility to include foster children from other states that have foster care extended beyond 18. The agency is adding text to the rule to make this clarification.

PART THREE

23.02 Affordable coverage for employer-sponsored MEC

Comment: The HCA (Office of the Health Care Advocate at Vermont Legal Aid) suggests that HBEE Rule 23.02 be amended to mirror the proposed federal rules that address the "family glitch." The Department of Treasury and the IRS have released proposed rules on this issue, and the HBEE rules should mirror the proposed federal rules. The proposed rules will change how affordability is calculated for family members when one member of the household has an offer of employer insurance.

Under current regulations employer-based health insurance is defined as "affordable" if the coverage solely for the employee, and not for family members, meets the affordability requirements. That means that affordability is calculated based on what it would cost for the employee to purchase a self-only plan. If the cost of the employee only plan meets the current affordability test, the employee and their family members are not eligible for Advance Premium Tax Credit (APTC). This is called the "family glitch" because it makes family members ineligible for APTC, even though the cost of a family plan with the employer is not "affordable." The proposed rule change would allow for two separate calculations: one for the employee and the other for family members. Under the proposed federal rules, if the cost of covering family members were not affordable, they would be eligible for APTC. This change addresses a long-standing problem and will allow more Vermonters to enroll in affordable coverage on Vermont Health Connect.

Response: The agency agrees with this comment. The agency is adding text to the rule at 23.02 to address the "family glitch" consistent with the rule proposed by the Internal Revenue Service (IRS) on April 7, 2022. The IRS has indicated that it will finalize this policy change prior to 2023. In revising this section of the rule, the agency is also simplifying the rule text by eliminating examples at (d), some of which are outdated under the family glitch change, and instead referring to the current illustrative examples provided by the IRS.

Annotated Text

Table of Contents

Part One
General Provisions and Definitions

1.00 Administration of health benefits (01/15/2017, GCR 16-094)

The Agency of Human Services (AHS) was created in 1969 to serve as the umbrella organization for all human-service activities within state government. It is the Single State Agency for Medicaid purposes and the adopting authority for this rule.

2.00 General description of health benefits in Vermont (subject to specific criteria in subsequent sections) (10/01/2021, GCR 20-001)

2.01 Types of health benefits (01/15/2017, GCR 16-094)

(a) In general. The state offers several types of health benefits, including:

- Medicaid;
- Children's Health Insurance Program (CHIP);
- Enrollment in a Qualified Health Plan (QHP) with financial assistance.

The benefits for which a person is eligible is determined based on the individual's income, resources (in specified cases), and circumstances as covered in succeeding sections.

(b) Benefit choice. Except as may be otherwise restricted, an individual may select the particular health benefit or benefits that they wish to be considered for. In the absence of such a selection, AHS will determine an individual's eligibility for the most advantageous benefit that they qualify for.

(c) Redetermination of eligibility. If an individual becomes ineligible for one benefit, AHS will determine eligibility for the next most advantageous benefit that they then qualify for.

2.02 Medicaid (10/01/2021, GCR 20-001)

(a) Overview of the Medicaid Program. The Medicaid program is authorized in Title XIX of the Social Security Act (the Act).

(b) Medicaid eligibility. Vermont provides Medicaid to those who meet the requirements of one of three eligibility groups:

- Mandatory categorically needy;
- Optional categorically needy; and
- Medically needy.

To be eligible for federal funds, states are required to provide Medicaid coverage for certain groups of individuals. These groups–the mandatory categorically needy–derive from the historic ties to programs that provided federally-assisted income-maintenance payments (*e.g.*, SSI and Aid to Families with Dependent Children). States are also required to provide Medicaid to related groups not receiving cash payments.

States also have the option of providing Medicaid coverage for other "categorically related" groups. These optional groups share characteristics of the mandatory groups (that is, they fall within defined categories), but the eligibility criteria are somewhat more liberally defined.

The medically-needy option allows states to extend Medicaid eligibility to additional groups of people. These individuals would be eligible for Medicaid under one of the mandatory or optional groups, except that they do not meet the income or resource standards for those groups. Individuals may qualify immediately or may "spend down" by incurring medical expenses greater than the amount by which their income or resources exceed their state's medically-needy standards.[1]

(c) Vermont's Medicaid Program.[2] The Vermont Medicaid program covers all mandatory categories of enrollees. It also offers all mandatory services—general hospital inpatient; outpatient hospital and rural health clinics; other laboratory and x-ray; nursing facility, Early Periodic Screening, Diagnosis and Treatment (EPSDT), and family planning services and supplies; physician's services and medical and surgical services of a dentist; home health services; and nurse-midwife and nurse practitioner services.[3] Vermont includes certain, but not all, optional categories of enrollees. Vermont has also elected to cover certain, but not all, optional services for which federal financial participation is available. It also operates health care programs permitted by research demonstration waiver authority under § 1115 of the Social Security Act.

Vermont is authorized to establish reasonable standards, consistent with the objectives of the Medicaid statute, for determining the extent of coverage in the optional categories[4] based on such criteria as medical necessity or utilization control.[5] In establishing such standards for coverage, Vermont ensures that the amount, duration, and scope of coverage are reasonably sufficient to achieve the purpose of the service.[6] Vermont may not limit services based upon diagnosis, type of illness, or condition.[7]

2.03 Children's Health Insurance Program (CHIP) (01/01/2018, GCR 17-043)

(a) In general. CHIP (known from its inception until March 2009 as the State Children's Health Insurance Program, or SCHIP) is authorized by Title XXI of the Social Security Act.

(b) Vermont CHIP. Vermont utilizes CHIP to provide health coverage to uninsured children with household incomes above 237% and at or below 312% of the federal poverty level (FPL). CHIP is part of the coverage

[1] In Vermont, the Medically Needy Income Level is known as the "Protected Income Level," or "PIL."

[2] Former Medicaid Rule 4100.

[3] For rules that govern Medicaid covered services, refer to Health Care Administrative Rules (HCAR).

[4] 42 USC § 1396a(a)(17).

[5] 42 CFR § 440.230(d).

[6] 42 CFR § 440.230(b).

[7] 42 CFR § 440.230(c).

array known as "Dr. Dynasaur." All of the provisions in this rule that apply to the "child" Medicaid coverage group (§ 7.03(a)(3)) apply with equal effect to an individual who is enrolled in CHIP.

2.04 The Health Benefits Exchange (01/15/2019, GCR 18-060)

(a) In general. Vermont has elected to establish and operate its own Exchange. Vermont Act No. 48 of 2011, "An act relating to a universal and unified health system," established the Vermont health benefit exchange (Vermont Health Connect, VHC). The purpose of VHC is to facilitate the purchase of affordable, qualified health benefit plans by individuals, and small employers in the merged individual and small group markets; and later in the large group market in Vermont in order to reduce the number of uninsured and underinsured; to reduce disruption when individuals lose employer-based insurance; to reduce administrative costs in the insurance market; to contain costs; to promote health, prevention, and healthy lifestyles by individuals; and to improve quality of health care.

Qualified health plans (QHPs) must provide a comprehensive set of services (essential health benefits), meet specific standards for actuarial value and the limitation of cost-sharing.

Additionally, catastrophic plans are available to certain individuals.

The state will certify health plans offered through VHC on an annual basis.

(b) Financial assistance through VHC. Eligible individuals who purchase insurance through VHC may receive federal premium tax credits and Vermont premium reductions. Some also qualify for federal and Vermont cost-sharing reductions (CSR).

Federal premium tax credits are available to eligible individuals and families with incomes up to 400 percent of the FPL to purchase insurance through VHC.[8]

The state will supplement the federal premium tax credits with premium reductions for individuals and families with income at or below 300% of the federal poverty level.

In addition to premium subsidies, eligible individuals receive federal and state CSRs for silver level plans (see level of coverage in § 3.00) and in other limited circumstances. These subsidies reduce the cost-sharing amounts and annual cost-sharing limits and have the effect of increasing the actuarial value of the plan.

Modified adjusted gross income (MAGI) is used to determine eligibility for federal and state premium subsidies and CSRs. In order to be eligible for federal CSR, state premium reductions and state CSR, the individual must be eligible for federal premium tax credits.[9]

(c) Administrative Requirements. Federal health-care regulations contain a number of provisions aimed at the administration of the health-benefits eligibility-determination process. These provisions are intended to

[8] 26 CFR 1.36B-2.

[9] See 26 CFR § 1.36B-2.

promote administratively-efficient, streamlined, and coordinated eligibility business processes.

2.05 Administration of eligibility for health benefits (01/15/2017, GCR 16-094)

(a) AHS administers eligibility for the state's health-benefits programs and for enrollment in a QHP in accordance with applicable provisions of federal and state law and regulations.

(b) The eligibility determination process is administered such that:[10]

(1) Individual dignity and self-respect are maintained;

(2) The constitutional and other legal rights of individuals are respected;

(3) Practices do not violate the individual's privacy or dignity or harass the individual in any way;

(4) Disclosure of information concerning applicants or enrollees is limited to purposes directly connected with the administration of the applicable health-benefits program or with enrollment in a QHP or as otherwise required by law;

(5) Each individual who wishes to do so is given an opportunity to apply or reapply for benefits without delay;

(6) Prompt action is taken on each application and reapplication and individuals are notified in writing of the decision on the application;

(7) Decisions are based on recorded information showing either that all pertinent eligibility requirements are met or that one or more requirements are not met;

(8) Benefits are given promptly and continue regularly to all eligible individuals until they are found to be ineligible;

(9) Eligibility is redetermined when circumstances change or at the time of renewal, in accordance with the same principles as initial application;

(10) Individuals are the primary sources of information about their eligibility;

(11) Individuals are informed of their responsibility to furnish complete and accurate information, including prompt notification of changes affecting their eligibility or amount of aid or benefits, and of the penalties for willful misrepresentation to obtain benefits to which they are not entitled;

(12) Individuals are helped to obtain needed information; and

(13) Verification of conditions of eligibility are limited to what is reasonably necessary to assure that expenditures under a health-benefits program are legal, in accordance with federal and state law and

[10] Derived from ESD All Programs Rule 2000.

regulations.

(c) Application of these principles in specific areas is covered in succeeding sections.

3.00 Definitions (01/01/2023~~10/01/2021~~, GCR 22-029~~20-001~~)

As used in this rule, the following terms have the following meanings:

Adjusted monthly premium.[11] The premium an insurer charges for the applicable benchmark plan (ABP) to cover all members of the tax filer's coverage family.

Advance payment of the premium tax credit (APTC).[12] The payment of premium tax credits specified in section 36B of the Internal Revenue Code that are provided on an advance basis on behalf of an eligible individual enrolled in a QHP through VHC and paid directly to the QHP issuer.

Affordable Care Act (ACA).[13] The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), as amended by the Three Percent Withholding Repeal and Job Creation Act (Pub. L. 112-56).

Aid to the Aged, Blind, or Disabled (AABD).[14] Vermont's supplemental security income (SSI) state supplement program.

Alternate reporter. A person who is authorized to receive either original notifications or copies of such notifications on behalf of an individual. (See, § 5.02(b)(1)(iv)).

Annual open enrollment period (AOEP).[15] The period each year during which a qualified individual may enroll or change coverage in a QHP.

Applicable benchmark plan (ABP).[16] As defined in § 60.06, the second-lowest-cost silver plan offered through VHC.

Applicant[17]

(a) An individual seeking eligibility for health benefits for themselves through an application submission.

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[11] 26 CFR § 1.36B-3(e).

[12] 42 CFR § 435.4; 45 CFR § 155.20; § 36B of the Code (as added by § 1401 of the ACA); 3 VSA § 1812.

[13] 26 CFR § 1.36B-1(j); 42 CFR § 435.4; 45 CFR § 155.20.

[14] 33 VSA § 1301 et seq.; AABD Rule 2700 et seq.

[15] 45 CFR § 155.20.

[16] 26 CFR § 1.36B-3(f).

[17] 42 CFR § 435.4; 45 CFR §§ 155.20 and 156.20.

(b) An employer or employee seeking eligibility for enrollment in a QHP, where applicable.

Application.[18] A single, streamlined application for health benefits, submitted by or on behalf of an applicant. For determining eligibility on a basis other than the applicable MAGI standard, the single, streamlined application may be supplemented with form(s) to collect additional information needed, or an appropriate alternative application may be used.

Application date

(a) The day the application is received by AHS, if it is received on a business day; or

(b) The first business day after the application is received, if it is received on a day other than a business day.

If an application is supplemented with form(s) to collect additional information, including the use of an alternative application, the application date is the date the initial application is received by AHS.

Application filer[19]

(a) Applicant;

(b) Adult who is in the applicant's household;

(c) Authorized representative; or

(d) If the applicant is a minor or incapacitated, someone acting responsibly for the applicant.

Approve. To determine that an individual is eligible for health benefits.

Approval month. The month in which the individual's eligibility is approved.

Authorized representative. 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. See, § 5.02.

Benefit year (or taxable year).[20] A calendar year for which a health plan provides coverage for health benefits.

Broker.[21] A person or entity licensed by the state as a broker or insurance producer.

[18] 42 CFR § 435.4; 45 CFR § 155.410(a).

[19] 42 CFR § 435.907; 45 CFR § 155.20.

[20] 45 CFR §§ 155.20 and 156.20. The Treasury regulations employ the term "taxable year." The Internal Revenue Code defines the "benefit year" as "the calendar year, or the fiscal year ending during such calendar year, upon the basis of which the taxable income is computed under subtitle A. . . ." 26 USC § 7701(a)(23). For most individuals, the benefit year is the calendar year, and thus, synonymous with the Exchange regulation's definition of "benefit year."

[21] 45 CFR § 155.20.

Business day. Any day during which state offices are open to serve the public.

Cancel. To determine that an applicant who was approved for health benefits but not yet enrolled is no longer eligible for health benefits.

Caretaker relative[22]

(a) A relative of a dependent child (as defined in this § 3.00) by blood, adoption, or marriage, with whom the dependent child is living, who assumes primary responsibility for the dependent child's care (as may, but is not required to, be indicated by claiming the dependent child as a tax dependent for Federal income tax purposes).

(b) As used in this definition, a "relative" is the child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece. The term relative includes:

(1) An individual connected to the dependent child by blood, including half-blood;

(2) An individual of preceding generations denoted by grand, great, or great-great;

(3) The spouses or civil-union partners of such relatives, even after the marriage or union is terminated by death or dissolution; and

(4) An adult not related to the dependent child by blood, adoption, or marriage, but who lives with the dependent child and has primary responsibility for the dependent child's care.

Case file. The permanent collection of documents and information required to determine eligibility and to provide benefits to individuals.

Categorically needy.[23] Families and children; aged, blind, or disabled individuals; and pregnant women, described under subparts B and C of 42 CFR part 435 who are eligible for Medicaid. Subpart B describes the mandatory eligibility groups who, generally, are receiving or are deemed to be receiving cash assistance under the Act. These mandatory groups are specified in §§ 1902(a)(10)(A)(i),1902(e),1902(f), and 1928 of the Act. Subpart C describes the optional eligibility groups of individuals who, generally, meet the categorical requirements or income or resource requirements that are the same as or less restrictive than those of the cash assistance programs and who are not receiving cash payments. These optional groups are specified in §§ 1902(a)(10)(A)(ii),1902(e), and 1902(f) of the Act.

Catastrophic plan.[24] A health plan available to an individual up to age 30 or to an individual who is exempt from the mandate to purchase coverage that:

(a) Meets all applicable requirements for health insurance coverage in the individual market and is offered only in

[22] 42 CFR § 435.4; former Medicaid ANFC Rule 4343.

[23] 42 CFR § 435.4.

[24] 45 CFR § 156.155

the individual market;

(b) Does not provide a bronze, silver, gold, or platinum level of coverage; and

(c) Provides coverage of essential health benefits once the annual limitation on cost sharing is reached, with the following exceptions:

(1) A catastrophic plan must provide coverage for at least three primary-care visits per year before reaching the deductible.

(2) A catastrophic plan may not impose any cost-sharing requirements for preventive services, in accordance with § 2713 of the Public Health Service Act.

Certified application counselors. Staff and volunteers of organizations who are authorized and registered by AHS to provide assistance to individuals with the application process and during renewal of eligibility. See, § 5.05

Close. To determine that an enrollee is no longer eligible to receive health benefits.

Code. Internal Revenue Code.

Community spouse (CS). For purposes of Medicaid, the spouse of an institutionalized individual who is not living in a medical institution or a nursing facility. An individual is considered a community spouse even when receiving Medicaid coverage of long-term care services and supports in a home and community-based setting if they are the spouse of an individual who is also receiving Medicaid coverage of long-term care services and supports.

Cost sharing.[25] Any expenditure required by or on behalf of an individual with respect to essential health benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance-billing amounts for non-network providers, and spending for non-covered services.

Cost-sharing reductions (CSR).[26] Reductions in cost sharing for an individual who is enrolled in a silver-level QHP or for an individual who is an Indian enrolled in a QHP.

Couple. Two individuals who are married to each other or are parties to a civil union, according to the laws of the State of Vermont, except, for purposes of APTC/CSR, two individuals who are married to each other within the meaning of 26 CFR § 1.7703-1. IRS's regulations do not recognize parties to civil unions as married couples. Couples in civil unions are not permitted to file joint federal tax returns, but may qualify for APTC/CSR by filing separate tax returns.

Coverage. The scope of health benefits provided to an individual.

Coverage date. The date coverage begins.

[25] 45 CFR §§ 155.20 and 156.20.

[26] 45 CFR §§ 155.20 and 156.20; 33 VSA § 1812.

Coverage family.[27] See, § 60.02(b).

Coverage group.[28] Category of Medicaid eligibility, defined by particular categorical, financial, and nonfinancial criteria.

Coverage island. A discrete period of Medicaid coverage that is available in certain defined circumstances. See, § 70.02(d).

Coverage month.[29] A month for which, as of the first day of the month:

(a) An individual is receiving coverage;

(b) If a premium is charged for coverage, the individual's premium is paid in full or, if the individual is enrolled in a QHP with APTC, the individual is in the first month of a premium grace period (see § 64.06(a)(1) for a description of the grace period for an individual enrolled in a QHP with APTC); and

(c) If the individual is enrolled in a QHP with APTC, the individual is not eligible for Minimum Essential Coverage (MEC) other than coverage in the individual market, as referenced in § 5000A(f)(1)(C) of the Code.

Date of application. See, application date.

Day. A calendar day unless a business day is specified.

Deny. To determine that an applicant is ineligible for health benefits.

Dependent child.[30] An individual who is:

(a) Under the age of 18; or

(b) Age 18 and a full-time student in secondary school (or equivalent vocational or technical training), if before attaining age 19 the child may reasonably be expected to complete such school or training.

Disability[31]

(a) Individual age 18 and older. An individual age 18 and older is considered disabled if they are unable to engage in any substantial gainful activity because of any medically-determinable physical or mental impairment, or combination of impairments, that can be expected to result in death, or has lasted or can be expected to last for a continuous period of not fewer than 12 months. To meet this definition, an individual must have a severe

[27] 26 CFR § 1.36B-3(b)(1).

[28] 42 CFR § 435.10(b).

[29] 26 CFR § 1.36B-3(c).

[30] 42 CFR § 435.4.

[31] Former Medicaid SSI Rule 4213.

impairment, which makes them unable to do their previous work or any other substantial gainful activity that exists in the national economy. To determine whether an individual is able to do any other work, AHS considers their residual functional capacity, age, education, and work experience.

(b) Individual under age 18. An individual under age 18 is considered disabled if they have a medically-determinable physical or mental impairment, or combination of impairments, resulting in marked and severe functional limitations, that can be expected to result in death or that have lasted or can be expected to last for at least 12 consecutive months. An individual under age 18 who engages in substantial gainful activity may not be considered disabled.

Disenroll. To end coverage.

Dr. Dynasaur. The collection of programs that provide health benefits to children under age 19 in the group defined in § 7.03(a)(3) and pregnant women in the group defined in § 7.03(a)(2).

Electronic account.[32] An electronic file that includes all information collected and generated by the state regarding each individual's health-benefits eligibility and enrollment, including all documentation required under § 4.04 and including information collected or generated as part of a fair hearing process conducted with regard to health-benefits eligibility and enrollment.

Eligible. The status of an individual determined to meet all financial and nonfinancial qualifications for health benefits.

Eligible employer-sponsored plan[33]

(a) With respect to an employee, a group health plan or group health insurance coverage offered by an employer to the employee which is:

(1) A governmental plan (within the meaning of § 2791(d)(8) of the Public Health Service (PHS) Act); or

(2) Any other plan or coverage offered in the small or large group market within a state.

