FINAL PROPOSED RULE # 23-P30

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, State Fair Hearings and Expedited Eligibility Appeals (Part 8)

/s/ Todd W. Daloz , on 10/23/23
(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

1. TITLE OF RULE FILING:
Health Benefits Eligibility and Enrollment Rule, State Fair Hearings and Expedited Eligibility Appeals (Part 8)

2. PROPOSED NUMBER ASSIGNED BY THE SECRETARY OF STATE
23P030

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 054671-1000

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 NOT RAISED FOR OR AGAINST THE ORIGINAL PROPOSAL.

12. THE AGENCY HAS NOT INCLUDED COPIES OF ALL WRITTEN SUBMISSIONS AND SYNOPSES OF ORAL COMMENTS RECEIVED.

13. THE AGENCY HAS NOT 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 1-5, and 7-8 of the 8-part Health Benefits Eligibility and Enrollment (HBEE) rule. Parts 1, 2, 3, 5, and 7 were last amended effective January 1, 2023. Part 4 was last amended effective January 15, 2019. Part 8 was last amended effective October 1, 2021. Substantive revisions include: implementing 12 months of Medicaid continuous eligibility for children; codifying ineligibility for Qualified Health Plan subsidy if failure to reconcile tax credits for 2 consecutive years; allowing self-attestation of income for Qualified Health Plan subsidies if no tax information is available through data sources; and codifying 2 new income and resource

exclusions for purposes of Medicaid eligibility for the Aged, Blind, and Disabled (MABD).

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; and

Agency of Human Services including its departments.

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

AHS anticipates that one proposed change to HBEE will have an economic impact on the State's budget, beginning in SFY2024. The estimated gross annualized budget impact of implementing 12 months of Medicaid continuous eligibility for children is $2.8 million. Federal law requires state Medicaid agencies to implement this change. There is no anticipated impact from the new income and resource exclusions for MABD eligibility.

Changes related to eligibility for Qualified Health Plan (QHP) subsidies stem from federal rule changes. These

federal rule changes make it easier for certain individuals to get and maintain federal subsidies. The fiscal impact for changes related to eligibility for QHP subsidies will be carried by the federal government.

Other changes in Parts 1-5 and 7-8 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: 10/6/2023

Time: 01:00 PM

Street Address: Virtual Hearing - Phone or Microsoft Teams Call in (audio only)
(802) 522-8456; Conference ID: 700 267 252#

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

Zip Code: 05671

URL for Virtual: https://teams.microsoft.com/l/meetup-join/19%3ameeting_YjI4NGVjODctZmMwYi00YzYwLTgwZWYtNDdmZTdmMmVjMTli%40thread.v2/0?context=%7b%22Tid%22%3a%2220b4933b-baad-433c-9c02-70edcc7559c6%22%2c%22Oid%22%3a%22beb0dd2a-7ce6-4285-9bad-e79977845027%22%7d

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Date:

Time: AM

Street Address:

Zip Code:

URL for Virtual:

Date:
Time: AM
Street Address:
Zip Code:
URL for Virtual:

Date:
Time: AM
Street Address:
Zip Code:
URL for Virtual:

21. DEADLINE FOR COMMENT (NO EARLIER THAN 7 DAYS FOLLOWING LAST HEARING):
10/13/2023

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

Health Benefits Eligibility and Enrollment
Vermont Health Connect
Exchange
Medicaid
QHP
Qualified Health Plan
Health Benefit
Special Enrollment Period
SEP
Annual Open Enrollment Period
AOEP
Children

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

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: Sarah Copeland Hanzas, Secretary of State, Vermont Secretary of State Office
Rep. Trevor Squirrell, 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 23, 2023

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:

- 23P024 HBEE Part One – General Provisions and Definitions
- 23P025 HBEE Part Two – Eligibility Standards
- 23P026 HBEE Part Three – Nonfinancial Eligibility Requirements
- 23P027 HBEE Part Four – Special Rules for Medicaid Coverage of Long-Term Care Services and Supports – Eligibility and Post-Eligibility
- 23P028 HBEE Part Five – Financial Methodologies
- 23P029 HBEE Part Seven – Eligibility and Enrollment Procedures
- 23P030 HBEE Part Eight – State Fair Hearings and Expedited Eligibility Appeals

No public comments were received during the public comment period.

The following technical changes were made to HBEE Part Two since the proposed filing:

- Section 7.03(a)(3) was revised to more closely align with the language in federal law, and, in light of recent guidance from the Centers for Medicare and Medicaid Services (CMS), to clarify that the continuous eligibility for children requirement does not apply to children who are eligible for Medicaid through a medically needy coverage group and those that get their eligibility on the basis of Transitional Medical Assistance.
- Section 8.03(d) was revised to clarify that the continuous eligibility for children requirement applies to children who are eligible for Medicaid on the basis of disability or blindness.

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

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

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, State Fair Hearings and Expedited Eligibility Appeals (Part 8)
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 # 22P014, effective 1/1/2023; Part 2 - Eligibility Standards, SOS #22P015, effective 1/1/2023; Part 3 - Nonfinancial Eligibility Requirements, SOS # 22P016,

effective 1/1/2023; Part 4 - Special Rules for Medicaid Coverage of Long-Term Care Services and Supports - Eligibility and Post-Eligibility, SOS # 18P046, effective 1/15/2019; Part 5 - Financial Methodologies, SOS # 22P017, effective 1/1/2023; Part 7 - Eligibility and Enrollment Procedures, SOS # 22P018, effective 1/1/2023; Part 8 - State Fair Hearings and Expedited Eligibility Appeals, SOS # 21P008, effective 10/1/2021.

State of Vermont
Agency of Administration
109 State Street
Montpelier, VT 05609-0201
www.aoa.vermont.gov

[phone] 802-828-3322

Kristin L. Clouser, Secretary

INTERAGENCY COMMITTEE ON ADMINISTRATIVE RULES (ICAR) MINUTES

Meeting Date/Location: August 14, 2023, virtually via Microsoft Teams
Members Present: Chair Sean Brown, Jared Adler, Jennifer Mojo, John Kessler, Michael Obuchowski, and Nicole Dubuque
Members Absent: Diane Sherman and Brendan Atwood
Minutes By: Melissa Mazza-Paquette

- 2:00 p.m. meeting called to order, welcome and introductions.
- Review and approval of minutes from the June 12, 2023 meeting.
- No additions/deletions to agenda. Agenda approved as drafted.
- Note: The following emergency rules were supported:
    1) On 06/30/23: 'Pandemic-Era General Assistance Emergency Housing Transition' from the Agency of Human Services, Department for Children and Families
        a) The Department for Children and Families must establish eligibility criteria to continue providing temporary housing assistance to the populations identified in Act 81 and the Executive Order dated June 30, 2023.
    2) On 07/28/23: 'Rules Governing Medication-Assisted Treatment for Opioid Use Disorder', Agency of Human Services
        a) This emergency rule eliminates the X Waiver requirements, which can no longer be met due to federal changes. This update will ensure Vermont's MAT regulations do not inhibit access to MAT providers by those in need.
    3) On 08/03/23: 'Reportable and Communicable Diseases Rule', Agency of Human Services, Department of Health
        a) This rule adds Mpox to the list of reportable diseases, due to the virus' increased public health threat. This also reduces the administrative burden for reporters by eliminating the need to report negative COVID results.
    4) On 08/07/23: Amyotrophic Lateral Sclerosis (ALS) Registry Rule, Agency of Human Services, Department of Health
        a) 18 V.S.A. § 176 requires the Department to establish this registry by 7/1/23. The regular ALS Registry rule will not be adopted for several months. Without this e-rule, some incidence data may not be reported as required.
- Public comments made by Jay Greene, Office of Racial Equity, on the Health Benefits Eligibility and Enrollment Rules
- Presentation of Proposed Rules on pages 3-11 to follow.
    1) Vermont Passenger Tramway Rules, Vermont Department of Labor/page 3
    2) Health Benefits Eligibility and Enrollment Rule, General Provisions and Definitions (Part 1), Agency of Human Services, page 4
    3) Health Benefits Eligibility and Enrollment Rule, Eligibility Standards (Part 2), Agency of Human Services, page 5
    4) Health Benefits Eligibility and Enrollment Rule, Nonfinancial Eligibility Requirements (Part 3), Agency of Human Services, page 6

