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Table of Contents

Part One
General Provisions and Definitions

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

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

2.00 General description of health benefits in Vermont (subject to specific criteria in subsequent sections) (01/15/2019, GCR 18-060)

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

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

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

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

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

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

2.02 Medicaid (01/15/2017, GCR 16-094)

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

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

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

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

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

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

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

The scope of coverage for children under the EPSDT provisions of Title XIX is different and more extensive than coverage for adults. The EPSDT provisions of Medicaid law specify that services that are optional for adults are mandatory covered services for all Medicaid-eligible children under age 21 when such services are determined necessary as a result of an EPSDT screen. Specifically, Vermont is required to provide

> such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of [1396d] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State [Medicaid] plan.[3]

A further definition of the scope of EPSDT services is found in 42 USC § 1396d(a)(13) which requires states to provide

> other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, home, or other setting) recommended by a physician or other licensed professional of the healing arts within the scope of their practice under State Law, for the maximum reduction of physical or mental disability and restoration of an individual to the best functional level.

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

[2] Former Medicaid Rule 4100.

[3] 42 USC § 1396d(r)(5).

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

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

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

(b) Vermont CHIP. Vermont utilizes CHIP to provide health coverage to uninsured children with household incomes above 237% and at or below 312% of the federal poverty level (FPL). CHIP is part of the coverage array known as "Dr. Dynasaur." All of the provisions in this rule that apply to the "child" Medicaid coverage group (§ 7.03(a)(3)) apply with equal effect to an individual who is enrolled in CHIP.

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

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

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

Additionally, catastrophic plans are available to certain individuals.

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

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

[4] 42 USC § 1396a(a)(17).

[5] 42 CFR § 440.230(d).

[6] 42 CFR § 440.230(b).

[7] 42 CFR § 440.230(c).

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

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

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

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

(c) Administrative Requirements. Federal health-care regulations contain a number of provisions aimed at the administration of the health-benefits eligibility-determination process. These provisions are intended to promote administratively-efficient, streamlined, and coordinated eligibility business processes.

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

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

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

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

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

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

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

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

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

[8] 26 CFR 1.36B-2.

[9] See 26 CFR § 1.36B-2.

[10] Derived from ESD All Programs Rule 2000.

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

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

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

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

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

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

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

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

3.00 Definitions (01/15/2019, GCR 18-060)

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

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

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

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

[11] 26 CFR § 1.36B-3(e).

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

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

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

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

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

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

Applicant[17]

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

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

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

Application date

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

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

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

Application filer[19]

(a) Applicant;

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

[15] 45 CFR § 155.20.

[16] 26 CFR § 1.36B-3(f).

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

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

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

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

(c) Authorized representative; or

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

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

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

Authorized representative. A person or entity designated by an individual to act responsibly in assisting the individual with their application, renewal of eligibility and other ongoing communications. See, § 5.02.

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

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

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

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

Caretaker relative[22]

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

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

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

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

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

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

[21] 45 CFR § 155.20.

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

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

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

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

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

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

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

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

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

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

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

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

Code. Internal Revenue Code.

Community spouse (CS). For purposes of Medicaid, the spouse of an institutionalized individual who is not living in a medical institution or a nursing facility. An individual is considered a community spouse even when receiving

[23] 42 CFR § 435.4.

[24] 45 CFR § 156.155

Medicaid coverage of long-term care services and supports in a home and community-based setting if they are the spouse of an individual who is also receiving Medicaid coverage of long-term care services and supports.

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

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

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

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

Coverage date. The date coverage begins.

Coverage family.[27] See, § 60.02(b).

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

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

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

(a) An individual is receiving coverage;

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

(c) If the individual is enrolled in a QHP with APTC, the individual is not eligible for Minimum Essential Coverage

[25] 45 CFR §§ 155.20 and 156.20.

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

[27] 26 CFR § 1.36B-3(b)(1).

[28] 42 CFR § 435.10(b).

[29] 26 CFR § 1.36B-3(c).

(MEC) other than coverage in the individual market, as referenced in § 5000A(f)(1)(C) of the Code.

Date of application. See, application date.

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

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

Dependent child.[30] An individual who is:

(a) Under the age of 18; or

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

Disability[31]

(a) Individual age 18 and older. An individual age 18 and older is considered disabled if they are unable to engage in any substantial gainful activity because of any medically-determinable physical or mental impairment, or combination of impairments, that can be expected to result in death, or has lasted or can be expected to last for a continuous period of not fewer than 12 months. To meet this definition, an individual must have a severe impairment, which makes them unable to do their previous work or any other substantial gainful activity that exists in the national economy. To determine whether an individual is able to do any other work, AHS considers their residual functional capacity, age, education, and work experience.

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

Disenroll. To end coverage.

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

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

[30] 42 CFR § 435.4.

[31] Former Medicaid SSI Rule 4213.

[32] 42 CFR §§ 435.4 and 435.914.

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

Eligible employer-sponsored plan[33]

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

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

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

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

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

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

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

Enroll. To initiate coverage for an approved individual.

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

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

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

[34] 26 USC § 5000A(f)(1)(D).

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

[36] 45 CFR § 155.20.

[37] 42 CFR § 435.4.

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

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

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

Family size. See, § 28.02(b).

Federal poverty level (FPL).[41] The poverty guidelines most recently published in the Federal Register by the Secretary of HHS under the authority of 42 USC § 9902(2), as in effect for the applicable budget period used to determine an individual's income eligibility for means-tested health benefits.

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

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

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

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

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

[39] 45 CFR § 155.20.

[40] 26 CFR § 1.36B-1(m).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Individual. An applicant or enrollee for health benefits.

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

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

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

[47] 45 CFR § 155.20.

[48] 25 CFR § 900.6.

[49] 25 CFR § 900.6.

[50] 42 CFR § 435.1010. This is the definition referred to in 42 CFR § 435.403(b) and 45 CFR § 155.305(a)(3). "Assisted living" is considered a community setting and not a medical institution or nursing facility because assisted living does not

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

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

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

Lawfully present. See, § 17.01(g).

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

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

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

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

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

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

(b) Traumatic brain injury services (TBI);

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

(d) Children's mental health services.

include 24-hour care, has privacy, a lockable door, and is a homelike setting. Former PP&D to Former Medicaid Rule 4201.

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

[52] 42 CFR § 435.603(j)(4).

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

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

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

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

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

Medicaid services.[54] Medical benefits funded through Medicaid. They include Medicaid services (Medicaid Covered Services Rules 7201 – 7508.7), long-term care services and supports (Medicaid Covered Services Rules 7601 – 7608), services defined in regulations for Choices for Care, Developmental Disabilities, and the waiver for Traumatic Brain Injury supports, as specified in relevant waiver authorizations.

Medical incapacity. See, § 64.09.

Medical institution.[55] An institution that:

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

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

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

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

[53] 42 CFR §§ 435.4 and 435.603(e).

[54] *See,* Medicaid Covered Services Rules 7201-7508.7 (Medicaid services) and 7601-7608 (long-term care services).

[55] 42 CFR § 435.1010.

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

Minimum essential coverage (MEC).[57] Health coverage under government-sponsored programs, employer-sponsored plans that meet specific criteria, grandfathered health plans, individual health plans, and certain other health-benefits coverage. See, § 23.00.

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

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

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

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

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

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

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

Patient share. See, § 24.00.

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[56] 42 CFR § 435.4.

[57] 42 CFR § 435.4; 45 CFR § 155.20.

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

[59] 45 CFR § 155.20; 33 VSA § 1807.

[60] 42 CFR § 435.4.

[61] 42 CFR § 435.4.

[62] 42 CFR § 435.4.

Physician's certificate. See, § 64.09.

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

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

Pregnant woman.[65] A woman during pregnancy and the post partum period, which begins on the date the pregnancy ends, extends 60 days, and then ends on the last day of the month in which the 60-day period ends.

Premium

(a) In general. A monthly charge that must be paid by an individual as a condition of initial and ongoing health-benefits eligibility and enrollment.

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

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

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

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

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

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

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

[63] 45 CFR §§ 155.20 and 156.20.

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

[65] 42 CFR § 435.4.

[66] Former Medicaid rules 4218.2 and 4332.2.

[67] Former Medicaid rules 4218.1 and 4332.1.

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

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

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

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

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

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

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

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

Reasonable compatibility. See, § 57.00(a).

Reenroll. To restore coverage after closure.

Reinstate. To restore eligibility after cancellation or closure.

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

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

[68] 45 CFR §§ 155.20 and 156.20. 26 CFR § 1.36B-1(c) defines the term as follows: "QHP. The term QHP has the same meaning as in section 1301(a) of the ACA (42 USC § 18021(a)) but does not include a catastrophic plan described in section 1302(e) of the ACA (42 USC § 18022(e)."

[69] 45 CFR §§ 155.20 and 156.20.

[70] 45 CFR §§ 155.20 and 156.20.

[71] 45 CFR § 155.300.

[72] 42 CFR § 435.4.

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

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

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

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

Substantial gainful activity

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

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

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

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

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

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

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

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

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

[73] 26 CFR § 1.36B-1(l).

[74] 45 CFR § 155.20.

[75] 45 CFR § 155.300.

Tax dependent

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

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

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

4.00 General program rules (01/15/2019, GCR 18-060)

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

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

4.02 Rights of individuals with respect to application for and receipt of health benefits through AHS (01/01/2018, GCR 17-043)

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

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

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

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

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

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

(g) Right to be assisted by others

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

[76] See, 45 CFR §§ 92.101 and 155.120(c)(1); see, also, ESD All Programs Rule 2000(C).

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

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

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

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

(i) Right to appeal. An individual has the right to appeal, as provided in § 68.00.

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

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

(2) AHS determines that such services are necessary.

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

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

(b) Responsibility to report changes[77]

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

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

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

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

(5) An individual, or an application filer on behalf of the individual, will be allowed to report changes via the

[77] Derived from former Medicaid Rule 4140.

channels available for the submission of an application, as described in § 52.02.

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

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

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

(1) Applications for benefits;

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

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

(ii) Budgetary computations;

(iii) Eligibility decisions; and

(iv) Payment authorizations.

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

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

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

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

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

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

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

[78] From former All-Programs Rule 2013.

[79] From former Medicaid Rule 4104.

to check facts with the individual.

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

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

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

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

(1) "[K]nowingly fails, by false statement, misrepresentation, impersonation, or other fraudulent means, to disclose a material fact used in making a determination as to the qualifications of that person to receive aid or benefits under a state or federally funded assistance program, or who knowingly fails to disclose a change in circumstances in order to obtain or continue to receive under a program aid or benefits to which he or she is not entitled or in an amount larger than that to which he or she is entitled, or who knowingly aids and abets another person in the commission of any such act . . . ;"[80] or

(2) "[K]nowingly uses, transfers, acquires, traffics, alters, forges, or possesses, or who knowingly attempts to use, transfer, acquire, traffic, alter, forge, or possess, or who knowingly aids and abets another person in the use, transfer, acquisition, traffic, alteration, forgery, or possession of a . . . certificate of eligibility for medical services, or Medicaid identification card in a manner not authorized by law . . . ."[81]

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

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

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

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

(2) Was the omission or incorrect representation an error or result of the individual's misunderstanding of

[80] 33 VSA § 141(a).

[81] 33 VSA § 141(b).

eligibility requirements or the responsibility to provide information?

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

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

(e) Examples

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

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

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

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

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

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

(f) Methods of investigation. Any investigation of a case of suspected fraud is pursued with the same regard for confidentiality and protection of the legal and other rights of the individual as with a determination of eligibility.

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

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

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

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

(a) When personally-identifiable information is collected or created for the purposes of determining eligibility for enrollment in a QHP, determining eligibility for health-benefits programs, or determining eligibility for exemptions from the individual responsibility provisions in § 5000A of the Code, such information will be used or disclosed only to the extent such information is necessary to administer health care program functions in accordance with federal and state laws.

(b) Requirements of AHS. AHS must establish and implement privacy and security standards that are consistent

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

with the following principles.

(1)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.00 Eligibility and enrollment assistance (01/15/2019, GCR 18-060)

5.01 Assistance offered through AHS (01/15/2017, GCR 16-094)

(a) In general.[85] AHS will provide assistance to any individual seeking help with the application or renewal process in person, over the telephone, and online, and in a manner that is accessible to individuals with disabilities and those who are limited English proficient. Eligibility and enrollment assistance that meets the accessibility standards in paragraph (c) of this subsection is provided, and referrals are made to assistance programs in the state when available and appropriate. These functions include assistance provided directly to any individual seeking help with the application or renewal process.

[83] 45 CFR § 155.270(a).

[84] 45 CFR § 155.270(b).

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

(b) Assistance tools

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

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

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

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

(A) Premium and cost-sharing information;

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

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

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

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

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

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

(H) The provider directory made available to VHC.

(iii) Publishes the following financial information:

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

(B) Any regulatory fees required by VHC;

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

(D) Administrative costs of VHC; and

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

(iv) Provides individuals with information about Navigators as described in § 5.03 and other consumer

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

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

assistance services, including the toll-free telephone number of the call center required in paragraph (b)(1) of this subsection.

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

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

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

(c) Accessibility[88]

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

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

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

(i) Oral interpretation;

(ii) Written translations;

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

(iv) Website translations.

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

(d) Availability of program information[89]

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

(i) The eligibility requirements;

(ii) Available health benefits and services; and

(iii) The rights and responsibilities of individuals.

(2) Bulletins or pamphlets that explain the rules governing eligibility and appeals in simple and

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

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

understandable terms will be published in quantity and made available.

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

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

(f) Americans with Disabilities Act (ADA).[91] As required by the Americans with Disabilities Act, reasonable accommodations and modifications will be made to policies, practices, or procedures when necessary, as determined by the appropriate commissioners or their designees, to provide equal access to programs, services and activities, or when necessary to avoid discrimination on the basis of disability. An individual may appeal the commissioner's determination regarding necessity to the appropriate fair hearings entity or appeals entity in accordance with departmental regulations governing appeals and fair hearings.

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

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

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

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

(a) In general

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

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

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

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

(3) Except as provided in paragraph (h) of this subsection, and consistent with current state policy and

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

[91] All Programs Rule 2030.

[92] 45 CFR § 155.120(c)(1).

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

practice, designation of an authorized representative must be in writing, including the individual's signature, or through another legally binding format subject to applicable authentication and data security standards.

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

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

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

(b) Scope of authority

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

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

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

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

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

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

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

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

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

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

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

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

(c) Duration of authorization

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

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

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

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

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

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

(1) Is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation, as described in paragraph (b) of this subsection, to the same extent as the individual they represent; and

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

(e) Condition of representation

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

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

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

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

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

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

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

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

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

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

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

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

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

5.03 Navigator program (01/01/2018, GCR 17-043)

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

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

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

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

(i) The needs of underserved and vulnerable populations;

(ii) Eligibility and enrollment rules and procedures;

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

[95] From All Programs Rule 2014.

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

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

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

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

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

(vi) The process of filing eligibility appeals;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[98] 45 CFR § 155.210(c).

[99] 45 CFR § 155.210(d).

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

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

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

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

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

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

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

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

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

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

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

[100] 45 CFR § 155.215(a).

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

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

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

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

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

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

(4) Provide information about and facilitate employers' establishment of cafeteria or premium-only plans under § 125 of the Code that allow employees to pay for health insurance premiums with pretax dollars.

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

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

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

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

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

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

with the Americans with Disabilities Act and § 504 of the Rehabilitation Act;

(10) Ensure that individuals:

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

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

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

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

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

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

(i) Understanding the process of filing eligibility appeals;

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

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

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

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

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

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

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

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

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

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

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

(b) Agreement.[103] Prior to enrolling a qualified individual, employee, or employer in a QHP through VHC, or assisting an individual in applying for a QHP with financial assistance, a broker must have an executed agreement with AHS, and must comply with the terms of that agreement, which includes at least the following requirements:

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

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

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

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

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

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

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

(b) Certification

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

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

[104] 33 V.S.A. § 1805(17).

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

(2) To be certified, application counselors must:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Individuals are informed, prior to receiving assistance, of the functions and responsibilities of certified application counselors, including that certified application counselors are not acting as tax advisers or

attorneys when providing assistance as certified application counselors and cannot provide tax or legal advice within their capacity as certified application counselors;

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

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

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

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

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

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

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

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

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

(g) Non-discrimination and organizations receiving federal funds to provide services to defined populations.[106] Notwithstanding the non-discrimination provisions of § 5.01(g), an organization that receives federal funds to provide services to a defined population under the terms of federal legal authorities that participates in the

[106] 45 CFR § 155.120(c)(2).

certified application counselor program may limit its provision of certified application counselor services to the same defined population, but must comply with § 5.01(g) with respect to the provision of certified application counselor services to that defined population, If the organization limits its provision of certified application counselor services pursuant to this exception, but is approached for certified application counselor services by an individual who is not included in the defined population that the organization serves, the organization must refer the individual to other AHS-approved resources that can provide assistance. If the organization does not limit its provision of certified application counselor services pursuant to this exception, the organization must comply with § 5.01(g).

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Part Two
Eligibility Standards

The term “health benefits” encompasses a wide range of programs and benefits, including various categories of Medicaid, pharmacy benefits, eligibility for enrollment in a Qualified Health Plan (QHP), and tax credits and cost-sharing reductions that make QHPs more affordable. Part Two describes the eligibility standards for each program or benefit.

6.00 Medicaid – in general (01/15/2017, GCR 16-095)

(a) In general. To qualify for Medicaid, an individual must meet nonfinancial, categorical, and financial eligibility criteria.

(b) Nonfinancial criteria. The nonfinancial criteria include the following:

(1) Citizenship or immigration status (§ 17.00);

(2) Vermont residency (§ 21.00);

(3) Social Security number requirements (§ 16.00);

(4) Assignment-of-rights and cooperation requirements (§ 18.00);

(5) Living-arrangement requirements (§ 20.00); and

(6) Pursuit of potential unearned income (§ 22.00).

(c) Categorical criteria. An individual must meet the categorical criteria (*e.g.*, age, disability, etc.) of at least one coverage group to be eligible for health benefits through the Medicaid program.

(d) Financial criteria. Although there are a few coverage groups with no financial requirements, financial eligibility generally requires that an individual have no more than a specified amount of income or, in some cases, resources. The Medicaid financial eligibility requirements are:

(1) Income within the income limit appropriate to the individual's covered group.

(2) Resources within the resource limit appropriate to the individual's covered group.

(3) Asset-transfer limitations for an individual who needs long-term care services and supports.

7.00 Medicaid for children and adults (MCA) (01/01/2018, GCR 17-044)

7.01 In general (01/15/2017, GCR 16-095)

An individual is eligible for MCA if they meet the nonfinancial, categorical, and financial criteria outlined in this section.

7.02 Nonfinancial criteria (01/15/2017, GCR 16-095)

The individual must meet all of the following nonfinancial eligibility criteria for Medicaid:

(a) Social Security number (§ 16.00);

(b) Citizenship or immigration status (§ 17.00)[1];

(c) Residency (§ 21.00)[2;]

(d) Living arrangements (§ 20.00);

(e) Assignment of rights and cooperation requirements (§ 18.00)[3]; and

(f) Pursuit of potential unearned income (§ 22.00).

7.03 Categorical and financial criteria (01/01/2018, GCR 17-044)

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

(1) Parent and other caretaker relative.[4] A parent or caretaker relative of a dependent child (as defined in § 3.00) and their spouse, if living within the same household as the parent or caretaker relative, with a MAGI-based household income, as defined in § 28.03, that is at or below a specified dollar amount that is set based on the parent or caretaker relative's family size and whether they live in or outside of Chittenden County. A chart of these dollar amounts is made publicly available via website.

(2) Pregnant woman[5]

(i) A pregnant woman, as defined in § 3.00 as a woman during pregnancy and the post partum period, which begins on the date the pregnancy ends, extends 60 days, and then ends on the last day of the month in which the 60-day period ends, with a MAGI-based household income, as defined in § 28.03, that is at or below 208 percent of the FPL for the applicable family size.

(ii) *Retroactive eligibility:*

[1] 42 CFR § 435.406.

[2] 42 CFR § 435.403.

[3] 42 CFR § 435.610.

[4] 42 CFR § 435.110.

[5] 42 CFR § 435.116.

A woman may be retroactively granted Medicaid eligibility under this coverage group if she was pregnant and met all eligibility criteria. However, she would not be eligible for Medicaid under this coverage group for the 60-day post partum period if she applied for Medicaid after her pregnancy ended.

(iii) *Continuous eligibility:*

(A) An eligible pregnant woman who would lose eligibility because of a change in household income is deemed to continue to be eligible throughout the pregnancy and the 60-day post partum period without regard to the change in income.[6]

(B) This provision applies to a medically-needy pregnant woman as follows: If the woman meets her spenddown while pregnant, her spenddown amount in any subsequent budget period during her pregnancy and post partum period cannot be any higher than her original spenddown amount. This is so even if she experiences an increase in her household income.

(3) Child[7]

(i) An individual, who is under the age of 19[8], with a MAGI-based household income, as defined in § 28.03, that is at or below 312 percent of the FPL for the applicable family size.

(ii) *Continuous eligibility for a hospitalized child[9]:*

(A) This provision implements section 1902(e)(7) of the Act.

(B) Medicaid will be provided to an individual eligible and enrolled under this sub clause until the end of an inpatient stay for which inpatient services are furnished, if the individual:

(I) Was receiving inpatient services covered by Medicaid on the date the individual is no longer eligible under this sub clause, based on the individual's age; and

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

(4) [Reserved]

(5) Adult[10]

(i) Effective January 1, 2014, an individual who:

[6] 42 CFR § 435.170(c).

[7] 42 CFR § 435.118.

[8] Medicaid will be provided to a child eligible and enrolled under this sub clause for the full calendar month within which their 19th birthday occurs (former Medicaid Rule 4311).

[9] 42 CFR § 435.172.

[10] 42 CFR § 435.119.

(A) Is age 19 or older and under age 65;

(B) Is not pregnant;

(C) Is not entitled to or enrolled in Medicare under parts A or B of Title XVIII of the Act;[11]

(D) Is not otherwise eligible for and enrolled in a mandatory coverage group; and

(E) Has household income that is at or below 133 percent of the FPL for the applicable family size.

(ii) *Coverage for children under 21:*[12]

Medicaid cannot be provided under this sub clause to a parent or other caretaker relative living with a child who is under the age of 21 unless such child is receiving benefits under Medicaid or Dr. Dynasaur, or otherwise is enrolled in MEC.

(6) Families with Medicaid eligibility extended because of increased earnings; Transitional Medical Assistance under § 1925 of the Social Security Act[13]

(i) In general. Families who become ineligible for Medicaid because a parent or caretaker relative has new or increased earnings may be eligible for Transitional Medical Assistance (TMA) for up to 12 months, beginning with the month immediately following the month in which they become ineligible. TMA will be provided to a parent or other caretaker relative who was eligible and enrolled for Medicaid under § 7.03(a)(1), and any dependent child of such parent or other caretaker relative who was eligible and enrolled under § 7.03(a)(3), in at least 3 out of the 6 months immediately preceding the month that eligibility for the parent or other caretaker relative under § 7.03(a)(1) was lost due to increased earnings. If a dependent child of the parent or caretaker relative remains eligible for Medicaid under § 7.03(a)(3), the child will continue to receive Medicaid coverage under that category.

(ii) Initial six-month extension. For a parent or caretaker relative to remain eligible for the first six-month extension, they must continue to have a dependent child, as defined in § 3.00, living with them. Parents, caretaker relatives, and children eligible for TMA must continue to reside in Vermont.

(iii) Additional six-month extension

(A) To be eligible for TMA for the six-month period following the initial six-month extension, parents and caretaker relatives must meet the criteria for the initial six-month extension in (ii) above, and must also:

[11] Note: The definition of adult in Medicaid (42 CFR § 435.119) and the Exchange (45 CFR § 155.305) rules varies with respect to whether the individual can be entitled to Medicare part B, but not yet enrolled. AHS has adopted the Medicaid version.

[12] 42 CFR § 435.119(c).

[13] §§ 408(a)(11)(A), 1902(e)(1)(A), 1925, and 1931(c)(2) of the Social Security Act.

(I) Report, by the 21st day of the fourth, seventh, and tenth months of the 12-month TMA period, gross earnings and child care expenses necessary for employment in the preceding three months, or establish good cause, as determined by AHS, for failure to report on a timely basis;

(II) Have earnings in all of the previous three months, unless the lack of earnings was due to an involuntary loss of employment, illness, or other good cause as determined by AHS; and

(III) Have average gross monthly earnings (less costs for child care necessary for employment) during the immediately preceding 3-month period less than or equal to 185 percent of the FPL for the applicable family size.

(B) If TMA for a parent, caretaker relative or child is terminated due to failure to meet the criteria described in (A) above, Medicaid coverage will continue under another Medicaid category if the parent, caretaker relative, or child is eligible under that category.

(C) If a parent or caretaker relative fails to meet the quarterly reporting requirement without good cause, as determined by AHS, AHS will terminate TMA. TMA will not be reinstated until the month after the quarterly report is received.

(7) Families with Medicaid eligibility extended because of increased collection of spousal support[14]

(i) Eligibility. Extended Medicaid coverage will be provided to a parent or other caretaker relative who was eligible and enrolled for Medicaid under § 7.03(a)(1), and any dependent child of such parent or other caretaker relative who was eligible and enrolled under § 7.03(a)(3), in at least 3 out of the 6 months immediately preceding the month that eligibility for the parent or other caretaker relative under § 7.03(a)(1) was lost due to increased collection of spousal support under Title IV-D of the Act.

(ii) The extended Medicaid coverage is for 4 months following the month in which the individual becomes ineligible for Medicaid due to increased collection of spousal support by the parent or other caretaker relative.

(8) Medically Needy

(i) In general.[15] An individual under age 21, a pregnant woman, or a parent or other caretaker relative, as described above, may qualify for MCA as medically needy even if their income exceeds coverage group limits.

(ii) Income eligibility.[16] For purposes of determining medically-needy eligibility under this sub clause, AHS applies the MAGI-based methodologies defined in § 28.03 subject to the requirements of §

[14] 42 CFR § 435.115, §§ 408(a)(11)(B) and 1931(c)(1) of the Social Security Act.

[15] Former Medicaid Rule 4203.

[16] 42 CFR § 435.831.

28.04.

(iii) Eligibility based on countable income. If countable income determined under paragraph (a)(8)(ii) of this sub clause is equal to or less than the PIL for the individual's family size, the individual is eligible for Medicaid.

(iv) Spenddown rules. The provisions under § 30.00 specify how an individual may use non-covered medical expenses to "spend down" their income to the applicable limits.

(9) Coverage of long-term care services and supports.[17] For an individual eligible for MCA who seeks Medicaid coverage of long-term care services and supports under MCA, AHS will apply the following rules in determining the individual's eligibility for such coverage:

(i) Substantial home-equity under § 29.09(d)(6); and

(ii) Income and resource transfers under § 25.00.

(b) No resource tests. There are no resource tests for the coverage groups described under (a) of this subsection.

8.00 Medicaid for the aged, blind, and disabled (MABD)[18] (01/15/2019, GCR 18-061)

8.01 In general (01/15/2017, GCR 16-095)

An individual is eligible for MABD if they meet the nonfinancial, categorical, and financial criteria outlined in this section.[19]

8.02 Nonfinancial criteria (01/15/2017, GCR 16-095)

The individual must meet all of the following nonfinancial eligibility criteria for Medicaid:

(a) Social Security number (§ 16.00);

(b) Citizenship or immigration status (§ 17.00);

(c) Residency (§ 21.00);

(d) Living arrangements (§ 20.00);

(e) Assignment of rights and cooperation requirements (§ 18.00); and

(f) Pursuit of potential unearned income (§ 22.00).

[17] CMS, State Medicaid Director Letter, dated February 21, 2014 (SMDL #14-001, ACA #29).

[18] Former Medicaid Rules 4200 et seq.

[19] Individuals are not required to apply for Medicare part B as a condition of eligibility for Medicaid.

8.03 Categorical relationship to SSI (01/15/2017, GCR 16-095)

An individual applying for MABD must establish their categorical relationship to SSI by qualifying as one or more of the following:

(a) Aged. An individual qualifying on the basis of age must be at least 65 years of age in or before the month in which eligibility begins.

(b) Blind. An individual qualifying on the basis of blindness must be:

(1) Determined blind by AHS's disability determination unit, or

(2) In receipt of social security disability benefits based on blindness.

(c) Disabled. An individual qualifying on the basis of disability must be:

(1) Determined disabled by AHS's disability determination unit, or

(2) In receipt of social security disability benefits based on disability.

(d) Definition: blind or disabled child. A blind or disabled individual who is either single or not the head of a household; and

(1) Under age 18, or

(2) Under age 22 and a student regularly attending school, college, or university, or a course of vocational or technical training to prepare them for gainful employment.

See, also, § 29.02(a)(1).

8.04 Determination of blindness or disability (01/15/2017, GCR 16-095)

(a) Disability and blindness determinations. Disability and blindness determinations are made by AHS in accordance with the applicable requirements of the Social Security Administration based on information supplied by the individual and by reports obtained from the physicians and other health care professionals who have treated the individual. AHS will explain the disability determination process to individuals and help them complete the required forms.

(b) Bases for a determination of disability or blindness. AHS may determine an individual is disabled in any of the following circumstances:

(1) An individual who has not applied for SSI/AABD.

(2) An individual who has applied for SSI/AABD and was found ineligible for a reason other than disability.

(3) An individual who has applied for SSI/AABD and SSA has not made a disability determination within 90 days from the date of their application for Medicaid.

(4) An individual who has been found "not disabled" by SSA, has filed a timely appeal with SSA, and a final determination has not been made by SSA.

(5) An individual who claims that:

(i) Their condition has changed or deteriorated since the most recent SSA determination of "not disabled;"

(ii) A new period of disability meets the durational requirements of the Act;

(iii) The SSA determination was more than 12 months ago; and

(iv) They have not applied to SSA for a determination with respect to these allegations.

(6) An individual who claims that:

(i) Their condition has changed or deteriorated since the most recent SSA determination of "not disabled,"

(ii) The SSA determination was fewer than 12 months ago;

(iii) A new period of disability meets the durational requirements of the Act; and

(iv) They have applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations, or they no longer meet the nondisability requirements for SSI but may meet AHS's nondisability requirements for Medicaid.

(c) Additional examinations. AHS has responsibility for assuring that adequate information is obtained upon which to base the determination. If additional information is needed to determine whether individuals are disabled or blind according to the Act, consulting examinations may be required. AHS will pay the reasonable charge for any medical examinations required to render a decision on disability or blindness.

8.05 The categorically-needy coverage groups (01/15/2019, GCR 18-061)

An individual applying for MABD must meet the criteria of one or more of the following categories.

(a) Individual enrolled in SSI/AABD[20]

(1) An individual who is granted SSI/AABD by the SSA is automatically eligible for MABD. In addition to SSI/AABD enrollees, this group includes an individual who is:

(i) Receiving SSI pending a final determination of blindness or disability; or

(ii) Receiving SSI under an agreement with the SSA to dispose of resources that exceed the SSI dollar limits on resources (recoupment).

[20] 42 CFR § 435.120; former Medicaid Rule 4202.1.

(2) Medicaid eligibility for an individual in this group is automatic; there are no Medicaid income or resource standards that apply.

(b) Individual who is SSI-eligible[21]

(1) An individual who would be eligible for SSI/AABD except that they:

(i) Have not applied for SSI/AABD; or

(ii) Do not meet SSI/AABD requirements not applicable to Medicaid (e.g., participation in vocational rehabilitation or a substance abuse treatment program).

(2) An individual in this group must:

(i) Have MABD income for the individual's financial responsibility group (as defined in § 29.03) that is at or below the SSI/AABD payment level for the individual's Medicaid group (as defined in § 29.04);

(ii) Have MABD resources for the individual's financial responsibility group that is at or below the SSI/AABD maximum for the individual's Medicaid group; and

(iii) Meet the MABD nonfinancial criteria.

(c) Individual eligible for SSI but for earnings[22] (Section 1619(b) of the Social Security Act)

(1) An individual whom the SSA determines eligible under the Act (§1619(b)) because they meet all SSI/AABD eligibility requirements except for the amount of their earnings and who:

(i) Does not have sufficient earnings to provide the reasonable equivalent of publicly-funded attendant care services that would be available if they did not have such earnings; and

(ii) Is seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment.

(2) Medicaid eligibility for an individual in this group is automatic; there are no Medicaid income or resource standards that apply.

(d) Individual with disabilities who is working (Medicaid for working people with disabilities (MWPD))

(1) An individual with disabilities who is working and, except for the amount of their income and resources, is otherwise eligible for MABD, and who:

(i) Has MABD income for the individual's financial responsibility group (as defined in § 29.03), that is:

[21] 42 CFR § 435.122; former Medicaid Rule 4202.2A.

[22] 42 CFR § 435.120(c); former Medicaid Rule 4202.2B.

(A) Below 250% of the FPL for the individual's Medicaid group (as defined in § 29.04); and

(B) After disregarding the working disabled person's earnings, Social Security Disability Insurance benefits (SSDI) including, if applicable, Social Security retirement benefits automatically converted from SSDI[23], and any veterans' disability benefits, and, if married, all income of the working disabled person's spouse[24], has MABD income that is:

(I) Less than the applicable PIL if they are in a Medicaid group of one; or

(II) Less than the applicable SSI/AABD payment level if they are in a Medicaid group of two.