(b) This term also includes a grandfathered health plan[34] offered in a group market.

Eligibility determination.[35] An approval or denial of eligibility as well as a renewal or termination of eligibility.

Eligibility process. Activities conducted for the purposes of determining, redetermining, and maintaining the eligibility of an individual.

[32] 42 CFR §§ 435.4 and 435.914.

[33] 26 CFR § 1.36-2(c)(3)(i); 26 USC § 5000A(f)(2).

[34] 26 USC § 5000A(f)(1)(D).

[35] 42 CFR § 435.4. *See also,* 42 CFR §§ 435.911 and 435.916; 45 CFR § 155.302.

Employer contributions.[36] Any financial contributions toward an employer-sponsored health plan, or other eligible employer-sponsored benefit made by the employer including those made by salary reduction agreement that is excluded from gross income.

Enroll. To initiate coverage for an approved individual.

Enrollee.[37] An individual who has been approved and is currently receiving health benefits. The term "enrollee" includes the term "beneficiary,' which is an individual who has been determined eligible for, and is currently receiving, Medicaid.

Exchange (Vermont Health Connect (VHC)).[38] A state-managed entity through which individuals, qualified employees, and small businesses can compare, shop for, purchase, and enroll in QHPs; and individuals can apply for and enroll in health-benefits programs. In Vermont, the Exchange is known as Vermont Health Connect (VHC).

Exchange service area.[39] The area in which the Exchange (in Vermont, VHC) is certified to operate.

Family coverage.[40] Health insurance that covers more than one individual and provides coverage for essential health benefits.

Family size. See, § 28.02(a).

Federal poverty level (FPL).[41] 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 budget period used to determine an individual's income eligibility for means-tested health benefits.

[36] 45 CFR § 155.20.

[37] 42 CFR § 435.4.

[38] 26 CFR § 1.36B-1(k); 45 CFR § 155.20. There will be a single "service area" in Vermont, for both Medicaid and QHP enrollment.

[39] 45 CFR § 155.20.

[40] 26 CFR § 1.36B-1(m).

[41] 26 CFR § 1.36B-1(h); 42 CFR § 435.4; 45 CFR § 155.410. The Treasury regulations uses the term "FPL" to describe this indicator: "FPL. The FPL means the most recently published poverty guidelines (updated periodically in the Federal Register by the Secretary of Health and Human Services under the authority of 42 USC § 9902(2)) as of the first day of the regular enrollment period for coverage by a QHP offered through an Exchange for a calendar year. Thus, the FPL for computing the premium tax credit for a benefit year is the FPL in effect on the first day of the initial or annual open enrollment period preceding that benefit year. See 45 CFR 155.410." 26 CFR § 1.36B-1(h). For the sake of consistency, AHS has adopted HHS's term for this concept, and uses it throughout this rule.

Financial responsibility group. For purposes of MABD, the individuals whose income or resources are considered when determining eligibility for a Medicaid group (defined below). See § 29.03 for rules on the formation of the financial responsibility group for MABD eligibility purposes.

Grace period. The period of time during which an enrollee who has failed to pay all outstanding premiums remains enrolled in coverage, with or without pended claims.

Grandfathered health plan coverage.[42] Coverage provided by a group health plan, or a group or individual health insurance issuer, in which an individual was enrolled on March 23, 2010 (for as long as it maintains that status under federal criteria).

Group health plan.[43] An employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees (including both current and former employees) or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

Health-benefits program.[44] A program that is one of the following:

(a) A state Medicaid program under Title XIX of the Act.

(b) A state children's health insurance program (CHIP) under Title XXI of the Act.

(c) A program that makes available coverage in QHPs with financial assistance.

Health benefits. Any health-related program or benefit, administered or regulated by the state, including, but not limited to, QHPs, APTC, premium reductions, federal or state CSR, and Medicaid.

Health insurance coverage.[45] Benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage and individual health insurance coverage.

Health insurance issuer or issuer.[46] An insurance company, nonprofit hospital and medical service corporation, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a state and that is subject to state law that regulates insurance (within the meaning of section 514(b)(2) of ERISA).

[42] 45 CFR § 155.20; 45 CFR § 147.140.

[43] 45 CFR §§ 155.20 and 156.20; 45 CFR § 144.103; 45 CFR § 146.145(a).

[44] This term includes the programs referred to as "insurance affordability programs" in federal regulations. See, 42 CFR § 435.4; 45 CFR § 155.300.

[45] 45 CFR § 155.20; 45 CFR § 144.103.

[46] 45 CFR §§ 155.20 and 156.20; 45 CFR § 144.103; 18 VSA § 9402(8).

Health plan.[47] This term has the meaning given in § 1301(b)(1) of the ACA. That section incorporates the definition found in § 2791(a) of the Public Health Service Act.

Human Services Board. AHS's fair hearings entity for eligibility issues. See, § 80.01.

Indian.[48] A person who is a member of an Indian tribe.

Indian tribe.[49] Any Indian tribe, band, nation or other organized group, or community, including pueblos, rancherias, colonies and any Alaska Native Village, or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act, which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

Individual. An applicant or enrollee for health benefits.

Institution.[50] An establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more individuals unrelated to the proprietor.

Institutionalized individual. A person requesting Medicaid coverage of long-term care services and supports, whether the care is received in a home and community-based setting or in an institution licensed by AHS.

Institutionalized spouse (IS). For purposes of Medicaid, an institutionalized individual whose spouse qualifies as a community spouse.

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

Lawfully present. See, § 17.01(g).

Level of coverage.[51] One of four standardized actuarial values for plan coverage as defined by § 1302(d)(1) of the ACA: bronze, silver, gold or platinum.

Limited English proficiency. 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.

[47] 45 CFR § 155.20.

[48] 25 CFR § 900.6.

[49] 25 CFR § 900.6.

[50] 42 CFR § 435.1010. This is the definition referred to in 42 CFR § 435.403(b) and 45 CFR § 155.305(a)(3). "Assisted living" is considered a community setting and not a medical institution or nursing facility because assisted living does not include 24-hour care, has privacy, a lockable door, and is a homelike setting. Former PP&D to Former Medicaid Rule 4201.

[51] 45 CFR § 156.20; § 1302(d)(2) of the ACA.

Long-term care. Highest-need and high-need care, as determined by AHS, received by an individual living in a nursing facility, rehabilitation center, intermediate-care facility for the developmentally disabled (ICF-DD), and other medical facility for at least 30 consecutive days. It also includes care received by an individual in a home and community-based setting as specified in relevant waiver authorizations and any related program regulations.

For more information on Vermont's waiver governing terms and conditions, see: http://dvha.vermont.gov/administration.

Long-term care services and supports.[52] A range of medical, personal, and social services that can help an individual with functional limitations live their life more independently. Supports range from daily living (e.g. grocery shopping and food preparation) to 24-hour medical care provided in nursing facilities. Examples of long-term care services and supports include nursing facility services; a level of care in any institution equivalent to nursing facility services; home and community-based services to qualifying individuals as specified in relevant waiver authorizations or in any related program regulations, to include:

(a) Home-based and enhanced residential care services for the aged and disabled (known as "Choices for Care");

(b) Traumatic brain injury services (TBI);

(c) Home and community-based waiver services for the developmentally disabled (DS); and

(d) Children's mental health services.

For more information on Vermont's waiver governing terms and conditions, see: http://dvha.vermont.gov/administration. See, also, DVHA's Medicaid Covered Services Rule 7601.

MAGI-based income.[53] See, § 28.03(c).

Medicaid for Children and Adults (MCA). The health-benefits program available to a member of a Medicaid coverage group for parents and other caretaker relatives, children, pregnant women, or adults under 65 years of age.

Medicaid for the Aged, Blind, and Disabled (MABD). The health-benefits program available to a member of a Medicaid coverage group for people who are aged, blind, or disabled. MABD is based on the requirements for two financial assistance programs federally administered by the Social Security Administration: the supplemental security income program (SSI) and aid to the aged, blind, and disabled program (AABD).

Medicaid group. Individuals who are considered in the financial-eligibility determination for MABD. The countable income and resources of the financial responsibility group are compared against the income and resource standards applicable to the Medicaid group's size. See § 29.04 for rules on the formation of the Medicaid group.

[52] 42 CFR § 435.603(j)(4).

[53] 42 CFR §§ 435.4 and 435.603(e).

Medicaid services.[54] Medical benefits funded through Medicaid as specified in related program rules and waiver authorizations.

Medical incapacity. See, § 64.09.

Medical institution.[55] An institution that:

(a) Is organized to provide medical care, including nursing and convalescent care;

(b) Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing and other health needs of patients on a continuing basis and in accordance with accepted standards;

(c) Is authorized under state law to provide medical care; and

(d) Is staffed by professional personnel who are responsible to the institution for professional medical and nursing services. The services must include adequate and continual medical care and supervision by a physician; registered nurse or licensed practical nurse supervision and services and nurses' aid services, sufficient to meet nursing care needs; and a physician's guidance on the professional aspects of operating the institution.

Medically needy.[56] Families; children; individuals who are aged, blind, or disabled; and pregnant women who are not categorically needy but who may be eligible for Medicaid because their income and, for individuals who are aged, blind or disabled, their resources are within limits set by the state under its Medicaid plan (including persons whose income and, if applicable, resources fall within these limits after their incurred expenses for medical or remedial care are deducted).

Minimum essential coverage (MEC).[57] 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. See, § 23.00.

Minimum value.[58] When used to describe coverage in an eligible employer-sponsored plan, minimum value means that the percentage of the total allowed costs of benefits provided under the plan is greater than or equal to 60 percent, and the benefits under the plan include substantial coverage of inpatient hospital services and physician services.

Modified adjusted gross income (MAGI). See, § 28.00.

[54] *See,* Health Care Administrative Rules (HCAR) and Global Commitment to Health Section 1115 Waiver.

[55] 42 CFR § 435.1010.

[56] 42 CFR § 435.4.

[57] 42 CFR § 435.4; 45 CFR § 155.20.

[58] 45 CFR § 155.300; 45 CFR § 156.145; 26 CFR §§ 1.36B-2(c)(3)(vi) and 1.36B-6.

Navigator.[59] An entity or individual selected by AHS and awarded a grant to provide assistance to individuals and employers with enrollment in Medicaid programs and qualified health plans, and to engage in the activities and meet the standards described in § 5.03.

Non-applicant.[60] A person who is not seeking an eligibility determination for himself or herself and is included in an applicant's or enrollee's household to determine eligibility for such applicant or enrollee.

Nonpayment. Failure to pay any or all of a premium due.

OASDI.[61] Old age, survivors, and disability insurance under Title II of the Act.

Optional state supplement.[62] A cash payment made by a state, under § 1616 of the Act, to an aged, blind, or disabled individual. *See*, AABD.

Patient share. See, § 24.00.

Physician's certificate. See, § 64.09.

Plan year.[63] A consecutive 12-month period during which a health plan provides coverage. For plan years beginning on January 1, 2015, a plan year must be a calendar year.

Plain language.[64] Language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing.

Pregnant woman.[65] A woman during pregnancy and the post partum period, which begins on the date the pregnancy ends and extends as follows:

(a) Effective April 1, 2023

Effective April 1, 2023, the post partum period extends 12 months, and then ends on the last day of the month in which the 12-month period ends.

[59] 45 CFR § 155.20; 33 VSA § 1807.

[60] 42 CFR § 435.4.

[61] 42 CFR § 435.4.

[62] 42 CFR § 435.4.

[63] 45 CFR §§ 155.20 and 156.20.

[64] 45 CFR § 155.20. Incorporates meaning of this term given in § 1311(e)(3)(B) of the ACA.

[65] 42 CFR § 435.4.

(b) Through March 31, 2023

Through March 31, 2023, the post partum period , extends 60 days, and then ends on the last day of the month in which the 60-day period ends, unless the woman is still enrolled in Medicaid on April 1, 2023 and is pregnant or within 12 months of the end of a pregnancy on that date. In the latter situation, the 12-month post partum period described in (a) above applies.

Premium

(a) In general. A monthly charge that must be paid by an individual in order to receive health benefits.

(b) Initial premium. The premium for the first month of coverage.

(c) Ongoing premium. The premium for successive months of coverage, which are billed and due on a monthly basis.

Premium due date. The day on which a health-benefits premium is due.

Premium Reduction. State subsidy paid directly to the QHP issuer to reduce monthly premiums for an eligible individual enrolled in a QHP through VHC.

Private facility.[66] Any home privately owned and operated, or any home or institution supported by private or charitable funds, over which neither the state nor any of its subdivisions has supervision or control even though individuals may be boarded or cared for therein at public expense. Vermont private institutions include boarding homes, fraternal homes, religious homes, community care homes, residential care facilities, medical facilities (i.e. general hospitals) and nursing facilities licensed by the State of Vermont.

Protected Income Level (PIL). The income standard for the medically-needy Medicaid coverage groups.

Public Institution.[67] Any institution meeting all of the following conditions:

(a) The institution is owned, maintained, or operated in whole or in part by public funds;

(b) Control is exercised, in whole or in part, by any public agency or an official or employee of that agency; and

(c) The institution furnishes shelter and care and can be termed a public institution by reason of its origin, charter, ownership, maintenance or supervision.

Qualified Health Plan (QHP). A health plan certified by Vermont's Department of Financial Regulation (DFR) and offered by Vermont Health Connect.[68]

[66] Former Medicaid rules 4218.2 and 4332.2.

[67] Former Medicaid rules 4218.1 and 4332.1.

[68] 45 CFR §§ 155.20 and 156.20. 26 CFR § 1.36B-1(c) defines the term as follows: "QHP. The term QHP has the same meaning as in section 1301(a) of the ACA (42 USC § 18021(a)) but does not include a catastrophic plan described in

QHP issuer.[69] A health insurance issuer that offers a QHP in accordance with a certification from DFR.

Qualified individual.[70] For purposes of QHP, an individual who has been determined eligible by AHS to enroll in a QHP.

Qualifying coverage in an employer-sponsored plan.[71] Coverage in an eligible employer-sponsored plan that meets the affordability and minimum-value standards specified in 26 CFR § 1.36B-2(c)(3), and described in §§ 23.02 (affordable) and 23.03 (minimum value).

Quality control (QC). A system of continuing review to measure the accuracy of eligibility decisions. Also, the name of the AHS unit that is responsible for administering quality-control functions.

Reasonable compatibility. See, § 57.00(a).

Reenroll. To restore coverage after closure.

Reinstate. To restore eligibility after cancellation or closure.

Renew. To redetermine eligibility at a specified periodic interval (*e.g.*, annual renewal of eligibility).

Secure electronic interface.[72] An interface that allows for the exchange of data between information technology systems and adheres to the requirements in subpart C of 42 CFR part 433.

Self-only coverage.[73] Health insurance that covers one individual and provides coverage for essential health benefits.

Special enrollment period (SEP).[74] A period during which a qualified individual or enrollee who experiences certain qualifying events may enroll in, or change enrollment in, a QHP outside of AOEPs.

Spouse. A husband, a wife or a party to a civil union according to the laws of the State of Vermont, except, for purposes of APTC/CSR, a husband or a wife if married within the meaning of 26 CFR § 1.7703-1. IRS's regulations do not recognize parties to civil unions as "spouses." Parties to civil unions are not permitted to file joint federal tax returns, but may qualify for APTC/CSR by filing separate tax returns.

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section 1302(e) of the ACA (42 USC § 18022(e)."

[69] 45 CFR §§ 155.20 and 156.20.

[70] 45 CFR §§ 155.20 and 156.20.

[71] 45 CFR § 155.300.

[72] 42 CFR § 435.4.

[73] 26 CFR § 1.36B-1(l).

[74] 45 CFR § 155.20.

SSI. Supplemental security income program under Title XVI of the Act.

Substantial gainful activity

(a) Work activity that is both substantial and gainful, defined as follows:

(1) Substantial work activity involves doing significant physical or mental activities. Work may be substantial even if it is done on a part-time basis or if individuals do less, get paid less or have less responsibility than when they worked before.

(2) Gainful work activity is the kind of work done for pay or profit whether or not a profit is realized.

(b) Individuals who are working with disabilities shall be exempt from the substantial gainful activity (SGA) step of the sequential evaluation of the disability determination if they otherwise meet the requirements set forth in § 8.05 for the categorically needy working disabled.

Tax filer.[75] For purposes of eligibility for a QHP with financial assistance, an individual who indicates that they expect:

(a) To file an income tax return for the benefit year;

(b) If married (within the meaning of 26 CFR § 1.7703-1), to file a joint tax return for the benefit year with their spouse (who, together with the individual, is considered the tax filer) unless the tax filer meets the exceptions criteria defined in § 12.03(b) (victim of domestic abuse or spousal abandonment);

(c) That no other taxpayer will be able to claim them as a tax dependent for the benefit year; and

(d) To claim a personal exemption deduction under § 151 of the Code on their tax return for one or more applicants, who may or may not include the individual or their spouse.

Tax dependent

(a) For purposes of eligibility for MAGI-based Medicaid, see, § 28.03(a).

(b) For purposes of eligibility for a QHP with financial assistance, see, § 28.05(a).

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

4.00 General program rules (10/01/2021, GCR 20-001)

4.01 Receiving health benefits from another state (01/15/2017, GCR 16-094)

An individual who is receiving health benefits from another state is not eligible for health benefits in Vermont.

4.02 Rights of individuals with respect to application for and receipt of health benefits through

[75] 45 CFR § 155.300.

AHS (10/01/2021, GCR 20-001)

(a) Notice of rights and responsibilities. Policies are administered in accordance with federal and state law. Individuals will be informed of their rights and responsibilities with respect to application for and receipt of health benefits.

(b) Right to nondiscrimination and equal treatment.[76] AHS does not unlawfully discriminate on the basis of race, color, religion, national origin, disability, age, sex, gender identity, or sexual orientation in the administration of its health-benefits programs or activities.

(c) Right to confidentiality. The confidentiality of information obtained during the eligibility process is protected in accordance with federal and state laws and regulations. The use and disclosure of information concerning applicants, enrollees, and legally-liable third parties is restricted to purposes directly connected with the administration of health-benefits programs, with enrollment in a QHP or as otherwise required by law.

(d) Right to timely provision of benefits. Eligible individuals have the right to the timely provision of benefits, as defined in § 61.00.

(e) Right to information. Individuals who inquire have the right to receive information about health benefits, coverage-type requirements, and their rights and responsibilities as enrollees of health-benefits programs or as enrollees in QHPs.

(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 benefits.

(g) Right to be assisted by others

(1) The individual has the right to be represented by a legal representative.

(2) The individual has the right to be accompanied and represented by an authorized representative during the eligibility or appeal processes.

(3) 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.

(4) An authorized representative may file an application for health benefits or an appeal on behalf of a deceased person.

(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 the right to appeal, as provided in § 68.00.

(j) Right to interpreter services. Individuals will be informed of the availability of interpreter services. Unless the

[76] See, 42 USC § 18116; 45 CFR §§ 92.2 and 155.120(c)(1); 9 VSA § 4502; see, also, ESD All Programs Rule 2000(C).

individual chooses to provide their own interpreter services, AHS will provide either 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.

4.03 Responsibilities of individuals with respect to application for and receipt of health benefits through AHS (01/15/2017, GCR 16-094)

(a) Responsibility to cooperate. An individual must cooperate in providing information necessary to establish and maintain their eligibility, and must comply with all rules and regulations, including recovery and obtaining or maintaining available health insurance.

(b) Responsibility to report changes[77]

(1) An individual must report changes that may affect eligibility. Such changes include, but are not limited to, income, the availability of health insurance, and third-party liability.

(2) A Medicaid enrollee must report such changes within 10 days of learning of the change.

(3) Except as specified in paragraphs (b)(4) and (5) of this subsection, a QHP enrollee must report such changes within 30 days of such change.

(4) A QHP enrollee who did not request an eligibility determination for APTC or CSR, and is not receiving APTC or CSR, need not report changes that affect eligibility for health-benefits programs.

(5) An individual, or an application filer on behalf of the individual, will be allowed to report changes via the channels available for the submission of an application, as described in § 52.02.

(c) Cooperation with quality control. An individual enrolled in a health-benefits program must cooperate with any quality-control (QC) review of their case. (§ 4.05)

4.04 Case records (01/15/2017, GCR 16-094)

(a) Contents. Case records include the following information:

(1) Applications for benefits;

(2) Factual data that supports eligibility findings, including, but not limited to:

(i) Documentation of verification of information submitted and any supplementary investigation of eligibility factors;

[77] Derived from former Medicaid Rule 4140.