5) Health Benefits Eligibility and Enrollment Rule, Special Rules for Medicaid Coverage of Long-Term Services and Supports - Eligibility and Post-Eligibility (Part 4), Agency of Human Services, page 7
6) Health Benefits Eligibility and Enrollment Rule, Financial Methodologies (Part 5), Agency of Human Services, page 8
7) Health Benefits Eligibility and Enrollment Rule, Eligibility-and-Enrollment Procedures (Part 7), Agency of Human Services, page 9
8) Health Benefits Eligibility and Enrollment Rule, State Fair Hearings and Expedited Eligibility Appeals (Part 8), Agency of Human Services, page 10
9) Water Supply Rule, Agency of Natural Resources, page 11

- No Other Business
- Upcoming Scheduled Meetings:
  - Wednesday, August 30, 2023 at 2:00 p.m. – Special Meeting for Committee Discussion only
  - Monday, September 11, 2023 at 2:00 p.m. – Regular monthly meeting
- 3:15 PM Meeting Adjourned

Proposed Rule: Health Benefits Eligibility and Enrollment Rule, State Fair Hearings and Expedited Eligibility Appeals (Part 8), Agency of Human Services

Presented By: Robin Chapman and Danielle Fuoco

Motion made to accept the rule by Nicole Dubuque, seconded by Jen Mojo, and passed unanimously with the following recommendation:

1. Proposed Filing - Coversheet, #12: Clarify the division of impact by federal and state governments.

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, State Fair Hearings and Expedited Eligibility Appeals (Part 8)

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; and

Agency of Human Services including its departments.

Anticipated costs and benefits of this rule:

AHS anticipates that one proposed change to HBEE will have an economic impact on the State's budget, beginning in SFY2024. The estimated gross annualized budget impact of implementing 12 months of Medicaid continuous eligibility for children is $2.8 million. Federal law requires state Medicaid agencies to implement this change. There is no anticipated impact from the new income and resource exclusions for MABD eligibility.

Changes related to eligibility for Qualified Health Plan (QHP) subsidies stem from federal rule changes. These federal rule changes make it easier for certain individuals to get and maintain federal subsidies. The fiscal impact for changes related to eligibility for QHP subsidies will be carried by the federal government.

Other changes in Parts 1-5 and 7-8 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.

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, State Fair Hearings and Expedited Eligibility Appeals (Part 8)

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 IMPACTS 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, State Fair Hearings and Expedited Eligibility Appeals (Part 8)

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. AHS took input from the Office of the Health Care Advocate/Vermont Legal Aid, Qualified Health Plan issuers, members, and providers through the Medicaid & Exchange Advisory Committee.

   The proposed rule were posted on the AHS website for public comment, and a public hearing was held on October 6, 2023. No one attended the hearing. When the proposed 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 October 13, 2023. No comments were received. Part 2 has been amended since the proposed filing with technical changes to improve clarity. The technical changes are included in the

Global Commitment Register notice as well as the cover memo for this filing. There are no changes to Parts 1, 3, 4, 5, 7, and 8 since the proposed filing.

The Global Commitment Register is a database that provides notification of policy changes and clarification of existing Medicaid policy, including rulemaking, under Vermont's 1115 Global Commitment to Health waiver. Anyone can subscribe to the Global Commitment Register. Subscribers will 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.

Annotated Text

Table of Contents

Part Eight
State fair hearings/expedited eligibility appeals

80.00 State fair hearings and expedited eligibility appeals[1] (01/01/2024~~10/01/2021~~, GCR 23-088~~20-005~~)

80.01 Definitions[2] (07/01/2019, GCR 18-126)

State fair hearing request. A clear expression, either orally or in writing, by an individual (applicant or enrollee) to have any decision by AHS affecting the individual's eligibility or level of benefits or services reviewed by the AHS Human Services Board.

State fair hearings entity. The Human Services Board, the body designated by law to hear State fair hearings of eligibility determinations or redeterminations. AHS determines whether an expedited eligibility appeal request meets the expedited appeal standard pursuant to § 80.07(b), and decides expedited eligibility appeals for QHPs pursuant to § 80.07(e).

80.02 Informing individuals of State fair hearing procedures[3] (07/01/2019, GCR 18-126)

(a) In general. State fair hearings are processed in accordance with State fair hearing rules as promulgated by the Human Services Board pursuant to 3 VSA § 3091(b), and, in the case of an expedited State fair hearing, consistent with 3 VSA § 3091(e)(3).

(b) Requesting a State fair hearing. An individual may submit a State fair hearing request either orally or in writing by contacting AHS or the Human Services Board. See § 80.04(a) for the methods individuals may use to submit a State fair hearing request. A State fair hearing request may be submitted by the individual, or, with the consent of the individual, their authorized representative as defined in § 3.00, their legal counsel, a relative, a friend, or another spokesperson. The State fair hearing request process must comply with accessibility requirements in § 5.01(c).[4]

An individual, treating provider, or other person identified at § 80.02(b) may request an expedited eligibility appeal by indicating that the time otherwise permitted for a State fair hearing could jeopardize the individual's life or health or ability to attain, maintain or regain maximum function. For the rule on expedited eligibility appeals, see § 80.07.

[1] For rules that govern internal appeals, State fair hearings grievances, and notices on Medicaid Services, refer to HCAR 8.100.

[2] 45 CFR § 155.505.

[3] 42 CFR § 431.206; 45 CFR § 155.515.

[4] 45 CFR §§ 155.505(e) and (f).

(c) Notification of State fair hearing rights. AHS will, at the times specified in § 68.01(c), provide every individual in writing with an explanation of their State fair hearing rights as described in § 68.01(b)(2) and their right to request an expedited eligibility appeal pursuant to § 80.07.

80.03 Right to a State fair hearing (10/01/2021, GCR 20-005)

(a) When a State fair hearing is required.[5] AHS will grant an opportunity for a State fair hearing to any individual who requests it because AHS terminates, suspends, denies or reduces their eligibility, reduces their level of benefits or services, their claim is not acted upon with reasonable promptness, they are aggrieved by any other action taken by AHS affecting their receipt of assistance, benefits or services or by agency policy as it affects their situation, or they believe an action or decision by AHS has been taken erroneously. This includes, if applicable:

(1) A determination of the amount of medical expenses which must be incurred to establish Medicaid eligibility in accordance with § 7.03(a)(8) or § 8.06;

(2) A determination of income for the purposes of imposing Medicaid premiums and cost-sharing requirements;

(3) A determination for any month that an individual is ineligible for APTC because the individual is considered eligible for other MEC under § 12.02(b) and § 23.00. This includes, but is not limited to, determinations of affordability and minimum value for employer-sponsored plans;

(4) An initial determination of eligibility, including the amount of APTC, the Vermont Premium Reduction and level of federal or state CSR;

(5) A redetermination of eligibility, including the amount of APTC, the Vermont Premium Reduction and level of federal or state CSR;

(6) A failure by AHS to provide timely notice of a determination; and

(7) A determination of eligibility for a special enrollment period.

(b) Exception: SSI enrollees. An applicant for or recipient of SSI/AABD benefits who is denied SSI/AABD benefits or has their SSI/AABD benefits terminated because the SSA or its agent found the individual to be not disabled, may not appeal the Medicaid denial or termination that results from this action by the SSA or its agent to the Human Services Board (see Disability Determination Appeal under § 81.00).

(c) Exception: Mass changes. There is no right to a State fair hearing or an expedited eligibility appeal when either state or federal law requires automatic case adjustments for classes of enrollees, unless the reason for an individual's appeal is incorrect eligibility determination.

[5] 42 CFR § 431.220; 45 CFR § 155.505.

80.04 Request for a State fair hearing[6] (07/01/2019, GCR 18-126)

(a) Method for requesting a State fair hearing. An individual, or an authorized representative on behalf of an individual, or a person identified at § 80.02(b), may submit a State fair hearing request:

(1) By telephone;

(2) Via mail;

(3) In person;

(4) Through other commonly available electronic means; and

(5) Via the internet.

(b) AHS's responsibilities related to a State fair hearing request.[7] AHS will:

(1) Assist the individual making the State fair hearing request, if requested;

(2) Not limit or interfere with the individual's right to make a State fair hearing request; and

(3) Consider a State fair hearing request to be valid if it is submitted in accordance with § 80.03 and paragraphs (a) and (c) of this subsection § 80.04.