(ii) Has resources at the time of enrollment in the group that do not exceed $10,000.00[25] for a single individual and $15,000.00[26] for a couple (see § 29.08(i)(8) for resource exclusion after enrollment).

(2) The individual's earnings must be documented by evidence of:

(i) Federal Insurance Contributions Act tax payments;

(ii) Self-employment Contributions Act tax payments; or

(iii) A written business plan approved and supported by a third-party investor or funding source.

(3) Earnings, SSDI, and veterans' disability benefits of the working disabled person and, if married, the income of their spouse are not disregarded for an individual with spend-down requirements who does not meet all of the above requirements and seeks coverage under the medically-needy coverage group (see § 8.06).

(e) Child under 18 who lost SSI because of August 1996 change in definition of disability. An individual under the age of 18 who lost their SSI or SSI/AABD eligibility because of the more restrictive definition of disability enacted in August 1996 but who continues to meet all other MABD criteria until their 18th birthday.[27] The definition of disability for this group is the definition of childhood disability in effect prior to the 1996 revised definition.

(f) Certain spouses and surviving spouses. An individual with a disability if they meet all of the following conditions:

[23] See, 2015 Acts and Resolves No. 51, Sec. C.9.

[24] See, 2015 Acts and Resolves No. 51, Sec. C.9.

[25] See, 2015 Acts and Resolves No. 51, Sec. C.9.

[26] See, 2015 Acts and Resolves No. 51, Sec. C.9.

[27] Personal Responsibility and Work Opportunity Reconciliation Act of 1996 § 211(a); Balanced Budget Act of 1997 § 4913.

(1) The individual is:

(i) A surviving spouse; or

(ii) A spouse who has obtained a legal dissolution and:

(A) Was the spouse of the insured for at least 10 years; and

(B) Remains single.

(2) The individual meets one of the following groups of criteria under the Act:[28]

(i) The individual:

(A) Applied for SSI-related Medicaid no later than July 1, 1988;

(B) Was receiving SSI/AABD in December 1983;

(C) Lost SSI/AABD in January 1984 due to a statutory elimination of an additional benefit reduction factor for surviving spouses before attainment of age 60;

(D) Has been continuously entitled to surviving spouse insurance based on disability since January 1984; and

(E) Would continue to be eligible for SSI/AABD if they had not received the increase in social security disability or retirement benefits.

(ii) The individual:

(A) Lost SSI/AABD benefits due to a mandatory application for and receipt of social security disability, retirement or survivor benefits;

(B) Is not yet eligible for Medicare Part A;

(C) Is at least age 50[29], but has not yet attained age 65; and

(D) Would continue to be eligible for SSI/AABD if they were not receiving social security disability or retirement benefits.

(3) An individual in this group must:

(i) After deducting the increase in social security disability or retirement benefits, have MABD income for the individual's financial responsibility group (as defined in § 29.03) that is at or below the SSI/AABD payment level for the individual's Medicaid group (as defined in § 29.04);

(ii) Have MABD resources for the individual's financial responsibility group that is at or below the

[28] SSA §§ 1634(b)(1) and 1634(d); 42 USC §§ 1383c(b)(1) and 1383c(d).

[29] Note: 42 CFR § 435.138 says at least age 60. However, it has been determined that the reference to age 50 is correct. See, SSA's Program Operations Manual System (POMS) SI 01715.015(B)(5)(c).

SSI/AABD maximum for the individual's Medicaid group; and

(iii) Meet the MABD nonfinancial criteria.

(g) Disabled adult child (DAC)[30]

(1) An individual with a disability under the Act (§1634(c)) who:

(i) Is at least 18 years of age;

(ii) Has blindness or a disability that began before age 22;

(iii) Is entitled to social security benefits on their parents' record due to retirement, death, or disability benefits and lost SSI/AABD due to receipt of this benefit or an increase in this benefit; and

(iv) Would remain eligible for SSI/AABD in the absence of the social security retirement, death, or disability benefit or increases in that benefit.

(2) An individual in this group must:

(i) After deducting the social security benefits on their parents' record, have MABD income for the individual's financial responsibility group (as defined in § 29.03) that is at or below the SSI/AABD payment level for the individual's Medicaid group (as defined in § 29.04);

(ii) Have MABD resources for the individual's financial responsibility group that is at or below the SSI/AABD maximum for the individual's Medicaid group; and

(iii) Meet the MABD nonfinancial criteria.

(h) Individual eligible under the Pickle Amendment[31]

(1) An individual determined eligible under the Pickle Amendment to Title XIX of the Act (§1939(a)(5)(E)) who:

(i) Is receiving social security retirement or disability benefits (OASDI);

(ii) Became eligible for and received SSI or SSI/AABD for at least one month after April 1977; and

(iii) Lost SSI/AABD benefits but would be eligible for them if all increases in the social security benefits due to annual cost-of-living adjustments (COLAs) were deducted from their income.

[30] SSA § 1634(c); Vermont State Medicaid Plan, Attachment 2.2-A, p. 6e. Note: Former Medicaid Rule 4202.5(C)(1) provided that the age requirement was "over age 18." AHS interprets this to mean at least age 18. AHS is modifying this language to more clearly reflect the appropriate age requirement for this group.

[31] Section 503 of P.L. 94-566; 42 C.F.R. § 435.135(a)(3); Vermont State Medicaid Plan, Attachment 2.2-A, p. 8.

(2) An individual in this group must:

(i) After deducting the increase in social security benefits due to annual COLAs, have MABD income for the individual's financial responsibility group (as defined in § 29.03) that is at or below the SSI/AABD payment level for the individual's Medicaid group (as defined in § 29.04);

(ii) Have MABD resources for the individual's financial responsibility group that is at or below the SSI/AABD maximum for the individual's Medicaid group; and

(iii) Meet the MABD nonfinancial criteria.

(i) Individual eligible for Medicaid in December 1973.[32] An individual who was eligible for Medicaid in December 1973 and meets at least one of the following criteria:

(1) An institutionalized individual who was eligible for Medicaid in December 1973, or any part of that month, as an inpatient of a medical institution or intermediate care facility that was participating in the Medicaid program and who, for each consecutive month after December 1973:

(i) Continues to meet the Medicaid eligibility requirements in effect in December 1973 for institutionalized individuals;

(ii) Continues to reside in the institution; and

(iii) Continues to be classified as needing institutionalized care.

(2) A blind or disabled individual who does not meet current criteria for blindness or disability, but:

(i) Was eligible for Medicaid in December 1973 as a blind or disabled individual, whether or not they were receiving cash assistance in December 1973;

(ii) For each consecutive month after December 1973 continues to meet the criteria for blindness or disability and the other conditions of eligibility in effect in December 1973;

(iii) Has MABD income for the individual's financial responsibility group (as defined in § 29.03) that is at or below the SSI/AABD payment level for the individual's Medicaid group (as defined in § 29.04);

(iv) Has MABD resources for the individual's financial responsibility group that are at or below the SSI/AABD maximum for the individual's Medicaid group; and

(v) Meets the MABD nonfinancial criteria.

(3) An individual who was eligible for Medicaid in December 1973 as an essential spouse of an aged, blind, or disabled individual who was receiving cash assistance, if the following conditions are met:[33]

[32] See 42 CFR §§ 435.131, 435.132 and 435.133.

[33] An "essential spouse" is defined as one who is living with the individual, whose needs were included in determining the

(i) The aged, blind, or disabled individual continues to meet the December 1973 Medicaid eligibility requirements; and

(ii) The essential spouse continues to meet the conditions that were in effect in December, 1973 for having their needs included in computing the payment to the aged, blind, or disabled individual.

(j) Individual eligible for AABD in August 1972[34]

(1) An individual who meets the following conditions:

(i) In August 1972 the individual was entitled to social security retirement or disability and eligible for AABD, or would have been eligible if they had applied, or were not in a medical institution or intermediate care facility; and

(ii) Would currently be eligible for SSI or SSI/AABD except that the 20 percent cost-of-living increase in social security benefits effective September 1972 raised their income over the AABD limit.

(2) An individual in this group must:

(i) After deducting the increase in social security benefits due to COLA increase effective September 1972, have MABD income for the individual's financial responsibility group (as defined in § 29.03) that is at or below the SSI/AABD payment level for the individual's Medicaid group (as defined in § 29.04);

(ii) Have MABD resources for the individual's financial responsibility group that is at or below the SSI/AABD maximum for the individual's Medicaid group; and

(iii) Meet the MABD nonfinancial criteria.

(k) Individual eligible for MABD-based Medicaid coverage of long-term care services and supports

(1) [Reserved]

(2) Individual who would be eligible for cash assistance if they were not in a medical institution[35]

(i) Basis. This section implements section 1902(a)(10)(A)(ii)(IV) of the Act.

(ii) Eligibility. An aged, blind, or disabled individual who is in a medical institution and who:

(A) Is ineligible for SSI/AABD because of lower income standards used under the program to

amount of SSI or SSI/AABD payment to an aged, blind, or disabled individual living with the essential spouse, and who is determined essential to the individual's well-being.

[34] See 42 CFR § 435.134.

[35] 42 CFR § 435.211.

determine eligibility for institutionalized individuals; but

(B) Would be eligible for SSI/AABD if they were not institutionalized.

(3) Individual living in a medical institution eligible under a special income level.[36] An aged, blind or disabled individual who is living in a medical institution and who:

(i) Has lived in an institution for at least 30 consecutive days;

(ii) Has MABD income for the individual's financial responsibility group (as defined in § 29.03) that does not exceed 300 percent of the maximum SSI federal payment to an individual living independently in the community (institutional income standard (IIS));[37]

(iii) Has MABD resources for the individual's financial responsibility group that is at or below the SSI/AABD maximum for the individual's Medicaid group (as defined in § 29.04), except that if an individual's resources are in excess of the SSI/AABD maximum and the individual has a spouse, a resource evaluation process of assessment and allocation must be performed at the beginning of the individual's first continuous period of long-term care, as set forth in § 29.10(e); and

(iv) Meets the MABD non-financial criteria.

(4) Individual in special income group who qualifies for home and community-based services. An individual who qualifies for home and community-based services and who:

(i) Would be eligible for MABD under paragraph (k)(3) of this subsection if they were living in a medical institution;

(ii) Has MABD income for the individual's financial responsibility group that is above the PIL and at or below the IIS; and

(iii) Can receive appropriate long-term medical care in the community as determined by AHS.

(5) Individual under special income level who is receiving hospice services. An individual who:

(i) Would be eligible for MABD under paragraph (k)(3) of this subsection if they were living in a medical institution;

(ii) Can receive appropriate medical care in the community, the cost of which is no greater than the estimated cost of medical care in an appropriate institution; and

[36] Former Medicaid Rule 4202.3A; 42 CFR § 435.236. This group includes the group referred to in the Vermont State Plan at Attachment 2.2-A, Page 19.

[37] For the purpose of determining income eligibility, an individual applying for Medicaid coverage of long-term care services and supports under MABD is a Medicaid group of one, even if they have a spouse (see § 29.04(d) (former Medicaid Rule 4222.3)).

(iii) Receives hospice care as described in § 30.01(d) and defined in § 1905(o) of the SSA.

(6) Disabled child in home care (DCHC, Katie Beckett).[38] A disabled individual who:

(i) Requires the level of care provided in a medical institution;

(ii) Except for income or resources, would be eligible for MABD if they were living in a medical institution;

(iii) Can receive appropriate medical care in the community, the cost of which is no greater than the estimated cost of medical care in an appropriate institution;

(iv) Is age 18 or younger;

(v) Has MABD income (§ 29.11), excluding their parents' income, no greater than the IIS; and

(vi) Has MABD resources (§ 29.07), excluding their parents' resources, no greater than the resource limit for a Medicaid group of one.

(7) Individual eligible for MWPD. An individual who qualifies for home and community-based services and meets the eligibility requirements for MWPD as set forth in § 8.05(d).

(8) Individual under the PIL who qualifies for home and community-based services. An individual who qualifies for home and community-based services and who:

(i) Would be eligible for MABD under paragraph (k)(3) of this subsection if they were living in a medical institution;

(ii) Has MABD income for the individual's financial responsibility group that is at or below the PIL; and

(iii) Can receive appropriate long-term medical care in the community as determined by AHS.

8.06 Medically-needy coverage group (01/15/2017, GCR 16-095)

(a) In general.[39] An individual who would be a member of a categorically-needy coverage group, as described in § 8.05, may qualify for MABD as medically needy even if their income or resources exceed coverage group limits.

(b) Income standard. An otherwise-qualifying individual is eligible for this coverage group if their MABD income for the individual's financial responsibility group (as defined in § 29.03) is at or below the PIL for the individual's Medicaid group (as defined in § 29.04), or, as described in paragraph (d) of this subsection, they incur enough non-covered medical expenses to reduce their income to that level.

(c) Resource standard. To qualify for this coverage group, an individual must have MABD resources for the

[38] Social Security Act § 1902(e)(3).

[39] Former Medicaid Rule 4203.

individual's financial responsibility group that are at or below the SSI/AABD maximum for the individual's Medicaid group, or, as described in paragraph (d) of this subsection, they incur enough expenses to reduce their resources to that level.

(d) Spenddown rules. The rules in § 30.00 specify how an individual may use non-covered medical expenses to "spend down" their income or resources to the applicable limits.

8.07 Medicare Cost-Sharing (01/01/2018, GCR 17-044)

(a) In general

(1) An individual is eligible for Medicaid payment of certain Medicare costs if they meet one of the criteria specified in paragraph (b) of this subsection.

(2) An individual eligible for one of the Medicare cost-sharing coverage groups identified in (b) below may also be eligible for the full range of Medicaid covered services if they also meet the requirements for one of the categorically-needy (§ 8.05) or medically-needy (§ 8.06) coverage groups.

(3) An individual may not spend down income to meet the financial eligibility tests for these coverage groups.

(b) Coverage groups

(1) Qualified Medicare Beneficiaries (QMB)[40]

(i) An individual is eligible for Medicaid payment of their Medicare part A and part B premiums, deductibles, and coinsurance if the individual is:

(A) A member of a Medicaid group (as defined in § 29.04) with MABD income at or below 100 percent of the FPL; and

(B) Entitled to Medicare part A with or without a premium (but not entitled solely because they are eligible to enroll under § 1818A of the Act, which provides that certain working disabled individuals may enroll for premium part A).

(ii) There is no resource test for this group.

(iii) Benefits become effective on the first day of the calendar month immediately following the month in which the individual is determined to be eligible.

(iv) Retroactive eligibility is not available.[41]

(v) *Special income disregard for an individual who is receiving a monthly insurance benefit under Title II of the Social Security Act.* If an individual receives a Title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit payable as a result of a Title II cost-of-

[40] SSA § 1905(p)(1).

[41] Medicaid State Plan, Attachment 2.6-A, p. 25.

living adjustment (COLA) is not counted as income until the beginning of the second month following the month of publication of the revised annual FPL. For individuals who have Title II income, the new poverty levels are effective beginning with the month after the last month for which COLAs are disregarded. For individuals without Title II income, the new poverty levels are effective no later than the date of publication in the Federal Register.[42]

(2) Specified Low-Income Medicare Beneficiaries (SLMB)[43]

(i) An individual is eligible for Medicaid payment of their Medicare part B premiums if the individual:

(A) Would be eligible for benefits as a QMB, except for income; and

(B) Is a member of a Medicaid group (as defined in § 29.04) with MABD income greater than 100 percent but less than 120 percent of the FPL.

(ii) There is no resource test for this group.

(iii) Benefits become effective on the first day of the month within which an application is received by AHS provided the individual is determined to be eligible for that month.

(iv) Retroactive eligibility (of up to three calendar months prior to the month an application is received by AHS) applies if the individual met all SLMB eligibility criteria in the retroactive period.

(v) *Special income disregard for an individual who is receiving a monthly insurance benefit under Title II of the Social Security Act*. If an individual receives a Title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit payable as a result of a Title II cost-of-living adjustment (COLA) is not counted as income until the beginning of the second month following the month of publication of the revised annual FPL. For individuals who have Title II income, the new poverty levels are effective beginning with the month after the last month for which COLAs are disregarded. For individuals without Title II income, the new poverty levels are effective no later than the date of publication in the Federal Register.[44]

(3) Qualified Individuals (QI-1)[45]

(i) An individual is eligible for Medicaid payment of their Medicare part B premiums if the individual:

[42] Vermont gives effect to this rule by estimating the new year's FPL levels in January of each year. Vermont applies the new FPL against the new income during a January eligibility desk review. By using the adjusted FPLs, Vermont effectively disregards the title II COLA and ensures that the income increase has no negative effect on eligibility.

[43] SSA § 1902(a)(10)(E)(iii).

[44] Vermont gives effect to this rule by estimating the new year's FPL levels in January of each year. Vermont applies the new FPL against the new income during a January eligibility desk review. By using the adjusted FPLs, Vermont effectively disregards the title II COLA and ensures that the income increase has no negative effect on eligibility.

[45] SSA § 1902(a)(10)(E)(iv).

(A) Would be eligible for benefits as a QMB, except for income;

(B) Is a member of a Medicaid group (as defined in § 29.04) with MABD income that is at least 120 percent but less than 135 percent of the FPL; and

(C) Does not receive other federally-funded medical assistance (except for coverage for excluded drug classes under part D when the individual is enrolled in part D).

(ii) There is no resource test for this group.

(iii) Benefits under this provision become effective on the first day of the month within which an application is received by AHS provided the individual is determined to be eligible for that month.

(iv) Retroactive eligibility (of up to three calendar months prior to the month an application is received by AHS) applies if:

(A) The individual met all QI-1 eligibility criteria in the retroactive period; and

(B) The retroactive period is no earlier than January 1 of that calendar year.[46]

(v) The benefit period ends in December of each calendar year. An individual requesting this coverage must reapply each calendar year.

(4) Qualified Disabled and Working Individuals (QDWI)

(i) An individual is eligible for Medicaid payment of their Medicare part A premiums if the individual:

(A) Has lost their premium-free Part A Medicare benefits based on disability because they returned to work;

(B) Is disabled and under the age of 65;

(C) Is a member of a Medicaid group (as defined in § 29.04) with MABD income at or below 200 percent of the FPL;

(D) Is a member of a Medicaid group with MABD resources at or below twice the MABD resource limit; and

(E) Is not otherwise eligible for Medicaid.

(ii) Benefits become effective on either the date of application or the date on which all eligibility criteria are met, whichever is later.

(iii) Benefits for a retroactive period of up to three months prior to that effective date may be granted, provided that the individual meets all eligibility criteria during the retroactive period.

9.00 Special Medicaid groups (01/01/2018, GCR 17-044)

[46] CMS State Medicaid Manual, § 3492.

9.01 In general (01/15/2017, GCR 16-095)

An individual is eligible for a special Medicaid group if they meet the nonfinancial, categorical, and financial criteria outlined in this section.

9.02 Nonfinancial criteria (01/15/2017, GCR 16-095)

The individual must meet all of the following nonfinancial eligibility criteria for Medicaid:

(a) Social Security number (§ 16.00);

(b) Citizenship or immigration status (§ 17.00);

(c) Residency (§ 21.00);

(d) Living arrangements (§ 20.00);

(e) Assignment of rights and cooperation requirements (§ 18.00); and

(f) Pursuit of potential unearned income (§ 22.00).

9.03 Categorical and financial criteria (01/01/2018, GCR 17-044)

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

(b) Deemed newborn[47]

(1) Basis. This sub clause implements §§ 1902(e)(4) and 2112(e) of the Act.

(2) Eligibility

(i) Medicaid coverage will be provided to a child from birth until the child's first birthday without application if, on the date of the child's birth, the child's mother was eligible for and received covered services under Medicaid or CHIP (including during a retroactive period of eligibility under § 70.01(b)) regardless of whether payment for services for the mother is limited to services necessary to treat an emergency medical condition, as defined in § 17.02(d);[48]

(ii) The child is deemed to have applied and been determined eligible for Medicaid effective as of the date of birth, and remains eligible regardless of changes in circumstances (except if the child dies or ceases to be a resident of the state or the child's representative requests a voluntary termination of the child's eligibility) until the child's first birthday.

[47] 42 CFR § 435.117.

[48] Refugee Medical Assistance (Refugee Assistance Rule 5100), is not Medicaid and does not satisfy this requirement.

(iii) A child qualifies for this group regardless of whether they continue to live with their mother.

(iv) This provision applies in instances where the labor and delivery services were furnished prior to the date of application and covered by Medicaid based on retroactive eligibility.

(v) Exception: A child born to a woman who has not met her spenddown on the day of delivery is ineligible for coverage under this group.

(vi) There are no Medicaid income or resource standards that apply.

(3) Medicaid identification number

(i) The Medicaid identification number of the child's mother serves as the child's identification number, and all claims for covered services provided to the child may be submitted and paid under such number, unless and until AHS issues the child a separate identification number in accordance with (3)(ii) of this paragraph.

(ii) AHS will issue a separate Medicaid identification number for the child prior to the effective date of any termination of the mother's eligibility or prior to the date of the child's first birthday, whichever is sooner, unless the child is determined to be ineligible (such as, because the child is not a state resident), except that AHS will issue a separate Medicaid identification number for the child promptly after it is notified of a child under 1 year of age residing in the state and born to a mother whose coverage is limited to services necessary for the treatment of an emergency medical condition, consistent with § 17.02(c).

(c) Children with adoption assistance, foster care, or guardianship care under title IV-E[49]

(1) Basis. This sub clause implements §§ 1902(a)(10)(A)(i)(I) and 473(b)(3) of the Act.

(2) Eligibility. Medicaid coverage will be provided to an individual under age 21, living in Vermont for whom:

(i) An adoption assistance agreement is in effect with a state or tribe under Title IV-E of the Act, regardless of whether adoption assistance is being provided or an interlocutory or other judicial decree of adoption has been issued; or

(ii) Foster care or kinship guardianship assistance maintenance payments are being made by a state or tribe under Title IV-E of the Act.

(3) Income standard. There is no Medicaid income standard that applies. Committed children in the custody of the state who are not IV-E eligible must pass the applicable eligibility tests before their eligibility for Medicaid can be established.

[49] 42 CFR § 435.145.

(d) Special needs adoption[50]

(1) Basis. This sub clause implements § 1902(a)(10)(A)(ii)(VIII) of the Act.

(2) Eligibility. Medicaid coverage will be provided to an individual under age 21:

(i) For whom an adoption assistance agreement (other than an agreement under Title IV-E of the Act) between a state and the adoptive parent or parents is in effect;

(ii) Whom the state agency which entered into the adoption agreement determined could not be placed for adoption without Medicaid coverage because the child has special needs for medical or rehabilitative care; and

(iii) Who, prior to the adoption agreement being entered into, was eligible for Medicaid.

(3) Income standard. There is no Medicaid income standard that applies.

(e) Former foster child[51]

(1) Basis. This sub clause implements § 1902(a)(10)(A)(i)(IX) of the Act.

(2) Eligibility. Medicaid coverage will be provided to an individual who:

(i) Is under age 26;

(ii) Is not eligible and enrolled for mandatory coverage under §§ 7.03(a)(1), (2), (3), (6), (7); 8.05(a), (b), (c), (f), (h), (i), (j); or 9.03(c); and

(iii) Was in foster care under the responsibility of the state and enrolled in Medicaid under the state's Medicaid State plan or 1115 demonstration upon attaining age 18.

(3) Income standard. There is no Medicaid income standard that applies.

(f) Individual with breast or cervical cancer[52]

(1) Basis. This sub clause implements §§ 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.

(2) Eligibility

(i) Medicaid coverage will be provided to an individual who:

[50] 42 CFR § 435.227.

[51] 42 CFR § 435.150; SSA § 1902(a)(10)(A)(i)(IX).

[52] 42 CFR § 435.213; CMS State Health Official Letter, dated January 4, 2001, available at http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/sho010401.pdf.

(A) Is under age 65;

(B) Is not eligible and enrolled for mandatory coverage under the state's Medicaid State plan;

(C) Has been determined to need treatment for breast or cervical cancer through a screening under the Centers for Disease Control and Prevention (CDC) breast and cervical cancer early detection program (BCCEDP);[53] and

(D) Does not otherwise have creditable coverage, as defined in § 2704(c) of the PHS Act, for treatment of their breast or cervical cancer. Creditable coverage is not considered to be available just because the individual may:

(I) Receive medical services provided by the Indian Health Service, a tribal organization, or an Urban Indian organization; or

(II) Obtain health insurance coverage only after a waiting period of uninsurance.

(ii) An individual whose eligibility is based on this group is entitled to full Medicaid coverage; coverage is not limited to coverage for treatment of breast and cervical cancer.

(iii) Medicaid eligibility for an individual in this group begins following the screening and diagnosis and continues as long as a treating health professional verifies the individual is in need of cancer treatment services.

(iv) There is no waiting period of prior uninsurance before an individual who has been screened can become eligible for Medicaid under this group.

(3) Treatment need. An individual is considered to need treatment for breast or cervical cancer if, in the opinion of the individual's treating health professional (i.e., the individual who conducts the screen or any other health professional with whom the individual consults), the screen (and diagnostic evaluation following the clinical screening) determines that:

(i) Definitive treatment for breast or cervical cancer is needed, including a precancerous condition or early stage cancer, and which may include diagnostic services as necessary to determine the extent and proper course of treatment; and

(ii) More than routine diagnostic services or monitoring services for a precancerous breast or cervical condition are needed.

(4) Income standard. In order to qualify for screening under (f)(2)(i)(C) above, an individual must be determined by BCCEDP to have limited income. In addition to meeting the criteria described in this sub clause, the individual must meet all other Medicaid nonfinancial criteria.

[53] A woman is considered to have been screened and eligible for this group if she has received a screening mammogram, clinical breast exam, or Pap test; or diagnostic services following an abnormal clinical breast exam, mammogram, or Pap test; and a diagnosis of breast or cervical cancer or of a pre-cancerous condition of the breast or cervix as the result of the screening or diagnostic service.

(g) Family planning services[54]

(1) Basis. This sub clause implements §§ 1902(a)(10)(A)(ii)(XXI) and 1902(ii) and clause (XVI) in the matter following 1902(a)(10)(G) of the Act.

(2) Eligibility. Medicaid coverage of the services described in (g)(4) of this sub clause will be provided to an individual (male and female) who meets all of the following requirements:

(i) Is not pregnant; and

(ii) Meets the income eligibility requirements under (g)(3) of this sub clause.

(3) Income standard. The individual has MAGI-based household income (as defined in § 28.03) that is at or below the income standard for a pregnant woman as described in § 7.03(a)(2). The individual's household income is determined in accordance with § 28.03(j).

(4) Covered services. An individual eligible under this sub clause is covered for family planning and family planning-related benefits.

(h) HIV/AIDS. See, HIV/AIDS Rule 5800 *et seq*.

(i) Refugee Medical Assistance. See, Refugee Medical Assistance Rule 5100 *et seq*.

10.00 Pharmacy benefits (01/15/2017, GCR 16-095)

10.01 VPharm program (01/15/2017, GCR 16-095)

The VPharm program rules located in Rule 5400 *et seq*. will remain in effect.

10.02 Healthy Vermonter Program (HVP) (01/15/2017, GCR 16-095)

The Healthy Vermonter Program (HVP) rules located in Rule 5700 *et seq*. will remain in effect.

11.00 Enrollment in a QHP (01/15/2017, GCR 16-095)

11.01 In general (01/15/2017, GCR 16-095)

Eligibility for enrollment in a QHP.[55] An individual is eligible for enrollment in a QHP if the individual meets the nonfinancial criteria outlined in this section.

11.02 Nonfinancial criteria (01/15/2017, GCR 16-095)

The individual must meet all of the following nonfinancial criteria:

[54] 42 CFR § 435.214.

[55] 45 CFR § 155.305(a).

(a) Citizenship, status as a national, or lawful presence (§ 17.00). The individual must be reasonably expected to be a citizen, national, or a non-citizen who is lawfully present for the entire period for which enrollment is sought;

(b) Incarceration (§ 19.00); and

(c) Residency (§ 21.00).

11.03 Eligibility for QHP enrollment periods[56] (01/15/2017, GCR 16-095)

An individual is eligible for a QHP enrollment period if they meet the criteria for an enrollment period, as specified in § 71.00.

12.00 Advance payments of the premium tax credit (APTC) (01/01/2018, GCR 17-044)

12.01 In general (01/15/2017, GCR 16-095)

A tax filer is eligible for APTC on behalf of an individual if the tax filer meets the criteria outlined in this section. A tax filer must be eligible for APTC on behalf of an individual in order for the individual to receive the Vermont Premium Reduction. APTC and the Vermont Premium Reduction are paid directly to the QHP issuer on behalf of the tax filer.

12.02 Nonfinancial criteria[57] (01/15/2017, GCR 16-095)

An applicable tax filer (within the meaning of § 12.03) is eligible for APTC for any month in which one or more individuals for whom the tax filer expects to claim a personal exemption deduction on their tax return for the benefit year, including the tax filer and their spouse:

(a) Meets the requirements for eligibility for enrollment in a QHP, as specified in § 11.00; and

(b) Is not eligible for MEC (within the meaning of § 23.00) other than coverage in the individual market.

12.03 Applicable tax filer[58] (01/01/2018, GCR 17-044)

(a) In general. Except as otherwise provided in this subsection, an applicable tax filer is a tax filer who expects to have household income of at least 100 percent but not more than 400 percent of the FPL for the tax filer's family size for the benefit year.

For purposes of calculating the household income of an applicable tax filer and determining their financial eligibility for APTC, see § 28.05.

[56] 45 CFR § 155.305(b).

[57] See generally, 26 CFR § 1.36B-2 and 45 CFR § 155.305(f).

[58] 26 CFR § 1.36B-2(b); 45 CFR § 155.305.

(b) Married tax filers must file joint return

(1) Except as provided in (2) below, a tax filer who is married (within the meaning of 26 CFR § 1.7703-1) at the close of the benefit year is an applicable tax filer only if the tax filer and the tax filer's spouse file a joint return for the benefit year.

(2) *Victims of domestic abuse and spousal abandonment:* Except as provided in (5) below, a married tax filer will satisfy the joint filing requirement if the tax filer files a tax return using a filing status of married filing separately and:

(i) Is living apart from their spouse at the time they file their tax return;

(ii) Is unable to file a joint return because they are a victim of domestic abuse as defined in (3) below or spousal abandonment as defined in (4) below; and

(iii) Certifies on their tax return, in accordance with the relevant instructions, that they meet the criteria under (i) and (ii) above.

(3) *Domestic abuse*. Domestic abuse includes physical, psychological, sexual, or emotional abuse, including efforts to control, isolate, humiliate and intimidate, or to undermine the victim's ability to reason independently. All the facts and circumstances are considered in determining whether an individual is abused, including the effects of alcohol or drug abuse by the victim's spouse. Depending on the facts and circumstances, abuse of the victim's child or another family member living in the household may constitute abuse of the victim.

(4) *Abandonment.* The tax filer is a victim of spousal abandonment for the taxable year if, taking into account all facts and circumstances, the tax filer is unable to locate their spouse after reasonable diligence.

(5) *Three-year rule*. Paragraph (2) above does not apply if the tax filer met the requirements of the paragraph for each of the three preceding taxable years.

(c) Tax dependent. An individual is not an applicable tax filer if another tax filer may claim a deduction under 26 USC § 151 for the individual for a benefit year beginning in the calendar year in which the individual's benefit year begins.

(d) Individual not lawfully present or incarcerated.[59] An individual who is not lawfully present in the United States or is incarcerated (other than incarceration pending disposition of charges) is not eligible to enroll in a QHP through VHC. However, the individual may be an applicable tax filer for purposes of claiming the premium tax credit if a family member is eligible to enroll in a QHP.

(e) Individual lawfully present. An individual is also an applicable tax filer if:

(1) The tax filer would be an applicable tax filer but for income;

[59] See, ACA §§ 1312(f)(1)(B) and 1312(f)(3) (42 USC § 18032(f)(1)(B) and (f)(3)) and 26 CFR § 1.36B-2(b)(4).

(2) The tax filer expects to have household income of less than 100 percent of the FPL for the tax filer's family size for the benefit year for which coverage is requested;

(3) One or more applicants for whom the tax filer expects to claim a personal exemption deduction on their tax return for the benefit year, including the tax filer and spouse, is a non-citizen who is lawfully present and ineligible for Medicaid by reason of immigration status.

(f) Special rule for tax filers with household income below 100 percent of the FPL for the benefit year.[60] A tax filer (other than a tax filer described in paragraph (e) of this subsection) whose household income for a benefit year is less than 100 percent of the FPL for the tax filer's family size is treated as an applicable tax filer for purposes of claiming the premium tax credit if:

(1) The tax filer or a family member enrolls in a QHP through VHC for one or more months during the taxable year;

(2) AHS estimates at the time of enrollment that the tax filer's household income will be at least 100 but not more than 400 percent of the FPL for the benefit year;

(3) APTCs are authorized and paid for one or more months during the benefit year; and

(4) The tax filer would be an applicable tax filer if the tax filer's household income for the benefit year was at least 100 but not more than 400 percent of the FPL for the tax filer's family size.