(ii) Budgetary computations;

(iii) Eligibility decisions; and

(iv) Payment authorizations.

(3) Copies of all correspondence with and concerning individuals, including, but not limited to, notices of case decisions.

(b) Use of case information. Case information may contribute in statistical or other general terms to material needed for planning, research, and overall administration of human-services programs. Individual case information shall, however, be held in accordance with the confidentiality requirements set forth in § 4.08.

(c) Retention.[78] Case records are retained as required by federal and state requirements for audit and/or review.

4.05 Quality-control review[79] (01/15/2017, GCR 16-094)

(a) AHS's Quality Control (QC) Unit periodically conducts independent reviews of eligibility factors in a sampling of cases. These reviews help to ensure that program rules are clear and consistently applied and that individuals understand program requirements and give correct information in support of their applications for benefits.

(b) A random sample of active Medicaid enrollees is chosen each month for a full field review of their eligibility. Each eligibility factor must be verified with the enrollee and with collateral sources.

(c) A similar sample of negative actions (e.g., denials, closures, benefit decreases) is also chosen each month. These reviews do not usually require a contact with the individual, although the reviewer may sometimes need to check facts with the individual.

(d) When a case is selected for review, the individual must cooperate with the QC representative. Cooperation includes, but is not limited to, participation in a personal interview and the furnishing of requested information. If the individual does not cooperate, eligibility for the individual's household may be closed and the individual members may be disenrolled.

(e) When there is a discrepancy between the eligibility facts, as discovered during a QC review, and those contained within the case record, AHS will schedule an eligibility review and take action to correct errors or review the effect of the changes.

4.06 Fraud (01/15/2017, GCR 16-094)

(a) Fraud. A person commits fraud in Vermont if he or she:

(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

[78] From former All-Programs Rule 2013.

[79] From former Medicaid Rule 4104.

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 . . . ;"[80] 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, alteration, forgery, or possession of a . . . certificate of eligibility for medical services, or Medicaid identification card in a manner not authorized by law . . . ."[81]

(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. An individual may report suspected fraud to AHS. When AHS suspects that fraud may have been committed, it will investigate the case. If appropriate, the case will be referred to the State's Attorney or Attorney General for a decision on whether or not to prosecute.

(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?

(e) Examples

(1) The following are examples of instances in which fraud might be suspected and referral considered:

(i) The individual accepts and continues paid employment without reporting such employment after having been clearly informed of the necessity of such notification.

(ii) The individual fails to acknowledge or report income from pensions, Social Security, or relatives when it is reasonably clear that there was a willful attempt to conceal such income.

(iii) The individual disposes of property (either real or personal) and attempts to conceal such disposal.

[80] 33 VSA § 141(a).

[81] 33 VSA § 141(b).

(iv) The individual misrepresents a material fact, such as residency status or dependent relationship or status, in order to receive benefits to which they would not otherwise be eligible.

(2) These examples are intended as a guideline; each case will be evaluated individually.

(f) Methods of investigation. 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.

(g) Review and documentation of investigation. Procedures will be established for review and documentation of a fraud investigation.

(h) Referral to Law Enforcement Agencies. The final decision regarding referral to a law enforcement agency shall be the responsibility of the appropriate department's commissioner.

4.07 [Reserved] (01/15/2017, GCR 16-094)

4.08 Privacy and security of personally identifiable information[82] (01/15/2019, GCR 18-060)

(a) When personally-identifiable information is collected or created for the purposes of determining eligibility for enrollment in a QHP, determining eligibility for health-benefits programs, or determining eligibility for exemptions from the individual responsibility provisions in § 5000A of the Code, 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 must establish and implement privacy and security standards that are consistent with the following principles.

(1)

(i) *Individual access*. Individuals should be provided with a simple and timely means to access and obtain their personally identifiable information in a readable form and format;

(ii) *Correction*. Individuals should be provided with a timely means to dispute the accuracy or integrity of their personally identifiable information and to have erroneous information corrected or to have a dispute documented if their requests are denied;

(iii) *Openness and transparency*. There should be openness and transparency about policies, procedures, and technologies that directly affect individuals and/or their personally identifiable information;

(iv) *Individual choice*. Individuals should be provided a reasonable opportunity and capability to make informed decisions about the collection, use, and disclosure of their personally identifiable information;

[82] See generally, Social Security Act §§ 1137 and 1902(a)(7); 26 USC § § 6103; § 1413(c)(1) and (c)(2) of the ACA; 42 CFR Part 431, Subpart F; 45 CFR § 155.260; 45 CFR § 155.280.

(v) *Collection, use, and disclosure limitations.* Personally identifiable information should be created, collected, used, and/or disclosed only to the extent necessary to accomplish a specified purpose(s) and never to discriminate inappropriately;

(vi) *Data quality and integrity.* Persons and entities should take reasonable steps to ensure that personally identifiable information is complete, accurate, and up-to-date to the extent necessary for the person's or entity's intended purposes and has not been altered or destroyed in an unauthorized manner;

(vii) *Safeguards.* Personally identifiable information should be protected with reasonable operational, administrative, technical, and physical safeguards to ensure its confidentiality, integrity, and availability and to prevent unauthorized or inappropriate access, use, or disclosure; and

(viii) *Accountability.* These principles should be implemented, and adherence assured, through appropriate monitoring and other means and methods should be in place to report and mitigate non-adherence and breaches.

(2) Safeguards. For the purposes of implementing the principle described in paragraph (a)(1)(vii) of this subsection, AHS must establish and implement operational, technical, administrative and physical safeguards that are consistent with any applicable laws (including this subsection) to ensure:

(i) The confidentiality, integrity, and availability of personally identifiable information created, collected, used, and/or disclosed by AHS;

(ii) Personally identifiable information is only used by or disclosed to those authorized to receive or view it;

(iii) Return information, as such term is defined by § 6103(b)(2) of the Code, is kept confidential under § 6103 of the Code;

(iv) Personally identifiable information is protected against any reasonably anticipated threats or hazards to the confidentiality, integrity, and availability of such information;

(v) Personally identifiable information is protected against any reasonably anticipated uses or disclosures of such information that are not permitted or required by law; and

(vi) Personally identifiable information is securely destroyed or disposed of in an appropriate and reasonable manner and in accordance with retention schedules.

(3) Monitoring. AHS must monitor, periodically assess, and update the security controls and related system risks to ensure the continued effectiveness of those controls.

(4) Secure interfaces. AHS must develop and utilize secure electronic interfaces when sharing personally identifiable information electronically.

4.09 Use of standards and protocols for electronic transactions (01/15/2017, GCR 16-094)

(a) HIPAA administrative simplification.[83] To the extent that electronic transactions are performed with a covered entity, standards, implementation specifications, operating rules, and code sets adopted by the Secretary of HHS in 45 CFR parts 160 and 162 will be used.

(b) HIT enrollment standards and protocols.[84] Interoperable and secure standards and protocols developed by the Secretary of HHS in accordance with § 3021 of the PHS Act will be incorporated. Such standards and protocols will be incorporated within VHC information technology systems.

5.00 Eligibility and enrollment assistance (10/01/2021, GCR 20-001)

5.01 Assistance offered through AHS (10/01/2021, GCR 20-001)

(a) In general.[85] AHS will provide assistance to any individual seeking help with the application or renewal process in person, over the telephone, and online, 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 paragraph (c) of this subsection 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 tools

(1) Call center.[86] A toll-free call center is provided to address the needs of individuals requesting assistance and meets the accessibility requirements outlined in paragraph (c) of this subsection.

(2) Internet website.[87] An up-to-date internet website that meets the requirements outlined in paragraph (c) of this subsection is maintained. The website:

(i) Supports applicant and enrollee activities, including accessing information on the health-benefit programs available in the state, applying for and renewing coverage and providing assistance to individuals seeking help with the application or renewal process;

[83] 45 CFR § 155.270(a).

[84] 45 CFR § 155.270(b).

[85] 42 CFR § 435.908; 45 CFR § 155.205(d). Note: While the consumer-assistance responsibilities of Medicaid agencies and Exchanges may be distinct, "[s]ome aspects of [the Medicaid agency's] applicant and beneficiary assistance may be integrated with the consumer assistance tools and programs of the Exchange." See, CMS "Summary of Proposed Provisions and Analysis of and Responses to Public Comments," 77 Fed. Reg. 17144, 17166 (Mar. 23, 2011). Vermont has opted to operate one health-benefits assistance call center, serving the needs of all applicants and beneficiaries of health benefits.

[86] 42 CFR § 435.908; 45 CFR § 155.205(a).

[87] Social Security Act § 1943 (42 USC § 1396w-3); 42 CFR § 435.1200(f); 45 CFR § 155.205(b).

(ii) Provides standardized comparative information on each available QHP, which may include differential display of standardized options on consumer-facing plan comparison and shopping tools, including at a minimum:

(A) Premium and cost-sharing information;

(B) The summary of benefits and coverage established under § 2715 of the PHS Act;

(C) Identification of whether the QHP is a bronze, silver, gold, or platinum level plan as defined by § 1302(d) of the ACA, or a catastrophic plan as defined by § 1302(e) of the ACA;

(D) The results of the enrollee satisfaction survey, as described in § 1311(c)(4) of the ACA;

(E) Beginning 2015, quality ratings assigned in accordance with § 1311(c)(3) of the ACA;

(F) Medical loss ratio information as reported to HHS in accordance with 45 CFR part 158;

(G) Transparency of coverage measures reported to VHC during certification; and

(H) The provider directory made available to VHC.

(iii) Publishes the following financial information:

(A) The average costs of licensing required by VHC;

(B) Any regulatory fees required by VHC;

(C) Any payments required by VHC in addition to fees under paragraphs (b)(2)(iii)(A) and (B) of this subsection;

(D) Administrative costs of VHC; and

(E) Monies lost to waste, fraud, and abuse.

(iv) Provides individuals with information about Navigators as described in § 5.03 and other consumer assistance services, including the toll-free telephone number of the call center required in paragraph (b)(1) of this subsection.

(v) Allows for an eligibility determination to be made in accordance with § 58.00.

(vi) Allows a qualified individual to select a QHP in accordance with § 71.00.

(vii) Makes available by electronic means a calculator to facilitate the comparison of available QHPs after the application of any APTC, premium reductions and any federal or state CSR.

(c) Accessibility[88]

(1) Information is provided in plain language and in a manner that is accessible and timely.

(2) Individuals living with disabilities will be provided with, among other things, accessible websites and

[88] 42 CFR § 435.905(b); 45 CFR § 155.205(c).

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) 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.

(d) Availability of program information[89]

(1) The following information is furnished in electronic and paper formats, and orally as appropriate, to all individuals who request it:

(i) The eligibility requirements;

(ii) Available health benefits and services; and

(iii) The rights and responsibilities of individuals.

(2) Bulletins or pamphlets that explain the rules governing eligibility and appeals in simple and understandable terms will be published in quantity and made available.

(3) Such information is provided in a manner that meets the standards in paragraph (c) of this subsection.

(e) Outreach and education.[90] Outreach and education activities that meet the standards in paragraph (c) of this subsection to educate consumers about VHC and Vermont's health-benefits programs to encourage participation will be conducted.

(f) Americans with Disabilities Act (ADA).[91] As required by the Americans with Disabilities Act, reasonable accommodations and modifications will be made to policies, practices, or procedures when necessary, as determined by the appropriate commissioners or their designees, to provide equal access to programs, services and activities, or when necessary to avoid discrimination on the basis of disability. An individual may

[89] 42 CFR § 435.905; 45 CFR § 155.205.

[90] Social Security Act § 1943 (42 USC § 1396w-3); 45 CFR § 155.205(e).

[91] All Programs Rule 2030.

appeal the commissioner's determination regarding necessity to the appropriate fair hearings entity or appeals entity in accordance with departmental regulations governing appeals and fair hearings.

(g) Non-discrimination.[92] AHS assistance programs and activities will:

(1) Comply with applicable non-discrimination statutes; and

(2) Not discriminate based on race, color, national origin, disability, age, sex, gender identity or sexual orientation.

5.02 Authorized representatives[93] (01/15/2019, GCR 18-060)

(a) In general

(1) An individual may designate another person or organization to accompany, assist, and represent or to act responsibly on their behalf in assisting with the individual's application and renewal of eligibility and other ongoing communications with AHS. These include:

(i) Guardians and people with powers of attorney (§ 5.02(i)); and

(ii) Any other person of the individual's choice.

(2) AHS may permit an applicant or enrollee to authorize a representative to perform fewer than all of the activities described in paragraph (b)(1) of this subsection, provided that AHS tracks the specific permissions for each authorized representative.

(3) Except as provided in paragraph (h) of this subsection, and consistent with current state policy and practice, designation of an authorized representative must be in writing, including the individual's signature, or through another legally binding format subject to applicable authentication and data security standards.

(4) Designation will be permitted at the time of application and at other times.

(5) Legal documentation of authority to act on behalf of an individual under state law, such as a court order establishing legal guardianship or a power of attorney, shall serve in the place of written authorization by the individual. In such cases AHS may recognize an individual as an authorized representative before the legal documentation is provided to AHS.

(6) When an individual dies before applying for retroactive Medicaid coverage, the administrator or executor of the individual's estate, a surviving relative or responsible person may act as the individual's representative.

[92] 42 USC § 18116; 45 CFR §§ 92.2 and 155.120(c)(1); 9 VSA § 4502.

[93] 42 CFR §§ 435.908(b) and 435.923; 45 CFR § 155.227.

(b) Scope of authority

(1) Representatives may be authorized to do any or all of the following:

(i) Assist the individual in completing and submitting any health-benefits application, verification, or other documentation with AHS;

(ii) Give and receive information regarding the individual's application or enrollment;

(iii) Sign an application on the individual's behalf;

(iv) Receive copies of the individual's notices and other communications. A person who receives authority to only receive copies of communications is referred to as an "alternate reporter";

(v) Request a fair hearing or file a grievance; and

(vi) Act on behalf of the individual in any other matters with AHS.

(2) The kinds of information that may be shared may include the following:

(i) Information or proofs needed to complete the application or redetermination of eligibility;

(ii) The status of the application including the program or programs the household members are enrolled in and the effective dates of enrollment;

(iii) The reason the individual or household is not eligible for a benefit, if the application is denied or benefits end; and

(iv) The effective date of redetermination and any outstanding information or verifications needed to complete a redetermination.

(c) Duration of authorization

(1) The power to act as an authorized representative is valid with AHS until:

(i) The individual modifies the authorization or notifies AHS, using one of the methods available for the submission of an application, as described in § 52.02(b)(2), that the representative is no longer authorized to act on their behalf;

(ii) The authorized representative informs AHS that they no longer are acting in such capacity; or

(iii) There is a change in the legal authority upon which the individual or organization's authority was based.

(2) Any notification described in (c)(1) of this subsection, except as stated in (c)(1)(i), must be in writing and should include the individual's or authorized representative's signature as appropriate.

(d) Duties of the authorized representative. The authorized representative:

(1) Is responsible for fulfilling all responsibilities encompassed within the scope of the authorized

representation, as described in paragraph (b) of this subsection, to the same extent as the individual they represent; and

(2) Must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding the individual provided.

(e) Condition of representation

(1) The authorized representative must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding the applicant or enrollee provided by AHS.

(2) When an organization is designated as an authorized representative, as a condition of serving, staff members or volunteers of that organization must sign an agreement that they will adhere to the regulations in § 4.08 (relating to confidentiality of information), federal regulations relating to the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf, as well as other relevant state and federal laws concerning conflicts of interest and confidentiality of information.

(f) Form of authorization. For purposes of this subsection, electronic, including telephonically recorded, signatures and handwritten signatures transmitted by facsimile or other electronic transmission will be accepted. Designations of authorized representatives will be accepted through all of the modalities described in § 52.02(b).

(g) Disclosures. The authorization form or the AHS call center representative (if the authorization is made over the telephone) shall advise that:

(1) The individual need not give permission to share information.

(2) If the individual decides not to give permission, that will not affect eligibility for, or enrollment in, benefits;

(3) If the individual does not give permission, the information will not be released unless the law otherwise allows it;

(4) AHS is not responsible for what an unrelated authorized representative does with the individual's information after it is shared pursuant to a valid authorization;

(5) The individual may change or stop this authorization at any time by notifying AHS by telephone or in writing. However, doing so will not affect previously shared information;

(6) If the individual does not change or stop the authorization, it will remain in effect as long as the individual (or household) continues to receive health-care benefits; and

(7) The individual will be provided with a copy of the authorization upon request.

(h) Minors and incapacitated adults.[94] If the individual is a minor or an incapacitated adult, no authorization is required; someone acting responsibly for the individual may assist in the application process or during a redetermination of eligibility. Such person may also sign the initial application on the applicant's behalf.

(i) Judicially-appointed legal guardian or representative.[95] Upon presentment of a valid document of appointment, a judicially-appointed legal guardian or representative may act on an individual's behalf.

5.03 Navigator program (10/01/2021, GCR 20-001)

(a) General requirements.[96] AHS conducts a Navigator program consistent with this subsection through which it awards grants to eligible entities to perform the functions of navigator organizations, and certifies individuals as Navigators. The functions of navigator organizations include providing assistance to individuals and employers with enrollment in Medicaid programs and qualified health plans.

(b) Standards.[97] AHS maintains and publicly disseminates:

(1) A set of standards, to be met by all entities and individuals to be awarded Navigator grants, designed to prevent, minimize, and mitigate any conflicts of interest, financial or otherwise, that may exist for an entity to be awarded a Navigator grant, and to ensure that all entities and individuals carrying out Navigator functions have appropriate integrity; and

(2) A set of training standards, to be met by all entities and individuals carrying out Navigator functions under the terms of a Navigator grant, to ensure expertise in:

(i) The needs of underserved and vulnerable populations;

(ii) Eligibility and enrollment rules and procedures;

(iii) Benefits rules and regulations governing all health-benefits programs and QHPs offered in the state;

(iv) The range of QHP options and health-benefits programs;

(v) The privacy and security standards applicable under § 4.08;

(vi) The process of filing eligibility appeals;

(vii) General concepts regarding exemptions from the requirement to maintain minimum essential coverage and from the individual shared responsibility payment, including the application process for

[94] 42 CFR § 435.907(a); 45 CFR § 155.20.

[95] From All Programs Rule 2014.

[96] 45 CFR § 155.210(a); 33 VSA § 1807.

[97] 45 CFR §§ 155.205(d) and 155.210(b).

exemptions, and IRS resources and exemptions;

(viii) The premium tax credit reconciliation process and IRS resources on this process;

(ix) Basic concepts and rights related to health coverage and how to use it; and

(x) Providing referrals to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice.

(c) Entities and individuals eligible to be a Navigator.[98] To receive a Navigator grant, an entity must:

(1) Be capable of carrying out at least those duties described in paragraph (f) of this subsection;

(2) Demonstrate to AHS that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be eligible for enrollment in a QHP;

(3) Meet any licensing, certification or other standards prescribed by the state or AHS;

(4) Not have a conflict of interest during the term as Navigator; and

(5) Comply with the privacy and security standards applicable under § 4.08.

(d) Prohibition on Navigator conduct.[99] A Navigator must not:

(1) Be a health insurance issuer or issuer of stop loss insurance;

(2) Be a subsidiary of a health insurance issuer or issuer of stop loss insurance;

(3) Be an association that includes members of, or lobbies on behalf of, the insurance industry;

(4) Receive any consideration directly or indirectly from any health insurance issuer or issuer of stop loss insurance in connection with the enrollment of any individuals or employees in a QHP or a non-QHP;

(5) Charge any applicant or enrollee, or request or receive any form of remuneration from or on behalf of an individual applicant or enrollee, for application or other assistance related to Navigator duties;

(6) Provide to an applicant or potential enrollee gifts of any value as an inducement for enrollment. The value of gifts provided to applicants and potential enrollees for purposes other than an inducement for enrollment must not exceed nominal value, either individually or in the aggregate, when provided to that individual during a single encounter. For purposes of this paragraph, the term gifts includes gift items, gift cards, cash cards, cash, and promotional items that market or promote the products or services of a third party, but does not include the reimbursement of legitimate expenses incurred by a consumer in an effort

[98] 45 CFR § 155.210(c).