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

(c) Timely request. An individual must request a fair hearing within 90 days from the date that notice of decision is sent by AHS (see § 68.01).

(d) Scope of State fair hearing request.[8] If an individual has been denied eligibility for Medicaid, AHS will treat an appeal of a determination of eligibility for APTC or CSR as including a request for an appeal of the Medicaid determination.

80.05 AHS Secretary's decision and further appeal (01/01/2024~~07/01/2019~~, GCR 23-088~~18-126~~)

[6] 42 CFR § 431.221; 45 CFR § 155.520.

[7] 45 CFR § 155.520(a).

[8] 42 CFR § 431.221(e).

(a) AHS Secretary's decision[9]

(1) The Secretary of AHS will:

(i) Adopt the Human Services Board's decision or order, except that the Secretary may reverse or modify a decision or order of the Human Services Board if:

(A) The Human Services Board's findings of fact lack any support in the record; or

(B) The decision or order misinterprets or misapplies State or federal policy or rule.

(ii) Issue a written decision setting forth the legal, factual or policy basis for reversing or modifying a decision or order of the Human Services Board.

(2) An order of the Human Services Board will become the final and binding decision of AHS upon its approval by the Secretary. The Secretary will either approve, modify or reverse the Human Services Board's decision and order within 15 days of the date of the Human Services Board's decision and order. If the Secretary fails to issue a written decision within 15 days as required by this paragraph (a)(2), the Human Services Board's decision and order will be deemed to have been approved by the Secretary. The Secretary will approve, modify, or reverse a Human Services decision and order entered pursuant to § 80.07(f) within the timelines set forth in § 80.07(f)(2).

(b) Judicial review of AHS Secretary's decision.[10] An individual may, at the same time or independent of an HHS appeal (as described in (c) of this subsection), if applicable, appeal a decision of the AHS Secretary, made pursuant to § 80.05(a)(2), to the Supreme Court. Such appeals shall be pursuant to Rule 13 of the Vermont Rules of Appellate Procedure. The Supreme Court may stay the Secretary's decision upon the individual's showing of a fair ground for litigation on the merits. The Supreme Court will not stay the Secretary's order insofar as it relates to a denial of retroactive benefits.

(c) HHS appeal[11]

(1) An individual may make an appeal request to the HHS appeals entity within the time frame described in (2) of this paragraph (c) if the individual disagrees with the order of the Human Services Board or the AHS Secretary's reversal or modification, made pursuant to § 80.05(a)(2), regarding:

(i) A determination for any month that an individual is ineligible for APTC because the individual is considered eligible for other MEC under § 12.02(b) and § 23.00. This includes, but is not limited to, determinations of affordability and minimum value for employer-sponsored plans;

(ii) An initial determination of eligibility, including the amount of APTC, the Vermont Premium Reduction and level of federal or state CSR;

[9] 3 VSA § 3091(h).

[10] 3 V.S.A. § 3091(h)(3); 45 CFR § 155.505(g).

[11] 45 CFR § 155.520(c).

(iii) A redetermination of eligibility, including the amount of APTC, the Vermont Premium Reduction and level of federal or state CSR; and

(iv) A failure by AHS to provide timely notice, as required by § 68.02, in regard to the determinations described in (i) through (iii) above.

(2) An appeal request to the HHS appeals entity under (1) of this paragraph (c) must be made within 30 days of the date of the final and binding decision described in § 80.05(a)(2). Such a request may be made at the same time or independent of judicial review.

~~(2)~~(3) An individual who disagrees with the decision made by the HHS appeals entity may request review of the decision by the CMS Administrator. This administrative review process is described at 45 CFR § 155.505(g).

80.06 Implementation of State fair hearing decisions[12] (07/01/2019, GCR 18-126)

Upon receiving a final and binding decision as described in § 80.05(a)(2), AHS will promptly implement the decision.

(a) In connection with a QHP decision:

(1) Implementation of the decision will be effective:

(i) Prospectively, on the first day of the month following the date of the notice, or consistent with § 73.06 if applicable; or

(ii) Retroactively, to the coverage effective date the appellant did receive or would have received if the appellant had enrolled in coverage under the incorrect eligibility determination that is the subject of the appeal, at the option of the individual.

(2) AHS will redetermine the eligibility of household members who have not appealed their own eligibility determinations but whose eligibility may be affected by the State fair hearing decision.

(b) In connection with a Medicaid decision:

(1) *Corrective payments*. If the decision is favorable to the individual, corrective payments will be promptly made, retroactive to the date an incorrect action was taken; or

(2) If the decision is favorable to AHS:

(i) If the decision results in the individual's ineligibility, AHS will terminate continued coverage on the last day of the month in which AHS acts to implement the decision; or

(ii) If the decision results in a higher premium level, AHS will implement the higher premium level effective for the next monthly billing cycle following the decision.

[12] 45 CFR § 155.545(c).

80.07 Expedited eligibility appeals: expedited internal appeals and expedited State fair hearings[13] (07/01/2019, GCR 18-126)

(a) In general

(1) Right to expedited eligibility appeal for health benefit applicants/enrollees. Health benefit applicants and enrollees have a right to an expedited eligibility appeal, either through the internal appeal process (QHPs) or the State fair hearing process (Medicaid), when the individual has an immediate need for health services and taking the time otherwise permitted for a State fair hearing could jeopardize the individual's life or health or ability to attain, maintain or regain maximum function.

(i) QHPs. Individuals who request an expedited eligibility appeal related to a QHP through Vermont Health Connect have a right to an expedited internal appeal meeting, as described at § 80.07(e).

(ii) Medicaid. Individuals who request an expedited eligibility appeal related to Medicaid have a right to an expedited State fair hearing, as described at § 80.07(f).

(2) Assistance. AHS will assist the individual requesting the expedited eligibility appeal, if asked, and will not limit or interfere with the individual's right to appeal.

(3) Independent Reviewer

(i) The person or persons deciding an individual's expedited eligibility appeal request on behalf of AHS will not have been involved with the unfavorable determination or other issue that is the subject of the appeal.

(ii) If it is determined that the expedited eligibility appeal request meets the criteria for such appeals, the person or persons hearing and deciding the expedited internal appeal or the expedited State fair hearing on behalf of AHS will not have been involved in the unfavorable determination or other issue that is the subject of the appeal.

(4) Accessibility. The processes set forth in this subsection will comply with the accessibility requirements in § 5.01(c).

(b) Requesting an expedited eligibility appeal

(1) Who may request an expedited eligibility appeal. An individual, and with the consent of the individual, the treating provider, or another person identified at § 80.02(b) may request an expedited eligibility appeal.

(2) How to request an expedited eligibility appeal. A request for an expedited eligibility appeal may be made to AHS orally, in writing, or by any other method identified at § 80.04(a).

[13] 42 CFR § 431.224; 45 CFR § 155.540.

(3) When a State fair hearing request is considered an expedited eligibility appeal request. AHS will consider a State fair hearing request as an expedited eligibility appeal request if the individual, or other person appealing on the individual's behalf, indicates that the individual has an immediate need for health services and that taking the time otherwise permitted for a State fair hearing could jeopardize the individual's life or health or ability to attain, maintain or regain maximum function.

(4) Necessary information. AHS will act promptly and in good faith to obtain the information necessary to resolve the expedited eligibility appeal request. "Necessary information" may include the opinion of the treating provider and the results of any face-to-face clinical evaluation or second opinion that may be required.

(5) No punitive action. AHS will not take any punitive action against a provider who requests an expedited eligibility appeal or supports an individual's request.

(c) Denial of an expedited eligibility appeal request

(1) Timing of notice of denial.[14] If AHS denies a request for an expedited eligibility appeal because it does not meet the criteria at § 80.07(a)(1), AHS will inform the individual as expeditiously as possible that the request does not meet the criteria for expedited eligibility appeals and that the appeal will be processed within the standard State fair hearing timeframe.

(2) Telephonic notice. AHS will promptly (as expeditiously as possible but not more than two (2) business days from the date of the individual's request for an expedited eligibility appeal made pursuant to § 80.07(b)) provide telephonic notice of the denial of the request of the expedited eligibility appeal to the individual.

(3) Written notice. Telephonic notice to the individual will be followed with a written notice.