(g) Computation of premium-assistance amounts for tax filers with household income below 100 percent of the FPL. If a tax filer is treated as an applicable tax filer under paragraph (e) or (f) of this subsection, the tax filer's actual household income for the benefit year is used to compute the premium-assistance amounts under § 60.00.

12.04 Enrollment required[61] (01/15/2017, GCR 16-095)

APTC will only be provided on behalf of a tax filer if one or more individuals for whom the tax filer attests that they expect to claim a personal exemption deduction for the benefit year, including the tax filer and spouse, is enrolled in a QHP.

12.05 Compliance with filing requirement[62] (01/15/2017, GCR 16-095)

AHS may not determine a tax filer eligible for APTC if HHS notifies AHS as part of the process described in § 56.03 that APTCs were made on behalf of the tax filer or either spouse if the tax filer is a married couple for a year for which tax data would be utilized for verification of household income and family size in accordance with § 56.01(a),

[60] 26 CFR § 1.36B-2(b)(6).

[61] 45 CFR § 155.305(f)(3).

[62] 45 CFR § 155.305(f)(4).

and the tax filer or their spouse did not comply with the requirement to file an income tax return for that year as required by 26 USC § 6011, 6012, and implementing regulations, and reconcile the APTCs for that period.

12.06 Vermont Premium Reduction eligibility criteria (01/15/2017, GCR 16-095)

An individual is eligible for the Vermont Premium Reduction if the individual:

(a) Meets the requirements for eligibility for enrollment in a QHP, as specified in § 11.00;

(b) Meets the requirements for APTC, as specified in this § 12.00; and

(c) Is expected to have household income, as defined in § 28.05(c), that does not exceed 300 percent of the FPL for the benefit year for which coverage is requested.

13.00 Cost-sharing reductions (CSR) (01/15/2017, GCR 16-095)

13.01 Eligibility criteria[63] (01/15/2017, GCR 16-095)

(a) An individual is eligible for federal and/or state CSR if the individual:

(1) Meets the requirements for eligibility for enrollment in a QHP, as specified in § 11.00;

(2) Meets the requirements for APTC, as specified § 12.00; and

(3) Is expected to have household income, as defined in § 28.05(c), that does not exceed 300 percent of the FPL for the benefit year for which coverage is requested.

(b) An individual who is not an Indian may receive CSR only if they are enrolled in a silver-level QHP.

13.02 Eligibility categories[64] (01/15/2017, GCR 16-095)

The following eligibility categories for CSR will be used when making eligibility determinations under this section:

(a) An individual who is expected to have household income at least 100 but not more than 150 percent of the FPL for the benefit year for which coverage is requested, or for an individual who is eligible for APTC under § 12.03(e), household income less than 100 percent of the FPL for the benefit year for which coverage is requested;

(b) An individual who is expected to have household income greater than 150 but not more than 200 percent of the FPL for the benefit year for which coverage is requested;

(c) An individual who is expected to have household income greater than 200 but not more than 250 percent of

[63] 45 CFR § 155.305(g).

[64] 45 CFR § 155.305(g)(2).

the FPL for the benefit year for which coverage is requested; and

(d) An individual who is expected to have household income greater than 250 but not more than 300 percent of the FPL for the benefit year for which coverage is requested.

Income and benefit levels are as shown in the chart below. The actuarial value of the plan must be within one percentage point of the actuarial value listed below.

Income as a Percent of Federal Poverty Level	Tier	Actuarial Value of Plan with Federal and State CSR
Not more than 150%	I	94%
More than 150% but not more than 200%	II	87%
More than 200% but not more than 250%	III	77%
More than 250% but not more than 300%	IV	73%

13.03 Special rule for family policies[65] (01/15/2017, GCR 16-095)

To the extent that an enrollment in a QHP under a single policy covers two or more individuals who, if they were to enroll in separate policies would be eligible for different cost sharing, AHS will deem the individuals under such policy to be collectively eligible only for the category of eligibility last listed below for which all the individuals covered by the policy would be eligible.

(a) Individuals not eligible for changes to cost sharing;

(b) § 59.02 (Special cost-sharing rules for Indians, regardless of income);

(c) § 13.02(d);

(d) § 13.02(c);

(e) § 13.02(b);

(f) § 13.02(a);

(g) § 59.01 (Eligibility for CSR for Indians).

[65] 45 CFR § 155.305(g)(3).

Example: Person A is the mother of Person B, her 24-year-old son. Person A and Person B both work and file taxes separately. However, they are covered under the same QHP. Person A's income is equal to 125 percent of the FPL and Person B's income is 225 percent of the FPL. Since Person B's income is at the 225 percent level, the CSR that Person A and Person B will receive will be that available at the 225 percent level, which is in the 200 percent to 250 percent range.

14.00 Eligibility for enrollment in a catastrophic plan[66] (01/01/2018, GCR 17-044)

An individual is eligible for enrollment in a catastrophic plan[67] if they have met the requirements for eligibility for enrollment in a QHP, as specified in § 11.00, and they:

(a) Have not attained the age of 30 before the beginning of the plan year; or

(b) Have a certification in effect for any plan year that they are exempt from the requirement to maintain MEC by reason of hardship, including coverage being unaffordable (see § 23.06(a)).

[66] 45 CFR § 155.305(h).

[67] 45 CFR § 156.155.

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Part Three
Nonfinancial eligibility requirements

15.00 Nonfinancial eligibility requirements, in general (01/15/2017, GCR 16-096)

This part catalogs the nonfinancial eligibility requirements that apply across all health benefits. The provisions that assign these requirements to a particular program or benefit are set forth in Part Two of this rule.

16.00 Social Security number (01/15/2017, GCR 16-096)

16.01 Medicaid[1] (01/15/2017, GCR 16-096)

(a) In general

(1) Except as provided in paragraph (b) of this subsection, as a condition of Medicaid eligibility, each individual (including children) seeking Medicaid must furnish their Social Security number.

(2) AHS will advise the individual of:

(i) The statute or other authority under which it is requesting the individual's Social Security number; and

(ii) The uses that will be made of each Social Security number, including its use for verifying income, eligibility, and amount of medical assistance payments under §§ 53.00 through 56.00.

(3) If an individual cannot recall their Social Security number or Social Security numbers or has not been issued a Social Security number, AHS will:

(i) Assist the individual in completing an application for a Social Security number;

(ii) Obtain evidence required under SSA regulations to establish the age, the citizenship or non-citizenship status, and the true identity of the individual; and

(iii) Either send the application to SSA or, if there is evidence that the individual has previously been issued a Social Security number, request SSA to furnish the number.

(4) Services to an otherwise eligible individual will not be denied or delayed pending issuance or verification of the individual's Social Security number by SSA or if the individual meets one of the exceptions in paragraph (b) of this subsection.

(5) The Social Security number furnished by an individual will be verified to insure the Social Security number was issued to that individual, and to determine whether any other Social Security numbers were issued to that individual. See § 55.02(a) for information on the verification process.

[1] 42 CFR § 435.910.

(b) Exception

(1) The requirement of paragraph (a)(1) of this subsection does not apply, and a Medicaid identification number will be given, to an individual who:

(i) Is not eligible to receive a Social Security number;

(ii) Does not have a Social Security number and may only be issued a Social Security number for a valid non-work reason in accordance with 20 CFR § 422.104; or

(iii) Refuses to obtain a Social Security number because of well-established religious objections. The term "well-established religious objections" means that the individual is a member of a recognized religious sect or division of the sect, and adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number including a Social Security number.

(2) The Medicaid identification number may be either a Social Security number obtained on the individual's behalf or another unique identifier.

(3) An individual who has a Social Security number is not subject to this exception and must provide such number.

(c) Social Security numbers of Medicaid non-applicants.[2] AHS may request the Social Security number of a person who is not applying for Medicaid for themselves provided that:

(1) Provision of such Social Security number is voluntary;

(2) Such Social Security number is used only to determine an applicant's or enrollee's eligibility for a health-benefits program or for a purpose directly connected to the administration of the state plan; and

(3) At the time such Social Security number is requested, AHS provides clear notice to the individual seeking assistance, or person acting on such individual's behalf, that provision of the non-applicant's Social Security number is voluntary and information regarding how the Social Security number will be used.

16.02 QHP[3] (01/15/2017, GCR 16-096)

(a) An individual applying for a QHP, with or without APTC or CSR, and who has a Social Security number must provide it. The number provided will be verified by AHS. See § 55.02(a) for information on the verification process.

(b) Except as provided in paragraph (c) of this subsection, a person who is not seeking coverage for themselves need not provide a Social Security number.

[2] 42 CFR § 435.907(e)(3).

[3] 45 CFR § 155.310(a)(3).

(c) An application filer seeking APTC must provide the Social Security number of a tax filer who is not an applicant only if an applicant attests that the tax filer has a Social Security number and filed a tax return for the year for which tax data would be utilized for verification of household income and family size.[4]

17.00 Citizenship and immigration status[5] (01/15/2019, GCR 18-062)

17.01 Definitions (01/15/2019, GCR 18-062)

(a) U.S. Citizen

(1) An individual born in the 50 states, the District of Columbia, Puerto Rico, Guam, Virgin Islands, and the Northern Mariana Islands (except for individuals born to foreign diplomats);

(2) A naturalized citizen; or

(3) An individual who otherwise qualifies for U.S. citizenship under § 301 of the Immigration and Nationality Act (INA), 8 USC §§ 1401.

(b) Citizenship[6]. Includes status as a "national of the United States," and includes both citizens of the United States and non-citizen nationals of the United States.

(c) National[7]

(1) An individual who:

(i) Is a U.S. citizen; or

(ii) Though not a citizen, owes permanent allegiance to the United States.

(2) For purposes of determining health-benefits eligibility, including verification requirements, citizens and non-citizen nationals of the United States are treated the same.

(3) As a practical matter, non-citizen nationals include individuals born in American Samoa or Swains Island.

(d) Qualified non-citizen.[8] An individual who is:

[4] 45 CFR § 155.305(f)(6).

[5] This section establishes the health-benefits citizenship and immigration-status eligibility requirements. Rules covering the related attestation and verification requirements and outlining documentary evidence are set forth in § 54.00.

[6] 42 CFR § 435.4.

[7] 8 USC § 1101(a)(22).

[8] 42 CFR § 435.4 ("qualified non-citizen" includes the term "qualified alien" as defined at 8 USC § 1641(b) and (c)); 42

(1) A lawful, permanent resident of the United States (LPR);

(2) A refugee, including:

(i) An individual admitted to the United States under § 207 of the INA;

(ii) A Cuban or Haitian entrant, as defined in § 501(e)(2) of the Refugee Education Assistance Act of 1980. There are three general categories of individuals who are considered "Cuban and Haitian entrants." A Cuban/Haitian national meets the definition of "Cuban and Haitian entrant" if he or she:

(A) Was granted parole status as a Cuban/Haitian entrant (Status Pending) on or after April 21, 1980 or has been paroled into the United States on or after October 10, 1980;

(B) Is the subject of removal, deportation or exclusion proceedings under the Immigration and Nationality Act and with respect to whom a final, nonappealable, and legally enforceable order of removal, deportation or exclusion has not been entered; or

(C) Has an application for asylum pending with the Department of Homeland Security (DHS) and with respect to whom a final, nonappealable, and legally enforceable order of removal, deportation or exclusion has not been entered.

(iii) An Amerasian, admitted to the United States under § 584 of the Foreign Operations Export Financing, and Related Programs Appropriation Act, 1988 (as contained in § 101(e) of Public Law 100-202 and amended by the 9th proviso under Migration and Refugee Assistance in title II of the Foreign Operations Export Financing, and Related Programs Act, 1989, Public Law 100-461, as amended);

(3) An asylee, as defined in § 208 of the INA;

(4) A non-citizen whose deportation has been withheld under:

(i) § 243(h) of the INA, as in effect prior to April 1, 1997, (the effective date of § 307 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA), division C of Public Law 104-208); or

(ii) § 241(b)(3) of the INA, as amended by § 305(a) of division C of Public Law 104-208;

(5) An non-citizen who has been granted parole for at least one year by the USCIS under § 212(d)(5) of the INA;

(6) A non-citizen who has been granted conditional entry under § 203(a)(7) of the INA;

(7) A battered non-citizen, as defined in paragraph (e) of this subsection;

(8) A victim of a severe form of trafficking, in accordance with § 107(b)(1) of the Trafficking Victims Protection Act of 2000; or

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CFR § 435.406(a)(2).

(9) An American Indian, born outside the U.S. and who enters and re-enters and resides in the U.S. is, for Medicaid purposes, considered a lawful permanent resident and, as such, a qualified non-citizen. This includes:

(i) An American Indian who was born in Canada and who is of at least one-half American Indian blood. This does not include the non-citizen spouse or child of such an Indian or a non-citizen whose membership in an Indian tribe or family is created by adoption, unless such person is of at least 50% American Indian blood.

(ii) An American Indian who is a member of a Federally-recognized Indian tribe, as defined in § 4(e) of the Indian Self-Determination and Education Assistance Act, 25 USC § § 450b(e).[9]

(e) Battered non-citizen

(1) An individual who is:

(i) A victim of battering or cruelty by a spouse or a parent, or by a member of the spouse or parent's family residing in the same household as the victim and the spouse or parent consented to, or acquiesced in the battery or cruelty;

(ii) The parent of a child who has been such a victim, provided that the individual did not actively participate in the battery or cruelty; or

(iii) The child residing in the same household of such a victim.

(2) For the purposes of establishing qualified non-citizen status, the battered non-citizen must meet all of the following conditions:

(i) The individual must no longer be residing in the same household as the perpetrator of the abuse or cruelty;

(ii) The battery or cruelty must have a substantial connection with the need for medical assistance; and

(iii) The individual must have been approved for legal immigration status, or have a petition pending that makes a prima facie case for legal immigration status, under one of the following categories:

(A) Permanent residence under the Violence Against Women Act (VAWA);

(B) A pending or approved petition for legal permanent residence filed by a spouse or parent on USCIS Form I-130 or Form I-129f; or

(C) Suspension of deportation or cancellation of removal under VAWA.

(f) Nonqualified non-citizen. A non-citizen who does not meet the definition of qualified non-citizen (§17.01(d)).

(g) Lawfully present in the United States. An individual who is a non-citizen and who:

[9] Abenaki is not a federally-recognized tribe.

(1) Is a qualified non-citizen, as defined in paragraph (d) of this subsection;

(2) Is in a valid nonimmigrant status, as defined in 8 USC § 1101(a)(15) or otherwise under the immigration laws (as defined in 8 USC § 1101(a)(17));

(3) Is paroled into the United States in accordance with 8 USC § 1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

(4) Belongs to one of the following classes:

(i) Granted temporary resident status in accordance with 8 USC § 1160 or 1255a, respectively;

(ii) Granted Temporary Protected Status (TPS) in accordance with 8 USC § 1254a, and individuals with pending applications for TPS who have been granted employment authorization;

(iii) Granted employment authorization under 8 CFR § 274a.12(c);

(iv) Family Unity beneficiaries in accordance with § 301 of 101, as amended;

(v) Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

(vi) Granted Deferred Action status;

(vii) Granted an administrative stay of removal under 8 CFR part 241;

(viii) Beneficiary of approved visa petition who has a pending application for adjustment of status;

(5) Is an individual with a pending application for asylum under 8 USC § 1158, or for withholding of removal under 8 USC § 1231, or under the Convention Against Torture who—

(i) Has been granted employment authorization; or

(ii) Is under the age of 14 and has had an application pending for at least 180 days;

(6) Has been granted withholding of removal under the Convention Against Torture;

(7) Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 USC § 1101(a)(27)(J);

(8) Is lawfully present in American Samoa under the immigration laws of American Samoa; or

(9) Is a victim of a severe form of trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Public Law 106-386, as amended (22 USC § 7105(b)).

(10) *Exception*. An individual with deferred action under DHS's deferred action for childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012, memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (9) of this definition.

(h) Non-citizen.[10] Has the same meaning as the term "alien," as defined in section 101(a)(3) of the INA, (8 USC § 1101(a)(3)) and includes any individual who is not a citizen or national of the United States, defined at 8 USC § 1101(a)(22).

17.02 General Rules (01/15/2017, GCR 16-096)

(a) Health benefits, in general. Except as provided in paragraphs (b) through (d) of this subsection, as a condition of eligibility for health benefits, an individual must be a citizen or national of the United States and, for purposes of enrollment in a QHP, must reasonably expect to be a citizen or national for the entire period for which QHP enrollment is sought.

(b) Enrollment in Medicaid. An individual who is a non-citizen is eligible for Medicaid if the individual otherwise satisfies the eligibility requirements and is:

(1) A qualified non-citizen who is not subject to the five-year bar under § 17.03(b); or

(2) A non-citizen who is not subject to the five-year bar under § 17.03(c).

(c) Enrollment in a QHP, with or without APTC or CSR. An individual who is a non-citizen who is lawfully present in the United States is eligible for enrollment in a QHP, with or without APTC or CSR, if the individual otherwise satisfies the eligibility requirements for a QHP and is reasonably expected to be a non-citizen who is lawfully present for the entire period for which QHP enrollment is sought.

(d) Emergency medical services.[11] An individual who is ineligible for Medicaid solely because of immigration status is eligible for the treatment of emergency medical conditions if all of the following conditions are met:

(1) The individual has, after sudden onset, a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in serious:

(i) Jeopardy to the individual's health;

(ii) Impairment of bodily functions; or

(iii) Dysfunction of any bodily organ or part.

(2) The individual meets all eligibility requirements for Medicaid except that non-qualified non-citizens need not present a Social Security number or document immigration status.

(3) Emergency medical services do not include organ transplant procedures or routine prenatal or post partum care.

[10] 42 CFR § 435.4.

[11] A legally-present individual who is enrolled in a QHP, with or without subsidies, is nevertheless eligible for emergency Medicaid. See CMS Response to Comment, 77 FR 17144, 17170.

17.03 Medicaid five-year bar for qualified non-citizens (01/01/2018, GCR 17-045)

(a) Qualified non-citizens subject to 5-year bar.[12] Non-citizens who enter the United States on or after August 22, 1996, as qualified non-citizens are not eligible to receive Medicaid for five years from the date they enter the country. If they are not qualified non-citizens when they enter, the five-year bar begins the date they become a qualified non-citizen. The following qualified non-citizens are subject to the five-year bar:

(1) Lawful permanent residents (LPRs);

(2) Non-citizens granted parole for at least one year;

(3) Non-citizens granted conditional entry (however, as a practical matter the five-year bar will never apply to such non-citizens, since, by definition, they entered the U.S. and obtained qualified non-citizen status prior to August 22, 1996); and

(4) Battered non-citizens.

(b) Qualified non-citizens not subject to 5-year bar.[13] The following qualified non-citizens are not subject to the five-year bar:

(1) Refugees;

(2) Asylees;

(3) Cuban and Haitian Entrants;[14]

(4) Victims of a severe form of trafficking;

(5) Non-citizens whose deportation is being withheld;

(6) Qualified non-citizens who are:

(i) Honorably discharged veterans;

(ii) On active duty in the U.S. military; or

(iii) The spouse (including a surviving spouse who has not remarried) or unmarried dependent child of an honorably discharged veteran or individual on active duty in the U.S. Military;

(7) Non-citizens admitted to the country as Amerasian immigrants;

[12] 42 CFR § 435.406(a)(2); 8 USC § § 1613(a).

[13] 42 CFR § 435.406(a)(2); 8 USC § § 1613(b).

[14] From former PP&D at 4172.

(8) Legal permanent residents who first entered the United States under another exempt category (i.e., as a refugee, asylee, Cuban or Haitian entrant, trafficking victim, or non-citizen whose deportation was being withheld) and who later converted to the LPR status.

(9) Haitians granted Humanitarian Parole status; and

(10) Citizens and nationals of Iraq and Afghanistan with Special Immigrant status.[15]

(c) Non-citizens not subject to 5-year bar.[16] The five-year bar does not apply to:

(1) Non-citizens who are applying for treatment of an emergency medical condition only;

(2) Non-citizens who entered the United States and became qualified non-citizens prior to August 22, 1996; and

(3) Non-citizens who entered prior to August 22, 1996, and remained "continuously present" in the United States until becoming a qualified non-citizen on or after that date. Any single absence of more than 30 consecutive days or a combined total absence of 90 days before obtaining qualified non-citizen status is considered to interrupt "continuous presence."

(i) Non-citizens who do not meet "continuous presence" are subject to the five-year bar beginning from the date they become a qualified non-citizen.

(ii) Non-citizens do not have to remain continuously present in the United States after obtaining qualified non-citizen status.

(4) Members of a Federally-recognized Indian tribe;

(5) American Indians born in Canada to whom § 289 of the INA applies; and

(6) Children up to 21 years of age and women during pregnancy and the 60-day postpartum period, who are lawfully residing in the United States and otherwise eligible. AHS will verify that the child or pregnant woman is lawfully residing in the United States at the time of the individual's initial eligibility determination and at the time of eligibility redeterminations. A child or pregnant woman will be considered to be lawfully residing in the United States if they are:

(i) A qualified non-citizen as defined in § 431 of PRWORA (8 USC § 1641)(see 17.01(d));

(ii) A non-citizen in non-immigration status who has not violated the terms of the status under which they were admitted or to which they have changed after admission;

(iii) A non-citizen who has been paroled into the United States pursuant to § 212(d)(5) of the INA (8 USC

[15] From former PP&D at 4173.

[16] Interim Guidance on Verification of Citizenship, Qualified Alien Status and Eligibility Under Title IV of the Personal Responsibility and Work Opportunity Act of 1996; 62 Federal Register 61344 and 61415 (November 17, 1997).

§ 1182(d)(5)) for less than 1 year, except for a non-citizen paroled for prosecution, for deferred inspection or pending removal proceedings;

(iv) A non-citizen who belongs to one of the following classes:

(A) Non-citizens currently in temporary resident status pursuant to § 210 or 245A of the INA (8 USC § 1160 or 1255a, respectively);

(B) Non-citizens currently under Temporary Protected Status (TPS) pursuant to § 244 of the INA (8 USC § 1254a), and pending applicants for TPS who have been granted employment authorization;

(C) Non-citizens who have been granted employment authorization under 8 CFR § 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);

(D) Family Unity beneficiaries pursuant to § 301 of Pub. L. 101-649, as amended;

(E) Non-citizens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;

(F) Non-citizens granted an administrative stay of removal under 8 CFR § 241;

(G) Non-citizens currently in deferred action status; or

(H) Non-citizens whose visa petitions have been approved and who have pending applications for adjustment of status;

(v) A pending applicant for asylum under § 208(a) of the INA (8 USC § 1158) or for withholding of removal under § 241(b)(3) of the INA (8 USC § 1231) or under the Convention Against Torture who:

(A) Has been granted employment authorization; or

(B) Is under the age of 14 and has had an application pending for at least 180 days;

(vi) A non-citizen who has been granted withholding of removal under the Convention Against Torture;

(vii) A child who has a pending application for Special Immigrant Juvenile status as described in § 101(a)(27)(J) of the INA (8 USC § 1101(a)(27)(J));

(viii) A non-citizen who is present in American Samoa under the immigration laws of American Samoa; or

(ix) A victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 USC § 7105(b)).

(x) Exception: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (i)-(ix) who are considered to be lawfully residing in the United States.

(d) Ineligible non-citizens/nonimmigrants. The following categories of individuals are ineligible non-citizens/non-immigrants and are not eligible for Medicaid:

(1) Foreign government representatives on official business and their families and servants;

(2) Visitors for business or pleasure, including exchange visitors;

(3) Non-citizens in travel status while traveling directly through the U.S.;

(4) Crewmen on shore leave;

(5) Foreign students;

(6) International organization representation personnel and their families and servants;

(7) Temporary workers including agricultural contract workers; and

(8) Members of foreign press, radio, film, or other information media and their families.

18.00 Assignment of rights and cooperation requirements for Medicaid (01/01/2018, GCR 17-045)

18.01 In general[17] (01/15/2017, GCR 16-096)

As a condition of initial and continuing eligibility, a legally-able individual who is applying for or enrolled in Medicaid must meet the requirements related to the pursuit of medical support, third-party payments, and the requirement to enroll or remain enrolled in a group health insurance plan, as provided for below.

18.02 Assignment of rights to payments (01/15/2017, GCR 16-096)

(a) In general. An individual who is applying for, or enrolled in Medicaid, with the legal authority to do so, must assign their rights to medical support and third-party payments for medical care. If they have the legal authority to do so, they must also assign the rights of any other individual who is applying for or enrolled in Medicaid to such support and payments.

(b) Exceptions. No assignment is required for:

(1) Medicare payments; or

(2) Cash payments from the Department of Veterans Affairs for aid and attendance.

18.03 Cooperation in Obtaining Payments (01/01/2018, GCR 17-045)

(a) In general

(1) Applicants must attest that they will cooperate, and enrollees must cooperate in:

(i) Establishing the identity of a child's parents and in obtaining medical support and payments, unless

[17] 42 CFR § 435.610; Former Medicaid Rules 4138-4138.4.

the individual establishes good cause for not cooperating as described in § 18.04; and

(ii) Identifying and providing information to assist in pursuing third parties who may be liable to pay for care and services under the plan, unless the individual establishes good cause for not cooperating as described in § 18.04.

(2) To meet this requirement, an individual may be required to:

(i) Provide information or evidence relevant and essential to obtain such support or payments;

(ii) Appear as a witness in court or at another proceeding;

(iii) Provide information or attest to lack of information under penalty of perjury; or

(iv) Take any other reasonable steps necessary for establishing parentage or securing medical support or third-party payments.

(b) Exception. An unmarried pregnant woman with income under 208 percent of the FPL is exempted from the requirement to cooperate in establishing paternity or obtaining medical support and payments from, or derived from, the father of the child she expects to deliver or from the father of any of her children born out-of-wedlock. She shall remain exempt through the end of the calendar month in which the 60-day period beginning with the date of her delivery ends.

18.04 Good cause for noncooperation (01/15/2017, GCR 16-096)

(a) In general. An individual who is applying for or enrolled in Medicaid may request a waiver of the cooperation requirement under § 18.03. Those to whom a good-cause waiver for noncooperation has been granted are eligible for Medicaid, provided that all other program requirements are met. AHS will grant such waivers when either of the following circumstances has been substantiated to AHS's satisfaction:

(1) Compliance with the cooperation requirement is reasonably anticipated to result in physical or emotional harm to the individual responsible for cooperating or the person for whom medical support or third-party payments are sought. Emotional harm means an emotional impairment that substantially affects an individual's functioning; or

(2) Compliance with the cooperation requirement would entail pursuit of medical support for a child:

(i) Conceived as a result of incest or rape from the father of that child;

(ii) For whom adoption proceedings are pending; or

(iii) For whom adoptive placement is under active consideration.

(b) Required documentation. An Individual requesting a waiver of the cooperation requirement bears the primary responsibility for providing the documentation AHS deems necessary to substantiate their claims of good cause. AHS will consider an individual who has requested a good-cause waiver and submitted the required documentation to be eligible for Medicaid while a decision on the request is pending.

(c) Review of good-cause waiver. A review of the continued existence of good cause circumstances upon which a

waiver has been granted is required no less frequently than at each redetermination of eligibility for those cases in which determination of good cause is based on a circumstance that may change. A formal decision based upon resubmission of evidence is not required, however, unless AHS determines that a significant change of circumstances relative to good cause has occurred.

18.05 Enrollment in a health insurance plan (01/15/2017, GCR 16-096)

(a) An individual who is applying for, or enrolled in Medicaid, may be required to enroll or remain enrolled in a group health insurance plan for which AHS pays the premiums. (See Medicaid Covered Services Rule (MCSR) 7108.) Payment of group health insurance premiums shall be made only under the conditions specified in this subsection and in MCSR 7108.1 and remain entirely at AHS's discretion. Such payment of premiums shall not be considered an entitlement for any individual.

(b) As a condition of continuing eligibility, an individual may be required to remain enrolled in an individual health insurance plan, provided that they are enrolled in a plan for which the state has been paying the premiums on a continuous basis since July 2000.

(c) For the purposes of this subsection and MCSR 7108.1, a group health insurance plan is a plan that meets the definition of a group health insurance plan specified in 8 V.S.A. § 4079. An individual health insurance plan is a plan that does not meet that definition.

19.00 Incarceration and QHP eligibility (01/15/2017, GCR 16-096)

19.01 In general[18] (01/15/2017, GCR 16-096)

An incarcerated individual, other than an individual who is incarcerated pending the disposition of charges, is ineligible for enrollment in a QHP.

19.02 Exception[19] (01/15/2017, GCR 16-096)

An incarcerated individual may be an applicable tax filer if a family member is eligible to enroll in a QHP.

20.00 Living arrangements for Medicaid eligibility purposes (01/01/2018, GCR 17-045)

20.01 In general[20] (01/01/2018, GCR 17-045)

Individuals or couples meet the living-arrangement requirement for Medicaid eligibility purposes if they live in:

(a) Their own home;

[18] 26 CFR § 1.36B-2(a)(4); 45 CFR § 155.305(a)(2).

[19] 26 CFR § 1.36B-2(a)(4); See §§ 1312(f)(1)(B) and 1312(f)(3) of the ACA (42 USC § 18032(f)(1)(B) and (f)(3)) and 26 CFR § 1.36B-3(b)(2).

[20] Former Medicaid Rules 4218 and 4332

(b) The household of another; or

(c) The following public institutions:

(1) The Vermont Psychiatric Care Hospital (VPCH) or successor entity or entities, if the individual is:

(i) Under the age of 21 (if a Medicaid enrollee is a patient of VPCH upon reaching their 21st birthday, eligibility may be continued to the date of discharge or their 22nd birthday, whichever comes first, as long as they continue to meet all other eligibility requirements); or

(ii) Age 65 or older.

(2) An intermediate care facility for people with developmental disabilities (ICF-DD).

(3) A facility supported in whole or in part by public funds whose primary purpose is to provide medical care other than the treatment of mental disease, including nursing and convalescent care, inpatient care in a hospital, drug and alcohol treatment, etc.

(d) A private facility, if:

(1) The primary purpose of the facility is to provide medical care other than the treatment of mental diseases, including nursing and convalescent care, inpatient care in a hospital, drug and alcohol treatment, etc.; and

(2) The facility meets the following criteria:

(i) There is no agreement or contract obliging the institution to provide total support to the individual;

(ii) There has been no transfer of property to the institution by the individual or on their behalf, unless maintenance by the institution has been of sufficient duration to fully exhaust the individual's equity in the property transferred at a rate equal to the monthly charges to other residents in the institution; and

(iii) There is no restriction on the individual's freedom to leave the institution.

(3) An individual under the age of 21 or age 65 or older meets the living arrangement requirement if they live at the Brattleboro Retreat. In addition, an individual who is a patient at the facility upon reaching their 21st birthday, has eligibility continued to the date of discharge or their 22nd birthday, whichever comes first, as long as they continue to meet all other eligibility requirements.

20.02 Correctional facility (01/01/2018, GCR 17-045)

(a) In general.[21] An individual living in a correctional facility, including a juvenile facility, is not precluded from being determined eligible for Medicaid or from retaining their Medicaid eligibility if they were eligible before becoming incarcerated. However, the individual's Medicaid benefits will be suspended during their

[21] 42 CFR §§ 435.1009 and 435.1010.

incarceration period (described in (b) below).

(b) Incarceration period. Incarceration begins on the date of admission and ends when the individual moves out of the correctional facility.

(c) Inpatient exception: Transfer to a medical facility.[22] While incarcerated, Medicaid is available when the inmate is an inpatient in a medical institution not under the control of the corrections system. Such institutions include a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility.

20.03 Determination of residence in an institution (01/15/2017, GCR 16-096)

Residence in an institution is determined by the dates of admission and discharge. An individual at home in the community on a visiting pass is still a resident of the institution.

20.04 Homeless individuals (01/15/2017, GCR 16-096)

A homeless individual is considered to be living in their own home.

20.05 Financial responsibility and living arrangement (01/15/2017, GCR 16-096)

The financial responsibility of relatives varies depending upon the type of living arrangement.

21.00 Residency (01/01/2018, GCR 17-045)

21.01 In general[23] (01/15/2017, GCR 16-096)

AHS will provide health benefits to an eligible Vermont resident.

21.02 Incapability of indicating intent (01/15/2017, GCR 16-096)

For purposes of this section, an individual is considered incapable of indicating intent regarding residency if the individual:

(a) Has an I.Q. of 49 or less or has a mental age of 7 years or less, based on tests acceptable to AHS;

(b) Is judged legally incompetent; or

(c) Is found incapable of indicating intent based on medical documentation obtained from a physician, psychologist, or other person licensed by the state in the field of intellectual disabilities.

[22] 42 CFR §§ 435.1009 and 435.1010. This is also based on various letters from CMS to states, inquiring about the availability of federal funds participation for inmate inpatient health care.

[23] 42 CFR § 435.403; 45 CFR § 155.305(a)(3). Note: The Exchange rules speak in terms of residence within the Exchange's "service area." However, as there will be a single "service area" in Vermont, for both Medicaid and QHP enrollment, this rule speaks in terms of residence within the state.

21.03 Who is a state resident (01/15/2017, GCR 16-096)

A resident of the state is any individual who:

(a) Meets the conditions in §§ 21.04 through 21.08; or

(b) Meets the criteria specified in an interstate agreement under § 21.10.