[99] 45 CFR § 155.210(d).

to receive application assistance, such as, but not limited to, travel or postage expenses;

(7) Use AHS funds to purchase gifts or gift cards, or promotional items that market or promote the products or services of a third party, that would be provided to any applicant or potential enrollee;

(8) Solicit any individual for application or enrollment assistance by going door-to-door or through other unsolicited means of direct contact, including calling an individual to provide application or enrollment assistance without the individual initiating the contact, unless the individual has a pre-existing relationship with the individual Navigator or Navigator entity and other applicable state and federal laws are otherwise complied with. Outreach and education activities may be conducted by going door-to-door or through other unsolicited means of direct contact, including calling an individual; or

(9) Initiate any telephone call to an individual using an automatic telephone dialing system or an artificial or prerecorded voice, except in cases where the individual Navigator or Navigator entity has a relationship with the individual and so long as other applicable state and federal laws are otherwise complied with.

(e) Conflict-of-interest standards.[100] In addition to prohibited conduct in (d) of this subsection, the following standards apply to Navigators:

(1) All Navigator entities must submit to VHC a written attestation that the Navigator, including the Navigator's staff, complies with (d)(1).

(2) All Navigator entities must submit to VHC a written plan to remain free of conflicts of interest during the term as a Navigator.

(3) All Navigator entities, including the Navigator's staff, must provide information to consumers about the full range of QHP options and health-benefits programs for which they are eligible.

(4) All Navigator entities, including the Navigator's staff, must disclose to VHC and, in plain language, to each consumer who receives application assistance from the Navigator:

(i) Any lines of insurance business, not covered by the restrictions on participation and prohibitions on conduct in (d) of this subsection, which the Navigator intends to sell while carrying out the consumer assistance functions;

(ii) Any existing or anticipated financial, business, or contractual relationships with one or more health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance; and

(iii) For Navigator staff, any existing employment relationships, or any former employment relationships within the last 5 years, with any health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance, including any existing employment relationships between a spouse or domestic partner and any health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss

[100] 45 CFR § 155.215(a).

insurance.

(f) Duties of a Navigator.[101] An entity that serves as a Navigator must carry out at least the following duties:

(1) Maintain expertise in eligibility, enrollment, and program specifications and conduct public education activities to raise awareness about VHC;

(2) Conduct public education activities to raise awareness of the availability of qualified health benefit plans;

(3) Distribute information to health care professionals, community organizations, and others to facilitate the enrollment of individuals who are eligible for Medicaid, Dr. Dynasaur, VPharm, other public health-benefits programs, or QHP;

(4) Provide information and services in a fair, accurate and impartial manner, which includes providing information that assists individuals with submitting the eligibility application; clarifying the distinctions among health coverage options, including QHPs; and helping individuals make informed decisions during the health coverage selection process. Such information must acknowledge other health programs;

(5) Distribute fair and impartial information concerning enrollment in QHPs and concerning the availability of premium tax credits, premium reductions, and cost-sharing reductions;

(6) Facilitate selection of a QHP or public health-benefits program such as Medicaid, Dr. Dynasaur, or VPharm;

(7) Provide referrals to any applicable office of health insurance consumer assistance, health insurance ombudsman, or any other appropriate state agency or agencies, for any individual with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage;

(8) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by VHC, including individuals with limited English proficiency, and ensure accessibility and usability of Navigator tools and functions for individuals with disabilities in accordance with the Americans with Disabilities Act and § 504 of the Rehabilitation Act;

(9) Ensure that individuals:

(i) Are informed, prior to receiving assistance, of the functions and responsibilities of Navigators, including that Navigators are not acting as tax advisers or attorneys when providing assistance as Navigators and cannot provide tax or legal advice within their capacity as Navigators;

(ii) Provide authorization in a form and manner as determined by AHS prior to a Navigator's obtaining access to an individual's personally identifiable information, and that the Navigator maintains a record of the authorization provided in a form and manner as determined by AHS. AHS will establish

[101] 45 CFR § 155.210(e); 33 V.S.A. § 1807.

a reasonable retention period for maintaining these records; and

(iii) May revoke at any time the authorization provided to a Navigator.

(10) Maintain a physical presence in the service area, so that face-to-face assistance can be provided to applicants and enrollees.

(11) Provide targeted assistance to serve underserved or vulnerable populations, as identified by AHS.

(12) Provide information and assistance with the following topics:

(i) Understanding the process of filing eligibility appeals;

(ii) Understanding and applying for exemptions from the individual shared responsibility payment, understanding the availability of exemptions from the requirement to maintain minimum essential coverage and from the individual shared responsibility payment that are claimed through the tax filing process and how to claim them, and understanding the availability of IRS resources on this topic;

(iii) The premium tax credit reconciliation process, and understanding the availability of IRS resources on this process;

(iv) Understanding basic concepts and rights related to health coverage and how to use it; and

(v) Referrals to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice.

(g) Funding for Navigator grants Funding for navigator grants may not be from Federal funds received by the state to establish VHC.

5.04 Brokers (01/01/2018, GCR 17-043)

(a) General rule.[102] A broker may:

(1) Facilitate enrollment of an individual, employer, or employee in any QHP as soon as the QHP is offered;

(2) Subject to paragraphs (b) and (c) of this subsection, assist an individual in applying for a QHP with financial assistance; and

(3) Subject to paragraphs (b) and (c) of this subsection assist an employee or an employer in enrolling in any QHP.

(b) Agreement.[103] Prior to enrolling a qualified individual, employee, or employer in a QHP through VHC, or assisting an individual in applying for a QHP with financial assistance, a broker must have an executed

[102] 45 CFR § 155.220(a); 33 V.S.A. § 1805(17).

[103] 45 CFR § 155.220(d); 33 V.S.A. § 1805(17).

agreement with AHS, and must comply with the terms of that agreement, which includes at least the following requirements:

(1) Registering with AHS in advance of assisting a qualified individual, employee or employer, enrolling in QHPs through VHC;

(2) Receiving training in the range of QHP options and health-benefit programs;

(3) Complying with AHS's privacy and security standards adopted consistent with § 4.08; and

(4) Maintaining a physical presence in the service area, so that face-to-face assistance can be provided to applicants and enrollees.

(c) Payment mechanisms.[104] A broker who facilitates enrollment of an individual, employer, or employee in any QHP must comply with procedures, including payment mechanisms and standard fee or compensation schedules, established by AHS, that allow brokers to be appropriately compensated for assisting with the enrollment of qualified individuals and qualified employers in any QHP offered through VHC for which the individual or employer is eligible; and assisting a qualified individual in applying for financial assistance for a QHP purchased through VHC.

5.05 Certified application counselors[105] (01/01/2018, GCR 17-043)

(a) In general. AHS certifies staff and volunteers of state-partner organizations to act as application counselors, authorized to provide assistance to individuals with the application process and during renewal of eligibility.

(b) Certification

(1) Application counselors are certified by AHS to provide assistance at application and renewal with respect to one, some, or all of the permitted assistance activities, and enter into certification agreements with AHS.

(2) To be certified, application counselors must:

(i) Be authorized and registered by AHS to provide assistance at application and renewal;

(ii) Be effectively trained in the eligibility and benefits rules and regulations governing enrollment in a QHP and all health-benefits programs operated in Vermont;

(iii) Have successfully completed the required training and received a passing score on the certification examination;

(iv) Disclose to AHS and potential applicants any relationships the certified application counselor or sponsoring agency has with QHPs or insurance affordability programs, or other potential conflicts of

[104] 33 V.S.A. § 1805(17).

[105] 42 CFR § 435.908 (eff. 1/1/2014); 45 CFR § 155.225.

interest;

(v) Comply with AHS's privacy and security standards adopted consistent with § 4.08 and applicable authentication and data security standards;

(vi) Agree to act in the best interest of the applicants assisted;

(vii) Either directly or through an appropriate referral to the VHC call center, provide information in a manner that is accessible to individuals with disabilities, as defined by the Americans with Disabilities Act, as amended, 42 U.S.C. § 12101 *et seq.* and § 504 of the Rehabilitation Act, as amended, 29 USC § 794; and

(viii) Be recertified on at least an annual basis after successfully completing recertification training as required by AHS.

(c) Withdrawal of certification. AHS will establish procedures to withdraw certification from individual application counselors, or from all application counselors associated with a particular organization, when it finds noncompliance with the terms and conditions of the application counselor agreement.

(d) Duties. Certified application counselors are certified to:

(1) Provide information to individuals and employees about the full range of QHP options and health-benefits programs for which they are eligible, which includes providing fair, impartial and accurate information that assists individuals with submitting the eligibility application; clarifying the distinctions among health coverage options, including QHPs; and helping individuals make informed decisions during the health coverage selection process;

(2) Assist individuals and employees to apply for coverage in a QHP through VHC and for health-benefits programs; and

(3) Help to facilitate enrollment of eligible individuals in QHPs and health-benefits programs.

(e) Availability of information; authorization. AHS must establish procedures to ensure that:

(1) Individuals are informed, prior to receiving assistance, of the functions and responsibilities of certified application counselors, including that certified application counselors are not acting as tax advisers or attorneys when providing assistance as certified application counselors and cannot provide tax or legal advice within their capacity as certified application counselors;

(2) Individuals are able to provide authorization in a form and manner as determined by AHS prior to a certified application counselor obtaining access to personally identifiable information about the individual related to the individual's application for, or renewal of, health benefits, and that the organization or certified application counselor maintains a record of the authorization in a form and manner as determined by AHS. AHS will establish a reasonable retention period for maintaining these records;

(3) AHS does not disclose confidential individual information to an application counselor unless the individual has authorized the application counselor to receive such information; and

(4) Individuals may revoke at any time the authorization provided the certified application counselor.

(f) No charge for services. Application counselors may not:

(1) Impose any charge on individuals for application or other assistance related to VHC;

(2) Receive any consideration directly or indirectly from any health insurance issuer or issuer of stop-loss insurance in connection with the enrollment of any individual in a QHP or a non-QHP;

(3) Provide to an applicant or potential enrollee gifts of any value as inducement for enrollment. The value of gifts provided to applicants and potential enrollees for purposes other than as an inducement for enrollment must not exceed nominal value, either individually or in the aggregate, when provided to that individual during a single encounter. For purposes of this paragraph, the term gifts includes gift items, gift cards, cash cards, cash and promotional items that market or promote the products or services of a third party, but does not include the reimbursement of legitimate expenses incurred by a consumer in an effort to receive application assistance, such as, but not limited to, travel or postage expenses;

(4) Solicit any individual for application or enrollment assistance by going door-to-door or through other unsolicited means of direct contact, including calling an individual to provide application or enrollment assistance without the individual initiating the contact, unless the individual has a pre-existing relationship with the individual certified application counselor or designated organization and other applicable state and federal laws are otherwise complied with. Outreach and education activities may be conducted by going door-to-door or through other unsolicited means of direct contact, including calling an individual; or

(5) Initiate any telephone call to an individual using an automatic telephone dialing system or an artificial or prerecorded voice, except in cases where the individual certified application counselor or designated organization has a relationship with the individual and so long as other applicable state and federal laws are otherwise complied with.

(g) Non-discrimination and organizations receiving federal funds to provide services to defined populations.[106] Notwithstanding the non-discrimination provisions of § 5.01(g), an organization that receives federal funds to provide services to a defined population under the terms of federal legal authorities that participates in the certified application counselor program may limit its provision of certified application counselor services to the same defined population, but must comply with § 5.01(g) with respect to the provision of certified application counselor services to that defined population, If the organization limits its provision of certified application counselor services pursuant to this exception, but is approached for certified application counselor services by an individual who is not included in the defined population that the organization serves, the organization must refer the individual to other AHS-approved resources that can provide assistance. If the organization does not limit its provision of certified application counselor services pursuant to this exception, the organization must comply with § 5.01(g).

[106] 45 CFR § 155.120(c)(2).

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Table of Contents

Part One
General Provisions and Definitions

1.00 Administration of health benefits (01/15/2017, GCR 16-094)

The Agency of Human Services (AHS) was created in 1969 to serve as the umbrella organization for all human-service activities within state government. It is the Single State Agency for Medicaid purposes and the adopting authority for this rule.

2.00 General description of health benefits in Vermont (subject to specific criteria in subsequent sections) (10/01/2021, GCR 20-001)

2.01 Types of health benefits (01/15/2017, GCR 16-094)

(a) In general. The state offers several types of health benefits, including:

- Medicaid;
- Children's Health Insurance Program (CHIP);
- Enrollment in a Qualified Health Plan (QHP) with financial assistance.

The benefits for which a person is eligible is determined based on the individual's income, resources (in specified cases), and circumstances as covered in succeeding sections.

(b) Benefit choice. Except as may be otherwise restricted, an individual may select the particular health benefit or benefits that they wish to be considered for. In the absence of such a selection, AHS will determine an individual's eligibility for the most advantageous benefit that they qualify for.

(c) Redetermination of eligibility. If an individual becomes ineligible for one benefit, AHS will determine eligibility for the next most advantageous benefit that they then qualify for.

2.02 Medicaid (10/01/2021, GCR 20-001)

(a) Overview of the Medicaid Program. The Medicaid program is authorized in Title XIX of the Social Security Act (the Act).

(b) Medicaid eligibility. Vermont provides Medicaid to those who meet the requirements of one of three eligibility groups:

- Mandatory categorically needy;
- Optional categorically needy; and
- Medically needy.

To be eligible for federal funds, states are required to provide Medicaid coverage for certain groups of individuals. These groups--the mandatory categorically needy--derive from the historic ties to programs that provided federally-assisted income-maintenance payments (*e.g.*, SSI and Aid to Families with Dependent Children). States are also required to provide Medicaid to related groups not receiving cash payments.

States also have the option of providing Medicaid coverage for other "categorically related" groups. These optional groups share characteristics of the mandatory groups (that is, they fall within defined categories), but the eligibility criteria are somewhat more liberally defined.

The medically-needy option allows states to extend Medicaid eligibility to additional groups of people. These individuals would be eligible for Medicaid under one of the mandatory or optional groups, except that they do not meet the income or resource standards for those groups. Individuals may qualify immediately or may "spend down" by incurring medical expenses greater than the amount by which their income or resources exceed their state's medically-needy standards.[1]

(c) Vermont's Medicaid Program.[2] The Vermont Medicaid program covers all mandatory categories of enrollees. It also offers all mandatory services—general hospital inpatient; outpatient hospital and rural health clinics; other laboratory and x-ray; nursing facility, Early Periodic Screening, Diagnosis and Treatment (EPSDT), and family planning services and supplies; physician's services and medical and surgical services of a dentist; home health services; and nurse-midwife and nurse practitioner services.[3] Vermont includes certain, but not all, optional categories of enrollees. Vermont has also elected to cover certain, but not all, optional services for which federal financial participation is available. It also operates health care programs permitted by research demonstration waiver authority under § 1115 of the Social Security Act.

Vermont is authorized to establish reasonable standards, consistent with the objectives of the Medicaid statute, for determining the extent of coverage in the optional categories[4] based on such criteria as medical necessity or utilization control.[5] In establishing such standards for coverage, Vermont ensures that the amount, duration, and scope of coverage are reasonably sufficient to achieve the purpose of the service.[6] Vermont may not limit services based upon diagnosis, type of illness, or condition.[7]

2.03 Children's Health Insurance Program (CHIP) (01/01/2018, GCR 17-043)

(a) In general. CHIP (known from its inception until March 2009 as the State Children's Health Insurance Program, or SCHIP) is authorized by Title XXI of the Social Security Act.

(b) Vermont CHIP. Vermont utilizes CHIP to provide health coverage to uninsured children with household incomes above 237% and at or below 312% of the federal poverty level (FPL). CHIP is part of the coverage

[1] In Vermont, the Medically Needy Income Level is known as the "Protected Income Level," or "PIL."

[2] Former Medicaid Rule 4100.

[3] For rules that govern Medicaid covered services, refer to Health Care Administrative Rules (HCAR).

[4] 42 USC § 1396a(a)(17).

[5] 42 CFR § 440.230(d).

[6] 42 CFR § 440.230(b).

[7] 42 CFR § 440.230(c).

array known as "Dr. Dynasaur." All of the provisions in this rule that apply to the "child" Medicaid coverage group (§ 7.03(a)(3)) apply with equal effect to an individual who is enrolled in CHIP.

2.04 The Health Benefits Exchange (01/15/2019, GCR 18-060)

(a) In general. Vermont has elected to establish and operate its own Exchange. Vermont Act No. 48 of 2011, "An act relating to a universal and unified health system," established the Vermont health benefit exchange (Vermont Health Connect, VHC). The purpose of VHC is to facilitate the purchase of affordable, qualified health benefit plans by individuals, and small employers in the merged individual and small group markets; and later in the large group market in Vermont in order to reduce the number of uninsured and underinsured; to reduce disruption when individuals lose employer-based insurance; to reduce administrative costs in the insurance market; to contain costs; to promote health, prevention, and healthy lifestyles by individuals; and to improve quality of health care.

Qualified health plans (QHPs) must provide a comprehensive set of services (essential health benefits), meet specific standards for actuarial value and the limitation of cost-sharing.

Additionally, catastrophic plans are available to certain individuals.

The state will certify health plans offered through VHC on an annual basis.

(b) Financial assistance through VHC. Eligible individuals who purchase insurance through VHC may receive federal premium tax credits and Vermont premium reductions. Some also qualify for federal and Vermont cost-sharing reductions (CSR).

Federal premium tax credits are available to eligible individuals and families with incomes up to 400 percent of the FPL to purchase insurance through VHC.[8]

The state will supplement the federal premium tax credits with premium reductions for individuals and families with income at or below 300% of the federal poverty level.

In addition to premium subsidies, eligible individuals receive federal and state CSRs for silver level plans (see level of coverage in § 3.00) and in other limited circumstances. These subsidies reduce the cost-sharing amounts and annual cost-sharing limits and have the effect of increasing the actuarial value of the plan.

Modified adjusted gross income (MAGI) is used to determine eligibility for federal and state premium subsidies and CSRs. In order to be eligible for federal CSR, state premium reductions and state CSR, the individual must be eligible for federal premium tax credits.[9]

(c) Administrative Requirements. Federal health-care regulations contain a number of provisions aimed at the administration of the health-benefits eligibility-determination process. These provisions are intended to

[8] 26 CFR 1.36B-2.

[9] See 26 CFR § 1.36B-2.

promote administratively-efficient, streamlined, and coordinated eligibility business processes.

2.05 Administration of eligibility for health benefits (01/15/2017, GCR 16-094)

(a) AHS administers eligibility for the state's health-benefits programs and for enrollment in a QHP in accordance with applicable provisions of federal and state law and regulations.

(b) The eligibility determination process is administered such that:[10]

(1) Individual dignity and self-respect are maintained;

(2) The constitutional and other legal rights of individuals are respected;

(3) Practices do not violate the individual's privacy or dignity or harass the individual in any way;

(4) Disclosure of information concerning applicants or enrollees is limited to purposes directly connected with the administration of the applicable health-benefits program or with enrollment in a QHP or as otherwise required by law;

(5) Each individual who wishes to do so is given an opportunity to apply or reapply for benefits without delay;

(6) Prompt action is taken on each application and reapplication and individuals are notified in writing of the decision on the application;

(7) Decisions are based on recorded information showing either that all pertinent eligibility requirements are met or that one or more requirements are not met;

(8) Benefits are given promptly and continue regularly to all eligible individuals until they are found to be ineligible;

(9) Eligibility is redetermined when circumstances change or at the time of renewal, in accordance with the same principles as initial application;

(10) Individuals are the primary sources of information about their eligibility;

(11) Individuals are informed of their responsibility to furnish complete and accurate information, including prompt notification of changes affecting their eligibility or amount of aid or benefits, and of the penalties for willful misrepresentation to obtain benefits to which they are not entitled;

(12) Individuals are helped to obtain needed information; and

(13) Verification of conditions of eligibility are limited to what is reasonably necessary to assure that expenditures under a health-benefits program are legal, in accordance with federal and state law and

[10] Derived from ESD All Programs Rule 2000.

regulations.

(c) Application of these principles in specific areas is covered in succeeding sections.

3.00 Definitions (01/01/2023, GCR 22-029)

As used in this rule, the following terms have the following meanings:

Adjusted monthly premium.[11] The premium an insurer charges for the applicable benchmark plan (ABP) to cover all members of the tax filer's coverage family.

Advance payment of the premium tax credit (APTC).[12] The payment of premium tax credits specified in section 36B of the Internal Revenue Code that are provided on an advance basis on behalf of an eligible individual enrolled in a QHP through VHC and paid directly to the QHP issuer.