(4) Content of denial notice.[15] The denial notice will include:

(i) The reason for the denial;

(ii) An explanation that the appeal will continue to be processed within the standard fair hearing procedures and timeframe;

(iii) An explanation of the individual's rights under the State fair hearing process; and

(iv) Contact information for the Office of the Health Care Advocate.

[14] 42 CFR § 431.224(b); 45 CFR § 155.540(b).

[15] 45 CFR § 155.540(b)(2).

(5) No right to State fair hearing on denial. A denial of a request for an expedited eligibility appeal is not an independent basis for review by the Human Services Board.

(d) Approval of an expedited eligibility appeal request

(1) Timing of notice of approval.[16] If AHS determines that an individual's expedited eligibility appeal request meets the criteria for such appeals, AHS will inform the individual as expeditiously as possible that the request meets the criteria.

(i) Telephonic notice. AHS will promptly (as expeditiously as possible but not more than two (2) business days from the date of the individual's request for an expedited eligibility appeal) provide telephonic notice to the individual that AHS has approved the request for an expedited eligibility appeal.

(ii) Written notice. Telephonic notice to the individual will be followed with written notice. The notice is described at § 80.07(e)(1)(i) and (f)(1)(i).

(e) Expedited internal eligibility appeals (QHPs)[17]

(1) Procedures

(i) AHS will notify the individual of the following:

(A) The date and time of the meeting on the expedited eligibility appeal;

(B) The telephone number to call to participate in the meeting;

(C) Contact information for the Office of the Health Care Advocate; and

(D) The individual's rights during the expedited eligibility appeal process.

(ii) AHS will hold a meeting to decide the expedited eligibility appeal.

(iii) The individual will have the right to:

(A) Participate,

(B) Be accompanied and represented,

(C) Present oral and written evidence, and

(D) Present argument.

(iv) AHS will provide the individual with the opportunity to review the appeal record, including all documents and records considered by the decision-maker.

[16] 42 CFR § 431.224(b).

[17] 45 CFR § 155.540.

(v) AHS will consider the information used to determine the individual's eligibility as well as any additional relevant evidence presented during the course of the expedited appeal process, including at the appeal meeting.

(vi) Expedited eligibility appeals conducted under this subsection are not contested cases pursuant to 3 V.S.A. Chapter 25. The expedited internal appeal process, as described under this subsection, is not a fair hearing within the meaning of 3 V.S.A. § 3091. The decisions from expedited internal appeals have no precedential value.

(2) Timeline for resolving expedited eligibility appeals

(i) AHS will hold a meeting and send notice of the written decision within seven (7) business days following the date the individual requests the expedited appeal.

(ii) AHS will send the written decision within the timeframes in 80.07(e)(2)(i) above except in unusual circumstances in which case AHS will send the written decision within no more than 21 days following the individual's expedited eligibility appeal request.

(A) Unusual circumstances mean AHS cannot reach a decision because the individual requests delay or fails to take a required action or there is administrative or other emergency beyond AHS's control. AHS must send the individual written notice of the reason for the delay.

(3) Content of written notice of decision

(i) The written notice of decision will include:

(A) A statement of the decision, including a plain language description of the effect of the decision on the individual's eligibility;

(B) A summary of the facts relevant to the appeal;

(C) The legal basis, including the regulations, supporting the decision;

(D) The effective date of the decision;

(E) An explanation that the appeal will continue to be processed within the standard State fair hearing procedures and timeframe, unless the individual notifies the Human Services Board that the individual wishes to withdraw the request for a State fair hearing; and

(F) Contact information for the Office of the Health Care Advocate.

(f) Expedited eligibility State fair hearings (Medicaid)[18]

(1) Procedures

(i) The Human Services Board will notify the individual of the following:

(A) The date and time of the hearing on the expedited eligibility appeal;

[18] 42 CFR § 431.224.

(B) The location of the hearing, if it will be held in person, or a description of how to participate by telephone, if the hearing will be held by phone;

(C) Contact information for the Office of the Health Care Advocate; and

(D) The individual's rights during the expedited eligibility appeal process, including the right: to review the appeal record, including all documents and records considered by the person deciding the expedited eligibility appeal; to participate in the hearing; to be accompanied or represented during the hearing; to present oral and written evidence; and to present argument.

(ii) The Human Services Board will conduct a hearing to decide the expedited eligibility appeal.

(A) The hearing will be recorded.

(B) The individual will have the right to:

(I) Participate,

(II) Be accompanied and represented,

(III) Present oral and written evidence, and

(IV) Present argument.

(iii) The individual will be provided an opportunity to review the appeal record, including all documents and records to be considered by the hearing officer, at a reasonable time before the date of the hearing and during the hearing.[19]

(iv) The Human Services Board will consider the information used to determine the individual's eligibility as well as any additional relevant evidence presented during the course of the appeal process, including at the hearing.

(2) Timeline for resolving expedited eligibility appeals

(i) MCA: A final and binding decision or order will be sent to the individual as expeditiously as possible but not more than seven (7) business days following the date the individual requests the expedited eligibility appeal.

(ii) MABD and all long-term care Medicaid: A final and binding decision or order will be sent to the individual as expeditiously as possible following the date the individual requests the expedited eligibility appeal.[20]

(iii) A final and binding decision or order will be sent to the individual within the timeframes in § 80.07(f)(2)(i) and (ii) above except in unusual circumstances.

[19] 42 CFR § 431.242(a).

[20] 42 CFR § 431.244(f)(3)(i).

(A) Unusual circumstances mean the Human Services Board cannot reach a decision because the individual requests delay or fails to take a required action or there is an administrative or other emergency beyond the Human Services Board's control. The Human Services Board must document the reason for delay in the individual's appeal record and send the individual written notice of the reason for the delay.[21]

(B) In no case will the Human Services Board send its decision to the individual more than 21 days from the individual's request for an expedited State fair hearing.

(iv) If the U.S. Department of Health and Human Services (HHS) establishes a shorter timeframe for resolving expedited eligibility appeals, including the days available for extension, the Human Services Board will follow the timeframe established by HHS.

(3) Content of written notice of decision

(i) The written notice will include:

(A) A statement of the decision, including a plain language description of the effect of the decision on the individual's eligibility;

(B) A summary of the facts relevant to the appeal;

(C) The legal basis, including the regulations, supporting the decision;

(D) The effective date of the decision; and

(E) Contact information for the Office of the Health Care Advocate.

(g) Implementation of expedited internal appeal decisions and State fair hearing decisions or orders. AHS will promptly implement expedited internal appeal decisions and expedited State fair hearing decisions or orders in accordance with the eligibility determination set forth in the decision or order.

81.00 Disability determination appeal (01/15/2017, GCR 16-101)

(a) SSA disability decision

(1) A final SSA disability determination is binding on AHS for 12 months or, if earlier, until the determination is changed by SSA, and may not be appealed through AHS's appeal process. However, when an individual who has been found "not disabled" by the SSA meets the requirements specified in § 8.04, they, though not entitled to an appeal of the SSA determination through AHS's appeal process, are entitled to a separate state determination of disability for the purposes of determining their eligibility for Medicaid.

(2) AHS will refer all individuals who do not meet the requirements specified in § 8.04 for a separate state determination of disability and who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability, to SSA for reconsideration or reopening of the determination.

[21] 42 CFR § 431.244(f)(4)(i).

(b) State disability decision. If AHS has made a disability determination under the circumstances specified in § 8.04, the decision may be appealed to the Human Services Board.

82.00 Maintaining benefits/eligibility pending State fair hearing[22] (07/01/2019, GCR 18-126)

(a) In general – Medicaid. When an individual appeals a decision by AHS that ends their Medicaid eligibility, reduces their benefits or services, or imposes or increases a premium, the individual has the right, under certain conditions, to have their Medicaid eligibility, benefit and service level, and premium level continue as before the decision that resulted in the State fair hearing request until the State fair hearing is resolved, provided the individual submits the request before the effective date of the adverse action and pays any required premiums. If the last day before the adverse action date is on a weekend or holiday, the individual has until the end of the first subsequent working day to request the State fair hearing. If the individual was subject to a premium prior to the adverse action that resulted in the State fair hearing request, the individual must continue to pay premiums at the same level as the premiums prior to the adverse action in order for Medicaid eligibility to continue pending resolution of the State fair hearing.