21.04 Placement by a state in an out-of-state institution[24] (01/15/2017, GCR 16-096)

(a) Any state agency, including an entity recognized under state law as being under contract with the state for such purposes, that arranges for an individual to be placed in an institution located in another state is recognized as acting on behalf of the state in making a placement. The state arranging or actually making the placement is considered as the individual's state of residence.

(b) Any action beyond providing information to the individual and the individual's family would constitute arranging or making a state placement. However, the following actions do not constitute state placement:

(1) Providing basic information to individuals about another state's Medicaid program and information about the availability of health care services and facilities in another state.

(2) Assisting an individual in locating an institution in another state, provided the individual is capable of indicating intent and independently decides to move.

(3) When a competent individual leaves the facility in which the individual is placed by a state, that individual's state of residence for Medicaid purposes is the state where the individual is physically located.

(4) Where a placement is initiated by a state because the state lacks a sufficient number of appropriate facilities to provide services to its residents, the state making the placement is the individual's state of residence.

21.05 An individual receiving Aid to the Aged, Blind, and Disabled (AABD)[25] (01/15/2017, GCR 16-096)

(a) In general. For an individual of any age who is receiving a state supplemental payment (in Vermont, known as AABD), the state of residence is the state paying the state supplemental payment.

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[24] 42 CFR § 435.403(e).

[25] Effective January l, l974, the major portion of Vermont's federal-state program of AABD became the federal program of Supplemental Security Income (SSI) through amendment of title XVI of the Social Security Act. SSI guarantees a minimum national standard of assistance to aged, blind or disabled persons at full federal expense. Vermont supplements the SSI payment with a state-funded payment. While, federal government abandoned the AABD program title, Vermont has retained this name for this state supplementary payment. See, AABD Rule 2700.

(b) Exception.[26] A transient worker may claim Vermont as their state of residence and be granted Medicaid if they meet all other eligibility criteria. These individuals may be granted Vermont Medicaid even though they continue to receive a state supplement payment from another state.

21.06 An individual age 21 and over[27] (01/15/2017, GCR 16-096)

Except as provided in § 21.05, with respect to individuals age 21 and over:

(a) For an individual not residing in an institution, as defined in § 3.00, including a licensed foster care providing food, shelter, and supportive services to one or more persons unrelated to the proprietor, the state of residence is the state where the individual is living and:

(1) Intends to reside, including without a fixed address; or

(2) Has entered the state with a job commitment or is seeking employment (whether or not currently employed).

(b) For an individual not residing in an institution, as described in (a) of this subsection, who is incapable of stating intent, the state of residence is the state where the individual is living.

(c) For any institutionalized individual who became incapable of indicating intent before age 21, the state of residence is:

(1) That of the parent applying for Medicaid on the individual's behalf, if the parents reside in separate states (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's);

(2) The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's);

(3) The current state of residence of the parent or legal guardian who files the application if the individual is institutionalized in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's); or

(4) The state of residence of the person or party who files an application is used if the individual has been abandoned by his or her parent(s), does not have a legal guardian and is institutionalized in that state.

(d) For any institutionalized individual who became incapable of indicating intent at or after age 21, the state of residence is the state in which the individual is physically present, except where another state makes a placement.

[26] Former Medicaid Rule 4217(A).

[27] 42 CFR § 435.403(h); 45 CFR §§ 155.305(a)(3)(i) and (iii).

(e) For any other institutionalized individual, the state of residence is the state where the individual is living and intends to reside. An institutionalized individual cannot be considered a Vermont resident if the individual owns a home (see § 29.08(a)(1)) in another state which the individual intends to return to, even if the likelihood of return is apparently nil.[28]

21.07 An individual receiving Title IV-E payments[29] (01/15/2017, GCR 16-096)

For an individual of any age who is receiving federal payments for foster care or adoption assistance under Title IV-E of the Act, the state of residence is the state where the individual lives.

21.08 An individual under age 21[30] (01/15/2017, GCR 16-096)

For an individual under age 21 who is not eligible for Medicaid based on receipt of assistance under Title IV-E of the Act, as addressed in § 21.07, and is not receiving a state supplementary payment, as addressed in § 21.05, the state of residence is as follows:

(a) For an individual who is capable of indicating intent and who is emancipated from his or her parent or who is married, the state of residence is determined in accordance with § 21.06(a).

(b) For an individual not described in paragraph (a) of this subsection, not living in an institution, not eligible for Medicaid based on receipt of assistance under Title IV-E of the Act, and not receiving a state supplementary payment, the state of residence is:

(1) The state where the individual resides, including without a fixed address; or

(2) The state of residency of the parent or caretaker, in accordance with § 21.06(a), with whom the individual resides.

(c) For any institutionalized individual who is neither married nor emancipated, the state of residence is:

(1) The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's); or

(2) The current state of residence of the parent or legal guardian who files the application if the individual is institutionalized in that state (if a legal guardian has been appointed and parental rights are terminated, the state or residence of the guardian is used instead of the parent's).

[28] Former Medicaid Rule 4217(F).

[29] 42 CFR § 403(g); 45 CFR § 155.305(a)(3)(iii).

[30] 42 CFR § 435.403(i); 45 CFR §§ 155.305(a)(3)(ii) and (iii). Paragraphs (a) and (b) are derived from what was formerly 42 CFR § 435.403(h). Subparagraphs (1) and (2) are new. Paragraph (c) was originally designated as 42 CFR § 435.403(h)(4).

21.09 Specific prohibitions[31] (01/15/2017, GCR 16-096)

AHS will not:

(a) Deny health-benefits eligibility because an individual has not resided in Vermont for a specified period.

(b) Deny health-benefits eligibility to an individual in an institution, who satisfies the residency rules set forth in this section, on the grounds that the individual did not establish residence in Vermont before entering the institution.

(c) Deny or terminate a Vermont resident's health-benefits eligibility because of that person's temporary absence from the state, as defined in § 21.13, if the person intends to return to Vermont when the purpose of the absence has been accomplished, unless, for purposes of Medicaid eligibility, another state has determined that the person is a resident there (see § 21.13(c)).

21.10 Interstate agreements[32] (01/15/2017, GCR 16-096)

A state may have a written agreement with another state setting forth rules and procedures resolving cases of disputed residency. These agreements may establish criteria other than those specified in §§ 21.07 and 21.08, but must not include criteria that result in loss of residency in both states or that are prohibited by § 21.09. The agreements must contain a procedure for providing health benefits to individuals pending resolution of the case. States may use interstate agreements for purposes other than cases of disputed residency to facilitate administration of the program, and to facilitate the placement and adoption of a Title IV-E individual when the child and his or her adoptive parent(s) move into another state.

21.11 Cases of disputed residency[33] (01/15/2017, GCR 16-096)

If Vermont and any other state cannot resolve which state is the individual's state of residence, the state where the individual is physically located is the state of residence.

21.12 Special rule for tax households with members in multiple Exchange service areas[34] (01/15/2017, GCR 16-096)

(a) Except as specified in paragraph (b) of this subsection, if all of the members of a tax household are not within the same Exchange service area, in accordance with the applicable standards in §§ 21.04 through 21.08, any member of the tax household may enroll in a QHP through any of the Exchanges for which one of the tax filers meets the residency standard.

(b) If both spouses in a tax household enroll in a QHP through VHC, a tax dependent may only enroll in a QHP

[31] 42 CFR § 435.403(j).

[32] 42 CFR § 435.403(k); 45 CFR § 155.305(a)(3)(iii).

[33] 42 CFR § 435.403(m); 45 CFR § 155.305(a)(3)(iii).

[34] 45 CFR § 155.305(a)(3)(iv).

through VHC, or through the Exchange that services the area in which the dependent meets a residency standard described in §§ 21.04 through 21.08.

21.13 Temporary absences from the state[35] (01/01/2018, GCR 17-045)

(a) In general. Temporary absences from Vermont do not interrupt or end Vermont residence.

(b) Definition. An absence is temporary if the individual leaves the state with the intent to return when the purpose of the absence has been accomplished. Examples include, but are not limited to, absences for the purposes of:

(1) Visiting;

(2) Obtaining necessary medical care;

(3) Obtaining education or training under a program of Vocational Rehabilitation, Work Incentive, or higher education program; or

(4) Residence in a long-term care facility in another state, if arranged by an agent of the State of Vermont, unless the individual or their parents or legal guardian, as applicable, state intent to abandon Vermont residence and to reside outside Vermont upon discharge from long-term care.

(c) Exception. For purposes of Medicaid eligibility, an absence is not temporary if another state verifies that the individual meets the residency standard of such other state.[36]

21.14 Vermont residence as Medicaid payment requirement (01/15/2017, GCR 16-096)

An individual must be a resident of Vermont at the time a medical service is rendered in order for Vermont Medicaid to pay for that service. The service, however, does not have to be rendered in Vermont subject to certain restrictions.[37]

22.00 Pursuit of potential unearned income for Medicaid eligibility[38] (01/15/2017, GCR 16-096)

(a) As a condition of eligibility for Medicaid, an individual is required to take all necessary steps to obtain any annuities, pensions, retirement, or disability benefits to which they may be entitled, unless they can show good cause for not doing so. Annuities, pensions, retirement, and disability benefits include, but are not limited to, veterans' compensation and pensions, OASDI benefits, railroad retirement benefits, and unemployment

[35] 45 CFR § 155.305(a)(3)(v).

[36] 42 CFR § 435.403(j)(3).

[37] 42 CFR § 431.52.

[38] Former Medicaid Rule 4137.

compensation. Application for these benefits, when appropriate, must be verified prior to granting or continuing Medicaid.

(b) Individuals are not required to apply for Medicare part B or for cash assistance programs such as SSI/AABD or Reach Up as a condition of eligibility for Medicaid.

23.00 Minimum essential coverage (01/01/2018, GCR 17-045)

23.01 Minimum essential coverage (01/01/2018, GCR 17-045)

(a) In general.[39] Minimum essential coverage means coverage under any of the following: Government-sponsored programs, eligible employer-sponsored plans, grandfathered health plans, individual health plans and certain other health-benefits coverage.

Individuals and their tax dependents must have minimum essential coverage (MEC) to avoid the shared responsibility payment (penalty) imposed by the Internal Revenue Service unless they qualify for an exemption from this payment. See § 23.06 for details on the eligibility determination for MEC exemptions.

In addition, individuals who are eligible to enroll in health coverage that qualifies as MEC under this section are not eligible to receive federal tax credits and cost-sharing reductions if they enroll in a QHP. See §§ 23.01(b) through 23.01(e) for details on health coverage that qualifies as MEC for purposes of considering eligibility for the federal premium tax credit. As stated in § 23.01(c)(2), for an employer-sponsored plan to be considered as MEC when an employee or related individual applies for APTC, the plan must be affordable and meet minimum value criteria. See § 23.02 for details on affordability, and § 23.03 for details on minimum value.

See §§ 55.02(c) and (d) for descriptions of the process for verifying eligibility for MEC when determining eligibility for APTC and CSR.

(b) Government-sponsored MEC

(1) In general.[40] Subject to the limitation in paragraph (b)(2), an individual is eligible for government-sponsored MEC for purpose of considering eligibility for the federal premium tax credit if, as of the first day of the first full month the individual may receive benefits under the program, the individual meets the criteria for coverage under one of the following government-sponsored programs:

(i) The Medicare program under part A of Title XVIII of the Act, except for an individual who must pay a premium for part A coverage and who chooses not to enroll in part A coverage (see § 23.01(e)(1));

(ii) The Medicaid program under Title XIX of the Act, except for the following individuals:

(A) A woman who becomes pregnant while enrolled in a QHP and who, though eligible for Medicaid as a pregnant woman pursuant to § 7.03(a)(2), chooses not to enroll in Medicaid (see §

[39] 26 USC § 5000A(f); 26 CFR § 1.36B-2(c).

[40] 26 USC § 5000A(f)(1)(A); 26 CFR § 1.36B-2(c)(2)(i)

23.01(e)(5)).

(B) An individual who becomes eligible for Medicaid coverage as medically needy only after meeting a spenddown. Such individual may apply to HHS for a hardship exemption from the personal responsibility payment as described in § 23.06(a).

(C) An individual who is receiving coverage limited to family planning services as described in § 9.03(g).

(D) An individual who is receiving coverage limited to the treatment of emergency services as described in § 17.02(d);

(iii) The CHIP program under Title XXI of the Act;

(iv) Medical coverage under chapter 55 of Title 10, United States Code, including coverage under the TRICARE program;

(v) A health care program under chapter 17 or 18 of Title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of HHS and the Secretary of the Treasury; or

(vi) A health plan under § 2504(e) of Title 22, United States Code (relating to Peace Corps volunteers).

(2) Obligation to complete administrative requirements to obtain coverage.[41] An individual who meets the eligibility criteria for government-sponsored MEC must complete the requirements necessary to receive benefits. An individual who fails by the last day of the third full calendar month following the event that establishes eligibility under (b)(1) of this subsection to complete the requirements to obtain government-sponsored MEC (other than a veteran's health-care program) is treated as eligible for government-sponsored MEC as of the first day of the fourth calendar month following the event that establishes eligibility.

(3) Special rule for coverage for veterans and other individuals under chapter 17 or 18 of Title 38, USC §.[42] An individual is eligible for MEC under a health-care program under chapter 17 or 18 of Title 38, USC section only if the individual is enrolled in a health-care program under chapter 17 or 18 of Title 38, USC section identified as MEC in regulations issued under § 5000A of the Code.

(4) Retroactive effect of eligibility determination.[43] If an individual receiving APTC is determined to be eligible for government-sponsored MEC that is effective retroactively (such as Medicaid), the individual is treated as eligible for MEC under that program no earlier than the first day of the first calendar month beginning after the approval.

[41] 26 CFR § 1.36B-2(c)(2)(ii).

[42] 26 CFR § 1.36B-2(c)(2)(iii).

[43] 26 CFR § 1.36B-2(c)(2)(iv).

(5) Determination of Medicaid or CHIP ineligibility.[44] An individual is treated as not eligible for Medicaid or a similar program for a period of coverage under a QHP if, when the individual enrolls in the QHP, the individual is determined to be not eligible for Medicaid.

(6) Examples.[45] The following examples illustrate the provisions of this paragraph (b):

(i) Example 1. Delay in coverage effectiveness. On April 10, 2015, Tax filer D applies for coverage under a government-sponsored health-care program. D's application is approved on July 12, 2015, but her coverage is not effective until September 1, 2015. Under paragraph (b)(1), D is eligible for government-sponsored MEC on September 1, 2015.

(ii) Example 2. Time of eligibility. Tax filer E turns 65 on June 3, 2015, and becomes eligible for Medicare. Under § 5000A(f)(1)(A)(i), Medicare is MEC. However, E must enroll in Medicare to receive benefits. E enrolls in Medicare in September, which is the last month of E's initial enrollment period. Thus, E may receive Medicare benefits on December 1, 2015. Because E completed the requirements necessary to receive Medicare benefits by the last day of the third full calendar month after the event that establishes E's eligibility (E turning 65), under paragraph (b)(1) and (b)(2) of this subsection, E is eligible for government-sponsored MEC on December 1, 2015, the first day of the first full month that E may receive benefits under the program.

(iii) Example 3. Time of eligibility, individual fails to complete necessary requirements. The facts are the same as in Example 2, except that E fails to enroll in the Medicare coverage during E's initial enrollment period. E is treated as eligible for government-sponsored MEC under paragraph (b)(2) of this subsection as of October 1, 2015, the first day of the fourth month following the event that establishes E's eligibility (E turning 65).

(iv) Example 4. Retroactive effect of eligibility. In November 2014, Tax filer F enrolls in a QHP for 2015 and receives APTCs. F loses her part-time employment and on April 10, 2015, applies for coverage under the Medicaid program. F's application is approved on May 15, 2015, and her Medicaid coverage is effective as of April 1, 2015. Under paragraph (b)(4), F is eligible for government-sponsored MEC on June 1, 2015, the first day of the first calendar month after approval.

(v) Example 5. Determination of Medicaid ineligibility. In November 2014, Tax filer G applies to enroll in health coverage for 2015. AHS determines that G is not eligible for Medicaid and estimates that G's household income will be 140 percent of the FPL for G's family size for purposes of determining APTCs. G enrolls in a QHP and begins receiving APTCs. G experiences a reduction in household income during the year and his household income for 2015 is 130 percent of the FPL (within the Medicaid income threshold). However, under paragraph (b)(5), G is treated as not eligible for Medicaid for 2015.

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[44] 26 CFR § 1.36B-2(c)(2)(v). The phrase in this section: “or considers (within the meaning of 45 CFR § 155.302(b))” was omitted from this paragraph, as AHS does not conduct “assessment[s] of eligibility for Medicaid and CHIP” within the meaning of 45 CFR § 155.302(b), but rather, determines eligibility for such programs.

[45] These examples are extracted from 26 CFR § 1.36B-2(c)(2)(vi).

(vi) Example 6. Mid-year Medicaid eligibility redetermination. The facts are the same as in Example 5, except that G returns to the Exchange in July 2015 and AHS determines that G is eligible for Medicaid. AHS approves G for coverage and AHS discontinues G's APTCs effective August 1. Under paragraphs (b)(4) and (b)(5), G is treated as not eligible for Medicaid for the months when G is covered by a QHP. G is eligible for government-sponsored MEC for the months after G is approved for Medicaid and can receive benefits, August through December 2015.

(c) Employer-sponsored MEC

(1) Definition: related individual. For purposes of this subsection and §§ 23.02 through 23.04, a related individual is an individual who is not an employee of an employer offering an eligible employer-sponsored plan, but who can enroll in such plan because of their relationship to the employee. This definition has a similar meaning as the definition of "dependent" for purposes of the Small Employer Health-Benefits Program under Part Six of this rule.

(2) In general.[46] An employee and related individual who may enroll in an eligible employer-sponsored plan are eligible for MEC under the plan for purposes of considering eligibility for the federal premium tax credit for any month only if the plan is affordable (§ 23.02) and provides minimum value (§ 23.03). Government-sponsored programs described in paragraph (b) of this subsection are not eligible employer-sponsored plans.

(3) Plan year.[47] For purposes of this paragraph, a plan year is an eligible employer-sponsored plan's regular 12-month coverage period (or the remainder of a 12-month coverage period for a new employee or an individual who enrolls during a special enrollment period).

(4) Eligibility for months during a plan year

(i) Failure to enroll in plan.[48] An employee or related individual may be eligible for MEC under an eligible employer-sponsored plan for a month during a plan year if the employee or related individual could have enrolled in the plan for that month during an open or special enrollment period for the plan year. If an enrollment period relates to coverage for not only the upcoming plan year (or the current plan year in the case of an enrollment period other than an open enrollment period), but also coverage in one or more succeeding plan years, this paragraph applies only to eligibility for the coverage in the upcoming plan year (or the current plan year in the case of an enrollment period other than an open enrollment period).

(ii) Waiting periods.[49] An employee or related individual is not eligible for MEC under an eligible

[46] 26 CFR § 1.36B-2(c)(3)(i).

[47] 26 CFR § 1.36B-2(c)(3)(ii).

[48] 26 CFR § 1.36B-2(c)(3)(iii)(A).

[49] 26 CFR § 1.36B-2(c)(3)(iii)(B).

employer-sponsored plan during a required waiting period before the coverage becomes effective.

(iii) Example.[50] The following example illustrates the provisions of this paragraph (c)(4):

(A) Tax filer B is an employee of Employer X. X offers its employees a health insurance plan that has a plan year (within the meaning of paragraph (c)(3)) from October 1 through September 30. Employees may enroll during an open season from August 1 to September 15. B does not enroll in X's plan for the plan year October 1, 2014, to September 30, 2015. In November 2014, B enrolls in a QHP for calendar year 2015.

(B) B could have enrolled in X's plan during the August 1 to September 15 enrollment period. Therefore, unless X's plan is not affordable for B or does not provide minimum value, B is eligible for MEC under X's plan for the months that B is enrolled in the QHP during X's plan year (January through September 2015).

(5) Post-employment coverage.[51] A former employee (including a retiree), or an individual related (within the meaning of this paragraph (c)) to a former employee, who may enroll in eligible employer-sponsored coverage or in continuation coverage required under federal law or a state law that provides comparable continuation coverage is eligible for MEC under this coverage only for months that the former employee or related individual is enrolled in the coverage.

(d) Other coverage that qualifies as MEC. The following types of coverage are designated as MEC for purposes of considering eligibility for the federal premium tax credit[52]:

(1) *Self-funded student health coverage*. Coverage offered to students by an institution of higher education (as defined in the Higher Education Act of 1965), where the institution assumes the risk for payment of claims, are designated as MEC for plan or policy years beginning on or before December 31, 2014. For coverage beginning after December 31, 2014, sponsors of self-funded student health coverage may apply to be recognized as MEC.

(2) *Refugee Medical Assistance supported by the Administration for Children and Families*. Coverage under Refugee Medical Assistance, authorized under § 412(e)(7)(A) of the INA, provides up to eight months of coverage to certain noncitizens who are considered refugees.

(3) *Medicare advantage plans*. Coverage under the Medicare program pursuant to part C of Title XVIII of the Act, which provides Medicare parts A and B benefits through a private insurer.

(4) *State high risk pool coverage*. State high risk pools are designated as MEC for plan or policy years beginning on or before December 31, 2014. For coverage beginning after December 31, 2014, sponsors of high risk pool coverage may apply to be recognized as MEC.

[50] 26 CFR § 1.36B-2(c)(3)(iii)(C).

[51] 26 CFR § 1.36B-2(c)(3)(iv).

[52] 26 USC § 5000A(f)(1)(E).

(e) Eligibility based on enrollment.[53] An individual is eligible for MEC under the following programs for purposes of considering eligibility for the federal premium tax credit only if the individual is enrolled in the coverage:

(1) *Medicare part A coverage requiring payment of premiums*. Coverage offered under Medicare for which the individual must pay a premium for Medicare part A coverage under § 1818 of the Act.

(2) *State high risk pools*. Health coverage offered by a state under a qualified high risk pool as defined in § 2744(c)(2) of the PHS Act, to the extent the program is covered by a designation by HHS as MEC.

(3) *Student health plans*. Self-funded health coverage offered by a college or university to its students, to the extent the plan is covered by a designation by HHS as MEC.

(4) *TRICARE programs*. Coverage under the following TRICARE programs:

(i) The Continued Health Care Benefit Program (10 USC § 1078);

(ii) Retired Reserve (10 USC § 1076e);

(iii) Young Adult (10 USC § 1110b); and

(iv) Reserve Select (10 USC § 1076d).

(5) *MCA coverage for a pregnant woman enrolled in a QHP*. Coverage offered under Medicaid for a pregnant woman pursuant to the criteria described in § 7.03(a)(2) if the woman was enrolled in a QHP when she became pregnant.[54]

23.02 Affordable coverage for employer-sponsored MEC (01/15/2017, GCR 16-096)

An individual will not be eligible for a federal premium tax credit if the employer-sponsored plan in which they may enroll is affordable. The details of affordability are described in this subsection.

(a) In general

(1) Affordability for employee.[55] Except as provided in paragraph (a)(3) of this subsection, an eligible employer-sponsored plan is affordable for an employee if the portion of the annual premium the employee must pay, whether by salary reduction or otherwise (required contribution), for self-only coverage does not exceed the required contribution percentage (as defined in paragraph (c)) of the applicable tax filer's household income for the benefit year.

[53] See, IRS Notice 2013-41.

[54] See, IRS Notice 2014-71.

[55] 26 CFR § 1.36B-2(c)(3)(v)(A)(1).

(2) Affordability for related individual.[56] Except as provided in paragraph (a)(3) of this subsection, an eligible employer-sponsored plan is affordable for a related individual if the portion of the annual premium the employee must pay for self-only coverage does not exceed the required contribution percentage, as described in (a)(1) of this subsection.

(3) Employee safe harbor.[57] An employee or a related individual who is eligible for a safe harbor as defined in this sub clause will not be subject to repayment of APTC based on the finding that affordable MEC was in fact available to them for all or part of a plan year, should such fact be discovered at a time subsequent to enrollment in a QHP.

(i) An employer-sponsored plan is not affordable for an employee or a related individual for a plan year if, when the employee or a related individual enrolls in a QHP for a period coinciding with the plan year (in whole or in part), it is determined that the eligible employer-sponsored plan is not affordable for that plan year.

(ii) This paragraph does not apply to a determination made as part of the redetermination process described in § 75.00 unless the individual receiving a redetermination notification affirmatively responds and provides current information on affordability.

(iii) This paragraph does not apply for an individual who, with reckless disregard for the facts, provides incorrect information concerning the portion of the annual premium for coverage for the employee or related individual under the plan.

(4) Wellness program incentives.[58] Nondiscriminatory wellness program incentives offered by an eligible employer-sponsored plan that affect premiums are treated as earned in determining an employee's required contribution for purposes of affordability of an eligible employer-sponsored plan to the extent the incentives relate exclusively to tobacco use. Wellness program incentives that do not relate to tobacco use or that include a component unrelated to tobacco use are treated as not earned for this purpose. For purposes of this subsection, the term "wellness program incentive" has the same meaning as the term "reward" in 26 CFR § 54.9802-1(f)(1)(i).

(5) Employer contributions to health reimbursement arrangements.[59] Amounts newly made available for the current plan year under a health reimbursement arrangement that an employee may use to pay premiums, or may use to pay cost-sharing or benefits not covered by the primary plan in addition to premiums, reduce the employee's required contribution if the health reimbursement arrangement would be integrated, as that term is used in IRS Notice 2013-54 (2013-40 IRB 287), with an eligible employer-sponsored plan for an employee enrolled in the plan. The eligible employer-sponsored plan and the health reimbursement arrangement must be offered by the same employer. Employer contributions to a

[56] 26 CFR § 1.36B-2(c)(3)(v)(A)(2).

[57] 26 CFR § 1.36B-2(c)(3)(v)(A)(3).

[58] 26 CFR § 1.36B-2(c)(3)(v)(A)(4).

[59] 26 CFR § 1.36B-2(c)(3)(v)(A)(5).

health reimbursement arrangement reduce an employee's required contribution only to the extent the amount of the annual contribution is required under the terms of the plan or otherwise determinable within a reasonable time before the employee must decide whether to enroll in the eligible employer-sponsored plan.

(6) Employer contributions to cafeteria plans.[60] Amounts made available for the current plan year under a cafeteria plan, within the meaning of 26 USC § 125, reduce an employee's or a related individual's required contribution if:

(i) The employee may not opt to receive the amount as a taxable benefit;

(ii) The employee may use the amount to pay for minimum essential coverage; and

(iii) The employee may use the amount exclusively to pay for medical care, within the meaning of 26 USC § 213.

(b) Affordability for part-year period.[61] Affordability under paragraph (a)(1) of this subsection is determined separately for each employment period that is less than a full calendar year or for the portions of an employer's plan year that fall in different benefit years of an applicable tax filer (a part-year period). An eligible employer-sponsored plan is affordable for a part-year period if the employee's annualized required contribution for self-only coverage under the plan for the part-year period does not exceed the required contribution percentage of the applicable tax filer's household income for the benefit year. The employee's annualized required contribution is the employee's required contribution for the part-year period times a fraction, the numerator of which is 12 and the denominator of which is the number of months in the part-year period during the applicable tax filer's benefit year. Only full calendar months are included in the computation under this paragraph.

(c) Required contribution percentage.[62] The required contribution percentage for 2014 is 9.5 percent. For plan years beginning in a calendar year after 2014, the percentage will be adjusted by the ratio of premium growth to income growth for the preceding calendar year and may be further adjusted to reflect changes to the data used to compute the ratio of premium growth to income growth for the 2014 calendar year or the data sources used to compute the ratio of premium growth to income growth. Premium growth and income growth will be determined under IRS-published guidance. In addition, the percentage may be adjusted for plan years beginning in a calendar year after 2018 to reflect rates of premium growth relative to growth in the consumer price index.

(d) Examples.[63] The following examples illustrate the provisions of § 23.02. Unless stated otherwise, in each

[60] 26 CFR § 1.36B-2(c)(3)(v)(A)(6).

[61] 26 CFR § 1.36B-2(c)(3)(v)(B).

[62] 26 CFR § 1.36B-2(c)(3)(v)(C). For plan years after 2014, the required contribution percentage will be updated in accordance with IRS-published guidance, available at www.irs.gov. For example, the required contribution percentage for 2016 is located at: https://www.irs.gov/pub/irs-drop/rp-14-62.pdf.

[63] 26 CFR § 1.36B-2(c)(3)(v)(D).

example the tax filer is single and has no tax dependents, the employer's plan is an eligible employer-sponsored plan and provides minimum value, the employee is not eligible for other MEC, and the tax filer, related individual, and employer-sponsored plan have a calendar benefit year:

(1) Example 1. Basic determination of affordability. In 2014 Tax filer C has household income of $47,000. C is an employee of Employer X, which offers its employees a health insurance plan that requires C to contribute $3,450 for self-only coverage for 2014 (7.3 percent of C's household income). Because C's required contribution for self-only coverage does not exceed 9.5 percent of household income, under paragraph (a)(1), X's plan is affordable for C, and C is eligible for MEC for all months in 2014.

(2) Example 2. Basic determination of affordability for a related individual. The facts are the same as in Example 1, except that C is married to J and X's plan requires C to contribute $5,300 for coverage for C and J for 2014 (11.3 percent of C's household income). Because C's required contribution for self-only coverage ($3,450) does not exceed 9.5 percent of household income, under paragraph (a)(2) of this subsection, X's plan is affordable for C and J, and C and J are eligible for minimum essential coverage for all months in 2014.

(3) Example 3. Determination of unaffordability at enrollment

(i) Tax filer D is an employee of Employer X. In November 2013 AHS projects that D's 2014 household income will be $37,000. It also verifies that D's required contribution for self-only coverage under X's health insurance plan will be $3,700 (10 percent of household income). Consequently, AHS determines that X's plan is unaffordable. D enrolls in a QHP and not in X's plan. In December 2014, X pays D a $2,500 bonus. Thus, D's actual 2014 household income is $39,500 and D's required contribution for coverage under X's plan is 9.4 percent of D's household income.

(ii) Based on D's actual 2014 household income, D's required contribution does not exceed 9.5 percent of household income and X's health plan is affordable for D. However, when D enrolled in a QHP for 2014, AHS determined that X's plan was not affordable for D for 2014. Consequently, under paragraph (a)(3), X's plan is not affordable for D and D is not eligible for MEC under X's plan for 2014.

(4) Example 4. Determination of unaffordability for plan year. The facts are the same as in Example 3, except that X's employee health insurance plan year is September 1 to August 31. AHS determines in August 2014 that X's plan is unaffordable for D based on D's projected household income for 2014. D enrolls in a QHP as of September 1, 2014. Under paragraph (a)(3), X's plan is not affordable for D and D is not eligible for MEC under X's plan for the coverage months September to December 2014 and January through August 2015.

(5) Example 5. No affordability information affirmatively provided for annual redetermination.

(i) The facts are the same as in Example 3, except AHS redetermines D's eligibility for APTCs for 2015. D does not affirmatively provide AHS with current information regarding affordability and AHS determines that D's coverage is not affordable for 2015 and approves APTCs based on information from the previous enrollment period. In 2015, D's required contribution for coverage under X's plan is 9.4 percent of D's household income.

(ii) Because D does not respond to AHS's notification and AHS makes an affordability determination based on information from an earlier year, the employee safe harbor in paragraph (a)(3) does not apply. D's required contribution for 2015 does not exceed 9.5 percent of D's household income. Thus, X's plan is affordable for D for 2015 and D is eligible for MEC for all months in 2015.

(6) Example 6. Determination of unaffordability for part of plan year (part-year period)

(i) Tax filer E is an employee of Employer X beginning in May 2015. X's employee health insurance plan year is September 1 to August 31. E's required contribution for self-only coverage for May through August is $150 per month ($1,800 for the full plan year). AHS projects E's household income for purposes of eligibility for APTCs as $18,000. E's actual household income for the 2015 benefit year is $20,000.

(ii) Under paragraph (b) of this subsection, whether coverage under X's plan is affordable for E is determined for the remainder of X's plan year (May through August). E's required contribution for a full plan year ($1,800) exceeds 9.5 percent of E's household income (1,800/18,000 = 10 percent). Therefore, AHS determines that X's coverage is unaffordable for May through August. Although E's actual household income for 2015 is $20,000 (and E's required contribution of $1,800 does not exceed 9.5 percent of E's household income), under paragraph (a)(3), X's plan is unaffordable for E for the part of the plan year May through August 2015. Consequently, E is not eligible for MEC under X's plan for the period May through August 2015.

(7) Example 7. Affordability determined for part of a benefit year (part-year period)

(i) Tax filer F is an employee of Employer X. X's employee health insurance plan year is September 1 to August 31. F's required contribution for self-only coverage for the period September 2014 through August 2015 is $150 per month or $1,800 for the plan year. F does not enroll in X's plan during X's open season but enrolls in a QHP for September through December 2014. F does not request APTCs and does not ask AHS to determine whether X's coverage is affordable for F. F's household income in 2014 is $18,000.

(ii) Because F is a calendar year tax filer and Employer X's plan is not a calendar year plan, F must determine the affordability of X's coverage for the part-year period in 2014 (September-December) under paragraph (b) of this subsection. F determines the affordability of X's plan for the September through December 2014 period by comparing the annual premiums ($1,800) to F's 2014 household income. F's required contribution of $1,800 is 10 percent of F's 2014 household income. Because F's required contribution exceeds 9.5 percent of F's 2014 household income, X's plan is not affordable for F for the part-year period September through December 2014 and F is not eligible for MEC under X's plan for that period.