Affordable Care Act (ACA).[13] The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), as amended by the Three Percent Withholding Repeal and Job Creation Act (Pub. L. 112-56).

Aid to the Aged, Blind, or Disabled (AABD).[14] Vermont's supplemental security income (SSI) state supplement program.

Alternate reporter. A person who is authorized to receive either original notifications or copies of such notifications on behalf of an individual. (See, § 5.02(b)(1)(iv)).

Annual open enrollment period (AOEP).[15] The period each year during which a qualified individual may enroll or change coverage in a QHP.

Applicable benchmark plan (ABP).[16] As defined in § 60.06, the second-lowest-cost silver plan offered through VHC.

Applicant[17]

(a) An individual seeking eligibility for health benefits for themselves through an application submission.

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[11] 26 CFR § 1.36B-3(e).

[12] 42 CFR § 435.4; 45 CFR § 155.20; § 36B of the Code (as added by § 1401 of the ACA); 3 VSA § 1812.

[13] 26 CFR § 1.36B-1(j); 42 CFR § 435.4; 45 CFR § 155.20.

[14] 33 VSA § 1301 et seq.; AABD Rule 2700 et seq.

[15] 45 CFR § 155.20.

[16] 26 CFR § 1.36B-3(f).

[17] 42 CFR § 435.4; 45 CFR §§ 155.20 and 156.20.

(b) An employer or employee seeking eligibility for enrollment in a QHP, where applicable.

Application.[18] A single, streamlined application for health benefits, submitted by or on behalf of an applicant. For determining eligibility on a basis other than the applicable MAGI standard, the single, streamlined application may be supplemented with form(s) to collect additional information needed, or an appropriate alternative application may be used.

Application date

(a) The day the application is received by AHS, if it is received on a business day; or

(b) The first business day after the application is received, if it is received on a day other than a business day.

If an application is supplemented with form(s) to collect additional information, including the use of an alternative application, the application date is the date the initial application is received by AHS.

Application filer[19]

(a) Applicant;

(b) Adult who is in the applicant's household;

(c) Authorized representative; or

(d) If the applicant is a minor or incapacitated, someone acting responsibly for the applicant.

Approve. To determine that an individual is eligible for health benefits.

Approval month. The month in which the individual's eligibility is approved.

Authorized representative. 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. See, § 5.02.

Benefit year (or taxable year).[20] A calendar year for which a health plan provides coverage for health benefits.

Broker.[21] A person or entity licensed by the state as a broker or insurance producer.

[18] 42 CFR § 435.4; 45 CFR § 155.410(a).

[19] 42 CFR § 435.907; 45 CFR § 155.20.

[20] 45 CFR §§ 155.20 and 156.20. The Treasury regulations employ the term "taxable year." The Internal Revenue Code defines the "benefit year" as "the calendar year, or the fiscal year ending during such calendar year, upon the basis of which the taxable income is computed under subtitle A. . . ." 26 USC § 7701(a)(23). For most individuals, the benefit year is the calendar year, and thus, synonymous with the Exchange regulation's definition of "benefit year."

[21] 45 CFR § 155.20.

Business day. Any day during which state offices are open to serve the public.

Cancel. To determine that an applicant who was approved for health benefits but not yet enrolled is no longer eligible for health benefits.

Caretaker relative[22]

(a) A relative of a dependent child (as defined in this § 3.00) by blood, adoption, or marriage, with whom the dependent child is living, who assumes primary responsibility for the dependent child's care (as may, but is not required to, be indicated by claiming the dependent child as a tax dependent for Federal income tax purposes).

(b) As used in this definition, a "relative" is the child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece. The term relative includes:

(1) An individual connected to the dependent child by blood, including half-blood;

(2) An individual of preceding generations denoted by grand, great, or great-great;

(3) The spouses or civil-union partners of such relatives, even after the marriage or union is terminated by death or dissolution; and

(4) An adult not related to the dependent child by blood, adoption, or marriage, but who lives with the dependent child and has primary responsibility for the dependent child's care.

Case file. The permanent collection of documents and information required to determine eligibility and to provide benefits to individuals.

Categorically needy.[23] Families and children; aged, blind, or disabled individuals; and pregnant women, described under subparts B and C of 42 CFR part 435 who are eligible for Medicaid. Subpart B describes the mandatory eligibility groups who, generally, are receiving or are deemed to be receiving cash assistance under the Act. These mandatory groups are specified in §§ 1902(a)(10)(A)(i),1902(e),1902(f), and 1928 of the Act. Subpart C describes the optional eligibility groups of individuals who, generally, meet the categorical requirements or income or resource requirements that are the same as or less restrictive than those of the cash assistance programs and who are not receiving cash payments. These optional groups are specified in §§ 1902(a)(10)(A)(ii),1902(e), and 1902(f) of the Act.

Catastrophic plan.[24] A health plan available to an individual up to age 30 or to an individual who is exempt from the mandate to purchase coverage that:

(a) Meets all applicable requirements for health insurance coverage in the individual market and is offered only in

[22] 42 CFR § 435.4; former Medicaid ANFC Rule 4343.

[23] 42 CFR § 435.4.

[24] 45 CFR § 156.155

the individual market;

(b) Does not provide a bronze, silver, gold, or platinum level of coverage; and

(c) Provides coverage of essential health benefits once the annual limitation on cost sharing is reached, with the following exceptions:

(1) A catastrophic plan must provide coverage for at least three primary-care visits per year before reaching the deductible.

(2) A catastrophic plan may not impose any cost-sharing requirements for preventive services, in accordance with § 2713 of the Public Health Service Act.

Certified application counselors. Staff and volunteers of organizations who are authorized and registered by AHS to provide assistance to individuals with the application process and during renewal of eligibility. See, § 5.05

Close. To determine that an enrollee is no longer eligible to receive health benefits.

Code. Internal Revenue Code.

Community spouse (CS). For purposes of Medicaid, the spouse of an institutionalized individual who is not living in a medical institution or a nursing facility. An individual is considered a community spouse even when receiving Medicaid coverage of long-term care services and supports in a home and community-based setting if they are the spouse of an individual who is also receiving Medicaid coverage of long-term care services and supports.

Cost sharing.[25] Any expenditure required by or on behalf of an individual with respect to essential health benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance-billing amounts for non-network providers, and spending for non-covered services.

Cost-sharing reductions (CSR).[26] Reductions in cost sharing for an individual who is enrolled in a silver-level QHP or for an individual who is an Indian enrolled in a QHP.

Couple. Two individuals who are married to each other or are parties to a civil union, according to the laws of the State of Vermont, except, for purposes of APTC/CSR, two individuals who are married to each other within the meaning of 26 CFR § 1.7703-1. IRS's regulations do not recognize parties to civil unions as married couples. Couples in civil unions are not permitted to file joint federal tax returns, but may qualify for APTC/CSR by filing separate tax returns.

Coverage. The scope of health benefits provided to an individual.

Coverage date. The date coverage begins.

[25] 45 CFR §§ 155.20 and 156.20.

[26] 45 CFR §§ 155.20 and 156.20; 33 VSA § 1812.

Coverage family.[27] See, § 60.02(b).

Coverage group.[28] Category of Medicaid eligibility, defined by particular categorical, financial, and nonfinancial criteria.

Coverage island. A discrete period of Medicaid coverage that is available in certain defined circumstances. See, § 70.02(d).

Coverage month.[29] A month for which, as of the first day of the month:

(a) An individual is receiving coverage;

(b) If a premium is charged for coverage, the individual's premium is paid in full or, if the individual is enrolled in a QHP with APTC, the individual is in the first month of a premium grace period (see § 64.06(a)(1) for a description of the grace period for an individual enrolled in a QHP with APTC); and

(c) If the individual is enrolled in a QHP with APTC, the individual is not eligible for Minimum Essential Coverage (MEC) other than coverage in the individual market, as referenced in § 5000A(f)(1)(C) of the Code.

Date of application. See, application date.

Day. A calendar day unless a business day is specified.

Deny. To determine that an applicant is ineligible for health benefits.

Dependent child.[30] An individual who is:

(a) Under the age of 18; or

(b) Age 18 and a full-time student in secondary school (or equivalent vocational or technical training), if before attaining age 19 the child may reasonably be expected to complete such school or training.

Disability[31]

(a) Individual age 18 and older. An individual age 18 and older is considered disabled if they are unable to engage in any substantial gainful activity because of any medically-determinable physical or mental impairment, or combination of impairments, that can be expected to result in death, or has lasted or can be expected to last for a continuous period of not fewer than 12 months. To meet this definition, an individual must have a severe

[27] 26 CFR § 1.36B-3(b)(1).

[28] 42 CFR § 435.10(b).

[29] 26 CFR § 1.36B-3(c).

[30] 42 CFR § 435.4.

[31] Former Medicaid SSI Rule 4213.

impairment, which makes them unable to do their previous work or any other substantial gainful activity that exists in the national economy. To determine whether an individual is able to do any other work, AHS considers their residual functional capacity, age, education, and work experience.

(b) Individual under age 18. An individual under age 18 is considered disabled if they have a medically-determinable physical or mental impairment, or combination of impairments, resulting in marked and severe functional limitations, that can be expected to result in death or that have lasted or can be expected to last for at least 12 consecutive months. An individual under age 18 who engages in substantial gainful activity may not be considered disabled.

Disenroll. To end coverage.

Dr. Dynasaur. The collection of programs that provide health benefits to children under age 19 in the group defined in § 7.03(a)(3) and pregnant women in the group defined in § 7.03(a)(2).

Electronic account.[32] An electronic file that includes all information collected and generated by the state regarding each individual's health-benefits eligibility and enrollment, including all documentation required under § 4.04 and including information collected or generated as part of a fair hearing process conducted with regard to health-benefits eligibility and enrollment.

Eligible. The status of an individual determined to meet all financial and nonfinancial qualifications for health benefits.

Eligible employer-sponsored plan[33]

(a) With respect to an employee, a group health plan or group health insurance coverage offered by an employer to the employee which is:

(1) A governmental plan (within the meaning of § 2791(d)(8) of the Public Health Service (PHS) Act); or

(2) Any other plan or coverage offered in the small or large group market within a state.

(b) This term also includes a grandfathered health plan[34] offered in a group market.

Eligibility determination.[35] An approval or denial of eligibility as well as a renewal or termination of eligibility.

Eligibility process. Activities conducted for the purposes of determining, redetermining, and maintaining the eligibility of an individual.

[32] 42 CFR §§ 435.4 and 435.914.

[33] 26 CFR § 1.36-2(c)(3)(i); 26 USC § 5000A(f)(2).

[34] 26 USC § 5000A(f)(1)(D).

[35] 42 CFR § 435.4. *See also,* 42 CFR §§ 435.911 and 435.916; 45 CFR § 155.302.

Employer contributions.[36] Any financial contributions toward an employer-sponsored health plan, or other eligible employer-sponsored benefit made by the employer including those made by salary reduction agreement that is excluded from gross income.

Enroll. To initiate coverage for an approved individual.

Enrollee.[37] An individual who has been approved and is currently receiving health benefits. The term "enrollee" includes the term "beneficiary,' which is an individual who has been determined eligible for, and is currently receiving, Medicaid.

Exchange (Vermont Health Connect (VHC)).[38] A state-managed entity through which individuals, qualified employees, and small businesses can compare, shop for, purchase, and enroll in QHPs; and individuals can apply for and enroll in health-benefits programs. In Vermont, the Exchange is known as Vermont Health Connect (VHC).

Exchange service area.[39] The area in which the Exchange (in Vermont, VHC) is certified to operate.

Family coverage.[40] Health insurance that covers more than one individual and provides coverage for essential health benefits.

Family size. See, § 28.02(a).

Federal poverty level (FPL).[41] 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 budget period used to determine an individual's income eligibility for means-tested health benefits.

[36] 45 CFR § 155.20.

[37] 42 CFR § 435.4.

[38] 26 CFR § 1.36B-1(k); 45 CFR § 155.20. There will be a single "service area" in Vermont, for both Medicaid and QHP enrollment.

[39] 45 CFR § 155.20.

[40] 26 CFR § 1.36B-1(m).

[41] 26 CFR § 1.36B-1(h); 42 CFR § 435.4; 45 CFR § 155.410. The Treasury regulations uses the term "FPL" to describe this indicator: "FPL. The FPL means the most recently published poverty guidelines (updated periodically in the Federal Register by the Secretary of Health and Human Services under the authority of 42 USC § 9902(2)) as of the first day of the regular enrollment period for coverage by a QHP offered through an Exchange for a calendar year. Thus, the FPL for computing the premium tax credit for a benefit year is the FPL in effect on the first day of the initial or annual open enrollment period preceding that benefit year. See 45 CFR 155.410." 26 CFR § 1.36B-1(h). For the sake of consistency, AHS has adopted HHS's term for this concept, and uses it throughout this rule.

Financial responsibility group. For purposes of MABD, the individuals whose income or resources are considered when determining eligibility for a Medicaid group (defined below). See § 29.03 for rules on the formation of the financial responsibility group for MABD eligibility purposes.

Grace period. The period of time during which an enrollee who has failed to pay all outstanding premiums remains enrolled in coverage, with or without pended claims.

Grandfathered health plan coverage.[42] Coverage provided by a group health plan, or a group or individual health insurance issuer, in which an individual was enrolled on March 23, 2010 (for as long as it maintains that status under federal criteria).

Group health plan.[43] An employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees (including both current and former employees) or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

Health-benefits program.[44] A program that is one of the following:

(a) A state Medicaid program under Title XIX of the Act.

(b) A state children's health insurance program (CHIP) under Title XXI of the Act.

(c) A program that makes available coverage in QHPs with financial assistance.

Health benefits. Any health-related program or benefit, administered or regulated by the state, including, but not limited to, QHPs, APTC, premium reductions, federal or state CSR, and Medicaid.

Health insurance coverage.[45] Benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage and individual health insurance coverage.

Health insurance issuer or issuer.[46] An insurance company, nonprofit hospital and medical service corporation, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a state and that is subject to state law that regulates insurance (within the meaning of section 514(b)(2) of ERISA).

[42] 45 CFR § 155.20; 45 CFR § 147.140.

[43] 45 CFR §§ 155.20 and 156.20; 45 CFR § 144.103; 45 CFR § 146.145(a).

[44] This term includes the programs referred to as "insurance affordability programs" in federal regulations. See, 42 CFR § 435.4; 45 CFR § 155.300.

[45] 45 CFR § 155.20; 45 CFR § 144.103.

[46] 45 CFR §§ 155.20 and 156.20; 45 CFR § 144.103; 18 VSA § 9402(8).

Health plan.[47] This term has the meaning given in § 1301(b)(1) of the ACA. That section incorporates the definition found in § 2791(a) of the Public Health Service Act.

Human Services Board. AHS's fair hearings entity for eligibility issues. See, § 80.01.

Indian.[48] A person who is a member of an Indian tribe.

Indian tribe.[49] Any Indian tribe, band, nation or other organized group, or community, including pueblos, rancherias, colonies and any Alaska Native Village, or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act, which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

Individual. An applicant or enrollee for health benefits.

Institution.[50] An establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more individuals unrelated to the proprietor.

Institutionalized individual. A person requesting Medicaid coverage of long-term care services and supports, whether the care is received in a home and community-based setting or in an institution licensed by AHS.

Institutionalized spouse (IS). For purposes of Medicaid, an institutionalized individual whose spouse qualifies as a community spouse.

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

Lawfully present. See, § 17.01(g).

Level of coverage.[51] One of four standardized actuarial values for plan coverage as defined by § 1302(d)(1) of the ACA: bronze, silver, gold or platinum.

Limited English proficiency. 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.

[47] 45 CFR § 155.20.

[48] 25 CFR § 900.6.

[49] 25 CFR § 900.6.

[50] 42 CFR § 435.1010. This is the definition referred to in 42 CFR § 435.403(b) and 45 CFR § 155.305(a)(3). "Assisted living" is considered a community setting and not a medical institution or nursing facility because assisted living does not include 24-hour care, has privacy, a lockable door, and is a homelike setting. Former PP&D to Former Medicaid Rule 4201.

[51] 45 CFR § 156.20; § 1302(d)(2) of the ACA.

Long-term care. Highest-need and high-need care, as determined by AHS, received by an individual living in a nursing facility, rehabilitation center, intermediate-care facility for the developmentally disabled (ICF-DD), and other medical facility for at least 30 consecutive days. It also includes care received by an individual in a home and community-based setting as specified in relevant waiver authorizations and any related program regulations.

For more information on Vermont's waiver governing terms and conditions, see: http://dvha.vermont.gov/administration.

Long-term care services and supports.[52] A range of medical, personal, and social services that can help an individual with functional limitations live their life more independently. Supports range from daily living (e.g. grocery shopping and food preparation) to 24-hour medical care provided in nursing facilities. Examples of long-term care services and supports include nursing facility services; a level of care in any institution equivalent to nursing facility services; home and community-based services to qualifying individuals as specified in relevant waiver authorizations or in any related program regulations, to include:

(a) Home-based and enhanced residential care services for the aged and disabled (known as "Choices for Care");

(b) Traumatic brain injury services (TBI);

(c) Home and community-based waiver services for the developmentally disabled (DS); and

(d) Children's mental health services.

For more information on Vermont's waiver governing terms and conditions, see: http://dvha.vermont.gov/administration. See, also, DVHA's Medicaid Covered Services Rule 7601.

MAGI-based income.[53] See, § 28.03(c).

Medicaid for Children and Adults (MCA). The health-benefits program available to a member of a Medicaid coverage group for parents and other caretaker relatives, children, pregnant women, or adults under 65 years of age.

Medicaid for the Aged, Blind, and Disabled (MABD). The health-benefits program available to a member of a Medicaid coverage group for people who are aged, blind, or disabled. MABD is based on the requirements for two financial assistance programs federally administered by the Social Security Administration: the supplemental security income program (SSI) and aid to the aged, blind, and disabled program (AABD).

Medicaid group. Individuals who are considered in the financial-eligibility determination for MABD. The countable income and resources of the financial responsibility group are compared against the income and resource standards applicable to the Medicaid group's size. See § 29.04 for rules on the formation of the Medicaid group.

[52] 42 CFR § 435.603(j)(4).

[53] 42 CFR §§ 435.4 and 435.603(e).

Medicaid services.[54] Medical benefits funded through Medicaid as specified in related program rules and waiver authorizations.

Medical incapacity. See, § 64.09.

Medical institution.[55] An institution that:

(a) Is organized to provide medical care, including nursing and convalescent care;

(b) Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing and other health needs of patients on a continuing basis and in accordance with accepted standards;

(c) Is authorized under state law to provide medical care; and

(d) Is staffed by professional personnel who are responsible to the institution for professional medical and nursing services. The services must include adequate and continual medical care and supervision by a physician; registered nurse or licensed practical nurse supervision and services and nurses' aid services, sufficient to meet nursing care needs; and a physician's guidance on the professional aspects of operating the institution.

Medically needy.[56] Families; children; individuals who are aged, blind, or disabled; and pregnant women who are not categorically needy but who may be eligible for Medicaid because their income and, for individuals who are aged, blind or disabled, their resources are within limits set by the state under its Medicaid plan (including persons whose income and, if applicable, resources fall within these limits after their incurred expenses for medical or remedial care are deducted).

Minimum essential coverage (MEC).[57] 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. See, § 23.00.

Minimum value.[58] When used to describe coverage in an eligible employer-sponsored plan, minimum value means that the percentage of the total allowed costs of benefits provided under the plan is greater than or equal to 60 percent, and the benefits under the plan include substantial coverage of inpatient hospital services and physician services.

Modified adjusted gross income (MAGI). See, § 28.00.

[54] *See,* Health Care Administrative Rules (HCAR) and Global Commitment to Health Section 1115 Waiver.

[55] 42 CFR § 435.1010.

[56] 42 CFR § 435.4.

[57] 42 CFR § 435.4; 45 CFR § 155.20.

[58] 45 CFR § 155.300; 45 CFR § 156.145; 26 CFR §§ 1.36B-2(c)(3)(vi) and 1.36B-6.

Navigator.[59] An entity or individual selected by AHS and awarded a grant to provide assistance to individuals and employers with enrollment in Medicaid programs and qualified health plans, and to engage in the activities and meet the standards described in § 5.03.

Non-applicant.[60] A person who is not seeking an eligibility determination for himself or herself and is included in an applicant's or enrollee's household to determine eligibility for such applicant or enrollee.