(b) Exceptions – Medicaid

(1) Continuation of Medicaid benefits does not apply when an individual's citizenship or immigration status has not been verified by the end of the 90-day opportunity period for resolving inconsistencies as described in § 54.05.

(2) Continuation of Medicaid benefits without change does not apply when the fair hearing is based solely on a reduction or elimination of a benefit required by federal or state law affecting some or all individuals, or when the decision does not require the minimum advance notice.

(c) Waiver of right to continued Medicaid benefits. An individual may waive their right to continued Medicaid benefits. If they do so and are successful on a State fair hearing, benefits will be paid retroactively.

(d) Recovery of value of continued Medicaid benefits. The state may recover from the individual the value of any continued Medicaid benefits paid during the State fair hearing period when the individual withdraws the State fair hearing before the decision is made, or following a final disposition of the matter in favor of the state.

(e) Continuation of Medicaid benefits pending appeal of SSA determination of disability; SSI/AABD enrollees. When an SSI/AABD enrollee is determined "not disabled" by the SSA and appeals this determination, their Medicaid benefits continue as long as their SSI/AABD benefits are continued (or could have been continued but the individual chose not to receive them during the appeal period) pending a SSA decision on the appeal. When eligibility for SSI/AABD benefits is terminated following a determination of "not disabled", Medicaid benefits end unless the individual applies and is found eligible for Medicaid on the basis of a categorical factor other than disability.

(f) Continuation of Medicaid benefits pending appeal of determination of disability; SSI/AABD applicants. When an individual enrolled in Medicaid applies for SSI/AABD and is determined "not disabled" by the SSA and files a timely appeal of this determination with the SSA, their Medicaid benefits continue until a final decision is

[22] 42 CFR § 431.230; 45 CFR § 155.525.

made on the appeal, provided the SSA's determination of "not disabled" is the only basis on which they might be found ineligible for Medicaid. If they continue to appeal unfavorable decisions by SSA, the "final decision" is made by the SSA Appeals Council.

(g) Continuation of eligibility for enrollment in a QHP, APTC, and CSR pending appeal of redetermination. After receipt of a valid State fair hearing request or notice that concerns an appeal of a redetermination, if the individual (appellant) accepts eligibility pending an appeal, AHS will continue to consider the individual (appellant) eligible, while the State fair hearing is pending, for QHP, APTC, the Vermont Premium Reduction and federal or state CSR, as applicable, in accordance with the level of eligibility immediately before the redetermination being appealed.

83.00 [Reserved] (01/15/2017, GCR 16-101)

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Part Eight
State fair hearings/expedited eligibility appeals

80.00 State fair hearings and expedited eligibility appeals[1] (01/01/2024, GCR 23-088)

80.01 Definitions[2] (07/01/2019, GCR 18-126)

State fair hearing request. A clear expression, either orally or in writing, by an individual (applicant or enrollee) to have any decision by AHS affecting the individual's eligibility or level of benefits or services reviewed by the AHS Human Services Board.

State fair hearings entity. The Human Services Board, the body designated by law to hear State fair hearings of eligibility determinations or redeterminations. AHS determines whether an expedited eligibility appeal request meets the expedited appeal standard pursuant to § 80.07(b), and decides expedited eligibility appeals for QHPs pursuant to § 80.07(e).

80.02 Informing individuals of State fair hearing procedures[3] (07/01/2019, GCR 18-126)

(a) In general. State fair hearings are processed in accordance with State fair hearing rules as promulgated by the Human Services Board pursuant to 3 VSA § 3091(b), and, in the case of an expedited State fair hearing, consistent with 3 VSA § 3091(e)(3).

(b) Requesting a State fair hearing. An individual may submit a State fair hearing request either orally or in writing by contacting AHS or the Human Services Board. See § 80.04(a) for the methods individuals may use to submit a State fair hearing request. A State fair hearing request may be submitted by the individual, or, with the consent of the individual, their authorized representative as defined in § 3.00, their legal counsel, a relative, a friend, or another spokesperson. The State fair hearing request process must comply with accessibility requirements in § 5.01(c).[4]

An individual, treating provider, or other person identified at § 80.02(b) may request an expedited eligibility appeal by indicating that the time otherwise permitted for a State fair hearing could jeopardize the individual's life or health or ability to attain, maintain or regain maximum function. For the rule on expedited eligibility appeals, see § 80.07.

[1] For rules that govern internal appeals, State fair hearings grievances, and notices on Medicaid Services, refer to HCAR 8.100.

[2] 45 CFR § 155.505.

[3] 42 CFR § 431.206; 45 CFR § 155.515.

[4] 45 CFR §§ 155.505(e) and (f).

(c) Notification of State fair hearing rights. AHS will, at the times specified in § 68.01(c), provide every individual in writing with an explanation of their State fair hearing rights as described in § 68.01(b)(2) and their right to request an expedited eligibility appeal pursuant to § 80.07.

80.03 Right to a State fair hearing (10/01/2021, GCR 20-005)

(a) When a State fair hearing is required.[5] AHS will grant an opportunity for a State fair hearing to any individual who requests it because AHS terminates, suspends, denies or reduces their eligibility, reduces their level of benefits or services, their claim is not acted upon with reasonable promptness, they are aggrieved by any other action taken by AHS affecting their receipt of assistance, benefits or services or by agency policy as it affects their situation, or they believe an action or decision by AHS has been taken erroneously. This includes, if applicable:

(1) A determination of the amount of medical expenses which must be incurred to establish Medicaid eligibility in accordance with § 7.03(a)(8) or § 8.06;

(2) A determination of income for the purposes of imposing Medicaid premiums and cost-sharing requirements;

(3) A determination for any month that an individual is ineligible for APTC because the individual is considered eligible for other MEC under § 12.02(b) and § 23.00. This includes, but is not limited to, determinations of affordability and minimum value for employer-sponsored plans;

(4) An initial determination of eligibility, including the amount of APTC, the Vermont Premium Reduction and level of federal or state CSR;

(5) A redetermination of eligibility, including the amount of APTC, the Vermont Premium Reduction and level of federal or state CSR;

(6) A failure by AHS to provide timely notice of a determination; and

(7) A determination of eligibility for a special enrollment period.

(b) Exception: SSI enrollees. An applicant for or recipient of SSI/AABD benefits who is denied SSI/AABD benefits or has their SSI/AABD benefits terminated because the SSA or its agent found the individual to be not disabled, may not appeal the Medicaid denial or termination that results from this action by the SSA or its agent to the Human Services Board (see Disability Determination Appeal under § 81.00).

(c) Exception: Mass changes. There is no right to a State fair hearing or an expedited eligibility appeal when either state or federal law requires automatic case adjustments for classes of enrollees, unless the reason for an individual's appeal is incorrect eligibility determination.

[5] 42 CFR § 431.220; 45 CFR § 155.505.

80.04 Request for a State fair hearing[6] (07/01/2019, GCR 18-126)

(a) Method for requesting a State fair hearing. An individual, or an authorized representative on behalf of an individual, or a person identified at § 80.02(b), may submit a State fair hearing request:

(1) By telephone;

(2) Via mail;

(3) In person;

(4) Through other commonly available electronic means; and

(5) Via the internet.

(b) AHS's responsibilities related to a State fair hearing request.[7] AHS will:

(1) Assist the individual making the State fair hearing request, if requested;

(2) Not limit or interfere with the individual's right to make a State fair hearing request; and

(3) Consider a State fair hearing request to be valid if it is submitted in accordance with § 80.03 and paragraphs (a) and (c) of this subsection § 80.04.

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

(c) Timely request. An individual must request a fair hearing within 90 days from the date that notice of decision is sent by AHS (see § 68.01).

(d) Scope of State fair hearing request.[8] If an individual has been denied eligibility for Medicaid, AHS will treat an appeal of a determination of eligibility for APTC or CSR as including a request for an appeal of the Medicaid determination.

80.05 AHS Secretary's decision and further appeal (01/01/2024, GCR 23-088)

[6] 42 CFR § 431.221; 45 CFR § 155.520.

[7] 45 CFR § 155.520(a).

[8] 42 CFR § 431.221(e).

(a) AHS Secretary's decision[9]

(1) The Secretary of AHS will:

(i) Adopt the Human Services Board's decision or order, except that the Secretary may reverse or modify a decision or order of the Human Services Board if:

(A) The Human Services Board's findings of fact lack any support in the record; or

(B) The decision or order misinterprets or misapplies State or federal policy or rule.