(iii) F enrolls in coverage for 2015 and does not ask AHS to approve APTCs or determine whether X's coverage is affordable. F's 2015 household income is $20,000.

(iv) F must determine if X's plan is affordable for the part-year period January 2015 through August 2015. F's annual required contribution ($1,800) is 9 percent of F's 2015 household income. Because F's required contribution does not exceed 9.5 percent of F's 2015 household income, X's plan is affordable for F for the part-year period January through August 2015 and F is eligible for MEC for

that period.

(8) Example 8. Coverage unaffordable at year end. Tax filer G is employed by Employer X. In November 2014, AHS determines that G is eligible for affordable employer-sponsored coverage for 2015. G nonetheless enrolls in a QHP for 2015 but does not receive APTC. G's 2015 household income is less than expected and G's required contribution for employer-sponsored coverage for 2015 exceeds 9.5 percent of G's actual 2015 household income. Under paragraph (a)(1) of this subsection, G is not eligible for MEC under X's plan for 2015.

(9) Example 9. Wellness program incentives

(i) Employer X offers an eligible employer-sponsored plan with a nondiscriminatory wellness program that reduces premiums by $300 for employees who do not use tobacco products or who complete a smoking cessation course. Premiums are reduced by $200 if an employee completes cholesterol screening within the first six months of the plan year. Employee B does not use tobacco and the cost of his premiums is $3,700. Employee C uses tobacco and the cost of her premiums is $4,000.

(ii) Under paragraph (a)(4) of this subsection, only the incentives related to tobacco use are counted toward the premium amount used to determine the affordability of X's plan. C is treated as having earned the $300 incentive for attending a smoking cessation course regardless of whether C actually attends the course. Thus, the required contribution for determining affordability for both Employee B and Employee C is $3,700. The $200 incentive for completing cholesterol screening is treated as not earned and does not reduce their required contribution.

23.03 Minimum value for employer-sponsored MEC[64] (01/15/2017, GCR 16-096)

An individual will not be eligible for a federal premium tax credit if the employer-sponsored plan in which they may enroll provides minimum value. An eligible employer-sponsored plan provides minimum value only if the percentage of the total allowed costs of benefits provided under the plan is greater than or equal to 60 percent, and the benefits under the plan include substantial coverage of inpatient hospital services and physician services.

23.04 Enrollment in eligible employer-sponsored plan (01/15/2017, GCR 16-096)

(a) In general.[65] Except as provided in paragraph (b) of this subsection, the requirements of affordability and minimum value do not apply for months that an individual is enrolled in an eligible employer-sponsored plan.

(b) Automatic enrollment.[66] An employee or related individual is treated as not enrolled in an eligible employer-sponsored plan for a month in a plan year or other period for which the employee or related individual is automatically enrolled if the employee or related individual terminates the coverage before the later of the first day of the second full calendar month of that plan year or other period or the last day of any permissible opt-out period provided by the employer-sponsored plan or in regulations to be issued by the Department of Labor,

[64] 45 CFR § 156.145; see, also, 26 CFR §§ 1.36B-2(c)(3)(vi) and 1.36B-6.

[65] 26 CFR § 1.36B-2(c)(3)(vii)(A).

[66] 26 CFR § 1.36B-2(c)(3)(vii)(B).

for that plan year or other period.

(c) Examples.[67] The following examples illustrate the provisions of this subsection:

(1) Example 1. Tax filer H is employed by Employer X in 2014. H's required contribution for self-only employer coverage exceeds 9.5 percent of H's 2014 household income. H enrolls in X's calendar year plan for 2014. Under paragraph (a) of this subsection, H is eligible for MEC for 2014 because H is enrolled in an eligible employer-sponsored plan for 2014.

(2) Example 2. The facts are the same as in Example 1, except that H terminates plan coverage on June 30, 2014. Under paragraph (a) of this subsection, H is eligible for MEC under X's plan for January through June 2014 but is not eligible for MEC under X's plan for July through December 2014.

(3) Example 3. The facts are the same as in Example 1, except that Employer X automatically enrolls H in the plan for calendar year 2015. H terminates the coverage on January 20, 2015. Under paragraph (b) of this subsection, H is not eligible for MEC under X's plan for January 2015.

23.05 Special eligibility rules[68] (01/01/2018, GCR 17-045)

(a) Related individual not claimed as a personal exemption deduction. An individual who may enroll in MEC because of a relationship to another person eligible for the coverage, but for whom the other eligible person does not claim a personal exemption deduction, is treated as eligible for MEC under the coverage only for months that the related individual is enrolled in the coverage.

(b) VHC unable to discontinue APTC

(1) *In general*. If an individual who is enrolled in a QHP for which advance credit payments are made informs VHC that the individual is or will soon be eligible for other MEC and that advance credit payments should be discontinued, but VHC does not discontinue advance credit payments for the first calendar month beginning after the month the individual informs VHC, the individual is treated as eligible for the other MEC no earlier than the first day of the second calendar month beginning after the first month the individual may enroll in the other MEC.

(2) *Medicaid or CHIP*. If a determination is made that an individual who is enrolled in a QHP for which advance credit payments are made is eligible for Medicaid or CHIP but the advance credit payments are not discontinued for the first calendar month beginning after the eligibility determination, the individual is treated as eligible for Medicaid or CHIP no earlier than the first day of the second calendar month beginning after the eligibility determination.

[67] 26 CFR § 1.36B-2(c)(3)(vii)(C).

[68] 26 CFR § 1.36B-2(c)(4).

23.06 Eligibility determinations for MEC exemptions[69] (01/01/2018, GCR 17-045)

(a) In general.[70] AHS will satisfy the requirement to determine eligibility for an exemption from the shared responsibility payment by adopting an exemption eligibility determination made by HHS.

[69] See, 45 CFR §§ 155.600 through 155.635.

[70] 45 CFR § 155.625. Exemption applications and instructions are located at www.healthcare.gov/health-coverage-exemptions.

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Part Four
Special Rules for Medicaid Coverage of Long-Term Care Services and Supports - Eligibility and Post-Eligibility

24.00 Patient share payment for Medicaid coverage of long-term care services and supports (01/01/2018, GCR 17-046)

24.01 In general (01/15/2017, GCR 16-097)

(a) Definition: patient share.[1] Once AHS determines that an individual is eligible for Medicaid coverage of long-term care services and supports, it computes how much of their income must be paid to the long-term care provider each month for the cost of their care (this is called the "patient share").

A patient share is computed for an individual who qualifies for Medicaid coverage of long-term care services and supports under MABD in a medical institution or in a home and community-based setting under a special income coverage group (see § 8.05(k)) or as medically needy (see § 8.06). An individual's patient share is determined at initial eligibility, eligibility redeterminations, and when changes in circumstances occur.

(b) Computation of patient share

(1) An individual's patient share is determined by computing a maximum patient share and deducting allowable expenses. § 24.03 describes how the maximum patient share is determined. § 24.04 describes allowable deductions from the patient share. The actual patient share payable by the individual is the lesser of:

(i) The balance of the individual's income remaining after computing the patient share; and

(ii) The cost of care remaining after third-party payment.

(2) In cases in which allowable deductions exceed the individual's income, the patient-share payment is reduced by the deductions, sometimes resulting in no patient-share obligation, for as many months needed to exhaust the deductions against the individual's available income. The month when the remaining deductions no longer exceed the individual's income, the balance is the patient share payment for that month. When monthly income and allowable deductions are stable, the patient-share amount remains constant. When income or allowable deductions fluctuate, the patient-share payment is likely to vary.

(c) Patient share payment. An individual owes their patient share by the last day of the month in which they receive the income. Payment is made either to the facility in which the individual resided or to the highest-paid provider of long-term care services and supports. Patient-share amounts and payments to long-term care providers may be adjusted when a patient transitions from one setting to another, as specified in § 24.05.

[1] 42 CFR §§ 435.725, 435.726 and 435.735

24.02 Long-term care residence period (01/15/2017, GCR 16-097)

(a) In general. A patient share obligation is assessed in the month of admission to long-term care as long as the individual is expected to need long-term care services and supports for at least 30 consecutive days. If long-term care services and supports are expected to be needed for fewer than 30 consecutive days, no patient share is assessed. Instead, the individual's services are covered through Medicaid, other than Medicaid coverage of long-term care services and supports, if the individual meets medical necessity criteria (see Medicaid coverage rule § 7103) and relevant financial, nonfinancial and categorical eligibility criteria.

(b) Duration of the long-term care residence period

(1) Beginning of long-term care residence

(i) In a general hospital setting. A long-term care residence period in a general hospital setting begins with the first day that the utilization review committee finds acute hospital care is no longer medically necessary and skilled nursing care is medically necessary.

(ii) In other long-term care settings. A long-term care residence period in a long-term care setting, other than a general hospital, begins with the first day that the utilization review committee finds medical need for long-term care or the date of admission, whichever is later.

(2) Ending of long-term care residence period. A long-term care residence period ends with the earliest of:

(i) The individual's date of death;

(ii) The date of the individual's discharge from a long-term care living arrangement (as defined in § 30.01); or

(iii) The last day medical need for long-term care is established by the utilization review committee.

(3) Leave of absence or transfer. A long-term care residence period is not ended by a leave of absence from the current setting (see DVHA Rule 7604.1). A long-term care residence period also continues despite transfer from either:

(i) One long-term care setting to another long-term care setting;

(ii) A general hospital setting (where skilled nursing care has been continuously authorized while awaiting transfer) to another long-term care setting; or

(iii) A long-term care setting to a general hospital setting followed by return to the long-term care setting without an intervening residence period in a community living arrangement (as defined in § 30.01).

(4) Percentage of month in long-term care. The percentage of the month an individual is in long-term care is determined using the appropriate table below.

Percentage of Month in Long-Term Care: All months except February

Day of the month admitted to long-term care	Percentage of the month in long-term care	Day of the month admitted to long-term care	Percentage of the month in long-term care	Day of the month admitted to long-term care	Percentage of the month in long-term care
1	100%	11	67%	21	33%
2	97%	12	63%	22	30%
3	93%	13	60%	23	27%
4	90%	14	57%	24	23%
5	87%	15	53%	25	20%
6	83%	16	50%	26	17%
7	80%	17	47%	27	13%
8	77%	18	43%	28	10%
9	73%	19	40%	29	7%
10	70%	20	37%	30-31	3%

Percentage of Month in Long-Term Care: February

Day of the month admitted to long-term care	Percentage of the month in long-term care	Day of the month admitted to long-term care	Percentage of the month in long-term care	Day of the month admitted to long-term care	Percentage of the month in long-term care
1	100%	11	64%	21	29%
2	96%	12	61%	22	25%
3	93%	13	57%	23	21%
4	89%	14	54%	24	18%
5	86%	15	50%	25	14%
6	82%	16	46%	26	11%
7	79%	17	43%	27	7%
8	75%	18	39%	28	4%
9	71%	19	36%	29	0%
10	68%	20	32%		

24.03 Determining maximum patient share (01/15/2017, GCR 16-097)

To determine the maximum patient share, the individual's gross income less allowable deductions as specified in § 24.04 is considered. This is the most that an individual receiving Medicaid coverage of long-term care services and supports is obliged to pay toward the cost of their long-term care services and supports. If an individual was in long-term care for less than a full month, the maximum patient share is multiplied by the applicable percentage in the table set forth in § 24.02.

24.04 Allowable deductions from patient-share (01/01/2018, GCR 17-046)

(a) Income deductions. When determining the actual patient share payable by an individual, the following are deducted from the individual's gross income:

(1) SSI/AABD, AABD only and Reach Up benefit payments still being received when the person first enters long-term care;

(2) SSI/AABD payments intended to be used to maintain the community residence of an individual temporarily (not to exceed 3 months) in an institution;

(3) Austrian Reparation Payments;

(4) German Reparation Payments;

(5) Japanese and Aleutian Restitution Payments;

(6) Payments from the Agent Orange Settlement Fund;

(7) Radiation Exposure Compensation; and

(8) VA payments for aid and attendance paid to a veteran residing in a nursing facility or to the veteran's surviving spouse residing in a nursing facility.

(b) Other deductions. The following items are then deducted from the individual's patient share in the following order:

(1) A personal-needs allowance (PNA) or community-maintenance allowance (CMA) (see paragraph (c) of this subsection);

(2) Home-upkeep expenses, if applicable (see paragraph (d) of this subsection);

(3) Allocations to a community spouse or maintenance needs of family members living in the community, if applicable (see paragraph (e) of this subsection); and

(4) Reasonable medical expenses incurred, if applicable (see §§ 30.05 and 30.06). For the purposes of this paragraph (b)(4), "reasonable medical expenses" do not include expenses for long-term care services and supports received during penalty periods for Medicaid coverage of long-term care services and supports.

(5) NOTE: Unpaid patient-share obligations may not be used to reduce a current patient share obligation.

(c) Personal-needs allowance and community-maintenance allowance. A reasonable amount for clothing and other personal needs of an individual is deducted from their monthly income, as follows:

(1) For an individual receiving Medicaid coverage of long-term care services and supports in an institutional setting, a standard personal needs deduction (PNA) is applied.

(2) For an individual receiving Medicaid coverage of long-term care services and supports in a home and community-based setting, a standard community maintenance deduction (CMA) is applied. (NOTE: Unlike the individual in the institutional setting whose room and board is covered by Medicaid, an individual receiving long-term care services and supports in a home and community-based setting has a higher deduction to provide a reasonable amount for food, shelter, and clothing to meet their personal needs.)

(d) Home-upkeep deduction

(1) Expenses from the monthly income of an individual receiving Medicaid coverage of long-term care services and supports in an institution or receiving enhanced residential care (ERC) services in a residential care home are deducted to help maintain their owned or rented home in the community. This deduction is allowed for six months. It is available for each separate admission to long-term care, as long as the criteria listed below are met. The home-upkeep standard deduction is three-fourths of the SSI/AABD payment level for a single individual living in the community.

(2) The home-upkeep deduction is granted when the individual has income equal to or greater than the standard home-upkeep deduction and greater than their PNA. An individual who has less income than the standard home-upkeep deduction may deduct an amount for home upkeep equal to the difference between the individual's income and the PNA.

(i) The home-upkeep deduction may be applied at any point during the individual's institutionalization or receipt of ERC services, as the case may be, as long as both of the following criteria for the deduction are met:

(A) No one resides in the individual's home and receives an allocation as a community spouse or other eligible family member; and

(B) The individual submits a doctor's statement before the six-month deduction period, stating that the individual is expected to be discharged from the institution or ERC setting within six months and to return home immediately after discharge.

(ii) If the situation changes during the period the individual is receiving the home-upkeep deduction, the individual's eligibility for the deduction is redetermined. The deduction is denied or ended when:

(A) The individual's home is sold or rented;

(B) The rented quarters of the individual are given up; or

(C) The individual's health requires the long-term care admission period to last longer than six months.

(e) Allocations to family members

(1) In general. An individual is allowed to allocate their income to certain family members as described in this paragraph.

(i) Allocation to community spouse

(A) If an individual receiving Medicaid coverage of long-term care services and supports (the institutionalized spouse) has a spouse living in the community (the community spouse), an allocation may be deducted from the institutionalized spouse's income for the needs of the community spouse. The term "community spouse" applies to the spouse of the institutionalized spouse even if the community spouse is also receiving Medicaid coverage of long-term care services and supports in a home and community-based setting. When one spouse is receiving Medicaid coverage of long-term care services and supports in an institutional setting and the other is receiving Medicaid coverage of long-term care services and supports in a home and community-based setting, the spouse receiving home and community-based services and supports may receive an allocation. When both spouses are receiving home and community-based services and supports, either may allocate to the other.

(B) "Assisted living" is considered a community setting and not an institutional setting provided that assisted living does not include 24-hour care, has privacy, a lockable door, and is a homelike setting. If the spouse of an institutionalized spouse is living in an assisted living setting, they are considered a community spouse for purposes of the community spouse income allocation.

(C) An institutionalized spouse may allocate less than the full amount of the allocation to their community spouse or may allocate nothing. The allocation is reduced by the gross income, if any, of the community spouse. A community spouse, as well as an institutionalized spouse, has a right to request a fair hearing on the amount of the allocation.

(D) The standard community spouse income allocation equals 150 percent of the FPL for two. The actual community spouse income allocation equals the standard allocation plus any amount by which actual shelter expenses of the community spouse exceed the standard allocation, up to a maximum amount. The maximum community spouse income allocation equals a maximum provided by the federal government each year by November 1st.

(E) The presumptions set forth below are applied to the ownership interests in income when determining a community spouse's community spouse income allocation unless the institutionalized spouse establishes by a preponderance of the evidence that the ownership interests are other than as presumed.

(I) Income paid in the name of one spouse is presumed available only to the named spouse.

(II) Income paid in the name of both spouses is presumed available in equal shares to each spouse.

(III) Income paid in the name of either spouse and any other person is presumed available to that spouse in proportion to their ownership interest.

(IV) Income paid in the name of both spouses and any other person is presumed available to each spouse in an amount of one-half of the joint interest.

(ii) Allocation to other family members

(A) A deduction from the individual's income is allowed for the maintenance needs of certain other family members. If the individual has no community spouse living in the home, the countable resources of any such family member cannot exceed the community spouse resource allocation (CSRA) minimum (see Vermont's Medicaid Procedures Manual for the current CSRA minimum). If the individual has a community spouse living in the home, there is no limit on the amount of countable resources of any such family member.

For purposes of this deduction, a family member must be:

(I) A child of either the individual or the individual's spouse under age 18; or

(II) A dependent child, parent, or sibling of either the individual or the individual's spouse. For the purposes of this subparagraph, a family member is considered dependent if they meet each of the following three criteria:

(i) They have been or will be a member of the household of the individual or their spouse for at least one year;

(ii) More than one half of their total support is provided by the individual or the individual's spouse; and

(iii) They have gross annual income below $2,500 or are a child of the individual (or spouse) under age 19 or under age 24 and a full-time student during any five months of the tax year.

(B) *Deduction for family members living with the community spouse*. When family members live with the community spouse of the individual receiving Medicaid coverage of long-term care services and supports, the deduction equals the maintenance income standard reduced by the gross income of each family member and divided by three. The resulting amount is the maximum allocation that may be made to each family member.

(C) *Deduction for family members not living with the community spouse*. When family members do not live with the community spouse of the individual receiving Medicaid coverage of long-term care services and supports, the deduction equals the applicable PIL for the number of family members living in the same household, reduced by the gross income, if any, of the family members in the household.

(D) The family members described above may be required to apply for SSI, AABD or Reach Up, as long as this would not disadvantage them financially.

24.05 Transfer between settings (01/15/2017, GCR 16-097)

(a) In general. An individual receiving long-term care sometimes moves from one setting to another, such as from one nursing facility to another or from a nursing facility to a hospital and back to the same or another nursing facility. The patient share must be paid toward the cost of the individual's care from income received by the individual during each month of a continuous period of receiving Medicaid coverage of long-term care services and supports. As a general rule, the provider giving long-term care services and supports to the individual on the last day of the preceding month sends the individual a bill for the individual's share of the cost for that month. Payment is made to an institution if the individual was receiving Medicaid coverage of long-term care services and supports in the institution on the last day of the preceding month. Payment is made to the highest-paid provider of long-term care services and supports if the individual was receiving Medicaid coverage of long-

term care services and supports in a home and community-based setting on the last day of the preceding month. If payment of a patient share results in a credit to the provider, then the provider sends the excess to AHS. Exceptions to this rule are specified in the paragraphs below.

(b) Hospital admission from nursing facility. An individual receiving Medicaid coverage of long-term care services and supports who is hospitalized continues to receive Medicaid coverage of long-term care services and supports, and their patient share amount is not redetermined. Payment of the patient share is allocated to the providers as follows:

(1) Acute care. The patient share is paid directly to AHS when the individual is hospitalized and receiving acute hospital care on the last day of the month preceding the month in which income is received. Failure to pay the patient share may result in closure of the individual's eligibility for Medicaid coverage of long-term care services and supports.

(2) Long-term care. The patient share is paid to the hospital when the individual is hospitalized and receiving Medicaid coverage of long-term care services and supports in the hospital on the last day of the month preceding the month in which income is received.

(c) Transfer from home and community-based setting to nursing facility

(1) Respite services. The patient share amount is not adjusted when an individual receiving Medicaid coverage of long-term care services and supports in a home and community-based setting enters an institution for respite services. The patient share is paid to the highest-paid provider of the long-term care services and supports, even if the individual is in an institution on the last day of the month.

(2) Other services. AHS adjusts the patient share amount when an individual receiving Medicaid coverage of long-term care services and supports in a home and community-based setting enters an institution for services other than respite services and has been in the institution for a full calendar month. The patient share is paid to the institution since the individual was receiving Medicaid coverage of long-term care services and supports in an institution on the last day of the month.

(d) Discharge from nursing facility to home and community-based setting. The patient share amount is adjusted when an individual is in an institution for more than one full calendar month and discharged to a home and community-based setting. After the patient-share amount is redetermined using the community maintenance allowance (see § 24.04(c)), the first month's patient share is paid to the institution because the individual resided in the institution on the last day of the previous month. Thereafter, the patient share it is paid to the highest paid provider.

(e) Discharge from long-term care. All income an individual receiving Medicaid coverage of long-term care services and supports receives during the month they are discharged from long-term care and any month after discharge when the individual leaves a long-term care living arrangement (see § 30.01) is excluded. A long-term care provider must refund any patient-share payment made by an individual when the individual pays their patient share from income received in the month of their discharge.

(f) Termination of eligibility for long-term care. An individual receiving Medicaid coverage of long-term care services and supports becomes fully responsible for the total cost of any care they receive when they remain institutionalized after a medical-review team decision that they no longer need skilled nursing or intermediate

care, or they become ineligible for other reasons. The individual's responsibility begins after the effective date of the review team's decision. An individual usually must pay in advance for such care as a privately-paying patient. They incur no patient share obligation for the calendar month that the review team's decision takes effect. A long-term care provider must credit payment toward the cost of private care furnished after the effective date of the review team's decision to end Medicaid coverage of long-term care services and supports when an individual receiving Medicaid coverage of long-term care services and supports has already paid their patient share to the provider during the calendar month the review team's decision takes effect.

(g) Patient share in the month of death. Income received during the calendar month of the death of an individual receiving Medicaid coverage of long-term care services and supports is counted and applied to the cost of the care the individual received during the prior month. For example, if the individual dies on June 26th, the patient-share payment from income they received during June is due for care provided in May. If the individual dies on July 1st, the patient-share payment from income they received during July is due for care provided in June.

25.00 Income or resource transfers and eligibility for Medicaid coverage of long-term care services and supports (01/01/2018, GCR 17-046)

25.01 In general (01/15/2017, GCR 16-097)

(a) AHS determines whether transfers of income or resources made by an individual requesting Medicaid coverage of long-term care services and supports are allowable transfers under the rules set forth in this section.

(1) This section applies to an individual:

(i) Who is requesting Medicaid coverage of long-term care services and supports in a medical institution under MABD or MCA.

(ii) Who is requesting Medicaid coverage of long-term care services and supports in a home and community-based setting under MCA.

(iii) Who is requesting Medicaid coverage of long-term care services and supports in a home and community-based setting under MABD and is in a special income coverage group under § 8.05(k)) or is medically needy (§ 8.06).

(2) This section also applies to the spouse of an individual described in (1) above.

If AHS determines that a transfer is not allowable, the individual requesting Medicaid coverage of long-term care services and supports will not be eligible for such coverage until a penalty period has expired. The start date of the penalty period is based on when the individual would, but for the disallowed transfer, be otherwise eligible for Medicaid coverage of long-term care services and supports, as explained in more detail in this section. The duration of the penalty period is based on the value of the disallowed transfer.

(b) AHS makes determinations concerning transfers occurring before the individual requests Medicaid coverage of long-term care services and supports as part of its determination of the individual's initial eligibility. Once AHS has determined that a transfer is disallowed and has established a penalty period that transfer is not reconsidered unless AHS obtains new information about the transfer. If, after the initial determination, AHS

discovers that the individual made an additional transfer (or transfers), AHS also determines whether the additional transfer (or transfers) is allowable, whether the date of the additional transfer (or transfers) is before or after the initial determination, and establishes a penalty period (or periods) as required. If the individual requesting Medicaid coverage of long-term care services and supports has a spouse (community spouse), after the month in which the individual is determined eligible for Medicaid coverage of long-term care services and supports, no resources of the community spouse shall be determined available to the individual (the institutionalized spouse). Accordingly, no transfers by the community spouse after the initial month of the institutionalized spouse's eligibility are considered for purposes of the institutionalized spouse's ongoing eligibility.

(c) § 25.03 specifies the criteria for allowable transfers, to which no penalty period applies, effective for all initial determinations of eligibility for Medicaid coverage of long-term care services and supports and all redeterminations. No other transfers are allowable.

25.02 Definitions (01/15/2017, GCR 16-097)

(a) Transfer of income or resources. For the purposes of this section, a transfer of income or resources is any action taken by the individual requesting Medicaid coverage of long-term care services and supports, by the spouse of such individual, or by any other person with lawful access to the income or resources of the individual or such individual's spouse that disposes of the income or resources. The date of the transfer is the date the action was taken. It also applies to certain income and resources to which the individual or such individual's spouse is entitled but does not have access because of an action taken by:

(1) The individual or such individual's spouse;

(2) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse; or

(3) A person, including a court or administrative body, acting at the direction or upon the request of the individual or such individual's spouse.

(b) Fair market value. Unless otherwise specified, fair market value is an amount equal to the price of an item on the open market in the individual's locality at the time of a transfer, or contract for sale, if earlier.

25.03 Allowable transfers (01/01/2018, GCR 17-046)

(a) Transfers for fair-market value – in general. No penalty period is applied to income or resources transferred for fair market value.

AHS determines whether the individual requesting Medicaid coverage of long-term care services and supports, or the spouse of such individual, as the case may be, received fair market value for a transfer of income or resources by determining the difference, if any, between the fair market value of the income or resource reduced by any applicable deductions at the time of the transfer and the amount received for the income or resource. Any of the following deductions may be used to reduce fair market value:

(1) The amount of any legally enforceable liens or debts against the transferred income or resource at the time of transfer that reduced the transferor's equity in the income or resource;

(2) The reasonable and necessary costs of making the sale or transfer;

(3) The value of income or resources received by the transferor in exchange for the transferred income or resources;

(4) The value of income or resources returned to the transferor; and

(5) The following verified payments or in-kind support given to or on behalf of the transferor as compensation for receipt of the income or resources by the person who received the income or resources:

(i) Personal services;

(ii) Payments for medical care;

(iii) Funeral expenses of the individual's deceased spouse;

(iv) Taxes, mortgage payments, property insurance, or normal repairs, maintenance and upkeep on the transferred property; or

(v) Support and maintenance (*e.g.*, food, clothing, incidentals, fuel and utilities) provided in the transferor's own home or in the home of the person who received the income or resources from the transferor.

(b) Receipt of fair market value after the date of the transfer. If the value of a transferred resource is scheduled for receipt after the date of transfer, it is considered a transfer for fair market value only if the transferor can expect to receive the full fair-market value of the resource within their expected lifetime. Expected lifetime is determined as follows:

(1) When institutionalized individual is transferor. Expected lifetime of the institutionalized individual is measured at the time of the transfer as determined in accordance with actuarial publications of the Office of the Chief Actuary of the SSA (http://socialsecurity.gov/OACT/STATS/table4c6.html) and set forth in Vermont's Medicaid Procedures Manual.

(2) When spouse of institutionalized individual is transferor. Expected lifetime of the spouse of the institutionalized individual is measured at the time of the transfer as determined in accordance with actuarial publications of the Office of the Chief Actuary of the SSA) (http://socialsecurity.gov/OACT/STATS/table4c6.html) and set forth in Vermont's Medicaid Procedures Manual.

(3) Pursuant to the authority granted in Vermont Act 71 § 303(7)(2005), AHS may develop alternate actuarial tables that will be consistent with federal law and adopted by rule.

(c) Transfers for less than fair-market value – in general. A penalty period is not imposed for a transfer for less than fair market value that meets one or more of the following criteria:

(1) Time of transfer – beyond look-back period. The date of the transfer was more than 60 calendar months prior to the first month in which the individual both requests eligibility for Medicaid coverage of long-term care services and supports and meets all other requirements for eligibility.

(2) Transferred income or resources are returned. The transferred income or resources have been returned or otherwise remain available to the individual or the individual's spouse.

(3) Property transferred of a person other than the individual or their spouse. The action that constituted the transfer was the removal of the individual's (or spouse's) name from a joint account in a financial institution, and the individual (or spouse) has demonstrated, to AHS's satisfaction, that the funds in the account accumulated from the income and resources of another owner who is not the individual (or their spouse).

(4) Transfer of resource for a purpose other than creation or maintenance of eligibility for Medicaid coverage of long-term care services and supports. The transferor has documented to AHS's satisfaction convincing evidence that the resources were transferred exclusively for a purpose other than for the individual to become or remain eligible for Medicaid coverage of long-term care services and supports. A signed statement by the transferor is not, by itself, convincing evidence. Examples of convincing evidence are documents showing that:

(i) The transfer was not within the transferor's control (e.g., was ordered by a court);

(ii) The transferor could not have anticipated the individual's eligibility for Medicaid coverage of long-term care services and supports on the date of the transfer (e.g., the individual became disabled due to a traumatic accident after the date of transfer); or

(iii) A diagnosis of a previously undetected disabling condition leading to the individual's eligibility for Medicaid coverage of long-term care services and supports was made after the date of the transfer.

(5) Transfers of specified property for the benefit of certain family members. The transfer meets the criteria specified below for transfers involving trusts (see paragraph (d)), transfers of homes (see paragraph (e)), and transfers for the benefit of certain family members (see paragraph (g)).

(6) Intent to transfer for fair market value. The transferor has demonstrated to AHS's satisfaction that they intended to dispose of the income or resources either at fair market value, or for other valuable consideration.

(7) Transfer of excluded income or resources

(i) The transferor transferred excluded income or resources.

(ii) Penalties are imposed for the transfer for less than fair market value of any asset considered by the SSA's SSI program to be countable or excluded. For example, transfer of a home or of the proceeds of a loan are both subject to penalty.

(d) Allowable transfers involving trusts. A penalty period is not imposed for transfers involving trusts that meet one or more of the following criteria:

(1) The action that constituted the transfer was the establishment of an irrevocable trust that does not under any circumstances allow disbursements to or for the benefit of the individual, and the date of the transfer was more than 60 calendar months prior to the first month in which the individual requests Medicaid coverage of long-term care services and supports.

(2) The action that constituted the transfer was the establishment of a trust solely for the benefit of the individual if the individual was under age 65 when the trust was established and the trust meets all of the criteria at § 29.08(e)(1)(ii)(F).

(3) The action that constituted the transfer was the establishment of a pooled trust, as specified at § 29.08(e)(1)(ii)(G), unless the individual was age 65 or older when they established the trust. If so, the transfer is not exempted from the imposition of a transfer penalty period.

(4) The action that constituted the transfer was the establishment of a revocable trust. However, AHS considers any payment from the revocable trust to anyone other than the individual a transfer for less than fair-market value subject to penalty unless the payment is for their benefit.

(e) Allowable transfers of homes to family members. A penalty period is not imposed for the transfer of a home that meets the definition at § 29.08(a)(1) provided that title was transferred to one or more of the following persons:

(1) The spouse of the individual requesting Medicaid coverage of long-term care services and supports;

(2) The individual's child who was under age 21 on the date of the transfer;

(3) The individual's son or daughter who is blind or permanently and totally disabled, regardless of age;

(4) The brother or sister of the individual when:

(i) The brother or sister had an equity interest in the home on the date of the transfer; and

(ii) Was residing in the home continuously for at least one year immediately prior to the date the individual began to receive Medicaid coverage of long-term care services and supports, including services in a home and community-based setting; or

(5) The son or daughter of the individual provided that the son or daughter:

(i) Was residing in the home continuously for at least two years immediately prior to the date the individual (parent) began receiving Medicaid coverage of long-term care services and supports, including services in a home and community-based setting; and

(ii) Provided care to the individual during part or all of this period that allowed the individual to postpone receipt of Medicaid coverage of long-term care services and supports.

(f) Allowable transfers involving life-estate interests in another individual's home. A penalty period is not imposed for the purchase of a life-estate interest in another person's home when:

(1) It is the purchaser's residence; and

(2) The purchaser resides in the home for a period of at least one year after the purchase.

(g) Other allowable transfers. A penalty period is not imposed for transfers that meet any of the following criteria:

(1) The transfer was for the sole benefit of the individual requesting Medicaid coverage of long-term care

services and supports.

(2) The income or resource was transferred by the institutionalized spouse to their community spouse before the initial determination of the institutionalized spouse's eligibility for Medicaid coverage of long-term care services and supports. This also applies to a transfer made to a third party for the sole benefit of the community spouse.

(3) The income or resource was transferred to the individual's son or daughter who is blind or permanently and totally disabled or to a trust for the sole benefit of such son or daughter regardless of their age.

(4) The income or resource was transferred to a trust, including a trust described in § 29.08(e)(1)(F) or § 29.08(e)(1)(G), established solely for the benefit of an individual under the age of 65 years who is disabled.