Nonpayment. Failure to pay any or all of a premium due.

OASDI.[61] Old age, survivors, and disability insurance under Title II of the Act.

Optional state supplement.[62] A cash payment made by a state, under § 1616 of the Act, to an aged, blind, or disabled individual. *See*, AABD.

Patient share. See, § 24.00.

Physician's certificate. See, § 64.09.

Plan year.[63] A consecutive 12-month period during which a health plan provides coverage. For plan years beginning on January 1, 2015, a plan year must be a calendar year.

Plain language.[64] Language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing.

Pregnant woman.[65] A woman during pregnancy and the post partum period, which begins on the date the pregnancy ends and extends as follows:

(a) Effective April 1, 2023

Effective April 1, 2023, the post partum period extends 12 months, and then ends on the last day of the month in which the 12-month period ends.

[59] 45 CFR § 155.20; 33 VSA § 1807.

[60] 42 CFR § 435.4.

[61] 42 CFR § 435.4.

[62] 42 CFR § 435.4.

[63] 45 CFR §§ 155.20 and 156.20.

[64] 45 CFR § 155.20. Incorporates meaning of this term given in § 1311(e)(3)(B) of the ACA.

[65] 42 CFR § 435.4.

(b) Through March 31, 2023

Through March 31, 2023, the post partum period extends 60 days, and then ends on the last day of the month in which the 60-day period ends, unless the woman is still enrolled in Medicaid on April 1, 2023 and is pregnant or within 12 months of the end of a pregnancy on that date. In the latter situation, the 12-month post partum period described in (a) above applies.

Premium

(a) In general. A monthly charge that must be paid by an individual in order to receive health benefits.

(b) Initial premium. The premium for the first month of coverage.

(c) Ongoing premium. The premium for successive months of coverage, which are billed and due on a monthly basis.

Premium due date. The day on which a health-benefits premium is due.

Premium Reduction. State subsidy paid directly to the QHP issuer to reduce monthly premiums for an eligible individual enrolled in a QHP through VHC.

Private facility.[66] Any home privately owned and operated, or any home or institution supported by private or charitable funds, over which neither the state nor any of its subdivisions has supervision or control even though individuals may be boarded or cared for therein at public expense. Vermont private institutions include boarding homes, fraternal homes, religious homes, community care homes, residential care facilities, medical facilities (i.e. general hospitals) and nursing facilities licensed by the State of Vermont.

Protected Income Level (PIL). The income standard for the medically-needy Medicaid coverage groups.

Public Institution.[67] Any institution meeting all of the following conditions:

(a) The institution is owned, maintained, or operated in whole or in part by public funds;

(b) Control is exercised, in whole or in part, by any public agency or an official or employee of that agency; and

(c) The institution furnishes shelter and care and can be termed a public institution by reason of its origin, charter, ownership, maintenance or supervision.

Qualified Health Plan (QHP). A health plan certified by Vermont's Department of Financial Regulation (DFR) and offered by Vermont Health Connect.[68]

[66] Former Medicaid rules 4218.2 and 4332.2.

[67] Former Medicaid rules 4218.1 and 4332.1.

[68] 45 CFR §§ 155.20 and 156.20. 26 CFR § 1.36B-1(c) defines the term as follows: "QHP. The term QHP has the same meaning as in section 1301(a) of the ACA (42 USC § 18021(a)) but does not include a catastrophic plan described in

QHP issuer.[69] A health insurance issuer that offers a QHP in accordance with a certification from DFR.

Qualified individual.[70] For purposes of QHP, an individual who has been determined eligible by AHS to enroll in a QHP.

Qualifying coverage in an employer-sponsored plan.[71] Coverage in an eligible employer-sponsored plan that meets the affordability and minimum-value standards specified in 26 CFR § 1.36B-2(c)(3), and described in §§ 23.02 (affordable) and 23.03 (minimum value).

Quality control (QC). A system of continuing review to measure the accuracy of eligibility decisions. Also, the name of the AHS unit that is responsible for administering quality-control functions.

Reasonable compatibility. See, § 57.00(a).

Reenroll. To restore coverage after closure.

Reinstate. To restore eligibility after cancellation or closure.

Renew. To redetermine eligibility at a specified periodic interval (*e.g.*, annual renewal of eligibility).

Secure electronic interface.[72] An interface that allows for the exchange of data between information technology systems and adheres to the requirements in subpart C of 42 CFR part 433.

Self-only coverage.[73] Health insurance that covers one individual and provides coverage for essential health benefits.

Special enrollment period (SEP).[74] A period during which a qualified individual or enrollee who experiences certain qualifying events may enroll in, or change enrollment in, a QHP outside of AOEPs.

Spouse. A husband, a wife or a party to a civil union according to the laws of the State of Vermont, except, for purposes of APTC/CSR, a husband or a wife if married within the meaning of 26 CFR § 1.7703-1. IRS's regulations do not recognize parties to civil unions as "spouses." Parties to civil unions are not permitted to file joint federal tax returns, but may qualify for APTC/CSR by filing separate tax returns.

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section 1302(e) of the ACA (42 USC § 18022(e)."

[69] 45 CFR §§ 155.20 and 156.20.

[70] 45 CFR §§ 155.20 and 156.20.

[71] 45 CFR § 155.300.

[72] 42 CFR § 435.4.

[73] 26 CFR § 1.36B-1(l).

[74] 45 CFR § 155.20.

SSI. Supplemental security income program under Title XVI of the Act.

Substantial gainful activity

(a) Work activity that is both substantial and gainful, defined as follows:

(1) Substantial work activity involves doing significant physical or mental activities. Work may be substantial even if it is done on a part-time basis or if individuals do less, get paid less or have less responsibility than when they worked before.

(2) Gainful work activity is the kind of work done for pay or profit whether or not a profit is realized.

(b) Individuals who are working with disabilities shall be exempt from the substantial gainful activity (SGA) step of the sequential evaluation of the disability determination if they otherwise meet the requirements set forth in § 8.05 for the categorically needy working disabled.

Tax filer.[75] For purposes of eligibility for a QHP with financial assistance, an individual who indicates that they expect:

(a) To file an income tax return for the benefit year;

(b) If married (within the meaning of 26 CFR § 1.7703-1), to file a joint tax return for the benefit year with their spouse (who, together with the individual, is considered the tax filer) unless the tax filer meets the exceptions criteria defined in § 12.03(b) (victim of domestic abuse or spousal abandonment);

(c) That no other taxpayer will be able to claim them as a tax dependent for the benefit year; and

(d) To claim a personal exemption deduction under § 151 of the Code on their tax return for one or more applicants, who may or may not include the individual or their spouse.

Tax dependent

(a) For purposes of eligibility for MAGI-based Medicaid, see, § 28.03(a).

(b) For purposes of eligibility for a QHP with financial assistance, see, § 28.05(a).

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

4.00 General program rules (10/01/2021, GCR 20-001)

4.01 Receiving health benefits from another state (01/15/2017, GCR 16-094)

An individual who is receiving health benefits from another state is not eligible for health benefits in Vermont.

4.02 Rights of individuals with respect to application for and receipt of health benefits through

[75] 45 CFR § 155.300.

AHS (10/01/2021, GCR 20-001)

(a) Notice of rights and responsibilities. Policies are administered in accordance with federal and state law. Individuals will be informed of their rights and responsibilities with respect to application for and receipt of health benefits.

(b) Right to nondiscrimination and equal treatment.[76] AHS does not unlawfully discriminate on the basis of race, color, religion, national origin, disability, age, sex, gender identity, or sexual orientation in the administration of its health-benefits programs or activities.

(c) Right to confidentiality. The confidentiality of information obtained during the eligibility process is protected in accordance with federal and state laws and regulations. The use and disclosure of information concerning applicants, enrollees, and legally-liable third parties is restricted to purposes directly connected with the administration of health-benefits programs, with enrollment in a QHP or as otherwise required by law.

(d) Right to timely provision of benefits. Eligible individuals have the right to the timely provision of benefits, as defined in § 61.00.

(e) Right to information. Individuals who inquire have the right to receive information about health benefits, coverage-type requirements, and their rights and responsibilities as enrollees of health-benefits programs or as enrollees in QHPs.

(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 benefits.

(g) Right to be assisted by others

(1) The individual has the right to be represented by a legal representative.

(2) The individual has the right to be accompanied and represented by an authorized representative during the eligibility or appeal processes.

(3) 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.

(4) An authorized representative may file an application for health benefits or an appeal on behalf of a deceased person.

(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 the right to appeal, as provided in § 68.00.

(j) Right to interpreter services. Individuals will be informed of the availability of interpreter services. Unless the

[76] See, 42 USC § 18116; 45 CFR §§ 92.2 and 155.120(c)(1); 9 VSA § 4502; see, also, ESD All Programs Rule 2000(C).

individual chooses to provide their own interpreter services, AHS will provide either 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.

4.03 Responsibilities of individuals with respect to application for and receipt of health benefits through AHS (01/15/2017, GCR 16-094)

(a) Responsibility to cooperate. An individual must cooperate in providing information necessary to establish and maintain their eligibility, and must comply with all rules and regulations, including recovery and obtaining or maintaining available health insurance.

(b) Responsibility to report changes[77]

(1) An individual must report changes that may affect eligibility. Such changes include, but are not limited to, income, the availability of health insurance, and third-party liability.

(2) A Medicaid enrollee must report such changes within 10 days of learning of the change.

(3) Except as specified in paragraphs (b)(4) and (5) of this subsection, a QHP enrollee must report such changes within 30 days of such change.

(4) A QHP enrollee who did not request an eligibility determination for APTC or CSR, and is not receiving APTC or CSR, need not report changes that affect eligibility for health-benefits programs.

(5) An individual, or an application filer on behalf of the individual, will be allowed to report changes via the channels available for the submission of an application, as described in § 52.02.

(c) Cooperation with quality control. An individual enrolled in a health-benefits program must cooperate with any quality-control (QC) review of their case. (§ 4.05)

4.04 Case records (01/15/2017, GCR 16-094)

(a) Contents. Case records include the following information:

(1) Applications for benefits;

(2) Factual data that supports eligibility findings, including, but not limited to:

(i) Documentation of verification of information submitted and any supplementary investigation of eligibility factors;

[77] Derived from former Medicaid Rule 4140.

(ii) Budgetary computations;

(iii) Eligibility decisions; and

(iv) Payment authorizations.

(3) Copies of all correspondence with and concerning individuals, including, but not limited to, notices of case decisions.

(b) Use of case information. Case information may contribute in statistical or other general terms to material needed for planning, research, and overall administration of human-services programs. Individual case information shall, however, be held in accordance with the confidentiality requirements set forth in § 4.08.

(c) Retention.[78] Case records are retained as required by federal and state requirements for audit and/or review.

4.05 Quality-control review[79] (01/15/2017, GCR 16-094)

(a) AHS's Quality Control (QC) Unit periodically conducts independent reviews of eligibility factors in a sampling of cases. These reviews help to ensure that program rules are clear and consistently applied and that individuals understand program requirements and give correct information in support of their applications for benefits.

(b) A random sample of active Medicaid enrollees is chosen each month for a full field review of their eligibility. Each eligibility factor must be verified with the enrollee and with collateral sources.

(c) A similar sample of negative actions (e.g., denials, closures, benefit decreases) is also chosen each month. These reviews do not usually require a contact with the individual, although the reviewer may sometimes need to check facts with the individual.

(d) When a case is selected for review, the individual must cooperate with the QC representative. Cooperation includes, but is not limited to, participation in a personal interview and the furnishing of requested information. If the individual does not cooperate, eligibility for the individual's household may be closed and the individual members may be disenrolled.

(e) When there is a discrepancy between the eligibility facts, as discovered during a QC review, and those contained within the case record, AHS will schedule an eligibility review and take action to correct errors or review the effect of the changes.

4.06 Fraud (01/15/2017, GCR 16-094)

(a) Fraud. A person commits fraud in Vermont if he or she:

(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

[78] From former All-Programs Rule 2013.

[79] From former Medicaid Rule 4104.

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 . . . ;"[80] 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, alteration, forgery, or possession of a . . . certificate of eligibility for medical services, or Medicaid identification card in a manner not authorized by law . . . ."[81]

(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. An individual may report suspected fraud to AHS. When AHS suspects that fraud may have been committed, it will investigate the case. If appropriate, the case will be referred to the State's Attorney or Attorney General for a decision on whether or not to prosecute.

(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?

(e) Examples

(1) The following are examples of instances in which fraud might be suspected and referral considered:

(i) The individual accepts and continues paid employment without reporting such employment after having been clearly informed of the necessity of such notification.

(ii) The individual fails to acknowledge or report income from pensions, Social Security, or relatives when it is reasonably clear that there was a willful attempt to conceal such income.

(iii) The individual disposes of property (either real or personal) and attempts to conceal such disposal.

[80] 33 VSA § 141(a).

[81] 33 VSA § 141(b).

(iv) The individual misrepresents a material fact, such as residency status or dependent relationship or status, in order to receive benefits to which they would not otherwise be eligible.

(2) These examples are intended as a guideline; each case will be evaluated individually.

(f) Methods of investigation. 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.

(g) Review and documentation of investigation. Procedures will be established for review and documentation of a fraud investigation.

(h) Referral to Law Enforcement Agencies. The final decision regarding referral to a law enforcement agency shall be the responsibility of the appropriate department's commissioner.

4.07 [Reserved] (01/15/2017, GCR 16-094)

4.08 Privacy and security of personally identifiable information[82] (01/15/2019, GCR 18-060)

(a) When personally-identifiable information is collected or created for the purposes of determining eligibility for enrollment in a QHP, determining eligibility for health-benefits programs, or determining eligibility for exemptions from the individual responsibility provisions in § 5000A of the Code, 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 must establish and implement privacy and security standards that are consistent with the following principles.

(1)

(i) *Individual access.* Individuals should be provided with a simple and timely means to access and obtain their personally identifiable information in a readable form and format;

(ii) *Correction.* Individuals should be provided with a timely means to dispute the accuracy or integrity of their personally identifiable information and to have erroneous information corrected or to have a dispute documented if their requests are denied;

(iii) *Openness and transparency.* There should be openness and transparency about policies, procedures, and technologies that directly affect individuals and/or their personally identifiable information;

(iv) *Individual choice.* Individuals should be provided a reasonable opportunity and capability to make informed decisions about the collection, use, and disclosure of their personally identifiable information;

[82] See generally, Social Security Act §§ 1137 and 1902(a)(7); 26 USC § § 6103; § 1413(c)(1) and (c)(2) of the ACA; 42 CFR Part 431, Subpart F; 45 CFR § 155.260; 45 CFR § 155.280.

(v) *Collection, use, and disclosure limitations*. Personally identifiable information should be created, collected, used, and/or disclosed only to the extent necessary to accomplish a specified purpose(s) and never to discriminate inappropriately;

(vi) *Data quality and integrity*. Persons and entities should take reasonable steps to ensure that personally identifiable information is complete, accurate, and up-to-date to the extent necessary for the person's or entity's intended purposes and has not been altered or destroyed in an unauthorized manner;

(vii) *Safeguards*. Personally identifiable information should be protected with reasonable operational, administrative, technical, and physical safeguards to ensure its confidentiality, integrity, and availability and to prevent unauthorized or inappropriate access, use, or disclosure; and

(viii) *Accountability*. These principles should be implemented, and adherence assured, through appropriate monitoring and other means and methods should be in place to report and mitigate non-adherence and breaches.

(2) Safeguards. For the purposes of implementing the principle described in paragraph (a)(1)(vii) of this subsection, AHS must establish and implement operational, technical, administrative and physical safeguards that are consistent with any applicable laws (including this subsection) to ensure:

(i) The confidentiality, integrity, and availability of personally identifiable information created, collected, used, and/or disclosed by AHS;

(ii) Personally identifiable information is only used by or disclosed to those authorized to receive or view it;

(iii) Return information, as such term is defined by § 6103(b)(2) of the Code, is kept confidential under § 6103 of the Code;

(iv) Personally identifiable information is protected against any reasonably anticipated threats or hazards to the confidentiality, integrity, and availability of such information;

(v) Personally identifiable information is protected against any reasonably anticipated uses or disclosures of such information that are not permitted or required by law; and

(vi) Personally identifiable information is securely destroyed or disposed of in an appropriate and reasonable manner and in accordance with retention schedules.

(3) Monitoring. AHS must monitor, periodically assess, and update the security controls and related system risks to ensure the continued effectiveness of those controls.

(4) Secure interfaces. AHS must develop and utilize secure electronic interfaces when sharing personally identifiable information electronically.

4.09 Use of standards and protocols for electronic transactions (01/15/2017, GCR 16-094)

(a) HIPAA administrative simplification.[83] To the extent that electronic transactions are performed with a covered entity, standards, implementation specifications, operating rules, and code sets adopted by the Secretary of HHS in 45 CFR parts 160 and 162 will be used.

(b) HIT enrollment standards and protocols.[84] Interoperable and secure standards and protocols developed by the Secretary of HHS in accordance with § 3021 of the PHS Act will be incorporated. Such standards and protocols will be incorporated within VHC information technology systems.

5.00 Eligibility and enrollment assistance (10/01/2021, GCR 20-001)

5.01 Assistance offered through AHS (10/01/2021, GCR 20-001)

(a) In general.[85] AHS will provide assistance to any individual seeking help with the application or renewal process in person, over the telephone, and online, 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 paragraph (c) of this subsection 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 tools

(1) Call center.[86] A toll-free call center is provided to address the needs of individuals requesting assistance and meets the accessibility requirements outlined in paragraph (c) of this subsection.

(2) Internet website.[87] An up-to-date internet website that meets the requirements outlined in paragraph (c) of this subsection is maintained. The website:

(i) Supports applicant and enrollee activities, including accessing information on the health-benefit programs available in the state, applying for and renewing coverage and providing assistance to individuals seeking help with the application or renewal process;

[83] 45 CFR § 155.270(a).

[84] 45 CFR § 155.270(b).

[85] 42 CFR § 435.908; 45 CFR § 155.205(d). Note: While the consumer-assistance responsibilities of Medicaid agencies and Exchanges may be distinct, "[s]ome aspects of [the Medicaid agency's] applicant and beneficiary assistance may be integrated with the consumer assistance tools and programs of the Exchange." See, CMS "Summary of Proposed Provisions and Analysis of and Responses to Public Comments," 77 Fed. Reg. 17144, 17166 (Mar. 23, 2011). Vermont has opted to operate one health-benefits assistance call center, serving the needs of all applicants and beneficiaries of health benefits.

[86] 42 CFR § 435.908; 45 CFR § 155.205(a).

[87] Social Security Act § 1943 (42 USC § 1396w-3); 42 CFR § 435.1200(f); 45 CFR § 155.205(b).

(ii) Provides standardized comparative information on each available QHP, which may include differential display of standardized options on consumer-facing plan comparison and shopping tools, including at a minimum:

(A) Premium and cost-sharing information;

(B) The summary of benefits and coverage established under § 2715 of the PHS Act;

(C) Identification of whether the QHP is a bronze, silver, gold, or platinum level plan as defined by § 1302(d) of the ACA, or a catastrophic plan as defined by § 1302(e) of the ACA;

(D) The results of the enrollee satisfaction survey, as described in § 1311(c)(4) of the ACA;

(E) Beginning 2015, quality ratings assigned in accordance with § 1311(c)(3) of the ACA;

(F) Medical loss ratio information as reported to HHS in accordance with 45 CFR part 158;

(G) Transparency of coverage measures reported to VHC during certification; and

(H) The provider directory made available to VHC.

(iii) Publishes the following financial information:

(A) The average costs of licensing required by VHC;

(B) Any regulatory fees required by VHC;

(C) Any payments required by VHC in addition to fees under paragraphs (b)(2)(iii)(A) and (B) of this subsection;

(D) Administrative costs of VHC; and

(E) Monies lost to waste, fraud, and abuse.

(iv) Provides individuals with information about Navigators as described in § 5.03 and other consumer assistance services, including the toll-free telephone number of the call center required in paragraph (b)(1) of this subsection.

(v) Allows for an eligibility determination to be made in accordance with § 58.00.

(vi) Allows a qualified individual to select a QHP in accordance with § 71.00.

(vii) Makes available by electronic means a calculator to facilitate the comparison of available QHPs after the application of any APTC, premium reductions and any federal or state CSR.

(c) Accessibility[88]

(1) Information is provided in plain language and in a manner that is accessible and timely.