(ii) Issue a written decision setting forth the legal, factual or policy basis for reversing or modifying a decision or order of the Human Services Board.

(2) An order of the Human Services Board will become the final and binding decision of AHS upon its approval by the Secretary. The Secretary will either approve, modify or reverse the Human Services Board's decision and order within 15 days of the date of the Human Services Board's decision and order. If the Secretary fails to issue a written decision within 15 days as required by this paragraph (a)(2), the Human Services Board's decision and order will be deemed to have been approved by the Secretary. The Secretary will approve, modify, or reverse a Human Services decision and order entered pursuant to § 80.07(f) within the timelines set forth in § 80.07(f)(2).

(b) Judicial review of AHS Secretary's decision.[10] An individual may, at the same time or independent of an HHS appeal (as described in (c) of this subsection), if applicable, appeal a decision of the AHS Secretary, made pursuant to § 80.05(a)(2), to the Supreme Court. Such appeals shall be pursuant to Rule 13 of the Vermont Rules of Appellate Procedure. The Supreme Court may stay the Secretary's decision upon the individual's showing of a fair ground for litigation on the merits. The Supreme Court will not stay the Secretary's order insofar as it relates to a denial of retroactive benefits.

(c) HHS appeal[11]

(1) An individual may make an appeal request to the HHS appeals entity within the time frame described in (2) of this paragraph (c) if the individual disagrees with the order of the Human Services Board or the AHS Secretary's reversal or modification, made pursuant to § 80.05(a)(2), regarding:

(i) A determination for any month that an individual is ineligible for APTC because the individual is considered eligible for other MEC under § 12.02(b) and § 23.00. This includes, but is not limited to, determinations of affordability and minimum value for employer-sponsored plans;

(ii) An initial determination of eligibility, including the amount of APTC, the Vermont Premium Reduction and level of federal or state CSR;

[9] 3 VSA § 3091(h).

[10] 3 VSA § 3091(h)(3); 45 CFR § 155.505(g).

[11] 45 CFR § 155.520(c).

(iii) A redetermination of eligibility, including the amount of APTC, the Vermont Premium Reduction and level of federal or state CSR; and

(iv) A failure by AHS to provide timely notice, as required by § 68.02, in regard to the determinations described in (i) through (iii) above.

(2) An appeal request to the HHS appeals entity under (1) of this paragraph (c) must be made within 30 days of the date of the final and binding decision described in § 80.05(a)(2). Such a request may be made at the same time or independent of judicial review.

(3) An individual who disagrees with the decision made by the HHS appeals entity may request review of the decision by the CMS Administrator. This administrative review process is described at 45 CFR § 155.505(g).

80.06 Implementation of State fair hearing decisions[12] (07/01/2019, GCR 18-126)

Upon receiving a final and binding decision as described in § 80.05(a)(2), AHS will promptly implement the decision.

(a) In connection with a QHP decision:

(1) Implementation of the decision will be effective:

(i) Prospectively, on the first day of the month following the date of the notice, or consistent with § 73.06 if applicable; or

(ii) Retroactively, to the coverage effective date the appellant did receive or would have received if the appellant had enrolled in coverage under the incorrect eligibility determination that is the subject of the appeal, at the option of the individual.

(2) AHS will redetermine the eligibility of household members who have not appealed their own eligibility determinations but whose eligibility may be affected by the State fair hearing decision.

(b) In connection with a Medicaid decision:

(1) *Corrective payments.* If the decision is favorable to the individual, corrective payments will be promptly made, retroactive to the date an incorrect action was taken; or

(2) If the decision is favorable to AHS:

(i) If the decision results in the individual's ineligibility, AHS will terminate continued coverage on the last day of the month in which AHS acts to implement the decision; or

(ii) If the decision results in a higher premium level, AHS will implement the higher premium level effective for the next monthly billing cycle following the decision.

[12] 45 CFR § 155.545(c).

80.07 Expedited eligibility appeals: expedited internal appeals and expedited State fair hearings[13] (07/01/2019, GCR 18-126)

(a) In general

(1) Right to expedited eligibility appeal for health benefit applicants/enrollees. Health benefit applicants and enrollees have a right to an expedited eligibility appeal, either through the internal appeal process (QHPs) or the State fair hearing process (Medicaid), when the individual has an immediate need for health services and taking the time otherwise permitted for a State fair hearing could jeopardize the individual's life or health or ability to attain, maintain or regain maximum function.

(i) QHPs. Individuals who request an expedited eligibility appeal related to a QHP through Vermont Health Connect have a right to an expedited internal appeal meeting, as described at § 80.07(e).

(ii) Medicaid. Individuals who request an expedited eligibility appeal related to Medicaid have a right to an expedited State fair hearing, as described at § 80.07(f).

(2) Assistance. AHS will assist the individual requesting the expedited eligibility appeal, if asked, and will not limit or interfere with the individual's right to appeal.

(3) Independent Reviewer

(i) The person or persons deciding an individual's expedited eligibility appeal request on behalf of AHS will not have been involved with the unfavorable determination or other issue that is the subject of the appeal.

(ii) If it is determined that the expedited eligibility appeal request meets the criteria for such appeals, the person or persons hearing and deciding the expedited internal appeal or the expedited State fair hearing on behalf of AHS will not have been involved in the unfavorable determination or other issue that is the subject of the appeal.

(4) Accessibility. The processes set forth in this subsection will comply with the accessibility requirements in § 5.01(c).

(b) Requesting an expedited eligibility appeal

(1) Who may request an expedited eligibility appeal. An individual, and with the consent of the individual, the treating provider, or another person identified at § 80.02(b) may request an expedited eligibility appeal.

(2) How to request an expedited eligibility appeal. A request for an expedited eligibility appeal may be made to AHS orally, in writing, or by any other method identified at § 80.04(a).

[13] 42 CFR § 431.224; 45 CFR § 155.540.

(3) When a State fair hearing request is considered an expedited eligibility appeal request. AHS will consider a State fair hearing request as an expedited eligibility appeal request if the individual, or other person appealing on the individual's behalf, indicates that the individual has an immediate need for health services and that taking the time otherwise permitted for a State fair hearing could jeopardize the individual's life or health or ability to attain, maintain or regain maximum function.

(4) Necessary information. AHS will act promptly and in good faith to obtain the information necessary to resolve the expedited eligibility appeal request. "Necessary information" may include the opinion of the treating provider and the results of any face-to-face clinical evaluation or second opinion that may be required.

(5) No punitive action. AHS will not take any punitive action against a provider who requests an expedited eligibility appeal or supports an individual's request.

(c) Denial of an expedited eligibility appeal request

(1) Timing of notice of denial.[14] If AHS denies a request for an expedited eligibility appeal because it does not meet the criteria at § 80.07(a)(1), AHS will inform the individual as expeditiously as possible that the request does not meet the criteria for expedited eligibility appeals and that the appeal will be processed within the standard State fair hearing timeframe.

(2) Telephonic notice. AHS will promptly (as expeditiously as possible but not more than two (2) business days from the date of the individual's request for an expedited eligibility appeal made pursuant to § 80.07(b)) provide telephonic notice of the denial of the request of the expedited eligibility appeal to the individual.

(3) Written notice. Telephonic notice to the individual will be followed with a written notice.

(4) Content of denial notice.[15] The denial notice will include:

(i) The reason for the denial;

(ii) An explanation that the appeal will continue to be processed within the standard fair hearing procedures and timeframe;

(iii) An explanation of the individual's rights under the State fair hearing process; and

(iv) Contact information for the Office of the Health Care Advocate.

[14] 42 CFR § 431.224(b); 45 CFR § 155.540(b).

[15] 45 CFR § 155.540(b)(2).

(5) No right to State fair hearing on denial. A denial of a request for an expedited eligibility appeal is not an independent basis for review by the Human Services Board.

(d) Approval of an expedited eligibility appeal request

(1) Timing of notice of approval.[16] If AHS determines that an individual's expedited eligibility appeal request meets the criteria for such appeals, AHS will inform the individual as expeditiously as possible that the request meets the criteria.

(i) Telephonic notice. AHS will promptly (as expeditiously as possible but not more than two (2) business days from the date of the individual's request for an expedited eligibility appeal) provide telephonic notice to the individual that AHS has approved the request for an expedited eligibility appeal.