(h) Transfers involving annuities

(1) In general

(i) *Purchases*. Any annuity purchased by an individual requesting Medicaid coverage of long-term care services and supports, or, if married, their community spouse on or after February 8, 2006, must name Vermont Medicaid as the first remainder beneficiary of the annuity up to the amount of Medicaid payments, including payments for Medicaid coverage of long-term-care services and supports, made by the state on behalf of the individual. If there is a community spouse or a minor or disabled child, they may be named as a remainder beneficiary ahead of the state. Vermont Medicaid must then be named as the secondary remainder beneficiary. If Vermont Medicaid is not named as a remainder beneficiary in the correct position, the purchase of the annuity is considered a transfer for less than fair market value. When Vermont Medicaid is a remainder beneficiary of an annuity, the issuer of the annuity is required to notify Vermont Medicaid of any changes in the disbursement of income or principal from the annuity as well as any changes to the state's position as remainder beneficiary.

(ii) *Annuity-related transactions other than purchases*. In addition to the purchase of an annuity, certain transactions with respect to an annuity that occur on or after February 8, 2006, make an annuity, including one purchased before that date, subject to the provisions of this paragraph. Such transactions include any action taken by the individual requesting Medicaid coverage of long-term care services and supports or, if married, their community spouse that changes the course of payments to be made by the annuity or the treatment of the income or principal of the annuity. Routine changes and automatic events that do not require any action or decision are not considered transactions that would subject the annuity to this treatment.

(2) Additional requirements

(i) In addition to the requirement under paragraph (h)(1) that Vermont Medicaid be named as a remainder beneficiary in the correct position in order for the purchase of an annuity by an individual requesting Medicaid coverage of long-term care services and supports or, if married, their community spouse to not be considered a transfer for less than fair market value, if the purchase of the annuity is by the individual requesting Medicaid coverage of long-term care services and

supports, the purchase must also meet one or more of the four alternatives described below in order for it to not be subject to a transfer penalty. To determine that an annuity is established under any of the various provisions of the Code that are referenced in (C) and (D) below, AHS relies on verification from the financial institution, employer or employer association that issued the annuity. The burden of proof is on the individual to produce this documentation. Absent such documentation, AHS considers the purchase of the annuity a transfer for less than fair-market value and, as such, subject to a penalty.

(ii) The four alternatives are as follows:

(A) The annuity meets the provisions of §§ 29.08(d)(1) or 29.09(d)(1).

(B) The annuity is:

(I) Irrevocable and nonassignable;

(II) Provides for payments to the individual in equal intervals and equal amounts with no deferral and no balloon payments made;

(III) Is actuarially sound because it does not exceed the life expectancy of the individual, as determined using the actuarial publications of the Office of the Chief Actuary of the SSA (http://socialsecurity.gov/OACT/STATS/table4c6.html) and set forth in Vermont's Medicaid Procedures Manual; and

(IV) Returns to the individual at least the amount used to establish the contract and any additional payments plus earnings, as specified in the contract.

(C) The annuity is considered either:

(I) An individual retirement annuity (according to § 408(b) of the Code), or

(II) A deemed Individual Retirement Account (IRA) under a qualified employer plan (according to § 408(q) of the Code).

(D) The annuity is purchased with proceeds from one of the following:

(I) A traditional IRA (§ 408(a) of the Code);

(II) Certain accounts or trusts which are treated as traditional IRAs (§ 408(c) of the Code);

(III) A simplified retirement account (§ 408 (p) of the Code);

(IV) A simplified employee pension (§ 408 (k) of the Code); or

(V) A Roth IRA (§ 408A of the Code).

(3) Impermissible transfers. An annuity that does not meet the above criteria is assessed a transfer penalty based on its fair market value. The fair market value of an annuity equals the amount of money used to establish the annuity and any additional amounts used to fund the annuity, plus any earnings and minus any early withdrawals and surrender fees.

(i) Allowable transfers involving promissory notes and other income-producing resources

(1) Promissory notes or similar income-producing resources (contracts) are assessed a transfer penalty based on their fair market value unless they:

(i) Have a repayment term that is actuarially-sound as determined in accordance with actuarial publications of the Office of the Chief Actuary of the SSA (http://socialsecurity.gov/OACT/STATS/table4c6.html) and set forth in Vermont's Medicaid Procedures Manual;

(ii) Provide for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

(iii) Prohibit the cancellation of the balance upon the death of the lender.

(2) Fair market value equals the amount of money used to establish the contract and any additional payments used to fund it, plus any earnings and minus any payments already received as of the date of the application for Medicaid coverage of long-term care services and supports.

(j) Transfers involving jointly-owned income or resources

(1) Joint-ownership established on or after January 1, 1994. For any joint-ownership established on or after January 1, 1994, the portion of the jointly-owned asset subject to the imposition of a penalty period is evaluated based on the specific circumstances of the situation. An individual is presumed to own a jointly-owned resource using the rules in § 29.09. In the case of a jointly-owned account in a financial institution, for example, since the account is presumed to be owned entirely by the individual (see § 29.09(c)(5)(ii)), a transfer penalty is imposed against the individual for any amount withdrawn from the account by another joint owner on the account. The individual may rebut the presumption of ownership by establishing to AHS's satisfaction that the amount withdrawn was, in fact, the sole property of and contributed to the account by the other joint owner (or owners), and thus did not belong to the individual.

(2) Joint-ownership established before January 1, 1994. For a joint ownership established before January 1, 1994, the date of the transfer is the date the other person (or persons) became a joint owner. The value of the transfer equals the amount that the resource available to the individual or, if married, the individual's spouse was reduced in value when the other person (or persons) became a joint owner.

25.04 Penalty period for disallowed transfers (01/15/2017, GCR 16-097)

(a) Definition: Otherwise eligible

(1) For purposes of determining the start date of the penalty period because of disallowed transfers, an individual is considered "otherwise eligible" for Medicaid coverage of long-term care services and supports as of the earliest date they pass all eligibility criteria in the sequence listed below. They must also meet each of these criteria in any month for which they request retroactive eligibility:

(i) Clinical criteria (see definition of long-term care in § 3.00).

(ii) Citizenship and identity criteria (§ 17.00).

(iii) Category (§ 7.03 (MCA), §§ 8.05 and 8.06 (MABD)).

(iv) Residency (§ 21.00).

(v) Living arrangements (§ 20.00).

(vi) Resources (§ 29.07), if applicable.

(vii) Income (§§ 28.03 and 28.04 (MCA), § 29.11 (MABD) - for anyone with excess income, see explanation in (2) below).

(2) When an individual's income exceeds the income requirement for their applicable coverage group, the individual must spend down to the applicable PIL in the month of application or the next month. An individual with a penalty is subject to the penalty period start date beginning on the date the spenddown is met. If the spenddown is not met in the month of application or the next month, the individual is denied Medicaid coverage of long-term care services and supports. AHS then determines whether the person is eligible for Medicaid (other than Medicaid coverage of long-term care services and supports). If so, it assesses a 6-month spend down.

Examples:

(i) The individual applies in June for Medicaid coverage of long-term care services and supports under MABD and requests retroactive coverage as of April. The individual meets all eligibility criteria but their gross countable income exceeds the IIS and they have transfers that will result in a 38 day penalty period. The spenddown period is April – September. The individual meets their spenddown on April 23rd. April 23rd is the date the individual is considered to be "otherwise eligible." Their penalty period would be April 23rd – May 30th.

(ii) Same case as in (i), but no retroactive coverage is requested. The spenddown period is June-November. The spenddown is met June 23rd. June 23rd is the date the individual is considered to be "otherwise eligible." The penalty period is June 23rd – July 30th.

(b) Penalty period – in general. If a transfer is disallowed, a penalty period of restricted Medicaid coverage to an otherwise eligible individual is imposed. During this period, no Medicaid payments are made for the individual's long-term care services and supports. Payments are made for all other covered Medicaid services provided to the individual during the period of restricted coverage.

(c) Penalty date

(1) Transfers made in a single month. The penalty date is the beginning date of each penalty period imposed for a disallowed transfer. The penalty date starts on the first day in which the individual would have been otherwise eligible for Medicaid coverage of long-term care services and supports (see paragraph (a) of this subsection for explanation of "otherwise eligible").

(2) Transfers occurring in different months. Penalty periods run consecutively rather than concurrently, in the order in which the transfers occurred. If, after establishing a penalty period for disallowed transfers, it is determined that additional disallowed transfers were made in a subsequent month but before the end of the first penalty period, the first day following the end of the first penalty period will be designated as the

penalty date for the subsequent penalty period.

(d) Penalty period

(1) Calculation of penalty. The number of days in a penalty period are equal to the total value of all disallowed transfers made during a given calendar month divided by the average daily cost to a privately-paying patient of nursing facility services in the state as of the date of application or the date of discovery, if additional disallowed transfers are discovered after the initial determination of eligibility for Medicaid coverage of long-term care services and supports.

(2) Transfers in different calendar months. Penalty periods for transfers in different calendar months are consecutive and established in the order in which the disallowed transfers occurred.

(3) Continuous nature of penalty period. A penalty period runs continuously from the first date of the penalty period, even if the individual stops receiving long-term care services and supports.

(e) Penalty when both spouses request Medicaid coverage of long-term care services and supports

(1) In general. The following rules are applied to the assignment of penalty periods when both members of a couple are requesting or receiving Medicaid coverage of long-term care services and supports.

(2) Spouses eligible at same time. For spouses determined otherwise eligible for Medicaid coverage of long-term care services and supports at the same time, the value of the disallowed transfer is divided by two to determine the number of days of restricted coverage for each member of the couple.

(3) Penalty period for one spouse is running at the time the other requests Medicaid coverage of long-term care services and supports. If the penalty period established for one member of the couple has not yet expired when the other member of the couple requests and is determined otherwise eligible for Medicaid coverage of long-term care services and supports, the number of days remaining in the penalty period is divided by two to determine the number of days of restricted coverage for each member of the couple.

(4) Death of a spouse during penalty period. When the member of the couple for whom a penalty period has been established dies, the days remaining in that member's penalty period are not reassigned to their spouse if the spouse requests and is determined otherwise eligible for Medicaid coverage of long-term care services and supports.

(5) Penalty periods for transfer by second spouse to request Medicaid coverage of long-term care services and supports. When a penalty period is established for a disallowed transfer by the second member of the couple to request and be determined otherwise eligible for Medicaid coverage of long-term care services and supports, that penalty period is assigned to the spouse who made the transfer provided that it was made after the determination of disallowed transfers for the first spouse.

25.05 Undue Hardship (01/15/2017, GCR 16-097)

(a) In general. AHS does not establish a penalty period resulting from a disallowed transfer when it determines that restricted coverage will result in an undue hardship. Undue hardship is considered only in cases where AHS has first determined that a transfer has been made for less than fair market value and that no transfer exception

applies (see § 25.03).

(b) Definition: Undue hardship

(1) For purposes of this subsection, undue hardship means depriving the individual of:

(i) Medical care, such that the individual's health or life would be endangered; or

(ii) Food, clothing, shelter, or other necessities of life.

(2) Undue hardship does not exist when the application of a transfer penalty merely causes an individual or the individual's family member(s) inconvenience or restricts their lifestyle. Undue hardship does not exist when the individual transferred the assets to their community spouse and the community spouse has countable or excluded resources in excess of the community spouse resource allocation (CSRA) standard (§ 29.10(e)).

(c) Undue hardship reasons. In determining the existence of undue hardship, all circumstances involving the transfer and the situation of the individual are considered. Undue hardship is established when one or more of the following circumstances, or any other comparable reasons, exist:

(1) Whether imposition of the transfer penalty would result in the individual's immediate family qualifying for SSI; Reach Up; AABD; General Assistance; 3SquaresVTs; or another public assistance program requiring a comparable showing of financial need.

(2) Whether funds can be made available for the cost of the individual's long-term care services and supports only if assets such as a family farm or other family business are sold, and the assets are the primary source of income for the individual's spouse, parents, children or siblings.

(3) Whether an agent under a power of attorney (POA) or a guardian of the individual transferred the asset, and the POA or guardian was not acting in the best interest of the individual when the transfer was made as determined by AHS or a court, or the transfer forms the basis for a report to AHS for investigation of abuse, neglect or exploitation.

(4) Whether the individual was deprived of an asset by exploitation, fraud or misrepresentation. Such claims must be documented by official police reports or civil or criminal action against the alleged perpetrator or substantiated by AHS or by a sworn statement to AHS attesting to the fact that the claim was reported to the police or to the AHS department responsible for substantiating such claims.

(5) Whether the individual cannot recover the assets due to loss, destruction, theft, or other similar circumstances.

(6) *Presumption of care and rebuttal of presumption*.

(i) *Presumption*. When the transfer is to a person, AHS presumes the recipient of the transferred asset could make arrangements for the individual's care and the care of dependent family members up to the value of the transfer unless the evidence submitted indicates that there is no reasonable way that the person can make any of these arrangements. The facts and verification required to

determine if the recipient of the transferred asset can make other arrangements to pay or provide the care of the individual, or to provide for the needs of financially-dependent family members, may include the following, if applicable:

(A) A copy of the tax return for the preceding calendar year;

(B) All earnings pay stubs for the past 12 months;

(C) All bank books, stocks, bonds, certificates, life insurance policies (e.g. bank books must include those before and after receipt of the transferred asset); and

(D) All documents associated with the proceeds of the transferred asset which will show the value of any purchase of new assets from the sale proceeds of the transferred asset.

(E) When the transfer is made to a relative who is a minor, a family member with financial responsibility for the minor must be asked to provide the required facts and verification.

(ii) *Rebuttal*. If the individual rebuts the presumption and shows there is no reasonable way that the recipient of the transferred asset can make arrangements for the individual's care and the care of dependent family members up to the value of the transfer, AHS will consider whether the individual has exhausted all reasonable efforts to meet their needs from other available sources. This includes whether the individual has exhausted all reasonable efforts to obtain return of the asset transferred, and demonstrated that efforts to obtain return of the asset or adequate compensation would probably not succeed. AHS will take into consideration all excluded and countable assets above the protected resource standard and income above the monthly maintenance needs allowance. Burial funds (§ 29.08(c)) and the individual's principal place of residence (§ 29.08(a)(1)) will continue to be excluded.

(d) Authority of provider to file request for individual. For the purposes of this subsection, a long-term care provider may, with the consent of the individual or the personal representative of the individual, file a request for undue hardship on behalf of the individual.

(e) Process for reviewing undue hardship requests

(1) Notice of imposition of penalty period

(i) The individual will be informed of the right to request an undue hardship exception through written notice of a penalty period of ineligibility for Medicaid coverage of long-term care services and supports because of an impermissible asset transfer.

(ii) The notice will:

(A) Specify the factual and legal basis for the imposition of the penalty, and

(B) Explain how the individual may request an undue hardship exception.

(2) Timing of exception request. An individual may request an undue hardship exception within 20 days of receiving notification of the transfer penalty.

(3) Application requirements. To request an undue hardship exception, the individual must submit

documentation supporting their claim of undue hardship.

(4) Standard of proof. Undue hardship is established when the individual demonstrates by a preponderance of the evidence that denial of Medicaid coverage of long-term care services and supports will cause actual and not merely possible undue hardship.

(5) Nature of available relief. If the individual establishes undue hardship, AHS may waive all or a portion of the penalty period.

(6) Notice of decision on request. A notice of decision on the undue hardship exception request will be issued within 10 business days of receipt of all information determined by AHS as needed to evaluate the request. The notice will be in writing and will inform the individual of the right to request a fair hearing to appeal the decision.

(7) Notice of decision on eligibility for Medicaid coverage of long-term care services and supports. If no request for an undue hardship exception is received within 20 days after notification of the transfer penalty, or if the request is denied, an eligibility determination will be issued specifying the applicable penalty period. If the individual is receiving Medicaid coverage of long-term care services and supports, the notice will include the date the Medicaid coverage terminates and the right to request a fair hearing and continuing benefits.

(8) Exception: Request made within request for fair hearing. When an individual makes a request for an undue hardship exception for the first time at the same time they are requesting a fair hearing, the individual must raise all claims and submit all evidence permitting consideration of the undue hardship exception at least 10 business days in advance of the fair hearing. The undue hardship request must then be referred to AHS for consideration. AHS will then inform the fair hearings entity of its decision on the request within 10 business days of receiving it.

(9) Exception: Request made during penalty period on the basis of changed circumstances. A request for an undue hardship exception may be filed at any time during a penalty period if new circumstances leading to undue hardship arise during the duration of the penalty period. If granted, the request will be prospective from the date of the request.

(10) Limitation on obligation to pay for long-term care services and supports during penalty period. The state has no obligation to pay for cost of an individual's long-term care services and supports during the individual's penalty period unless an undue hardship exception has been granted or the individual prevails at a fair hearing.

(11) Extension of time period. The time periods specified in this paragraph (e) may be extended if AHS determines that extenuating circumstances require additional time.

26.00 [Reserved]

27.00 [Reserved]

Table of Contents

Part Five
Financial Methodologies

Part Five describes the financial standards and methodologies, including income and resource tests, that apply to the various health-benefits programs and categories of assistance.

28.00 Financial eligibility standards – application of modified adjusted gross income (MAGI) (01/15/2019, GCR 18-063)

28.01 Basis, scope, and implementation[1] (01/15/2019, GCR 18-063)

(a) This section implements § 1902(e)(14) of the Act.

(b) The financial methodologies set forth in this section will be applied in determining the financial eligibility of all individuals for health benefits, except for individuals identified in paragraph (i) of § 28.03.

28.02 Definitions (01/15/2017, GCR 16-098)

For purposes of this section:

(a) Family size[2]

(1) The number of persons counted as members of the individual's household. Family size may include individuals who are not subject to or are exempt from penalty for failing to maintain MEC.

(2) Special counting rule for Medicaid: In the case of determining the family size of a pregnant woman, or the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted as herself plus the number of children she is expected to deliver.

(b) Modified Adjusted Gross Income (MAGI).[3] Adjusted gross income (within the meaning of § 62 of the Code) increased by:

(1) Amounts excluded from gross income for citizens or residents of the United States living abroad;

(2) Tax-exempt interest the tax filer receives or accrues during the benefit year; and

(3) Social Security benefits not already included in adjusted gross income.

[1] 42 CFR § 435.603(a).

[2] 26 CFR § 1.36B-1(d); 42 CFR § 435.603(b). Note: The IRS rules do not include unborn children in the determination of family size.

[3] 26 CFR § 1.36B-1(e)(2); 42 CFR 435.4; 45 CFR § 155.300. These sections reference § 36B(d)(2)(B) of the Code. This is the definition found in that provision.

28.03 MAGI-Based Medicaid (01/01/2018, GCR 17-047)

(a) Definition: Tax dependent. For purposes of MAGI-based Medicaid, the term "tax dependent" has the same meaning as the term "dependent" under § 152 of the Code, and also includes an individual for whom another individual claims a deduction for a personal exemption under § 151 of the Code for the benefit year.[4]

(b) Basic rule.[5] Except as specified in paragraphs (h), (i), and (j) of this subsection, financial eligibility for MAGI-based Medicaid is determined based on household income, as defined in paragraph (c) of this subsection. Household composition is determined separately for each individual; see paragraph (e) of this subsection for details on household composition.

(c) Household income[6]

(1) General rule. Except as provided in paragraphs (c)(2) through (c)(4) of this subsection, household income for MAGI-based Medicaid is the sum of the MAGI-based income, as defined in paragraph (d) of this subsection, of every person included in the individual's household, as defined in paragraph (e) of this subsection.

(2) Income of children and tax dependents

(i) The MAGI-based income of a person who is included in the household of their natural, adopted, or step-parent, and is not expected to be required to file a federal tax return[7] for the benefit year in which eligibility for Medicaid is being determined, is not included in household income whether or not such person files a federal tax return.

(ii) The MAGI-based income of a tax dependent described in paragraph (e)(3)(i) of this subsection (individual other than a spouse or child who expects to be claimed as a tax dependent by another tax filer) who is not expected to be required to file a federal tax return[8] for the benefit year in which eligibility for Medicaid is being determined, is not included in the household income of the tax filer whether or not such tax dependent files a federal tax return.

(3) Available cash support not included. In the case of an individual described in paragraph (e)(3)(i) of this subsection (individual other than a spouse or child who expects to be claimed as a tax dependent by another tax filer), household income does not include cash support provided by the person claiming such individual as a tax dependent.

(4) Five-percent disregard. Effective January 1, 2014, in determining the eligibility of an individual for

[4] 42 CFR § 435.4

[5] 42 CFR § 435.603(c).

[6] 42 CFR § 435.603(d).

[7] As required under section 6012(a)(1) of the Code.

[8] *Id*

Medicaid under the eligibility group with the highest income standard under which the individual may be determined eligible using MAGI-based methodologies, an amount equivalent to 5 percentage points of the FPL for the applicable family size is deducted from household income.

(5) Sponsored noncitizens

(i) In determining the financial eligibility of a noncitizen who is admitted to the United States on or after August 22, 1996, based on a sponsorship under § 204 of the INA, the income of the sponsor and the sponsor's spouse, if living with the sponsor, must be counted as available to the noncitizen when all four of the conditions set forth in (A) through (D) below are met. The responsibility of a sponsor continues until the noncitizen is naturalized or credited with 40 qualifying quarters of coverage by the SSA (as described in (ii) below). Children and pregnant women who are exempt from the five-year bar pursuant to § 17.03(c)(6) are not subject to these provisions. The four conditions are as follows:

(A) The sponsor has signed an affidavit of support on a form developed by the United States Attorney General as required by PRWORA to conform to the requirements of § 213A(b) of INA;

(B) The noncitizen is lawfully admitted for permanent residence, and a five-year period of ineligibility for Medicaid following entry to the United States has ended;

(C) The noncitizen is not battered; and

(D) The noncitizen is not indigent, defined as unable to obtain food and shelter without assistance, because his or her sponsor is not providing adequate support.

(ii) *Qualifying quarters of coverage*.

(A) A noncitizen is credited with the following qualifying quarters of coverage (as defined under Title II of the Act);

(I) All of the qualifying quarters of coverage worked by the noncitizen;

(II) All of the qualifying quarters of coverage worked by a parent of such noncitizen while the noncitizen was under age 18; and

(III) All of the qualifying quarters of coverage worked by a spouse of such noncitizen during their marriage as long as the noncitizen remains married to such spouse or such spouse is deceased.

(B) No qualifying quarter of coverage for any period beginning after December 31, 1996 may be credited to a noncitizen under (II) or (III) above if the parent or spouse, as the case may be, of such noncitizen received any federal means-tested public benefit during the period for which the qualifying quarter of coverage is credited. Federal means-tested benefits for this purpose do not include:

(I) Emergency medical assistance;

(II) Short-term, non-cash, in-kind emergency disaster relief;

(III) Assistance under the National School Lunch Act or the Child Nutrition Act of 1966:

(IV) Public health assistance for immunizations or testing and treatment of symptoms of communicable diseases not paid by Medicaid;

(V) Payments for foster care and adoption assistance under parts B and E of Title IV of the Act, under certain conditions;

(VI) Programs, services or assistance specified by the Attorney General;

(VII) Programs of student assistance under Titles IV, V, IX and X of the Higher Education Act of 1965, and Titles III, VII and VIII of the PHS Act;

(VIII) Means-tested programs under the Elementary and Secondary Education Act of 1965;

(IX) Benefits under the Head Start Act; or

(X) Benefits under the Job Training Partnership Act.

(d) MAGI-based income.[9] For the purposes of this subsection, MAGI-based income means income calculated using the same financial methodologies used to determine MAGI, with the following exceptions:

(1) An amount received as a lump sum is counted as income only in the month received.

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

(3) *American Indian/Alaska Native exceptions*. The following are excluded from income:

(i) Distributions from Alaska Native Corporations and Settlement Trusts;

(ii) Distributions from any property held in trust, subject to federal restrictions, located within the most recent boundaries of a prior federal reservation, or otherwise under the supervision of the Secretary of the Interior;

(iii) Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from:

(A) Rights of ownership or possession in any lands described in paragraph (d)(3)(ii) of this subsection; or

(B) Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources;

(iv) Distributions resulting from real property ownership interests related to natural resources and improvements:

(A) Located on or near a reservation or within the most recent boundaries of a prior federal reservation; or

(B) Resulting from the exercise of federally-protected rights relating to such real property ownership interests;

(v) Payments resulting from ownership interests in or usage rights to items that have unique religious,

[9] 42 CFR § 435.603(e).

spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom;

(vi) Student financial assistance provided under the Bureau of Indian Affairs education programs.

(e) Household

(1) In general. For purposes of household composition:

(i) "Child" includes a natural or biological, adopted or step-child.

(ii) "Parent" includes a natural or biological, adopted or step-parent.

(iii) "Sibling" includes a natural or biological, adopted or step-sibling.

(2) Basic rule for tax filers not claimed as a tax dependent. In the case of an individual who expects to file a federal tax return for the benefit year in which an initial determination or renewal of eligibility is being made, and who does not expect to be claimed as a tax dependent by another tax filer, the household consists of the tax filer and, subject to paragraph (e)(6) of this subsection, all persons whom such individual expects to claim as a tax dependent.

(3) Basic rule for individuals claimed as a tax dependent. In the case of an individual who expects to be claimed as a tax dependent by another tax filer for the benefit year in which an initial determination or renewal of eligibility is being made, the household is the household of the tax filer claiming such individual as a tax dependent, except that the household must be determined in accordance with paragraph (e)(4) of this subsection in the case of:

(i) Individuals who expect to be claimed as a tax dependent by a tax filer who is not the individual's spouse or parent;

(ii) Individuals under the age specified under paragraph (e)(4)(iv) of this subsection who expect to be claimed by one parent as a tax dependent and are living with both parents but whose parents do not expect to file a joint federal tax return; and

(iii) Individuals under the age specified under paragraph (e)(4)(iv) of this subsection who expect to be claimed as a tax dependent by a non-custodial parent. For purposes of this paragraph:

(A) The custodial parent is the parent so named in a court order or binding separation, divorce, or custody agreement establishing physical custody; or

(B) If there is no such order or agreement, or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights.

(4) Rules for individuals who neither file a tax return nor are claimed as a tax dependent. In the case of an individual who does not expect to file a federal tax return and does not expect to be claimed as a tax dependent for the benefit year in which an initial determination or renewal of eligibility is being made, or who is described in paragraph (e)(3)(i), (e)(3)(ii), or (e)(3)(iii) of this subsection, the household consists of the individual and, if living with the individual:

(i) The individual's spouse;

(ii) The individual's children under the age specified in (iv) of this paragraph (e)(4); and

(iii) In the case of an individual under the age specified in (iv) of this paragraph (e)(4), the individual's parents and siblings under the age specified in (iv) of this paragraph (e)(4).

(iv) The age specified in this paragraph (e)(4) is age 19 or, in the case of a full-time student, age 21.

(5) Couples. In the case of a couple living together, each spouse is included in the household of the other spouse, regardless of whether they expect to file a joint federal tax return[10] or whether one spouse expects to be claimed as a tax dependent by the other spouse.

(6) Households of individuals whom tax filer cannot establish as a dependent. For purposes of paragraph (e)(2) of this subsection, if, consistent with the procedures adopted by the state in accordance with § 56.00, a tax filer cannot reasonably establish that another person is a tax dependent of the tax filer for the benefit year in which Medicaid is sought, the inclusion of such person in the household of the tax filer is determined in accordance with paragraph (e)(4) of this subsection.

(f) No resource test or income disregards.[11] In the case of an individual whose financial eligibility for Medicaid is determined in accordance with this subsection, AHS will not:

(1) Apply any resources test; or

(2) Apply any income or expense disregards under §§ 1902(r)(2) or 1931(b)(2)(C), or otherwise under Title XIX of the Act, except as provided in paragraph (c)(4) of this subsection.

(g) Budget period[12]

(1) Applicants and new enrollees. Financial eligibility for Medicaid for applicants, and other individuals not receiving Medicaid benefits at the point at which eligibility for Medicaid is being determined, must be based on current monthly household income and family size.

(2) Current beneficiaries. For an individual who has been determined financially eligible for Medicaid using the MAGI-based methods set forth in this section, AHS will base financial eligibility on projected annual household income and family size for the remainder of the current calendar year.

(h) Alternative methodology to avoid eligibility gap.[13] If an individual who meets the non-financial eligibility requirements for Medicaid is determined to be financially ineligible for Medicaid using the MAGI-based Medicaid methodologies set forth in this subsection, but their household income is determined to be less than 100 percent of the FPL using the MAGI methodologies for determining eligibility for APTC and CSR, as set

[10] See, § 6013 of the Code.

[11] 42 CFR § 435.603(g).

[12] 42 CFR § 435.603(h).

[13] 42 CFR § 435.603(i).

forth in § 28.05, the individual's eligibility for Medicaid will be determined using the MAGI methodologies set forth in § 28.05.

(i) Eligibility groups for which MAGI-based methods do not apply.[14] The financial methodologies described in this subsection are not applied in determining the Medicaid eligibility of individuals described in this paragraph. Except for the individuals described in (1) of this paragraph (i), the financial methods described in § 29.00 (MABD financial eligibility standards) will be used to determine Medicaid eligibility for such individuals.

(1) Individuals whose eligibility for Medicaid does not require a determination of income, including, but not limited to, individuals receiving SSI eligible for Medicaid under § 8.05(a) and individuals deemed to be receiving SSI and eligible for Medicaid under § § 8.05(c), (f) and (h).

(2) Individuals who are age 65 or older when age is a condition of eligibility.

(3) Individuals whose eligibility is being determined on the basis of being blind or disabled, or on the basis of being treated as being blind or disabled, including, but not limited to, individuals under § 8.05(k)(6)(Katie Beckett) and individuals receiving state supplements, but only for the purpose of determining eligibility on such basis.

(4) Individuals who request that the financial methods described in § 29.00 be used to determine their eligibility for Medicaid coverage of long-term care services and supports.

(5) Individuals who are being evaluated for eligibility for Medicare cost-sharing assistance under § 8.07, but only for purposes of determining eligibility for such assistance.

(j) Special rule: family planning services.[15] In the case of an individual whose eligibility is being determined under § 9.03(g) (family planning services), AHS will:

(1) Consider the household to consist of only the individual for purposes of paragraph (e) of this subsection;

(2) Count only the MAGI-based income of the individual for purposes of paragraph (c) of this subsection; and

(3) Increase the family size of the individual, as defined in § 28.02, by one.

28.04 Medically-needy MCA – income eligibility (01/01/2018, GCR 17-047)

(a) In general. Income eligibility of an individual requesting medically-needy MCA is determined by calculating the individual's MAGI-based income as described in § 28.03(d). The individual's MAGI-based income is then adjusted, if applicable, by apportioning the income of financially responsible family members according to the requirements set forth in paragraph (b) of this subsection.

For the individuals who may qualify for medically-needy MCA, see § 7.03(a)(8).

[14] 42 CFR § 435.603(j).

[15] 42 CFR § 435.603(k).

(b) Financial responsibility of relatives and other individuals[16]

(1) Financial responsibility of relatives and other persons for the individual is limited to the following:

(i) A spouse for their spouse when both are living in the same household; and

(ii) A parent, step-parent, or adoptive parent for their unmarried child under the age of 21 living in the same household unless the child is pregnant or a parent whose own child is living in the household and they make a monthly (or more frequent) room or board payment to their parents.

(2) Except for a spouse of an individual or a parent for a child who is under age 21, no income or resources of any other relative will be considered as available to the individual.

(3) When a couple ceases to live together, only the income of the individual spouse will be counted in determining their eligibility, beginning the first month following the month the couple ceases to live together.

(c) Spenddown. The income spenddown provisions set forth in § 30.00 apply to an individual requesting medically-needy MCA. For purposes of the spenddown provisions at § 30.00, anyone identified in paragraph (b) above as financially responsible for the individual is considered a member of the individual's financial responsibility group as that term is used throughout § 30.00.

28.05 APTC and CSR (01/15/2017, GCR 16-098)

(a) Definition: Tax dependent. For purposes of APTC and CSR, the term "tax dependent" has the same meaning as the term "dependent" under § 152 of the Code.

(b) Basic rule. Financial eligibility for APTC and CSR is determined based on household income as defined in paragraph (c) of this subsection.

(c) Household income.[17] Household income is the sum of:

(1) A tax filer's MAGI; plus

(2) The aggregate MAGI of all other individuals who:

(i) Are included in the tax filer's household (as defined in paragraph (d) of this subsection); and

(ii) Are required to file a federal income tax return for the benefit year.

(d) Household. The household consists of the tax filer, the tax filer's spouse (if married within the meaning of 26 CFR § 1.7703-1), and all individuals claimed as the tax filer's tax dependents. As described in § 58.02(b)(2), married couples must file joint federal tax returns in order to be considered for APTC and CSR, unless the tax filer meets the exception criteria defined in § 12.03(b) (victim of domestic abuse or spousal abandonment).

[16] 42 CFR § 435.602.

[17] 26 CFR § 1.36B-1(e).

Parties to a civil union may qualify for APTC and CSR by filing separate tax returns.