(2) Individuals living with disabilities will be provided with, among other things, accessible websites and

[88] 42 CFR § 435.905(b); 45 CFR § 155.205(c).

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) 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.

(d) Availability of program information[89]

(1) The following information is furnished in electronic and paper formats, and orally as appropriate, to all individuals who request it:

(i) The eligibility requirements;

(ii) Available health benefits and services; and

(iii) The rights and responsibilities of individuals.

(2) Bulletins or pamphlets that explain the rules governing eligibility and appeals in simple and understandable terms will be published in quantity and made available.

(3) Such information is provided in a manner that meets the standards in paragraph (c) of this subsection.

(e) Outreach and education.[90] Outreach and education activities that meet the standards in paragraph (c) of this subsection to educate consumers about VHC and Vermont's health-benefits programs to encourage participation will be conducted.

(f) Americans with Disabilities Act (ADA).[91] As required by the Americans with Disabilities Act, reasonable accommodations and modifications will be made to policies, practices, or procedures when necessary, as determined by the appropriate commissioners or their designees, to provide equal access to programs, services and activities, or when necessary to avoid discrimination on the basis of disability. An individual may

[89] 42 CFR § 435.905; 45 CFR § 155.205.

[90] Social Security Act § 1943 (42 USC § 1396w-3); 45 CFR § 155.205(e).

[91] All Programs Rule 2030.

appeal the commissioner's determination regarding necessity to the appropriate fair hearings entity or appeals entity in accordance with departmental regulations governing appeals and fair hearings.

(g) Non-discrimination.[92] AHS assistance programs and activities will:

(1) Comply with applicable non-discrimination statutes; and

(2) Not discriminate based on race, color, national origin, disability, age, sex, gender identity or sexual orientation.

5.02 Authorized representatives[93] (01/15/2019, GCR 18-060)

(a) In general

(1) An individual may designate another person or organization to accompany, assist, and represent or to act responsibly on their behalf in assisting with the individual's application and renewal of eligibility and other ongoing communications with AHS. These include:

(i) Guardians and people with powers of attorney (§ 5.02(i)); and

(ii) Any other person of the individual's choice.

(2) AHS may permit an applicant or enrollee to authorize a representative to perform fewer than all of the activities described in paragraph (b)(1) of this subsection, provided that AHS tracks the specific permissions for each authorized representative.

(3) Except as provided in paragraph (h) of this subsection, and consistent with current state policy and practice, designation of an authorized representative must be in writing, including the individual's signature, or through another legally binding format subject to applicable authentication and data security standards.

(4) Designation will be permitted at the time of application and at other times.

(5) Legal documentation of authority to act on behalf of an individual under state law, such as a court order establishing legal guardianship or a power of attorney, shall serve in the place of written authorization by the individual. In such cases AHS may recognize an individual as an authorized representative before the legal documentation is provided to AHS.

(6) When an individual dies before applying for retroactive Medicaid coverage, the administrator or executor of the individual's estate, a surviving relative or responsible person may act as the individual's representative.

[92] 42 USC § 18116; 45 CFR §§ 92.2 and 155.120(c)(1); 9 VSA § 4502.

[93] 42 CFR §§ 435.908(b) and 435.923; 45 CFR § 155.227.

(b) Scope of authority

(1) Representatives may be authorized to do any or all of the following:

(i) Assist the individual in completing and submitting any health-benefits application, verification, or other documentation with AHS;

(ii) Give and receive information regarding the individual's application or enrollment;

(iii) Sign an application on the individual's behalf;

(iv) Receive copies of the individual's notices and other communications. A person who receives authority to only receive copies of communications is referred to as an "alternate reporter";

(v) Request a fair hearing or file a grievance; and

(vi) Act on behalf of the individual in any other matters with AHS.

(2) The kinds of information that may be shared may include the following:

(i) Information or proofs needed to complete the application or redetermination of eligibility;

(ii) The status of the application including the program or programs the household members are enrolled in and the effective dates of enrollment;

(iii) The reason the individual or household is not eligible for a benefit, if the application is denied or benefits end; and

(iv) The effective date of redetermination and any outstanding information or verifications needed to complete a redetermination.

(c) Duration of authorization

(1) The power to act as an authorized representative is valid with AHS until:

(i) The individual modifies the authorization or notifies AHS, using one of the methods available for the submission of an application, as described in § 52.02(b)(2), that the representative is no longer authorized to act on their behalf;

(ii) The authorized representative informs AHS that they no longer are acting in such capacity; or

(iii) There is a change in the legal authority upon which the individual or organization's authority was based.

(2) Any notification described in (c)(1) of this subsection, except as stated in (c)(1)(i), must be in writing and should include the individual's or authorized representative's signature as appropriate.

(d) Duties of the authorized representative. The authorized representative:

(1) Is responsible for fulfilling all responsibilities encompassed within the scope of the authorized

representation, as described in paragraph (b) of this subsection, to the same extent as the individual they represent; and

(2) Must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding the individual provided.

(e) Condition of representation

(1) The authorized representative must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding the applicant or enrollee provided by AHS.

(2) When an organization is designated as an authorized representative, as a condition of serving, staff members or volunteers of that organization must sign an agreement that they will adhere to the regulations in § 4.08 (relating to confidentiality of information), federal regulations relating to the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf, as well as other relevant state and federal laws concerning conflicts of interest and confidentiality of information.

(f) Form of authorization. For purposes of this subsection, electronic, including telephonically recorded, signatures and handwritten signatures transmitted by facsimile or other electronic transmission will be accepted. Designations of authorized representatives will be accepted through all of the modalities described in § 52.02(b).

(g) Disclosures. The authorization form or the AHS call center representative (if the authorization is made over the telephone) shall advise that:

(1) The individual need not give permission to share information.

(2) If the individual decides not to give permission, that will not affect eligibility for, or enrollment in, benefits;

(3) If the individual does not give permission, the information will not be released unless the law otherwise allows it;

(4) AHS is not responsible for what an unrelated authorized representative does with the individual's information after it is shared pursuant to a valid authorization;

(5) The individual may change or stop this authorization at any time by notifying AHS by telephone or in writing. However, doing so will not affect previously shared information;

(6) If the individual does not change or stop the authorization, it will remain in effect as long as the individual (or household) continues to receive health-care benefits; and

(7) The individual will be provided with a copy of the authorization upon request.

(h) Minors and incapacitated adults.[94] If the individual is a minor or an incapacitated adult, no authorization is required; someone acting responsibly for the individual may assist in the application process or during a redetermination of eligibility. Such person may also sign the initial application on the applicant's behalf.

(i) Judicially-appointed legal guardian or representative.[95] Upon presentment of a valid document of appointment, a judicially-appointed legal guardian or representative may act on an individual's behalf.

5.03 Navigator program (10/01/2021, GCR 20-001)

(a) General requirements.[96] AHS conducts a Navigator program consistent with this subsection through which it awards grants to eligible entities to perform the functions of navigator organizations, and certifies individuals as Navigators. The functions of navigator organizations include providing assistance to individuals and employers with enrollment in Medicaid programs and qualified health plans.

(b) Standards.[97] AHS maintains and publicly disseminates:

(1) A set of standards, to be met by all entities and individuals to be awarded Navigator grants, designed to prevent, minimize, and mitigate any conflicts of interest, financial or otherwise, that may exist for an entity to be awarded a Navigator grant, and to ensure that all entities and individuals carrying out Navigator functions have appropriate integrity; and

(2) A set of training standards, to be met by all entities and individuals carrying out Navigator functions under the terms of a Navigator grant, to ensure expertise in:

(i) The needs of underserved and vulnerable populations;

(ii) Eligibility and enrollment rules and procedures;

(iii) Benefits rules and regulations governing all health-benefits programs and QHPs offered in the state;

(iv) The range of QHP options and health-benefits programs;

(v) The privacy and security standards applicable under § 4.08;

(vi) The process of filing eligibility appeals;

(vii) General concepts regarding exemptions from the requirement to maintain minimum essential coverage and from the individual shared responsibility payment, including the application process for

[94] 42 CFR § 435.907(a); 45 CFR § 155.20.

[95] From All Programs Rule 2014.

[96] 45 CFR § 155.210(a); 33 VSA § 1807.

[97] 45 CFR §§ 155.205(d) and 155.210(b).

exemptions, and IRS resources and exemptions;

(viii) The premium tax credit reconciliation process and IRS resources on this process;

(ix) Basic concepts and rights related to health coverage and how to use it; and

(x) Providing referrals to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice.

(c) Entities and individuals eligible to be a Navigator.[98] To receive a Navigator grant, an entity must:

(1) Be capable of carrying out at least those duties described in paragraph (f) of this subsection;

(2) Demonstrate to AHS that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be eligible for enrollment in a QHP;

(3) Meet any licensing, certification or other standards prescribed by the state or AHS;

(4) Not have a conflict of interest during the term as Navigator; and

(5) Comply with the privacy and security standards applicable under § 4.08.

(d) Prohibition on Navigator conduct.[99] A Navigator must not:

(1) Be a health insurance issuer or issuer of stop loss insurance;

(2) Be a subsidiary of a health insurance issuer or issuer of stop loss insurance;

(3) Be an association that includes members of, or lobbies on behalf of, the insurance industry;

(4) Receive any consideration directly or indirectly from any health insurance issuer or issuer of stop loss insurance in connection with the enrollment of any individuals or employees in a QHP or a non-QHP;

(5) Charge any applicant or enrollee, or request or receive any form of remuneration from or on behalf of an individual applicant or enrollee, for application or other assistance related to Navigator duties;

(6) Provide to an applicant or potential enrollee gifts of any value as an inducement for enrollment. The value of gifts provided to applicants and potential enrollees for purposes other than an inducement for enrollment must not exceed nominal value, either individually or in the aggregate, when provided to that individual during a single encounter. For purposes of this paragraph, the term gifts includes gift items, gift cards, cash cards, cash, and promotional items that market or promote the products or services of a third party, but does not include the reimbursement of legitimate expenses incurred by a consumer in an effort

[98] 45 CFR § 155.210(c).

[99] 45 CFR § 155.210(d).

to receive application assistance, such as, but not limited to, travel or postage expenses;

(7) Use AHS funds to purchase gifts or gift cards, or promotional items that market or promote the products or services of a third party, that would be provided to any applicant or potential enrollee;

(8) Solicit any individual for application or enrollment assistance by going door-to-door or through other unsolicited means of direct contact, including calling an individual to provide application or enrollment assistance without the individual initiating the contact, unless the individual has a pre-existing relationship with the individual Navigator or Navigator entity and other applicable state and federal laws are otherwise complied with. Outreach and education activities may be conducted by going door-to-door or through other unsolicited means of direct contact, including calling an individual; or

(9) Initiate any telephone call to an individual using an automatic telephone dialing system or an artificial or prerecorded voice, except in cases where the individual Navigator or Navigator entity has a relationship with the individual and so long as other applicable state and federal laws are otherwise complied with.

(e) Conflict-of-interest standards.[100] In addition to prohibited conduct in (d) of this subsection, the following standards apply to Navigators:

(1) All Navigator entities must submit to VHC a written attestation that the Navigator, including the Navigator's staff, complies with (d)(1).

(2) All Navigator entities must submit to VHC a written plan to remain free of conflicts of interest during the term as a Navigator.

(3) All Navigator entities, including the Navigator's staff, must provide information to consumers about the full range of QHP options and health-benefits programs for which they are eligible.

(4) All Navigator entities, including the Navigator's staff, must disclose to VHC and, in plain language, to each consumer who receives application assistance from the Navigator:

(i) Any lines of insurance business, not covered by the restrictions on participation and prohibitions on conduct in (d) of this subsection, which the Navigator intends to sell while carrying out the consumer assistance functions;

(ii) Any existing or anticipated financial, business, or contractual relationships with one or more health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance; and

(iii) For Navigator staff, any existing employment relationships, or any former employment relationships within the last 5 years, with any health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance, including any existing employment relationships between a spouse or domestic partner and any health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss

[100] 45 CFR § 155.215(a).

insurance.

(f) Duties of a Navigator.[101] An entity that serves as a Navigator must carry out at least the following duties:

(1) Maintain expertise in eligibility, enrollment, and program specifications and conduct public education activities to raise awareness about VHC;

(2) Conduct public education activities to raise awareness of the availability of qualified health benefit plans;

(3) Distribute information to health care professionals, community organizations, and others to facilitate the enrollment of individuals who are eligible for Medicaid, Dr. Dynasaur, VPharm, other public health-benefits programs, or QHP;

(4) Provide information and services in a fair, accurate and impartial manner, which includes providing information that assists individuals with submitting the eligibility application; clarifying the distinctions among health coverage options, including QHPs; and helping individuals make informed decisions during the health coverage selection process. Such information must acknowledge other health programs;

(5) Distribute fair and impartial information concerning enrollment in QHPs and concerning the availability of premium tax credits, premium reductions, and cost-sharing reductions;

(6) Facilitate selection of a QHP or public health-benefits program such as Medicaid, Dr. Dynasaur, or VPharm;

(7) Provide referrals to any applicable office of health insurance consumer assistance, health insurance ombudsman, or any other appropriate state agency or agencies, for any individual with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage;

(8) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by VHC, including individuals with limited English proficiency, and ensure accessibility and usability of Navigator tools and functions for individuals with disabilities in accordance with the Americans with Disabilities Act and § 504 of the Rehabilitation Act;

(9) Ensure that individuals:

(i) Are informed, prior to receiving assistance, of the functions and responsibilities of Navigators, including that Navigators are not acting as tax advisers or attorneys when providing assistance as Navigators and cannot provide tax or legal advice within their capacity as Navigators;

(ii) Provide authorization in a form and manner as determined by AHS prior to a Navigator's obtaining access to an individual's personally identifiable information, and that the Navigator maintains a record of the authorization provided in a form and manner as determined by AHS. AHS will establish

[101] 45 CFR § 155.210(e); 33 V.S.A. § 1807.

a reasonable retention period for maintaining these records; and

(iii) May revoke at any time the authorization provided to a Navigator.

(10) Maintain a physical presence in the service area, so that face-to-face assistance can be provided to applicants and enrollees.

(11) Provide targeted assistance to serve underserved or vulnerable populations, as identified by AHS.

(12) Provide information and assistance with the following topics:

(i) Understanding the process of filing eligibility appeals;

(ii) Understanding and applying for exemptions from the individual shared responsibility payment, understanding the availability of exemptions from the requirement to maintain minimum essential coverage and from the individual shared responsibility payment that are claimed through the tax filing process and how to claim them, and understanding the availability of IRS resources on this topic;

(iii) The premium tax credit reconciliation process, and understanding the availability of IRS resources on this process;

(iv) Understanding basic concepts and rights related to health coverage and how to use it; and

(v) Referrals to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice.

(g) Funding for Navigator grants Funding for navigator grants may not be from Federal funds received by the state to establish VHC.

5.04 Brokers (01/01/2018, GCR 17-043)

(a) General rule.[102] A broker may:

(1) Facilitate enrollment of an individual, employer, or employee in any QHP as soon as the QHP is offered;

(2) Subject to paragraphs (b) and (c) of this subsection, assist an individual in applying for a QHP with financial assistance; and

(3) Subject to paragraphs (b) and (c) of this subsection assist an employee or an employer in enrolling in any QHP.

(b) Agreement.[103] Prior to enrolling a qualified individual, employee, or employer in a QHP through VHC, or assisting an individual in applying for a QHP with financial assistance, a broker must have an executed

[102] 45 CFR § 155.220(a); 33 V.S.A. § 1805(17).

[103] 45 CFR § 155.220(d); 33 V.S.A. § 1805(17).

agreement with AHS, and must comply with the terms of that agreement, which includes at least the following requirements:

(1) Registering with AHS in advance of assisting a qualified individual, employee or employer, enrolling in QHPs through VHC;

(2) Receiving training in the range of QHP options and health-benefit programs;

(3) Complying with AHS's privacy and security standards adopted consistent with § 4.08; and

(4) Maintaining a physical presence in the service area, so that face-to-face assistance can be provided to applicants and enrollees.

(c) Payment mechanisms.[104] A broker who facilitates enrollment of an individual, employer, or employee in any QHP must comply with procedures, including payment mechanisms and standard fee or compensation schedules, established by AHS, that allow brokers to be appropriately compensated for assisting with the enrollment of qualified individuals and qualified employers in any QHP offered through VHC for which the individual or employer is eligible; and assisting a qualified individual in applying for financial assistance for a QHP purchased through VHC.

5.05 Certified application counselors[105] (01/01/2018, GCR 17-043)

(a) In general. AHS certifies staff and volunteers of state-partner organizations to act as application counselors, authorized to provide assistance to individuals with the application process and during renewal of eligibility.

(b) Certification

(1) Application counselors are certified by AHS to provide assistance at application and renewal with respect to one, some, or all of the permitted assistance activities, and enter into certification agreements with AHS.

(2) To be certified, application counselors must:

(i) Be authorized and registered by AHS to provide assistance at application and renewal;

(ii) Be effectively trained in the eligibility and benefits rules and regulations governing enrollment in a QHP and all health-benefits programs operated in Vermont;

(iii) Have successfully completed the required training and received a passing score on the certification examination;

(iv) Disclose to AHS and potential applicants any relationships the certified application counselor or sponsoring agency has with QHPs or insurance affordability programs, or other potential conflicts of

[104] 33 V.S.A. § 1805(17).

[105] 42 CFR § 435.908 (eff. 1/1/2014); 45 CFR § 155.225.

interest;

(v) Comply with AHS's privacy and security standards adopted consistent with § 4.08 and applicable authentication and data security standards;

(vi) Agree to act in the best interest of the applicants assisted;

(vii) Either directly or through an appropriate referral to the VHC call center, provide information in a manner that is accessible to individuals with disabilities, as defined by the Americans with Disabilities Act, as amended, 42 U.S.C. § 12101 *et seq.* and § 504 of the Rehabilitation Act, as amended, 29 USC § 794; and

(viii) Be recertified on at least an annual basis after successfully completing recertification training as required by AHS.

(c) Withdrawal of certification. AHS will establish procedures to withdraw certification from individual application counselors, or from all application counselors associated with a particular organization, when it finds noncompliance with the terms and conditions of the application counselor agreement.

(d) Duties. Certified application counselors are certified to:

(1) Provide information to individuals and employees about the full range of QHP options and health-benefits programs for which they are eligible, which includes providing fair, impartial and accurate information that assists individuals with submitting the eligibility application; clarifying the distinctions among health coverage options, including QHPs; and helping individuals make informed decisions during the health coverage selection process;

(2) Assist individuals and employees to apply for coverage in a QHP through VHC and for health-benefits programs; and

(3) Help to facilitate enrollment of eligible individuals in QHPs and health-benefits programs.

(e) Availability of information; authorization. AHS must establish procedures to ensure that:

(1) Individuals are informed, prior to receiving assistance, of the functions and responsibilities of certified application counselors, including that certified application counselors are not acting as tax advisers or attorneys when providing assistance as certified application counselors and cannot provide tax or legal advice within their capacity as certified application counselors;

(2) Individuals are able to provide authorization in a form and manner as determined by AHS prior to a certified application counselor obtaining access to personally identifiable information about the individual related to the individual's application for, or renewal of, health benefits, and that the organization or certified application counselor maintains a record of the authorization in a form and manner as determined by AHS. AHS will establish a reasonable retention period for maintaining these records;

(3) AHS does not disclose confidential individual information to an application counselor unless the individual has authorized the application counselor to receive such information; and

(4) Individuals may revoke at any time the authorization provided the certified application counselor.

(f) No charge for services. Application counselors may not:

(1) Impose any charge on individuals for application or other assistance related to VHC;

(2) Receive any consideration directly or indirectly from any health insurance issuer or issuer of stop-loss insurance in connection with the enrollment of any individual in a QHP or a non-QHP;

(3) Provide to an applicant or potential enrollee gifts of any value as inducement for enrollment. The value of gifts provided to applicants and potential enrollees for purposes other than as an inducement for enrollment must not exceed nominal value, either individually or in the aggregate, when provided to that individual during a single encounter. For purposes of this paragraph, the term gifts includes gift items, gift cards, cash cards, cash and promotional items that market or promote the products or services of a third party, but does not include the reimbursement of legitimate expenses incurred by a consumer in an effort to receive application assistance, such as, but not limited to, travel or postage expenses;

(4) Solicit any individual for application or enrollment assistance by going door-to-door or through other unsolicited means of direct contact, including calling an individual to provide application or enrollment assistance without the individual initiating the contact, unless the individual has a pre-existing relationship with the individual certified application counselor or designated organization and other applicable state and federal laws are otherwise complied with. Outreach and education activities may be conducted by going door-to-door or through other unsolicited means of direct contact, including calling an individual; or

(5) Initiate any telephone call to an individual using an automatic telephone dialing system or an artificial or prerecorded voice, except in cases where the individual certified application counselor or designated organization has a relationship with the individual and so long as other applicable state and federal laws are otherwise complied with.