(ii) Written notice. Telephonic notice to the individual will be followed with written notice. The notice is described at § 80.07(e)(1)(i) and (f)(1)(i).

(e) Expedited internal eligibility appeals (QHPs)[17]

(1) Procedures

(i) AHS will notify the individual of the following:

(A) The date and time of the meeting on the expedited eligibility appeal;

(B) The telephone number to call to participate in the meeting;

(C) Contact information for the Office of the Health Care Advocate; and

(D) The individual's rights during the expedited eligibility appeal process.

(ii) AHS will hold a meeting to decide the expedited eligibility appeal.

(iii) The individual will have the right to:

(A) Participate,

(B) Be accompanied and represented,

(C) Present oral and written evidence, and

(D) Present argument.

(iv) AHS will provide the individual with the opportunity to review the appeal record, including all documents and records considered by the decision-maker.

[16] 42 CFR § 431.224(b).

[17] 45 CFR § 155.540.

(v) AHS will consider the information used to determine the individual's eligibility as well as any additional relevant evidence presented during the course of the expedited appeal process, including at the appeal meeting.

(vi) Expedited eligibility appeals conducted under this subsection are not contested cases pursuant to 3 V.S.A. Chapter 25. The expedited internal appeal process, as described under this subsection, is not a fair hearing within the meaning of 3 V.S.A. § 3091. The decisions from expedited internal appeals have no precedential value.

(2) Timeline for resolving expedited eligibility appeals

(i) AHS will hold a meeting and send notice of the written decision within seven (7) business days following the date the individual requests the expedited appeal.

(ii) AHS will send the written decision within the timeframes in 80.07(e)(2)(i) above except in unusual circumstances in which case AHS will send the written decision within no more than 21 days following the individual's expedited eligibility appeal request.

(A) Unusual circumstances mean AHS cannot reach a decision because the individual requests delay or fails to take a required action or there is administrative or other emergency beyond AHS's control. AHS must send the individual written notice of the reason for the delay.

(3) Content of written notice of decision.

(i) The written notice of decision will include:

(A) A statement of the decision, including a plain language description of the effect of the decision on the individual's eligibility;

(B) A summary of the facts relevant to the appeal;

(C) The legal basis, including the regulations, supporting the decision;

(D) The effective date of the decision;

(E) An explanation that the appeal will continue to be processed within the standard State fair hearing procedures and timeframe, unless the individual notifies the Human Services Board that the individual wishes to withdraw the request for a State fair hearing; and

(F) Contact information for the Office of the Health Care Advocate.

(f) Expedited eligibility State fair hearings (Medicaid)[18]

(1) Procedures

(i) The Human Services Board will notify the individual of the following:

(A) The date and time of the hearing on the expedited eligibility appeal;

[18] 42 CFR § 431.224.

(B) The location of the hearing, if it will be held in person, or a description of how to participate by telephone, if the hearing will be held by phone;

(C) Contact information for the Office of the Health Care Advocate; and

(D) The individual's rights during the expedited eligibility appeal process, including the right: to review the appeal record, including all documents and records considered by the person deciding the expedited eligibility appeal; to participate in the hearing; to be accompanied or represented during the hearing; to present oral and written evidence; and to present argument.

(ii) The Human Services Board will conduct a hearing to decide the expedited eligibility appeal.

(A) The hearing will be recorded.

(B) The individual will have the right to:

(I) Participate,

(II) Be accompanied and represented,

(III) Present oral and written evidence, and

(IV) Present argument.

(iii) The individual will be provided an opportunity to review the appeal record, including all documents and records to be considered by the hearing officer, at a reasonable time before the date of the hearing and during the hearing.[19]

(iv) The Human Services Board will consider the information used to determine the individual's eligibility as well as any additional relevant evidence presented during the course of the appeal process, including at the hearing.

(2) Timeline for resolving expedited eligibility appeals

(i) MCA: A final and binding decision or order will be sent to the individual as expeditiously as possible but not more than seven (7) business days following the date the individual requests the expedited eligibility appeal.

(ii) MABD and all long-term care Medicaid: A final and binding decision or order will be sent to the individual as expeditiously as possible following the date the individual requests the expedited eligibility appeal.[20]

(iii) A final and binding decision or order will be sent to the individual within the timeframes in § 80.07(f)(2)(i) and (ii) above except in unusual circumstances.

[19] 42 CFR § 431.242(a).

[20] 42 CFR § 431.244(f)(3)(i).

(A) Unusual circumstances mean the Human Services Board cannot reach a decision because the individual requests delay or fails to take a required action or there is an administrative or other emergency beyond the Human Services Board's control. The Human Services Board must document the reason for delay in the individual's appeal record and send the individual written notice of the reason for the delay.[21]

(B) In no case will the Human Services Board send its decision to the individual more than 21 days from the individual's request for an expedited State fair hearing.

(iv) If the U.S. Department of Health and Human Services (HHS) establishes a shorter timeframe for resolving expedited eligibility appeals, including the days available for extension, the Human Services Board will follow the timeframe established by HHS.

(3) Content of written notice of decision

(i) The written notice will include:

(A) A statement of the decision, including a plain language description of the effect of the decision on the individual's eligibility;

(B) A summary of the facts relevant to the appeal;

(C) The legal basis, including the regulations, supporting the decision;

(D) The effective date of the decision; and

(E) Contact information for the Office of the Health Care Advocate.

(g) Implementation of expedited internal appeal decisions and State fair hearing decisions or orders. AHS will promptly implement expedited internal appeal decisions and expedited State fair hearing decisions or orders in accordance with the eligibility determination set forth in the decision or order.

81.00 Disability determination appeal (01/15/2017, GCR 16-101)

(a) SSA disability decision

(1) A final SSA disability determination is binding on AHS for 12 months or, if earlier, until the determination is changed by SSA, and may not be appealed through AHS's appeal process. However, when an individual who has been found "not disabled" by the SSA meets the requirements specified in § 8.04, they, though not entitled to an appeal of the SSA determination through AHS's appeal process, are entitled to a separate state determination of disability for the purposes of determining their eligibility for Medicaid.

(2) AHS will refer all individuals who do not meet the requirements specified in § 8.04 for a separate state determination of disability and who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability, to SSA for reconsideration or reopening of the determination.

[21] 42 CFR § 431.244(f)(4)(i).

(b) State disability decision. If AHS has made a disability determination under the circumstances specified in § 8.04, the decision may be appealed to the Human Services Board.

82.00 Maintaining benefits/eligibility pending State fair hearing[22] (07/01/2019, GCR 18-126)

(a) In general – Medicaid. When an individual appeals a decision by AHS that ends their Medicaid eligibility, reduces their benefits or services, or imposes or increases a premium, the individual has the right, under certain conditions, to have their Medicaid eligibility, benefit and service level, and premium level continue as before the decision that resulted in the State fair hearing request until the State fair hearing is resolved, provided the individual submits the request before the effective date of the adverse action and pays any required premiums. If the last day before the adverse action date is on a weekend or holiday, the individual has until the end of the first subsequent working day to request the State fair hearing. If the individual was subject to a premium prior to the adverse action that resulted in the State fair hearing request, the individual must continue to pay premiums at the same level as the premiums prior to the adverse action in order for Medicaid eligibility to continue pending resolution of the State fair hearing.

(b) Exceptions – Medicaid

(1) Continuation of Medicaid benefits does not apply when an individual's citizenship or immigration status has not been verified by the end of the 90-day opportunity period for resolving inconsistencies as described in § 54.05.

(2) Continuation of Medicaid benefits without change does not apply when the fair hearing is based solely on a reduction or elimination of a benefit required by federal or state law affecting some or all individuals, or when the decision does not require the minimum advance notice.

(c) Waiver of right to continued Medicaid benefits. An individual may waive their right to continued Medicaid benefits. If they do so and are successful on a State fair hearing, benefits will be paid retroactively.

(d) Recovery of value of continued Medicaid benefits. The state may recover from the individual the value of any continued Medicaid benefits paid during the State fair hearing period when the individual withdraws the State fair hearing before the decision is made, or following a final disposition of the matter in favor of the state.