29.00 Financial eligibility standards – Medicaid for the aged, blind, and disabled (MABD) (01/15/2019, GCR 18-063)

29.01 Introduction (01/15/2017, GCR 16-098)

An individual who meets the nonfinancial and categorical requirements for MABD must also meet the financial requirements specified in this section. AHS determines financial eligibility for MABD, including Medicaid coverage of long-term care services and supports under MABD.

To determine an individual's financial eligibility for MABD, AHS calculates the countable income and countable resources of the individual's financial responsibility group and compares those amounts to standards based on the size of the individual's Medicaid group. The first step in determining financial eligibility is to identify the members of the individual's financial responsibility group and the members of the individual's Medicaid group. An aged, blind, or disabled individual requesting MABD is always a member of both groups.

The rules for forming the financial responsibility group are specified in § 29.03.

The rules for forming the Medicaid group are specified in § 29.04.

The rules on resources are specified in §§ 29.07 through 29.10.

The rules on income are specified in §§ 29.11 through 29.15.

29.02 Definitions (01/15/2017, GCR 16-098)

As used in this § 29.00, the following terms have the following meanings:

(a) Child

(1) An individual who:

(i) Is under age 18 or is a student under age 22;

(ii) Has always been single; and

(iii) Lives with a parent.

(A) A child is not considered living with a parent when:

(I) The parent has relinquished control to a school or vocational facility;

(II) The child is confined to a public institution or is in the custody of a public agency;

(III) The child is a member of the armed forces;

(IV) The child lives in a private nonmedical facility; or

(V) The child has been admitted to long-term care.

(B) A child away at school who returns to a parent's home for vacations, holidays, or some weekends is considered living with that parent.

(2) An individual who qualifies for the Katie Beckett coverage group (see § 8.05(k)(6)) is not considered a child for the purposes of determining their financial eligibility for MABD.

(3) An individual is no longer considered a child on the first day of the month following the calendar month in which they no longer meet the definition of child.

(b) Adult. An individual who is not a child.

(c) Eligible child. For purposes of deeming, as described in § 29.05, a child who is a natural or adopted child under the age of 18, who lives in a household with one or both parents, is not married, and meets the non-financial eligibility requirements for MABD.

(d) Ineligible child. For deeming purposes, a child, as defined in (a) of this subsection, who does not meet the non-financial criteria for MABD, lives in the same household as the individual requesting MABD, and is:

(1) The natural child or adopted child of the individual;

(2) The natural or adopted child of the individual's spouse, or

(3) The natural or adopted child of the individual's parent or of the spouse of the individual's parent.

(e) Ineligible parent. For deeming purposes, a person who does not meet the non-financial criteria for MABD, lives with an eligible child, and is:

(1) A natural or adoptive parent of the child; or

(2) The spouse of a natural or adoptive parent of the child.

(f) Ineligible spouse. For deeming purposes, the spouse who lives with the individual requesting MABD and does not meet the nonfinancial eligibility criteria for MABD.

29.03 Formation of the financial responsibility group (01/15/2017, GCR 16-098)

(a) In general. The financial responsibility group for MABD consists of the individuals whose income and resources are considered available to the Medicaid group in the eligibility determination. With some exceptions, spouses are considered financially responsible for each other, and parents are considered financially responsible for their children. The following paragraphs set forth the rules for determining membership in the financial responsibility group and the portion of the group's income considered available to the Medicaid group.

(b) Financial responsibility group for an adult. The financial responsibility group for an adult requesting MABD, including Medicaid coverage of long-term care services and supports under MABD, is the same as the adult's Medicaid group.

(c) Financial responsibility group for a child. The financial responsibility group for a child requesting MABD includes the child and any parents living with the child until the child reaches the age of 18.

(d) Financial responsibility group for a sponsored noncitizen

(1) The financial responsibility group for a noncitizen admitted to the United States on or after August 22, 1996, based on a sponsorship under §204 of the INA, includes the income and resources of the sponsor and the sponsor's spouse, if living with the sponsor, when all four of the conditions set forth in (i) through (iv) below are met. Children and pregnant women who are exempt from the five-year bar pursuant to § 17.03(c)(6) are not subject to these provisions. The four conditions are as follows:

(i) The sponsor has signed an affidavit of support on a form developed by the United States Attorney General as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) to conform to the requirements of §213A(b) of the INA;

(ii) The noncitizen is lawfully admitted for permanent residence, and a five-year period of ineligibility for MABD following entry to the United States has ended;

(iii) The noncitizen is not battered; and

(iv) The noncitizen is not indigent, defined as unable to obtain food and shelter without assistance, because their sponsor is not providing adequate support.

(2) The financial responsibility of a sponsor continues until the noncitizen is naturalized or credited with 40 qualifying quarters of coverage by the SSA (see (3) below for crediting of qualifying quarters).

(3) A non-citizen is credited with the following qualifying quarters of coverage as defined under Title II of the Act:

(i) Those worked by the non-citizen;

(ii) Those worked by a parent of such non-citizen while the non-citizen was under age 18 unless the parent received any federal means-tested public benefit during the period for which the qualifying quarter of coverage is credited after December 31, 1996;

(iii) Those worked by a spouse of the non-citizen while they were spouses, as long as the non-citizen remains the spouse or the spouse is deceased and the spouse did not receive any federal means-tested public benefit during the period for which the qualifying quarter of cover is credited after December 31, 1996;

(iv) For this purpose, federal means-tested benefits do not include:

(A) Emergency medical assistance;

(B) Short-term, non-cash, in-kind emergency disaster relief;

(C) Assistance under the National School Lunch Act or the Child Nutrition Act of 1966;

(D) Public health assistance for immunizations or testing and treatment of symptoms of communicable diseases not paid by Medicaid;

(E) Payments for foster care and adoption assistance under parts B and E of Title IV of the Act, under certain conditions;

(F) Programs, services or assistance specified by the Attorney General;

(G) Programs for student assistance under Titles IV, V, IX, and X of the Higher Education Act of 1965, and Titles III, VII, and VIII of the Public Health Service Act;

(H) Means-tested programs under the Elementary and Secondary Education Act of 1965;

(I) Benefits under the Head Start Act; or

(J) Benefits under the WIA.

29.04 Formation of the Medicaid group (01/15/2017, GCR 16-098)

(a) In general. The Medicaid group consists of individuals whose needs are included in the financial eligibility determination for MABD. The following paragraphs set forth the rules for determining membership in the Medicaid group. AHS compares countable income and resources of the financial responsibility group to maximums based on the size of the Medicaid group.

(b) Medicaid group for a single adult. A single adult requesting MABD, including Medicaid coverage of long-term care services and supports under MABD, is treated as a Medicaid group of one.

(c) Medicaid group for an adult with a spouse

(1) When spouses are living together, both the individual requesting MABD and the individual's spouse are considered members of the individual's Medicaid group, a Medicaid group of two, unless one of the exceptions specified in paragraph (d) of this subsection applies. This is true whether or not the individual's spouse is also requesting MABD.

(2) Spouses are considered living together in any of the following circumstances:

(i) Until the first day of the month following the calendar month of death or separation, when one spouse dies or the couple separates.

(ii) When one spouse is likely to need long-term care for fewer than 30 consecutive days.

(iii) When the resources of the couple are assessed and allocated as of the date of initial application for Medicaid coverage of long-term care services and supports under MABD.

(d) Exceptions for an adult with a spouse. An adult requesting MABD with a spouse is treated as a Medicaid group of one in the following circumstances:

(1) When one spouse is applying for Medicaid coverage of long-term care services and supports under MABD, they are considered a Medicaid group of one for:

(i) The determination of their initial and ongoing income eligibility; and

(ii) Resource reviews of their eligibility.

(iii) AHS considers the spouses to be no longer living together as of the first day of the calendar month one spouse begins receiving Medicaid coverage of long-term care services and supports under MABD. This remains true even if the other spouse begins receiving Medicaid coverage of long-term

care services and supports in a subsequent month.

(2) When AHS determines the eligibility of one spouse for MABD when the other spouse already receives Medicaid coverage of long-term care services and supports in a home and community-based setting.

(3) When both spouses are admitted to the same residential care home, each spouse is considered a Medicaid group of one if the residential care home is designed for four or more residents.

(4) When both spouses have been admitted to the same institution for long-term care in the same month and have lived there at least six months beginning with the first month following the month of their admission, for purposes of determining each spouse's eligibility for Medicaid coverage of long-term care services and supports under MABD, each spouse is considered a Medicaid group of one for the determination of their initial and ongoing income eligibility and resource reviews of their eligibility. However, if it works to their advantage, they may be considered a Medicaid group of two.

(5) When one spouse is receiving custodial care in their home, as defined in AABD Rule 2766, they are considered a Medicaid group of one.

(e) Medicaid group for a child

(1) A child requesting MABD is treated as a Medicaid group of one.

(2) When a parent and child living together are both requesting MABD, they are treated as two Medicaid groups of one, if the parent is not living with a spouse. If the parent is living with a spouse, the parent and their spouse are treated as a Medicaid group of two and the child as a Medicaid group of one.

29.05 Deeming (01/15/2017, GCR 16-098)

(a) In general. MABD financial eligibility is based on the financial eligibility rules for the SSA's SSI program. Like SSI, the term "deeming" is used to identify countable resources and income from other people as belonging to the individual requesting MABD. When the deeming rules apply, it does not matter whether the resources or income of the other person are actually available to the individual.

(b) Categories of people whose income and resources are counted

(1) Resources and income from two categories of people may be counted as belonging to the individual. These people are members of the individual's financial responsibility group. AHS considers:

(i) Spousal resources and income to decide whether it must deem some of it to the Medicaid group; and

(ii) Parental resources and income for an eligible child to decide whether it must deem some of it to the Medicaid group.

(2) § 29.10 specifies the resources counted when determining MABD financial eligibility.

(3) § 29.14 specifies the income counted when determining MABD financial eligibility.

29.06 Temporary absences and deeming rules (01/15/2017, GCR 16-098)

(a) Effect of temporary absence. For purposes of deeming, during a temporary absence, the absent person continues to be considered a member of the individual's household.

(b) Definition of temporary absence. A temporary absence occurs when the individual or their ineligible spouse, parent, or an ineligible child leaves the household but intends to and does return in the same month or the next month.

(c) Treatment of absences due to schooling. An eligible child is considered temporarily absent from their parent's (or parents') household if they are away at school but come home on some weekends or lengthy holidays and are subject to the control of their parent(s).

(d) Absences related to active duty assignment. If the individual's ineligible spouse or parent is absent from the household due solely to a duty assignment as a member of the armed forces on active duty, that person is considered to be living in the same household as the individual, unless evidence indicates that the individual's spouse or parent should no longer be considered to be living in the same household. When such evidence exists, AHS stops deeming their resources and income beginning with the month after the spouse or parent no longer lived in the same household.

29.07 Resources (01/15/2017, GCR 16-098)

(a) In general

(1) Resources are cash and other property, real or personal, that an individual (or their spouse, if any):

(i) Owns;

(ii) Has the right, authority or power to convert to cash (if not already cash); and

(iii) Is available for their support and maintenance.

(2) Resources are treated in different ways depending on the rules of the coverage group involved and the type and liquidity of the resource.

(3) Resources are counted based upon their availability and the ease with which they can be converted into cash. Availability is often affected when more than one person has an ownership interest in the same resource.

(4) Resource limits vary depending on the type of category and services, and the size of the Medicaid group. Resource eligibility for each coverage group is determined by comparing the resources of the financial responsibility group to the resource limit based on the size of the Medicaid group. Resource maximums are specified in Vermont's Medicaid Procedures Manual.

(5) All resources of the members of the financial responsibility group must be counted except those specifically excluded. See § 29.08 for the resource exclusion rules.

(6) Equity value as well as availability is considered when determining the amount of a resource that counts. In general, equity value means the price an item can be reasonably expected to sell for on the local open market minus any encumbrances. See § 29.09 for the general rules on valuing countable resources.

(b) Types of resources. This paragraph describes some of the kinds of resources the availability of which are considered in determining MABD eligibility. The descriptions are divided into two categories – nonliquid resources and liquid resources. Except for cash, any kind of property may be either liquid or nonliquid. The liquidity (or nonliquidity) of a resource has no effect on the resource's countability for MABD eligibility purposes.

(1) Definition: Nonliquid resources. A nonliquid resource means property that is not cash, including real and personal property that cannot be converted to cash within 20 work days. Real property, life estates, life insurance and burial funds, described below, are some of the more common kinds of nonliquid resources. Certain other noncash resources, though they may occasionally be liquid, are nearly always nonliquid. These include, but are not limited to, household goods and personal effects, vehicles, livestock, and machinery.

(i) Real property. Land and generally whatever is erected, growing on, or affixed to land. See § 29.08(a) for information on the resource exclusion of real property.

(ii) Life estates. Life estate means a legal arrangement entitling the owner of the life estate (sometimes referred to as the "life tenant") to possess, rent, and otherwise profit from real or personal property during their lifetime. The owner of a life estate sometimes may have the right to sell the life estate, but does not normally have future rights to the property. Ownership of a life estate may be conditioned upon other circumstances, such as a new spouse. The document granting the life estate includes the conditions for the life estate and the right of the owner of the life estate to sell or bequeath it, if these property rights were retained. See § 29.08(a)(6) for information on the resource exclusion of life estates.

(iii) Life insurance. A contract that provides for its purchaser to pay premiums to the insurer, who agrees to pay a specific sum to a designated beneficiary upon the death of the insured. Life insurance is usually sold by an insurance company but may also be sold by other financial institutions, such as brokerage firms. See § 29.08(b) for information on the resource exclusion of life insurance.

The following are terms related to life insurance:

(A) Face value. The amount the life insurance policy pays the designated beneficiary upon the death of the insured.

(B) Term life insurance. A life insurance policy that does not accumulate any cash value as premiums are paid.

(C) Whole life insurance (sometimes called ordinary life, limited payment or endowment insurance). A life insurance policy that accumulates cash value as premiums are paid. It may also pay periodic dividends on this value when all premiums have been paid. These dividends may be paid to the owner, or they may be added to the cash surrender value (defined below) of the policy.

(D) Cash surrender value (CSV) of whole life insurance. The amount the owner would receive if the life insurance policy were terminated before the insured dies. It is a form of equity that accumulates over time as life insurance premiums are paid. The owner may borrow against the CSV according to the terms of the policy. A loan against a policy reduces its CSV.

(E) Group policy. A life insurance policy that is usually issued through a company or organization insuring the participating employees or members and, perhaps, their families. The group policy

may be paid partially by the employer. A group insurance policy generally has no CSV.

(iv) Burial Funds

(A) Any separately-identifiable fund clearly designated for burial expenses (which includes expenses for burial spaces, items related to burial spaces and services related to burial spaces) through the title to the fund or by a sworn statement provided. Burial funds include contracts, trusts, or other agreements, accounts, or instruments with a cash value. Some burial funds include accumulated interest, and the value of some burial funds may change through time (e.g., when the fund consists of bonds). See § 29.08(c) for information on the resource exclusion of burial funds.

(B) The cash value of life insurance policies may also be treated as a burial fund if owned by a person whose income and resources are considered in determining an individual's MABD eligibility and if designated as specified above.

(C) For the purposes of determining MABD eligibility, burial spaces, if not fully paid, are considered burial funds and include burial plots, gravesites, crypts, mausoleums, caskets, urns, and other repositories customarily and traditionally used for the deceased's bodily remains. Items related to burial spaces include, but are not limited to, vaults, headstones, markers, plaques, and burial containers for caskets. Services related to burial include, but are not limited to, embalming, opening and closing of the gravesite, and care and maintenance of the gravesite, sometimes called an endowment or perpetual care.

(2) Definition: Liquid resources. A liquid resource means cash or other property that can be converted to cash within 20 work days. Accounts in financial institutions; retirement funds; stocks, bonds, mutual funds, and money market funds; annuities; mortgages and promissory notes; and home equity conversion plans, described below, are some of the more common kinds of liquid resources.

(i) Accounts in financial institutions

(A) Accounts in depository financial institutions such as banks and credit unions include, but are not limited to, savings accounts, checking accounts, joint fiduciary accounts, and certificates of deposit. Depository institutions may also manage mutual fund and money market fund accounts for depositors.

(B) Nondepository financial institutions, such as brokerage firms, investment firms, and finance companies, also offer certificates of deposits as well as accounts and services related to the purchase and sale of stocks, bonds, mutual funds, money market funds, and other investments.

(ii) Stocks, bonds, and funds

(A) Legal instruments authenticating an investment, such as stocks, bonds, mutual funds, and money market funds pay interest at specified intervals, sometimes pay dividends, and are convertible into cash either on demand or at maturity.

(B) U. S. savings bonds are obligations of the federal government. Unlike other government bonds, they are not tradable in the usual sense through brokers and security traders and, as described below, the value of the bond depends on its type. See § 29.08(i)(11) for information on the resource exclusion of U.S. savings bonds.

(I) Series E and EE bonds are sold at one half of their face value and increase in redemption value as interest accrues.

(II) Series I bonds are sold at their full face value and increase in redemption value as interest accrues.

(III) Series H and HH bonds are sold at their full face value and do not increase in value. Instead, they pay interest to the owner each six months.

(iii) Annuities. A contract reflecting payment to an insurance company, bank, charitable organization, or other registered or licensed entity; it may also be a private contract between two parties. There are two phases to an annuity: An accumulation phase and a pay-out phase, and their countability as a resource for MABD eligibility purposes is impacted by the phase the annuity is in (see below). Annuities vary in how they accumulate and pay out money. Annuities may accumulate money by payment of a single lump sum or by payments on a schedule, which accumulate interest over time. Once an annuity has reached its pay-out phase (often referred to as "matured"), money is paid to the beneficiary according to the terms of the annuity contract.

(A) Parties to an annuity

(I) There are always two parties to an annuity: The writer of the annuity, usually an insurance carrier or charitable organization, and the purchaser who owns the annuity (sometimes referred to as the annuitant). There may also be a third party to the annuity if someone other than the owner is the annuitant.

(II) In addition, annuities also name a beneficiary. The beneficiary is the person who will be paid a regular stream of income from the annuity in equal payments. Anyone can be a beneficiary, including but not limited to, the owner of the annuity, a spouse, dependent, trust, estate, commercial entity, proprietorship, or charitable organization.

(III) Beneficiaries may be revocable or irrevocable. A revocable beneficiary can be changed by the owner of the annuity at any time. An irrevocable beneficiary can be changed only by the written permission of that beneficiary.

(IV) In addition to the beneficiary described in (II) above, annuities can also provide for a contingent beneficiary or residual beneficiary. A contingent or residual beneficiary will receive annuity payments upon the occurrence of a specified condition.

(B) Types of annuities. There are many types of annuities. For MABD purposes, AHS considers whether annuities of any type are available as a liquid resource. Since annuities are trust-like instruments, terminology similar to trusts is used when it describes the availability of cash from annuities.

(I) Annuity naming revocable beneficiaries. An annuity that names revocable beneficiaries is available to the owner because the owner can change the beneficiary. This type of an annuity is considered a countable resource for purposes of the owner's MABD eligibility. See subsection 29.09(d)(1) for information on how to value an annuity when it is a countable resource.

(II) Annuity that can be surrendered, cashed in or assigned. An annuity that can be surrendered, cashed in or assigned by the owner is presumed to be a revocable annuity. A revocable annuity is considered a countable resource for purposes of the owner's MABD eligibility. An annuity is presumed to be revocable when the annuity contract is silent on revocability. See § 29.09(d)(1) for information on how to value an annuity when it is a countable resource.

(III) Annuity owned by someone other than the applicant or spouse. An annuity is an unavailable resource for purposes of MABD eligibility when the owner of the annuity is not the individual requesting MABD or the individual's spouse, or the individual or their spouse has abandoned all rights of ownership. However, if payments from the annuity are being made to the individual (or spouse), those payments may be counted as income to the individual (or spouse).

(C) Standard of review

(I) For the purposes of MABD eligibility:

(i) An annuity in its accumulation phase is considered a countable resource of the owner because it can be liquidated or sold by the owner. See § 29.09(d)(1) for information on how to value an annuity when it is a countable resource.

(ii) An annuity in its pay-out phase may be excluded as a resource of the owner if certain criteria are met. See § 29.08(d)(1) for information on the resource exclusion of an annuity.

(II) For purposes of MABD for long-term care, an annuity purchased, or subjected to certain transactions, by an individual or their spouse on or after February 6, 2006, is subject to transfer review. See § 25.03(h) for information on transfer analysis of annuities.

(iv) Mortgages

(A) The pledging of real estate or conveyance of an interest in land to a creditor as security for repayment of a debt.

(B) A mortgage owned by an individual, as the creditor, may be excluded as a resource if certain criteria are met. See § 29.08(d)(2) for information on the resource exclusion of a mortgage. If a mortgage is a countable resource of the individual, see § 29.09(d)(5) for information about the valuation of the mortgage.

(v) Promissory notes

(A) Written promises to pay a certain sum of money to a certain person, the bearer, upon demand or on a specified date.

(B) A promissory note owned by an individual, as the bearer, may be excluded as a resource if certain criteria are met. See § 29.08(d)(2) for information on the resource exclusion of a promissory note. If a promissory note is a countable resource of the individual, see § 29.09(d)(5) for information about the valuation of the promissory note.

(vi) Retirement funds. Any resource set aside by a member of the individual's financial responsibility group to be used for self-support upon their withdrawal from active life, service, or business.

Retirement funds include but are not limited to IRAs, Keogh plans, 401K plans, pensions, mutual funds, stocks, bonds, securities, money market accounts, whole life insurance, and annuities. The value of a retirement fund is the amount of money that can currently be withdrawn from the fund.

See § 29.08(i)(5) for information on the resource exclusion of retirement funds. See § 29.08(f) for information on the exclusion of early withdrawal and surrender penalties.

(vii) Health savings accounts (HSAs). Accounts used to set aside funds to meet medical expenses. Unless the individual can demonstrate that the funds in their HSA are not available to them, the HSA is a countable resource.

(c) Resources managed by a third party. Resources, liquid and nonliquid, managed by a third party include, but are not limited to, trusts, guardianship accounts, and retirement funds. Resources of a member of the financial responsibility group managed by a third party (e.g., trustee, guardian, conservator, or agent under a power of attorney) are considered available to the member as long as the member can direct the third party to dispose of the resource or the third party has the legal authority to dispose of the resource on the member's behalf without the member's direction.

(1) Definitions

(i) Guardian. A person or institution appointed by a court in any state to act as a legal representative for another person, such as a minor or a person with disabilities. Guardianship funds are presumed to be available for the support and maintenance of the protected person. That person may rebut the presumption of the availability of guardianship funds by presenting evidence to the contrary, including, but not limited to, restrictive language in the court order establishing the account or in a subsequent court order regarding withdrawal of funds.

(ii) Power of attorney. A written document signed by a person giving another person authority to make decisions on behalf of the person signing it, according to the terms of the document. Vermont law requires a power of attorney to be executed according to certain formalities, such as being signed, witnessed, and acknowledged. Funds managed by an agent under a power of attorney are not property of the agent and cannot be counted as resources of the agent.

(iii) Representative payee. An individual, agency, or institution selected by a court or the SSA to receive and manage benefits on behalf of another person. A representative payee has responsibilities to use these payments only for the use and benefit of that person, to notify the payer of any event that will affect the amount of benefits the person receives or circumstances that would affect the performance of the representative payee's responsibilities, and account periodically for the benefits received. Funds managed by a representative payee are not property of the representative payee and cannot be counted as resources of the representative payee.

(iv) Trust. A trust is a property interest where property is held by an individual or an entity (called a "trustee") subject to a fiduciary duty to use the property for the benefit of another person (the "trust beneficiary"). A trust includes a legal instrument or device that is similar to a trust but may not be called a trust. See § 29.08(e) for information on resource exclusion of trusts. The following are terms related to trusts:

(A) Grantor (also known as settler or trustor)

(I) The person who transfers liquid or nonliquid property to another person or entity (the "trustee"), with the intention that it be held, managed, or administered by the trustee for the benefit of one or more persons (the "grantees") In some cases, the grantor is named as a grantee.

(II) A person is considered the grantor of a trust if:

(i) The assets of the person were used to form all or part of the principal of the trust; and

(ii) One of the following established the trust:

(A) The person;

(B) Another person, court, or administrative body, with legal authority to act in place of or on behalf of the person; or

(C) Another person, court, or administrative body, acting at the direction of or upon the request of the person.

(B) Trustee. The person or entity (such as a bank or insurance company) that holds, manages, or administers trust property for the benefit of the trust's grantee(s). In most cases, a trustee does not have the legal right to use the trust property for their own benefit. Some, but not all, trusts grant discretion to the trustee to use judgment as to when or how to handle trust principal or trust income. A trust may provide reasonable compensation to the trustee for managing the trust as well as reimbursement for reasonable costs associated with managing the trust property.

(C) Grantee (also known as beneficiary). The person or entity that receives the benefit of a trust. A trust can have more than one grantee at the same time; it can also have different grantees under different circumstances.

(D) Trust income (also known as trust earnings). Monies earned by the trust property. It may take various forms, such as interest, dividends, or rental payments. These amounts may be countable unearned income to any person legally able to use them for their support and maintenance.

(E) Trust principal (also known as trust corpus). The property that the grantor transfers to the trustee for the benefit of the grantee(s).

(F) Trust property. The sum of the trust principal and the trust income.

(G) Residual beneficiary. The person or entity named in the trust to receive the trust property upon termination of the trust.

29.08 Excluded resources (01/15/2019, GCR 18-063)

This subsection specifies the resources whose value is excluded in determining MABD eligibility.

(a) Real property

(1) Home and contiguous land

(i) Definition. Home means the property in which an individual resides and has an ownership interest and which serves as the individual's principal place of residence. This property includes the shelter in which the individual resides, the land on which the shelter is located, related outbuildings, and surrounding property not separated from the home by intervening property owned by others. Public rights of way, such as roads that run through the surrounding property and separate it from the home, will not affect the exemption of the property. The home includes contiguous land and any other nonresidential buildings located on the contiguous land that are related to the home.

(ii) Exclusion

(A) Except when determining an individual's eligibility for Medicaid coverage of long-term care services and supports, a home is excluded as a resource, regardless of its value.

(B) For Medicaid coverage of long-term care services and supports, the home is considered a resource when the equity in the home is substantial. See Vermont's Medicaid Procedures Manual for the current substantial home equity limit; see § 29.09(d)(6) for information on exceptions to the application of the substantial home equity limit. The home may also be considered as a resource when determining whether the home has been transferred and should be subject to a penalty period (see § 25.00)

(C) The home exclusion applies even if the owner is making an effort to sell the home.

(D) The home exclusion also applies if the owner is absent from the home due to institutionalization, provided they have not placed the home in a revocable trust, and any one of the following three conditions is satisfied:

(I) The owner intends to return to the home even if the likelihood of return is apparently nil.

(II) The owner has a spouse or dependent relative residing in the home. Dependent relative in this context applies to:

(i) Any kind of dependency (medical, financial, etc.); and

(ii) A relationship to the owner that is one of the following: child, step-child, or grandchild; parent, step-parent, or grandparent; aunt, uncle, niece, or nephew; brother or sister, step-brother or step-sister, half brother or half sister; cousin; or in-law.

(III) The owner has a medical condition that prevented them from residing in the home before institutionalization.

(E) Unless one of the exceptions listed in (D) applies, the home becomes a countable resource when the owner moves out of the home without the intent to return, because it is no longer their principal place of residence.

(F) Temporary absences, such as for hospitalization or convalescence with a relative, do not affect the determination of the owner's principal place of residence.

(2) Proceeds from the sale of an excluded home

(i) Proceeds from the sale of a home is excluded to the extent that the owner intends to use the proceeds and, in fact, uses or obligates them to purchase or construct another home within three months of the date the proceeds are received.

(ii) Use of proceeds from the sale of a home to pay costs of another home will be excluded only if the other costs are paid within three months of the sale of the home. Such costs are limited to the down payment, settlement costs, loan processing fees and points, moving expenses, necessary repairs to or replacements of the new home's structure or fixtures (e.g., roof, furnace, plumbing, built-in appliances) identified and documented prior to occupancy, and mortgage payments for the new home.

(iii) The value of a promissory note or similar installment sales contract constitutes a "proceed." Other proceeds consist of the down payment and the portion of any installment amount constituting

payment against the principal. These are also excluded if used within 3 months to make payment on the replacement home.

(iv) When all of the proceeds are not timely reinvested as specified above, the portion of the proceeds retained by the owner are combined with the value of the promissory note or installment sales contract and counted as a resource beginning with the month following the month the note or contract is executed. If the entire proceeds are fully reinvested in a replacement home at a later date, the value of the note or contract and reinvested proceeds are excluded beginning with the month after the month in which they are reinvested, but any proceeds not reinvested as specified above remain a countable resource until fully reinvested.

(3) Real property up-for-sale

(i) Real property is excluded from being a countable resource as long as the owner verifies that they are making reasonable efforts to sell it. Reasonable efforts to sell property means taking all necessary steps to sell it for fair market value in the geographic area covered by the media serving the area in which property is located, unless the owner is prevented by circumstances beyond their control from taking these steps.

(ii) The steps considered necessary to sell the property depend on the method of sale. An owner may choose to list the real property with a real estate agent or undertake to sell it themselves.

(iii) If the owner chooses to list the property with a real estate agency, they must take the necessary step of listing it and cooperating with the real estate agent's efforts to sell it.

(iv) If the owner chooses to sell the property without an agent, they must take all of the following necessary steps:

(A) Advertise the property in at least one of the appropriate local media continuously;

(B) Place a "For Sale" sign on the property continuously, unless prohibited by zoning regulations;

(C) Conduct open houses or otherwise show the property to prospective buyers; and

(D) Attempt any other appropriate methods of sale.

(v) If any prospective buyer makes a reasonable offer for the property, the owner must accept it or demonstrate why it was not a reasonable offer. Any offer of at least two-thirds of the most recent estimate of the property's fair market value is considered a reasonable offer.

(vi) Fair market value means:

(A) A certified appraisal; or

(B) An amount equal to the price of the property on the open market in its locality at the time of the transfer or contract for sale, if earlier.

(4) Home equity conversion plans

(i) Definition. Home equity conversion plans are financial instruments used to secure loans with real property as collateral. Home equity conversion plans include reverse mortgages, reverse annuity

mortgages, sale-leaseback arrangements, time-sale agreements, and deferred payment loans.

(ii) Exclusion as a resource in month received. In the month of receipt, funds an owner of the real property receives from any home equity conversion arrangements on their real property are excluded as a resource. Any funds received from a home equity conversion plan that are retained after the month of receipt are counted as a resource beginning the month after receipt.

For information on the treatment of the funds for purposes of income eligibility, see § 29.13(b)(30).

(5) Jointly-owned real property

(i) Exclusion due to joint owner's refusal to sell

(A) An owner's interest in jointly-owned real property is excluded as a resource as long as:

(I) At least one of the other joint owners refuses to sell the property; and

(II) The joint ownership was created more than 60 months before the date of the MABD application.

(B) The addition of a new joint owner (or joint owners) to a property is considered as the creation of a new joint ownership. The new joint ownership will be evaluated as a countable resource under § 29.09(d)(3) if the addition of the new joint owner was made within 60 months of the date of the MABD application.

(ii) Exclusion due to undue hardship. An owner's interest in jointly-owned real property is excluded as a resource if the sale of the property would cause the other joint owner (or owners) undue hardship due to loss of housing. Undue hardship would result when:

(A) The property serves as the principal place of residence for one or more of the other joint owners;

(B) Sale of the property would result in loss of that residence; and

(C) No other housing would be readily available for the displaced other owner.

(6) Life estates

(i) Treatment of life estate interest created on or after July 1, 2002. For a life estate ownership in real property created on or after July 1, 2002:

(A) The value of the life estate is excluded as a resource when the life estate owner does not retain the power to sell or mortgage the real property. For purposes of eligibility for Medicaid coverage of long term care services and supports, however, the life estate may be considered as a resource when determining whether it has been transferred and should be subject to a penalty period (see § 25.00).

(B) When the life estate owner retains the power to sell or mortgage the real property, including any remainder interest, the value of the life estate is excluded only if the life estate is an interest in the life estate owner's home (§ 29.08(a)(1)). Otherwise, the value of the life estate is counted. For this purpose, the value of the life estate includes the value of the remainder interest.

(C) When an individual transfers their home and retains a life estate with the power to sell or mortgage the property, the transfer is not subject to a transfer penalty analysis under § 25.00. In

this situation, no transfer has occurred because the individual's ownership interest in the home has not been reduced or eliminated.

(ii) Treatment of life estate interest created before July 1, 2002. For a life estate ownership created before July 1, 2002:

(A) When the life estate owner retains the power to sell the real property, including any remainder interest, the value of the life estate is excluded only if the life estate is excludable on another basis, such as because it is real property producing significant income. Otherwise, the value of the life estate is counted. For this purpose, the value of the life estate includes the value of the remainder interest.

(B) The life estate ownership is excluded as a resource when the life estate owner does not retain the power to sell the real property.

(7) Income-producing real property

(i) *Non-business real property*. Non-business real property is excluded as a resource if the property produces significant income to the owner. Real property is considered to produce significant income if it generates at least 6 percent of its fair market value in net annual income after allowable expenses related to producing the income are deducted.

(ii) *Real property used in a trade or business*. Real property is excluded as a resource if the real property is essential to the owner's self-support and used by the owner in a trade or business. For purposes of this exclusion, the property must be in current use in the type of activity that qualifies it as essential.