(g) Non-discrimination and organizations receiving federal funds to provide services to defined populations.[106] Notwithstanding the non-discrimination provisions of § 5.01(g), an organization that receives federal funds to provide services to a defined population under the terms of federal legal authorities that participates in the certified application counselor program may limit its provision of certified application counselor services to the same defined population, but must comply with § 5.01(g) with respect to the provision of certified application counselor services to that defined population, If the organization limits its provision of certified application counselor services pursuant to this exception, but is approached for certified application counselor services by an individual who is not included in the defined population that the organization serves, the organization must refer the individual to other AHS-approved resources that can provide assistance. If the organization does not limit its provision of certified application counselor services pursuant to this exception, the organization must comply with § 5.01(g).

[106] 45 CFR § 155.120(c)(2).

VERMONT **GENERAL ASSEMBLY**

The Vermont Statutes Online

Title 3 : Executive

Chapter 025 : Administrative Procedure

Subchapter 001 : General Provisions

(Cite as: 3 V.S.A. § 801)

§ 801. Short title and definitions

(a) This chapter may be cited as the "Vermont Administrative Procedure Act."

(b) As used in this chapter:

(1) "Agency" means a State board, commission, department, agency, or other entity or officer of State government, other than the Legislature, the courts, the Commander in Chief, and the Military Department, authorized by law to make rules or to determine contested cases.

(2) "Contested case" means a proceeding, including but not restricted to rate-making and licensing, in which the legal rights, duties, or privileges of a party are required by law to be determined by an agency after an opportunity for hearing.

(3) "License" includes the whole or part of any agency permit, certificate, approval, registration, charter, or similar form of permission required by law.

(4) "Licensing" includes the agency process respecting the grant, denial, renewal, revocation, suspension, annulment, withdrawal, or amendment of a license.

(5) "Party" means each person or agency named or admitted as a party, or properly seeking and entitled as of right to be admitted as a party.

(6) "Person" means any individual, partnership, corporation, association, governmental subdivision, or public or private organization of any character other than an agency.

(7) "Practice" means a substantive or procedural requirement of an agency, affecting one or more persons who are not employees of the agency, that is used by the agency in the discharge of its powers and duties. The term includes all such requirements, regardless of whether they are stated in writing.

(8) "Procedure" means a practice that has been adopted in writing, either at the election of the agency or as the result of a request under subsection 831(b) of this title. The term includes any practice of any agency that has been adopted in writing, whether or not labeled as a procedure, except for each of the following:

(A) a rule adopted under sections 836-844 of this title;

(B) a written document issued in a contested case that imposes substantive or procedural requirements on the parties to the case;

(C) a statement that concerns only:

(i) the internal management of an agency and does not affect private rights or procedures available to the public;

(ii) the internal management of facilities that are secured for the safety of the public and the individuals residing within them; or

(iii) guidance regarding the safety or security of the staff of an agency or its designated service providers or of individuals being provided services by the agency or such a provider;

(D) an intergovernmental or interagency memorandum, directive, or communication that does not affect private rights or procedures available to the public;

(E) an opinion of the Attorney General; or

(F) a statement that establishes criteria or guidelines to be used by the staff of an agency in performing audits, investigations, or inspections, in settling commercial disputes or negotiating commercial arrangements, or in the defense, prosecution, or settlement of cases, if disclosure of the criteria or guidelines would compromise an investigation or the health and safety of an employee or member of the public, enable law violators to avoid detection, facilitate disregard of requirements imposed by law, or give a clearly improper advantage to persons that are in an adverse position to the State.

(9) "Rule" means each agency statement of general applicability that implements, interprets, or prescribes law or policy and that has been adopted in the manner provided by sections 836-844 of this title.

(10) "Incorporation by reference" means the use of language in the text of a regulation that expressly refers to a document other than the regulation itself.

(11) "Adopting authority" means, for agencies that are attached to the Agencies of Administration, of Commerce and Community Development, of Natural Resources, of Human Services, and of Transportation, or any of their components, the secretaries of those agencies; for agencies attached to other departments or any of their components, the commissioners of those departments; and for other agencies, the chief officer of the agency. However, for the procedural rules of boards with quasi-judicial powers, for the Transportation Board, for the Vermont Veterans' Memorial Cemetery Advisory Board, and for the Fish and Wildlife Board, the chair or executive secretary of the board shall be the adopting authority. The Secretary of State shall be the adopting authority for the Office of Professional Regulation.

(12) "Small business" means a business employing no more than 20 full-time

employees.

(13)(A) "Arbitrary," when applied to an agency rule or action, means that one or more of the following apply:

(i) There is no factual basis for the decision made by the agency.

(ii) The decision made by the agency is not rationally connected to the factual basis asserted for the decision.

(iii) The decision made by the agency would not make sense to a reasonable person.

(B) The General Assembly intends that this definition be applied in accordance with the Vermont Supreme Court's application of "arbitrary" in Beyers v. Water Resources Board, 2006 VT 65, and In re Town of Sherburne, 154 Vt. 596 (1990).

(14) "Guidance document" means a written record that has not been adopted in accordance with sections 836-844 of this title and that is issued by an agency to assist the public by providing an agency's current approach to or interpretation of law or describing how and when an agency will exercise discretionary functions. The term does not include the documents described in subdivisions (8)(A) through (F) of this section.

(15) "Index" means a searchable list of entries that contains subjects and titles with page numbers, hyperlinks, or other connections that link each entry to the text or document to which it refers. (Added 1967, No. 360 (Adj. Sess.), § 1, eff. July 1, 1969; amended 1981, No. 82, § 1; 1983, No. 158 (Adj. Sess.), eff. April 13, 1984; 1985, No. 56, § 1; 1985, No. 269 (Adj. Sess.), § 4; 1987, No. 76, § 18; 1989, No. 69, § 2, eff. May 27, 1989; 1989, No. 250 (Adj. Sess.), § 88; 2001, No. 149 (Adj. Sess.), § 46, eff. June 27, 2002; 2017, No. 113 (Adj. Sess.), § 3; 2017, No. 156 (Adj. Sess.), § 2.)

VERMONT **GENERAL ASSEMBLY**

The Vermont Statutes Online

Title 33 : Human Services

Chapter 019 : Medical Assistance

Subchapter 001 : Medicaid

(Cite as: 33 V.S.A. § 1901)

§ 1901. Administration of program

(a)(1) The Secretary of Human Services or designee shall take appropriate action, including making of rules, required to administer a medical assistance program under Title XIX (Medicaid) and Title XXI (SCHIP) of the Social Security Act.

(2) The Secretary or designee shall seek approval from the General Assembly prior to applying for and implementing a waiver of Title XIX or Title XXI of the Social Security Act, an amendment to an existing waiver, or a new state option that would restrict eligibility or benefits pursuant to the Deficit Reduction Act of 2005. Approval by the General Assembly under this subdivision constitutes approval only for the changes that are scheduled for implementation.

(3) [Repealed.]

(4) A manufacturer of pharmaceuticals purchased by individuals receiving State pharmaceutical assistance in programs administered under this chapter shall pay to the Department of Vermont Health Access, as the Secretary's designee, a rebate on all pharmaceutical claims for which State-only funds are expended in an amount that is in proportion to the State share of the total cost of the claim, as calculated annually on an aggregate basis, and based on the full Medicaid rebate amount as provided for in Section 1927(a) through (c) of the federal Social Security Act, 42 U.S.C. § 1396r-8.

(b) [Repealed.]

(c) The Secretary may charge a monthly premium, in amounts set by the General Assembly, per family for pregnant women and children eligible for medical assistance under Sections 1902(a)(10)(A)(i)(III), (IV), (VI), and (VII) of Title XIX of the Social Security Act, whose family income exceeds 195 percent of the federal poverty level, as permitted under section 1902(r)(2) of that act. Fees collected under this subsection shall be credited to the State Health Care Resources Fund established in section 1901d of this title and shall be available to the Agency to offset the costs of providing Medicaid services. Any co-payments, coinsurance, or other cost sharing to be charged shall also be authorized and set by the General Assembly.

(d)(1) To enable the State to manage public resources effectively while preserving and

enhancing access to health care services in the State, the Department of Vermont Health Access is authorized to serve as a publicly operated managed care organization (MCO).

(2) To the extent permitted under federal law, the Department of Vermont Health Access shall be exempt from any health maintenance organization (HMO) or MCO statutes in Vermont law and shall not be considered to be an HMO or MCO for purposes of State regulatory and reporting requirements. The MCO shall comply with the federal rules governing managed care organizations in 42 C.F.R. Part 438. The Vermont rules on the primary care case management in the Medicaid program shall be amended to apply to the MCO except to the extent that the rules conflict with the federal rules.

(3) The Agency of Human Services and Department of Vermont Health Access shall report to the Health Care Oversight Committee about implementation of Global Commitment in a manner and at a frequency to be determined by the Committee. Reporting shall, at a minimum, enable the tracking of expenditures by eligibility category, the type of care received, and to the extent possible allow historical comparison with expenditures under the previous Medicaid appropriation model (by department and program) and, if appropriate, with the amounts transferred by another department to the Department of Vermont Health Access. Reporting shall include spending in comparison to any applicable budget neutrality standards.

(e) [Repealed.]

(f) The Secretary shall not impose a prescription co-payment for individuals under age 21 enrolled in Medicaid or Dr. Dynasaur.

(g) The Department of Vermont Health Access shall post prominently on its website the total per-member per-month cost for each of its Medicaid and Medicaid waiver programs and the amount of the State's share and the beneficiary's share of such cost.

(h) To the extent required to avoid federal antitrust violations, the Department of Vermont Health Access shall facilitate and supervise the participation of health care professionals and health care facilities in the planning and implementation of payment reform in the Medicaid and SCHIP programs. The Department shall ensure that the process and implementation include sufficient State supervision over these entities to comply with federal antitrust provisions and shall refer to the Attorney General for appropriate action the activities of any individual or entity that the Department determines, after notice and an opportunity to be heard, violate State or federal antitrust laws without a countervailing benefit of improving patient care, improving access to health care, increasing efficiency, or reducing costs by modifying payment methods. (Added 1967, No. 147, § 6; amended 1997, No. 155 (Adj. Sess.), § 21; 2005, No. 159 (Adj. Sess.), § 2; 2005, No. 215 (Adj. Sess.), § 308, eff. May 31, 2006; 2007, No. 74, § 3, eff. June 6, 2007; 2009, No. 156 (Adj. Sess.), § E.309.15, eff. June 3, 2010; 2009, No. 156 (Adj. Sess.), § I.43; 2011, No. 48, § 16a, eff. Jan. 1, 2012; 2011, No. 139 (Adj. Sess.), § 51, eff.

May 14, 2012; 2011, No. 162 (Adj. Sess.), § E.307.6; 2011, No. 171 (Adj. Sess.), § 41c; 2013, No. 79, § 23, eff. Jan. 1, 2014; 2013, No. 79, § 46; 2013, No. 131 (Adj. Sess.), § 39, eff. May 20, 2014; 2013, No. 142 (Adj. Sess.), § 98; 2017, No. 210 (Adj. Sess.), § 3, eff. June 1, 2018.)

VERMONT **GENERAL ASSEMBLY**

The Vermont Statutes Online

Title 33 : Human Services

Chapter 018 : Public-private Universal Health Care System

Subchapter 001 : Vermont Health Benefit Exchange

(Cite as: 33 V.S.A. § 1810)

§ 1810. Rules

The Secretary of Human Services may adopt rules pursuant to 3 V.S.A. chapter 25 as needed to carry out the duties and functions established in this subchapter. (Added 2011, No. 48, § 4.)

VERMONT

Proposed Rules Postings
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Deadline For Public Comment

Deadline: Aug 24, 2022

The deadline for public comment has expired. Contact the agency or primary contact person listed below for assistance.

Rule Details

Rule Number:	22P014
Title:	Health Benefits Eligibility and Enrollment Rule, General Provisions and Definitions (Part 1).
Type:	Standard
Status:	Proposed
Agency:	Agency of Human Services
Legal Authority:	3 V.S.A. 801(b)(11); 33 V.S.A. 1901(a)(1) and 1810
Summary:	This proposed rulemaking amends Parts 1, 2, 3, 5, and 7 of the 8-part Health Benefits Eligibility and Enrollment (HBEE) rule. Parts 1, 5 and 7 were last amended effective October 1, 2021. Parts 2 and 3 were last amended effective January 15, 2019. Substantive revisions include: codifying the annual open enrollment period for qualified health plans from November 1 - January 15; adding a new income-based special enrollment period for qualified health plans that allows ongoing enrollment for those at or below 200 of the Federal Poverty Level (FPL); extending the Medicaid postpartum period for pregnant women from 60 days to 12 months; adding Compacts of Free Association (COFA) migrants as qualified non-citizens eligible for Medicaid and exempt from the 5-year bar; and expanding Medicaid eligibility for former foster care children to include children aging out of foster care in another state.

Persons Affected:	Medicaid applicants/enrollees; Individuals who wish to purchase health coverage including those who apply for premium and cost-sharing assistance; Health insurance issuers; Eligibility and enrollment assisters, including agents and brokers; Health care providers; Health law, policy and related advocacy and community-based organizations and groups including the Office of the Health Care Advocate; Agency of Human Services including its departments; and Department of Financial Regulation.
Economic Impact:	AHS anticipates that some of the proposed changes to HBEE will have an economic impact on the State's budget, beginning in SFY2023. The estimated gross annualized budget impact of expanding postpartum Medicaid coverage for pregnant women from 60 days to 12 months is ~$2 million and accounted for in AHS's FY2023 budget. The estimated gross annualized budget impact of expanding Medicaid coverage to children who age out of foster care in any state is $52,700. There is no anticipated impact from the addition of COFA migrants. Changes related to Qualified Health Plan enrollment are not expected to have an economic impact except insofar as any opportunity to encourage enrollment and maintain VT's low uninsured rate is fiscally positive for VT. Other changes in Parts 1, 2, 3, 5, & 7 align the rule with federal and state guidance and law, provide clarification, correct information, improve clarity, and make technical corrections. These changes do not carry a specific economic impact on any person or entity.
Posting date:	Jul 13,2022

Hearing Information

Information for Hearing # 1

Hearing date:	08-17-2022 2:00 PM ADD TO YOUR CALENDAR
Location:	Waterbury State Office Complex, Cherry A Conference Room
Address:	280 State Drive
City:	Waterbury
State:	VT
Zip:	05671
Hearing Notes:	Also via MS Teams: Call in (audio only) 802-522-8456 Conference ID: 738063547# or visit: https://teams.microsoft.com/l/meetup-join/193ameeting_NzJjZWJjOTUtMjVlMS00ZTJkLTk4YzAtZjFkYTU3MTUxZmEw40thread.v2/0?context7b22Tid223a2220b4933b-baad-433c-9c02-70edcc7559c6222c22Oid223a22beb0dd2a-7ce6-4285-9bad-e79977845027227d

Contact Information

Information for Primary Contact

PRIMARY CONTACT PERSON - A PERSON WHO IS ABLE TO ANSWER QUESTIONS ABOUT THE CONTENT OF THE RULE.

Level:	Primary
Name:	Danielle Fuoco
Agency:	Agency of Human Services
Address:	280 State Drive, Center Building
City:	Waterbury
State:	VT
Zip:	05671

Telephone:	802-585-4265
Fax:	802-241-0450
Email:	danielle.fuoco@vermont.gov

SEND A COMMENT

Website Address: https://humanservices.vermont.gov/rules-policies/health-care-rules

VIEW WEBSITE

Information for Secondary Contact

SECONDARY CONTACT PERSON - A SPECIFIC PERSON FROM WHOM COPIES OF FILINGS MAY BE REQUESTED OR WHO MAY ANSWER QUESTIONS ABOUT FORMS SUBMITTED FOR FILING IF DIFFERENT FROM THE PRIMARY CONTACT PERSON.

Level:	Secondary
Name:	Jessica Ploesser
Agency:	Agency of Human Services
Address:	280 State Drive, Center Building
City:	Waterbury
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SEND A COMMENT

Keyword Information

Keywords:

HBEE
Health Benefits Eligibility and Enrollment
Vermont Health Connect
Exchange
Medicaid
QHP
Qualified Health Plan
Health Benefit
Pregnant
Foster Care
Special Enrollment Period
SEP
Annual Open Enrollment Period
AOEP
Post Partum

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	The Islander (islander@vermontislander.com)	Tel: 802-372-5600 FAX: 802-372-3025
	Vermont Lawyer (hunter.press.vermont@gmail.com)	Attn: Will Hunter

FROM: APA Coordinator, VSARA **Date of Fax:** July 12, 2022

RE: The "Proposed State Rules " ad copy to run on **July 21, 2022**

PAGES INCLUDING THIS COVER MEMO: **2**

NOTE **8-pt font in body. 12-pt font max. for headings - single space body. Please include dashed lines where they appear in ad copy. Otherwise minimize the use of white space. Exceptions require written approval.**

If you have questions, or if the printing schedule of your paper is disrupted by holiday etc. please contact VSARA at 802-828-3700, or E-Mail sos.statutoryfilings@vermont.gov, Thanks.

PROPOSED STATE RULES

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By law, public notice of proposed rules must be given by publication in newspapers of record. The purpose of these notices is to give the public a chance to respond to the proposals. The public notices for administrative rules are now also available online at https://secure.vermont.gov/SOS/rules/ . The law requires an agency to hold a public hearing on a proposed rule, if requested to do so in writing by 25 persons or an association having at least 25 members.

To make special arrangements for individuals with disabilities or special needs please call or write the contact person listed below as soon as possible.

To obtain further information concerning any scheduled hearing(s), obtain copies of proposed rule(s) or submit comments regarding proposed rule(s), please call or write the contact person listed below. You may also submit comments in writing to the Legislative Committee on Administrative Rules, State House, Montpelier, Vermont 05602 (802-828-2231).

Note: The five rules below have been promulgated by the Agency of Human Services who has requested the notices be combined to facilitate a savings for the agency. When contacting the agency about these rules please note the title and rule number of the rule(s) you are interested in.

- Health Benefits Eligibility and Enrollment Rule, General Provisions and Definitions (Part 1). - 22P014
- Health Benefits Eligibility and Enrollment Rule, Eligibility Standards (Part 2). - 22P015
- Health Benefits Eligibility and Enrollment Rule, Nonfinancial Eligibility Requirements (Part 3). - 22P016
- Health Benefits Eligibility and Enrollment Rule, Financial Methodologies (Part 5). - 22P017
- Health Benefits Eligibility and Enrollment Rule, Eligibility-and-Enrollment Procedures (Part 7). - 22P018

AGENCY: Agency of Human Services

CONCISE SUMMARY: This proposed rulemaking amends Parts 1, 2, 3, 5, and 7 of the 8-part Health Benefits Eligibility and Enrollment (HBEE) rule. Parts 1, 5 and 7 were last amended effective October 1, 2021. Parts 2 and 3 were last amended effective January 15, 2019. Substantive revisions include: codifying the annual open enrollment period for qualified health plans from November 1 - January 15; adding a new income-based special enrollment period for qualified health plans that allows ongoing enrollment for those at or below 200% of the Federal Poverty Level (FPL); extending the Medicaid postpartum period for pregnant women from 60 days to 12 months; adding Compacts of Free Association (COFA) migrants as qualified non-citizens eligible for Medicaid and exempt from the 5-year bar; and expanding Medicaid eligibility for former foster care children to include children aging out of foster care in another state.

FOR FURTHER INFORMATION, CONTACT: Danielle Fuoco, Agency of Human Services, 280 State Drive, Center Building, Waterbury, Vermont 05671-1000 Tel: 802-585-4265 Fax: 802-241-0450 Email: danielle.fuoco@vermont.gov URL: https://humanservices.vermont.gov/rules-policies/health-care-rules.

FOR COPIES: Jessica Ploesser, Agency of Human Services, 280 State Drive, Center Building, Waterbury, Vermont 05671-1000 Tel: 802-585-0454 Fax: 802-241-0450 Email: jessica.ploesser@vermont.gov.
