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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)