(e) Continuation of Medicaid benefits pending appeal of SSA determination of disability; SSI/AABD enrollees. When an SSI/AABD enrollee is determined "not disabled" by the SSA and appeals this determination, their Medicaid benefits continue as long as their SSI/AABD benefits are continued (or could have been continued but the individual chose not to receive them during the appeal period) pending a SSA decision on the appeal. When eligibility for SSI/AABD benefits is terminated following a determination of "not disabled", Medicaid benefits end unless the individual applies and is found eligible for Medicaid on the basis of a categorical factor other than disability.

(f) Continuation of Medicaid benefits pending appeal of determination of disability; SSI/AABD applicants. When an individual enrolled in Medicaid applies for SSI/AABD and is determined "not disabled" by the SSA and files a timely appeal of this determination with the SSA, their Medicaid benefits continue until a final decision is

[22] 42 CFR § 431.230; 45 CFR § 155.525.

made on the appeal, provided the SSA's determination of "not disabled" is the only basis on which they might be found ineligible for Medicaid. If they continue to appeal unfavorable decisions by SSA, the "final decision" is made by the SSA Appeals Council.

(g) Continuation of eligibility for enrollment in a QHP, APTC, and CSR pending appeal of redetermination. After receipt of a valid State fair hearing request or notice that concerns an appeal of a redetermination, if the individual (appellant) accepts eligibility pending an appeal, AHS will continue to consider the individual (appellant) eligible, while the State fair hearing is pending, for QHP, APTC, the Vermont Premium Reduction and federal or state CSR, as applicable, in accordance with the level of eligibility immediately before the redetermination being appealed.

83.00 [Reserved] (01/15/2017, GCR 16-101)

The Vermont Statutes Online

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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.)

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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.)

§ 1901l. Medication for opioid use disorder

(a) The Agency of Human Services shall provide coverage to Medicaid beneficiaries for medically necessary medication for opioid use disorder when prescribed by a health care professional practicing within the scope of the professional's license and participating in the Medicaid program.

(b) Pending approval of the Drug Utilization Review Board, the Agency shall cover at least one medication in each therapeutic class for methadone, buprenorphine, and naltrexone as listed on Medicaid's preferred drug list without requiring prior authorization. (Added 2023, No. 22, § 7, eff. September 1, 2023.)

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The Vermont Statutes Online have been updated to include the actions of the 2023 session of the General Assembly.

NOTE: The Vermont Statutes Online is an unofficial copy of the Vermont Statutes Annotated that is provided as a convenience.

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: Oct 13, 2023

The deadline for public comment has expired. Contact the agency or primary contact person listed below for assistance.

Rule Details

Rule Number:	23P030
Title:	Health Benefits Eligibility and Enrollment Rule, State Fair Hearings and Expedited Eligibility Appeals (Part 8).
Type:	Standard
Status:	Final 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:	These proposed filings amend Parts 1-5, and 7-8 of the 8-part Health Benefits Eligibility and Enrollment (HBEE) rules. Parts 1, 2, 3, 5, and 7 were last amended effective January 1, 2023. Part 4 was last

	amended effective January 15, 2019. Part 8 was last amended effective October 1, 2021. Substantive revisions include: implementing 12 months of Medicaid continuous eligibility for children; codifying ineligibility for Qualified Health Plan subsidy if failure to reconcile tax credits for 2 consecutive years; allowing self-attestation of income for Qualified Health Plan subsidies if no tax information is available through data sources; and codifying 2 new income and resource exclusions for purposes of Medicaid eligibility for the Aged, Blind, and Disabled (MABD).
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; and Agency of Human Services including its departments.
Economic Impact:	The Agency of Human Services (AHS) anticipates that one proposed change to HBEE will have an economic impact on the State's budget, beginning in SFY2024. The estimated gross annualized budget impact of implementing 12 months of Medicaid continuous eligibility for children is $2.8 million. Federal law requires state Medicaid agencies to implement this change. There is no anticipated impact from the new income and resource exclusions for MABD eligibility. Changes related to eligibility for Qualified Health Plan (QHP) subsidies stem from federal rule changes. These federal rule changes make it easier for certain individuals to get and maintain federal subsidies. The fiscal impact for changes related to eligibility for QHP subsidies will be carried by the federal government. Other changes in Parts 1-5 and 7-8 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:	Sep 06,2023

Hearing Information

Hearing date:	10-06-2023 1:00 PM ADD TO YOUR CALENDAR
Location:	Virtual Hearing via Microsoft Teams
Address:	Meeting ID: 212 780 018 243 Passcode: iGPmNH
City:	Call in (audio only) 1+(802) 522-8456; Conference ID: 700 267 252#
State:	VT
Zip:	n/a
Hearing Notes:	For Teams Link, view Public Notice in Global Commitment Register on AHS 9c02-70edcc7559c62522252c2522Oid2522253a2522beb0dd2a-7ce6-4285-9l e799778450272522257d&data057C017CSOS.StatutoryFilings40vermont.go

Contact Information

Information for Primary Contact

PRIMARY CONTACT PERSON - A PERSON WHO IS ABLE TO ANSWER QUE 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 COPI FILINGS MAY BE REQUESTED OR WHO MAY ANSWER QUESTIONS ABOUT SUBMITTED FOR FILING IF DIFFERENT FROM THE PRIMARY CONTACT PER

Level:	Secondary
Name:	Jessica Ploesser
Agency:	Agency of Human Services
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SEND A COMMENT

Keyword Information

Keywords:

Health Benefits Eligibility and Enrollment
Vermont Health Connect
Exchange
Medicaid
QHP
Qualified Health Plan
Health Benefit
Special Enrollment Period
SEP
Annual Open Enrollment Period
AOEP
Children

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	Newport Daily Express (jlafoe@newportvermontdailyexpress.com)	Tel: 334-6568 FAX: 334-6891 Attn: Jon Lafoe
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	St. Albans Messenger Legals (legals@samessenger.com)	Tel: 524-9771 ext. 117 FAX: 527-1948 Attn: Legals
	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:** September 6, 2023

RE: The "Proposed State Rules " ad copy to run on **September 14, 2023**

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 seven 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 proposed rule(s) you are interested in.

- Health Benefits Eligibility and Enrollment Rule, General Provisions and Definitions (Part 1).
  Vermont Proposed Rule: **23P024**
- Health Benefits Eligibility and Enrollment Rule, Eligibility Standards (Part 2).
  Vermont Proposed Rule: **23P025**
- Health Benefits Eligibility and Enrollment Rule, Nonfinancial Eligibility Requirements (Part 3).
  Vermont Proposed Rule: **23P026**
- Health Benefits Eligibility and Enrollment Rule, Special Rules for Medicaid Coverage of Long-Term Services and Supports - Eligibility and Post-Eligibility (Part 4).
  Vermont Proposed Rule: **23P027**
- Health Benefits Eligibility and Enrollment Rule, Financial Methodologies (Part 5).
  Vermont Proposed Rule: **23P028**
- Health Benefits Eligibility and Enrollment Rule, Eligibility-and-Enrollment Procedures (Part 7).
  Vermont Proposed Rule: **23P029**
- Health Benefits Eligibility and Enrollment Rule, State Fair Hearings and Expedited Eligibility Appeals (Part 8).
  Vermont Proposed Rule: **23P030**

AGENCY: Agency of Human Services

CONCISE SUMMARY: These proposed filings amend Parts 1-5, and 7-8 of the 8-part Health Benefits Eligibility and Enrollment (HBEE) rules. Parts 1, 2, 3, 5, and 7 were last amended effective January 1, 2023. Part 4 was last amended effective January 15, 2019. Part 8 was last amended effective October 1,

2021. Substantive revisions include: implementing 12 months of Medicaid continuous eligibility for children; codifying ineligibility for Qualified Health Plan subsidy if failure to reconcile tax credits for 2 consecutive years; allowing self-attestation of income for Qualified Health Plan subsidies if no tax information is available through data sources; and codifying 2 new income and resource exclusions for purposes of Medicaid eligibility for the Aged, Blind, and Disabled (MABD).

FOR FURTHER INFORMATION, CONTACT: Danielle Fuoco Agency of Human Services 280 State Drive, Waterbury, VT 05671-1000; Tel: 802-585-4265; Fax: 802-241-0450; E-mail: 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, NOB 1 South, Waterbury, VT 05671 Tel: 802-241-0454 Fax: 802-241-0450 E-Mail: jessica.ploesser@vermont.gov.