(8) Goods for home consumption. Non-business real property is excluded as a resource of the owner when used by the owner to produce goods for only home consumption (e.g., a garden plot used to raise vegetables to be eaten at home or a wood lot used to provide fuel to heat the home). When real property is used to produce goods for both home consumption and income production, only the part used to produce goods for home consumption is excluded. The part of the property used for income production is evaluated for exclusion under (7) above.

(b) Insurance

(1) Exclusion of life insurance

(i) Whole life insurance

(A) If the combined face values of the whole life insurance policies owned by any one member of the financial responsibility group do not exceed $1500, the cash surrender values of the policies are excluded.

(B) If the combined face values exceed $1500, the cash surrender values, excluding any amounts up to $1500, and all dividend additions are a countable resource.

(ii) Term life insurance. Regardless of its face value, a term life insurance policy is not a countable resource.

(2) Long-term care insurance partnership

(i) Definition: Qualified State Long-Term Care Insurance Partnership. A state plan amendment that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made under a long-term care insurance policy (including a certificate issued under a group insurance contract), but only if:

(A) The policy covers an insured who, at the time coverage under the policy first becomes effective, is a resident of such State or of a State that maintains a Qualified Long-Term Care Insurance Partnership;

(B) The policy is a qualified long-term care insurance contract within the meaning of § 7702B(b) of the Code;

(C) The policy provides some level of inflation protection as set forth in regulations promulgated by the Department of Financial Regulations (DFR);

(D) The policy satisfies any requirements of State or other applicable law that apply to a long-term care insurance policy as certified by the DFR; and

(E) The issuer of the policy reports:

(I) To the Secretary of HHS such information or data as the Secretary may require; and

(II) To the State, the information or data reported to the Secretary of HHS (if any), the information or data required under the minimum reporting requirements developed under § 2(c)(1) of the State Long-Term Care Partnership Act of 2005, and such additional information or data as the State may require.

(ii) Exclusion

(A) Subject to approval by CMS, assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a qualified State long-term care insurance partnership policy are excluded.

(B) This section is further contingent on the passage of changes to 33 VSA § 1908a necessary to bring the Vermont statute on Long-Term Care Partnership Insurance into conformance with the requirements of § 6021 of the federal Deficit Reduction Act of 2005.

(c) Burial Funds Exclusion

(1) For any person whose income and resources are considered in determining MABD eligibility, up to $10,000 of burial funds are excluded, as long as the person shows that the funds are designated for burial expenses through the title to the funds or by a sworn statement provided. The funds must be separately identifiable and not commingled with other funds.

(2) Burial funds may be excluded as of the first day of the month in which the person whose income and resources are considered in determining MABD eligibility established it. Interest and appreciation accrued on burial funds are excluded if the funds have been left to accumulate.

(3) The value of certain burial spaces may also be excluded under the allowable limit of $10,000 for each person whose income and resources are considered in determining MABD eligibility. Such spaces must be held for the burial of a member of the individual's immediate family. For this purpose, the immediate family includes the individual's spouse, children, brothers, sisters, and parents.

(4) Irrevocable burial trusts established prior to July 1, 2002 and funded in excess of $10,000 are excluded up to the value of the trust as of June 30, 2002.

(d) Other income-producing resources

(1) Annuities

(i) An annuity is excluded as a resource of an individual requesting MABD or of their spouse if the annuity is in its pay-out phase and meets all of the following conditions:

(A) Has no beneficiary (or payee) other than the individual requesting MABD or their spouse;

(B) Provides for payments to the beneficiary in equal intervals and equal amounts;

(C) Does not exceed the life expectancy of the beneficiary as determined by using the actuarial life table published by the Office of the Chief Actuary of the SSA (http://socialsecurity.gov/OACT/STATS/table4c6.html) and set forth in Vermont's Medicaid Procedures Manual;

(D) Returns to the beneficiary at least the amount used to establish the annuity contract and any additional payments plus any earnings, as specified in the contract; and

(E) Except as provided in (ii) below, does not pay anyone else, as residual beneficiary, in the event the beneficiary dies before the payment period ends.

(ii) An annuity will also be considered to meet the requirements of (A) and (E) of (i) above if the individual or their spouse, as the owner of the annuity, elects to designate Vermont Medicaid as the primary residual beneficiary up to the amount of Medicaid payments made on behalf of the individual (or their spouse), and names a contingent residual beneficiary other than the individual or their spouse to receive any surplus after Vermont Medicaid is paid.

(2) Promissory notes and other income-producing resources

(i) A promissory note or similar resource that produces income is excluded as a resource of an individual requesting MABD eligibility or of their spouse if:

(A) It meets the requirements in paragraph (1)(i)(A) through (E) above; or

(B) The owner owned a nonnegotiable or nonassignable promissory note executed before September 1, 2005 and they can expect to receive the full fair market value of the resource within their expected lifetime, as determined by using the actuarial life table published by the Office of the Chief Actuary of the SSA (http://socialsecurity.gov/OACT/STATS/table4c6.html) and set forth in Vermont's Medicaid Procedures Manual.

(ii) All other promissory notes and similar resources that produce income are evaluated for whether they are a countable resource as specified in § 29.09(d)(5) or, for purposes of Medicaid coverage of long-term care services and supports, subject to a transfer penalty as specified in § 25.00.

(e) Excluded trusts

(1) In general

(i) A trust is excluded as a resource if the member of the financial responsibility group is the grantor or grantee of the trust and cannot revoke the trust or receive trust property, whether or not the trustee exercises their full discretion. Trust property is also excluded as a resource when the grantor is a member of the financial responsibility group and establishes a trust by will (often referred to as a "testamentary trust").

(ii) The following trust property is excluded as a resource when either the grantor or the grantee is a member of the financial responsibility group:

(A) Trust property in a trust established prior to April 7, 1986, for the sole benefit of a person who is developmentally disabled residing in an ICF-DD.

(B) Trust property in a trust for which the grantee is a disabled child under the decision in Sullivan v. Zebley, 493 U. S. 521 (1990).

(C) Trust property or any portion of trust property that cannot be made available to the member of the financial responsibility group, either through full exercise of the trustee's discretion under the terms of the trust or through revocation of the trust by a member of the financial responsibility group.

(D) Trust property in a trust established by persons other than the individual or the individual's spouse (known as a third-party trust) unless the terms of the trust permit the individual (or their spouse) to revoke the trust or to have access to it without trustee intervention.

(E) Trust property in an irrevocable trust, including a home placed in an irrevocable trust by an institutionalized individual who intends to return to it, from which no payment under any circumstances could be made to the individual.

(F) A special needs trust that contains the assets of a disabled individual under the age of 65, and meets all of the criteria below:

(I)

(i) For a trust established on or after December 13, 2016, was established through the actions of the disabled individual, a parent, grandparent or legal guardian of the disabled individual, or by a court; or

(ii) For a trust established before December 13, 2016, was established through the actions of a parent, grandparent, or legal guardian of the disabled individual, or by a court;

(II) Was established for the sole benefit of the disabled individual which means that no person or entity except the disabled individual can benefit from the trust in any way, until after the death of the disabled individual and then not before Vermont Medicaid receives sums owed under the payback provision under (III) below; and

(III) Includes a payback provision which requires that, upon the death of the disabled individual, any amounts remaining in the trust will first be paid to Vermont Medicaid in an amount equal to the total Medicaid payments made on behalf of the disabled individual.

(G) A pooled trust that contains the assets of a disabled individual, and meets all of the criteria below:

(I) Was established and administered by a non-profit association;

(II) Maintains a separate account for the disabled individual, but assets are pooled for investing and management purposes;

(III) The separate account was established for the sole benefit of the disabled individual;

(IV) The account was established through the actions of the disabled individual, their parent, grandparent or legal guardian, or by a court; and

(V) The trust contains a pay-back provision which requires that to the extent any amounts in the separate account for the disabled individual upon their death are not retained by the trust, such amounts will first be paid to Vermont Medicaid in an amount equal to the total Medicaid payments made on behalf of the disabled individual.

(VI) Any asset of the disabled individual that is added to the trust after the disabled individual reaches the age of 65 may be subject to transfer penalty (see § 25.00) for purposes of the disabled individual's eligibility for Medicaid coverage of long-term care services and supports.

(iii) In the case of a trust with more than one grantor, these exclusions apply only to that portion of the trust attributable to the income or resources of a member of the financial responsibility group. In the case of a trust with more than one grantee, the exclusions apply only to that portion of the trust available for the benefit of a member of the financial responsibility group.

(2) Trusts excluded due to hardship

(i) Trust property that has not been distributed may be excluded if counting it as a resource would cause undue hardship to a grantor or grantee who is a member of the financial responsibility group.

(ii) Undue hardship includes situations in which a member of the financial responsibility group or someone in the member's immediate family would be forced to go without life-sustaining services because the trust property could not be made available to pay for the services. For this purpose, the immediate family includes the member's spouse, children, brothers, sisters, and parents.

(iii) The following situations also would cause undue hardship:

(A) Funds can be made available for medical care only if trust property is sold, and this property is the sole source of income for the member or someone in the member's immediate family; and

(B) Funds can be made available for medical care only if income-producing trust property is sold and, as a result of this sale, the member or someone in the member's immediate family would qualify for SSI, Reach Up, AABD, General Assistance, 3SquaresVT, or another public assistance program requiring a comparable showing of financial need.

(iv) Undue hardship does not exist when application of the trust regulations does not cause risk of serious deprivation to the member of someone in the member's immediate family.

(v) An individual claiming undue hardship must submit a written request and any supporting documentation. Required documentation from the individual can include, but is not limited to, the following:

(A) A statement from the individual's attorney, if one was involved;

(B) Verification of medical insurance coverage and statements from medical providers relative to usage not covered by the insurance; or

(C) A statement from the trustee of the trust.

(vi) When application of trust provisions are waived because they would cause the individual undue hardship, only amounts actually distributed from the trust and held for more than a month are counted as a resource.

(vii) Request for consideration of undue hardship does not limit an individual's right to appeal denial of eligibility for any reason, including the determination of undue hardship.

(f) Early withdrawal and surrender penalties

(1) Early withdrawal penalties and surrender fees assessed by a financial institution are excluded to the extent that they reduce the value of a countable resource that has been liquidated. Examples of resources to which this exclusion applies are retirement funds, annuities, bonds, and certificates of deposit.

(2) Income tax withholding and tax penalties for early withdrawal are not excluded.

(g) Jointly-owned accounts. A jointly-owned account in a financial institution is excluded as a resource only if the owner rebuts the presumption of availability by:

(1) Submitting a statement, along with a corroborating statement (or statements) from the other joint owner (or owners) of the account, regarding who owns the funds in the joint account, why there is a joint account, who has made deposits to and withdrawals from the account, and how withdrawals have been spent;

(2) Submitting account records showing deposits, withdrawals, and interest, if any, in the months for which ownership of funds is at issue; and

(3) Taking one of the following two actions:

(i) If the member of the financial responsibility group owns none of the funds in the account, correcting the account title to show that the member is no longer a co-owner of the account; or

(ii) If the member owns only a portion of the funds in the account, separating the funds owned by other account owners from the member's funds and correcting the account title on the member's funds to show they are solely owned by the member.

(h) Fiduciary for a joint fiduciary account[18]

(1) Definition: Joint fiduciary account. A deposit in a financial institution in the name of an owner naming one or more fiduciaries. The owner makes a clear statement about how the money can be used, and the

[18] 8 VSA § 14212

fiduciary is required to follow those instructions and keep track of how the money is spent.

(2) Exclusion. When an individual owns a joint fiduciary account, it is counted as a resource. When an individual is designated a fiduciary of a joint fiduciary account, the joint fiduciary account is an excluded resource for the fiduciary.

(i) Other excluded resources

(1) Household goods, personal effects and other personal property

(i) Except as provided in (ii), home furnishings, apparel, personal effects, and household goods are excluded as resources. Tools, equipment, uniforms and other nonliquid property required by the owner's employer or essential to the owner's self-support are also excluded as resources.

(ii) Items an owner acquires or holds because of their value or as an investment are not excluded.

(2) Vehicles

(i) Except as provided in (ii), all automobiles are excluded as resources. Other vehicles, such as trucks, boats, and snowmobiles, are excluded only if they are used to provide necessary transportation (i.e., an automobile is unavailable or cannot be used to transport the aged, blind or disabled individual).

(ii) Automobiles or other vehicles an owner acquires or holds because of their value or as an investment are not excluded.

(3) Independent living contracts

(i) Definitions

(A) Contracts for medical care, assistive technology devices, and home modifications. Any written agreement, contract, or accord (including modifications) for reasonable and necessary medical care, assistive technology devices, or home modifications not covered by Medicare, private insurance, or Medicaid and determined by AHS to be needed to keep an individual at home and out of a skilled nursing facility.

(B) Medical care. Care not covered under AHS's Choices for Care program, including but not limited to, general supervision when required by the cognitive impairment of the individual and/or unstable medical condition that requires monitoring of the individual.

(C) Assistive technology devices. Any item, piece of equipment or product system whether acquired commercially off the shelf, modified, or customized, to increase, maintain, or improve the individual's functional capabilities.

(D) Home modifications. Physical adaptations to the individual's home that ensure the health and welfare of the individual, or that improve the individual's ability to perform activities of daily living or instrumental activities of daily living.

(ii) Exclusion. Resources set aside under a contract or contracts for medical care, assistive technology devices, or home modifications are considered to be available resources unless all of the following criteria are met:

(A) The contract is in writing and signed before any services are provided;

(B) The funds, not to exceed a total of $30,000, are held in a separate bank account from other resources in the sole name of the individual applying for MABD;

(C) Any amounts due are paid after the services are rendered;

(D) The payments for:

(I) Medical care or assistive technology services do not exceed $500 per month; and

(II) Home modifications do not exceed a one-time expenditure of $7,500;

(E) The payments to nonlicensed individuals or providers do not exceed the fair market value of such services being provided by similarly situated and trained nonlicensed individuals, not to exceed the amount paid under AHS's Choices for Care program.

(F) Periodic accountings, as requested by AHS, must be provided specifying the amount of each expenditure, who was paid, the service given, and the number of hours and dates of service covered;

(G) The individual has the power to modify, revoke or terminate the contract for care;

(H) The contract ceases upon the death of the individual. It also ceases upon the individual's admission to an institution for long term care for more than 45 days if not eligible for the home upkeep deduction under § 24.04(d), or 6 months if eligible for the deduction. In addition, revocation or termination of the contract ceases the agreement.

(I) Upon cessation of the contract as specified above, any remaining balance of funds shall be treated as:

(I) An asset of the individual's estate, if the individual is deceased;

(II) An available resource that may not be converted to an excluded resource and must be applied at the Medicaid pay rate toward long term care services and supports if the individual is admitted to an institution for long-term care for more than 6 months. In cases where the individual dies before the resource is fully expended, the remainder shall become an asset of the individual's estate; or

(III) An excluded resource, if the individual revokes or terminates the contract and continues to receive services under AHS's Choices for Care program.

(4) Cash/liquid resources

(i) Income is excluded as a resource in the month of receipt, such as an automatic deposit of a social security check into a checking account.

(ii) Liquid resources used in the operation of the owner's trade or business as property essential to self-support are excluded.

(5) Exclusion of retirement funds

(i) Any retirement fund owned by a member of the financial responsibility group is excluded when:

(A) The member must terminate employment in order to obtain any payment from the fund;

(B) The member is not eligible for periodic payments from the fund and does not have the option of withdrawing a lump sum from the fund; or

(C) The member is drawing on the retirement fund at a rate consistent with their life expectancy, as specified in § 25.03(b).

(ii) If the member is eligible for periodic payments or a lump sum, the member must choose the periodic payments. If the member receives a denial on a claim for periodic retirement benefits, but can withdraw the funds in a lump sum, the lump sum value is counted in the resources determination for the month following that in which the member receives the denial notice.

(iii) When a member of the financial responsibility group is seeking Medicaid coverage of long-term care services and supports under MABD and has a spouse, any retirement fund held by the member in an individual retirement account (IRA) or in a work-related pension plan (including Keogh plans) as defined by the Code, does not require a change in the title of ownership in order for the fund to be treated as an excluded resource for the benefit of the spouse.

(6) Tax refunds. Tax refunds on real property, income, and food are excluded as resources.

(7) Student benefits. Any portion of any grant, scholarship, or fellowship used to pay fees, tuition, or other expenses necessary to securing an education is excluded. Portions used to defray costs of food or shelter must be counted.

(8) Savings from excluded income. Savings from excluded income and resources are excluded as resources. This includes, but is not limited to, the following:

(i) Liquid resources, including interest earned by the resources accumulated from earnings by a person working with disabilities (see § 8.05(d)) on or after January 1, 2000, and kept in a separate bank account from other liquid resources, unless no bank within a reasonable distance from the person's residence or place of work permits the person working with disabilities to establish a separate account without charging fees; and

(ii) Nonliquid resources purchased by a person working with disabilities on or after January 1, 2000, with savings from earnings or with a combination of savings from earnings and other excluded income or resources.

(9) Resources excluded by federal law. The following are excluded by federal law from both income and resources:

(i) The value of meals and food commodities distributed under the National School Lunch Act and the Child Nutrition Act.

(ii) The value of 3SquaresVT or 3SquaresVT cash-out checks.

(iii) The value of food or vouchers received through the WIC Program.

(iv) The value of food or meals received under the Older Americans Act.

(v) Compensation or remuneration received for volunteer work in ACTION programs including foster grandparents, RSVP, SCORE, ACV, ACE, VISTA, Senior Companion Program and UYA.

(vi) The value of assistance received under the U. S. Housing Act, U. S. Housing Authorization Act and the Housing and Urban Development Act.

(vii) The value of relocation assistance to displaced persons under the Uniform Relocation and Real Property Acquisition Policies Act.

(viii) Per capita distributions to certain Indian Tribes and receipts from lands held in trust for certain Indian Tribes.

(ix) Payments received under the Alaskan Native Claims Settlement Act.

(x) Grants or loans received for educational purposes under any U. S. Department of Education program.

(xi) Any assistance received under the Emergency Energy Conservation or Energy Crisis Program.

(xii) Any assistance received under the Low-Income Home Energy Assistance Act, either in cash or through vendor payments.

(xiii) Compensation paid to Americans of Japanese or Aleut ancestry as restitution for their incarceration during World War II.

(xiv) Agent Orange Settlement payments.

(xv) German reparations to concentration camp survivors, slave laborers, partisans, and other victims of the Holocaust. Settlement payments to victims of Nazi persecution or their legal heirs resulting from the confiscation of assets during World War II.

(xvi) War reparations paid under the Austrian government's pension system.

(xvii) Radiation Exposure Compensation Trust Fund payments.

(xviii) Assistance received under the Disaster Relief and Emergency Assistance Act or other assistance provided under a Federal statute because of a catastrophe which is declared to be a major disaster by the President of the United States. Comparable assistance received from a State or local government, or from a disaster assistance organization is also excluded. Interest earned on the assistance is also excluded.

(xix) Netherlands' Act on Benefits for Victims of Persecution 1940-1945 payments.

(xx) Any account, including interest or other earnings on the account, established and maintained in accordance with § 1631(a)(2)(F) of the Act. These accounts are established with retroactive SSI payments made to a child under age 18 and used in ways specified in the Act. The exclusion continues after the child has reached age 18.

(xxi) Earnings deposited in a special savings account under the Tangible Assets project managed by the Central Vermont Community Action Council and authorized by PRWORA.

(xxii) Payments as the result of a settlement in the case of Susan Walker v. Bayer Corporation, et al. made to hemophiliacs who contracted the HIV virus from contaminated blood products.

(xxiii) Any resource of a blind or disabled individual that is necessary for them to carry out their approved Plan for Achieving Self-Support (PASS). The plan must be approved by the SSA.

(10) Exclusions for limited periods. The following resources are excluded for specific periods:

(i) Retroactive Social Security and SSI/AABD. Retroactive payments of SSI, the AABD supplement to SSI, or Social Security benefits for nine months beginning with the month after the month of receipt. These payments are also excluded as resources during the month of receipt.

(ii) Funds for replacing excluded resources. Cash and interest earned on that cash received from any source, including casualty insurance, for the purpose of repairing or replacing an excluded resource that is lost, stolen, or damaged, if used to replace or repair that resource. The exclusion is allowed for nine months from the month of receipt. An extension of an additional nine months can be granted for good cause.

(iii) Earned income tax credit. State and federal earned income tax credit refunds and advance payments for nine months beginning with the month after the month of receipt.

(iv) Medical or Social Services payments. Cash received for medical or social services for the calendar month following the month of receipt. In the month following the month of receipt, it is counted as a resource if it has been retained.

(v) Victim's compensation payments. State-administered victims' compensation payments for nine months after the month of receipt.

(vi) Relocation payments. State and local government relocation payments for nine months after the month of receipt.

(vii) Expenses from last illness and burial. Payments, gifts, and inheritances occasioned by the death of another person provided that they are spent on costs resulting from the last illness and burial of the deceased by the end of the calendar month following the month of receipt.

(11) Exclusion of U. S. savings bonds

(i) A U. S. savings bond is excluded as a resource during its minimum retention period if the owner of the savings bond requested a hardship waiver based on financial need due to medical expenses and received a denial from the United States Department of the Treasury, Bureau of Public Debt, Accrual Services Division in Parkersburg, P. O. Box 1328, Parkersburg, West Virginia 26106-1328.

(ii) Upon verification of a denial of a hardship waiver, as described above, a U. S. savings bond is considered an available resource of the owner following the expiration of the minimum retention period. Once the minimum retention period expires, the denial of a hardship waiver is not a basis for exclusion of new bond purchases or other excluded assets purchased with the proceeds.

(iii) A U. S. savings bond purchased before June 15, 2004, that has its minimum retention period expire after that date, continues to be an excluded resource if it is not redeemed, exchanged, surrendered, reissued, used to purchase or fund other excluded assets, or otherwise becomes available.

(12) Home-based long-term care disregard. An additional resource disregard of $3,000 to the standard $2,000 resource disregard is allowed for an aged or disabled individual without a spouse who resides in and has

an ownership interest in their principal place of residence and chooses Medicaid coverage of long-term care services and supports under MABD to be provided in their residence provided all other eligibility criteria are met. This additional resource disregard remains available until the individual begins receiving Medicaid coverage of long term care services and supports under MABD in an institution or in a residential care home that provides enhanced residential care services. Thereafter, if the individual meets the requirements for a home upkeep deduction (see § 24.04(d)), they are eligible to continue this resource disregard for up to 6 months.

29.09 Value of resources counted toward the Medicaid resource limit (01/01/2018, GCR 17-047)

(a) In general. Unless an exception under paragraph (d) below applies, the ownership interests of resources of the members of the financial responsibility group are valued according to these general rules.

(1) Resources not excluded under § 29.08 are valued at their equity value (see (b) below for definition of equity value).

(2) The portion of jointly-owned resources not excluded and countable toward the MABD resource limit is determined according to the rules in paragraph (c) below.

(3) The equity value of any resource owned entirely by members of the financial responsibility group and not excluded under § 29.08 is counted toward the MABD resource limit.

(b) Definition: Equity value

(1) The fair market value of the resource minus the total amount owed on it in mortgages, liens, or other encumbrances.

(2) The original estimate of the equity value of a resource is used unless the owner submits evidence from a disinterested, knowledgeable source that, in AHS's judgment, establishes a reasonable lower value.

(c) Counting jointly-owned resources

(1) In general

(i) This paragraph defines each type of joint ownership and the amount of the resource that is counted when ownership is shared.

(ii) When two or more parties share rights to sell, transfer, or dispose of part or all of personal or real property, the ownership share held by members of the financial responsibility group is counted as prescribed by state law. Shared ownership or control occurs in different forms, including tenancy-in-common, joint tenancy, and tenancy-by-the-entirety. The type of shared ownership involved is determined and used to compute the countable value of the resource. If an individual submits evidence supporting another type of shared ownership, AHS will make a decision about which type applies. If AHS decides not to use the type submitted by the individual, it will provide the individual with a written notice stating the basis for its decision.

(iii) Under Vermont law, a co-owner may demand partition, the dividing of lands held by more than one person. For this reason, AHS counts the individual's proportionate share of the lands as an available

resource, unless excluded as a home or property up for sale.

(2) Definition: Tenancy-in-common

(i) In tenancy-in-common, two or more parties each have an undivided fractional interest in the whole property. These interests are not necessarily equal. One owner may sell, transfer or otherwise dispose of their share of the property without permission of the other owner(s) but cannot take these actions with respect to the entire property.

(ii) When a tenant-in-common dies, the surviving tenant(s) has no automatic survivorship rights to the deceased's ownership interest in the property. Upon a tenant's death, their interest passes to their estate or heirs.

(iii) Tenancy-in-common applies to all jointly-owned resources when title to the resource does not specify joint tenancy or tenancy-by-the-entirety.

(iv) See (c)(5) below for how a resource owned by a member of the financial responsibility group as a tenant-in-common is counted.

(3) Definition: Joint tenancy

(i) In joint tenancy, each of two or more parties has an undivided ownership interest in the whole property. In effect, each joint tenant owns all of the property. When the property is personal property, the interests of the joint tenants are equal. When the property is real property, the interests of the joint tenants can be equal or unequal (unless the instrument creating the joint tenancy contains language indicating a contrary intent, the joint tenants' interests are presumed to be equal).[19]

(ii) Upon the death of only one of two joint tenants, the survivor becomes the sole owner. Upon the death of one of three or more joint tenants, the survivors become joint tenants of the entire interest. For real property, the deceased joint tenant's interest is allocated among the surviving joint tenants in proportion to their respective interests at the time of the deceased joint tenant's death unless the instrument creating the joint tenancy contains language indicating a contrary intent.[20]

(iii) See (c)(5) below for how a resource owned by a member of the financial responsibility group as a joint tenant is counted.

(4) Definition: Tenancy-by-the-entirety

(i) Tenancy-by-the-entirety can only exist between members of a married couple, including parties to a civil union.

(ii) The couple, as a unit, owns the entire property which can be sold only with the consent of both parties.

(iii) Upon the death of one tenant-by-the-entirety, the survivor takes the whole. Upon legal dissolution,

[19] 27 VSA § 2(b)

[20] Id.

the former couple become tenants-in-common (see (c)(2) above), and one can sell their share without the consent of the other.

(iv) When a member of the financial responsibility group owns a resource as a tenant-by-the-entirety, the entire equity value of the resource is counted as available to the member.

(5) Countability

(i) General rule for tenancy-in-common and joint tenancy. With the exception noted in (ii) below and subject to the presumption under § 29.09(d)(3) regarding real property joint ownerships created within 60 months prior to the date of the MABD application, AHS assumes, absent evidence to the contrary, that each owner of shared property owns only their fractional interest in the property. The total value of the property is divided among all of the owners in direct proportion to the ownership share held by each.

(ii) Exception: Accounts in financial institutions. For an account in a financial institution, AHS assumes that all of the funds in the account belong to the individual. If another member (or members) of the individual's financial responsibility group is on the account, AHS assumes the funds in the account belong to those account owners in equal shares.

(d) Exceptions to general valuation rule. The following paragraphs describe exceptions to the general valuation rules described in paragraph (a) above.

(1) Annuities. Unless an annuity is excluded as a resource under § 29.08(d)(1) or, for purposes of Medicaid coverage of long term care services and supports, treated as a transfer under § 25.03(h), the fair market value of an annuity is counted. The fair market value is equal to the amount of money used to establish the annuity and any additional payments used to fund the annuity, plus any earnings and minus any early withdrawals and surrender fees. If evidence is furnished from a reliable source showing that the annuity is worth a lesser amount, AHS will consider a lower value. Reliable sources include banks, other financial institutions, insurance companies, and brokers, as well as any other source AHS considers, in its discretion, to be reliable.

(2) Life estates. Unless a life estate interest in property is excluded under § 29.08(a)(6) or the fair market value of the entire property (the life estate and the remainder) is counted as a resource, the fair market value of a life estate interest in property is established by multiplying the fair market value of the property at the time the life estate interest was created by the number in the life expectancy table that corresponds with the individual's age at that time. The life estate table is found in the SSA's POMS at SI 01140.120 (https://secure.ssa.gov/apps10/poms.nsf/lnx/0501140120). If an individual submits evidence supporting another method of establishing the fair market value of a life estate, AHS will make a decision about what method to use. If AHS decides not to use the method submitted, it will provide the individual with a written notice stating the basis for its decision.

(3) Jointly-owned real property. Regardless of a co-owner's refusal to sell jointly-owned real property pursuant to the resource exclusion under § 29.08(a)(5)(i), AHS presumes that a member of the financial responsibility group that owns real property jointly with another person (or persons) owns the entire equity value of the real property if the joint ownership was created less than 60 months prior to the date of the MABD application. This presumption may be rebutted by a showing, through reliable sources, that the other joint owner (or owners) purchased shares of the property at fair market value. Reliable sources

include cancelled checks or property transfer tax returns. When it has been established that one or more other co-owners purchased their shares of the property, the proportional interest owned by the member is counted.

(4) U. S. savings bonds. Unless a U. S. savings bond is excluded under § 29.08(i)(11), it is counted as a resource beginning on the date of purchase. To establish the value of the bond, the Savings Bond Calculator or the Comprehensive Savings Bond Value Table on the U. S. Bureau of Public Debt's internet website is used. Alternately, AHS obtains the value by telephone from a local bank. The following general rules apply to valuation:

(i) Series E and EE bonds are valued at their purchase price.

(ii) Series I bonds are valued at their face value.

(iii) Service HH bonds are valued at their face value.

(5) Income-producing promissory notes and contracts

(i) Unless the promissory note or other income-producing resource (contract) is excluded under § 29.08(d)(2) or, for purposes of Medicaid coverage of long-term care services and supports, treated as a transfer under § 25.03(i), the fair market value of a promissory note or contract is counted. Regardless of negotiability, fair market value equals the amount of money used to establish the note or contract and any additional payments used to fund it, plus any earnings and minus any payments already received. If evidence is furnished to AHS of a good faith effort to sell the note or contract by obtaining three independent appraisals by reliable sources which reflect that the value of the note or contract is less than fair market value, AHS will consider the note or contract available to its owner only in the amount of this discounted value. Reliable sources include banks, other financial institutions, insurance companies, and brokers, as well as any other source AHS considers, in its discretion, to be reliable.

(ii) For an individual requesting Medicaid coverage of long-term care services and supports under MABD, a note or contract valued at a discount will be treated as an available resource at the discounted amount and may also be subject to a transfer penalty to the extent of the amount discounted from the fair market value, in the discretion of AHS. Where the note or contract is determined to have no value on the open market, a transfer penalty will be applied for the full value used to establish the note or contract and any additional payments used to fund it, plus any earnings and minus any payments already received.

(6) Substantial home equity

(i) Definition: Home equity. The value of a home based on the town's assessment adjusted by the common level of appraisal (CLA), minus the total amount owed on it in mortgages, liens, or other encumbrances. When an individual requesting Medicaid owns their home in a joint ownership with someone other than their spouse, absent evidence to the contrary, the individual's equity interest in the home is reduced by the amount of the other joint owner's equity interest when the other joint owner resides in the home.

(ii) Counting rule

(A) A home is considered a resource, for purposes of eligibility for Medicaid coverage of long term care services and supports, when the owner's equity in the home is substantial. See Vermont's Medicaid Procedures Manual for the current substantial home equity limit. The substantial home equity limit increases from calendar year to year based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average) rounded to the nearest $1,000.

(B) Substantial home equity precludes payment for Medicaid coverage of long-term care services and supports unless one of the following individuals lawfully resides in the home:

(I) The owner's spouse;

(II) The owner's child who is under age 21; or

(III) The owner's child who is blind or permanently and totally disabled, regardless of age.

(C) A individual with excess equity in their home who is found ineligible for Medicaid coverage of long-term care services and supports may receive other Medicaid services besides long-term care services and supports if they meet the eligibility criteria for a coverage group that covers services other than long-term care services and supports.

(iii) Hardship waivers. An individual who is ineligible for Medicaid coverage of long-term care services and supports due to excess equity in their home may request an undue hardship waiver based on the criteria specified at § 25.05.

(iv) Home equity conversion plans (reverse mortgages) and home equity loans. An individual is permitted to use a home equity conversion plan (reverse mortgage) or a home equity loan to reduce their equity interest in their home. In such circumstances, the funds are valued as follows:

(A) The existence of a line of credit is not considered to diminish the equity value except in amounts from the line of credit actually paid to the borrower.

(B) In the month of receipt, lump-sum payments from a home equity conversion plan or from a home equity loan are excluded as a resource and proceeds paid in a stream of income are excludable income.

(C) Lump sum payments from home equity loans retained for more than a month continue to be an excluded resource.

Lump sum payments and streams of income are subject to transfer penalties if given away in the month of receipt or thereafter.

29.10 Determination of countable resources (01/01/2018, GCR 17-047)

(a) In general. Countable resources are determined by combining the resources of the members of the financial responsibility group, as described in § 29.03, and comparing them to the resource standard of the Medicaid group, as described in § 29.04. Countable resources are determined for different types of Medicaid groups: adults without spouses, adults with spouses, children, and individuals requesting Medicaid coverage of long-term care services and supports. If the resources of the Medicaid group fall below or are equal to the applicable resource standard, the resource test is passed. If an excess resource amount remains after all exclusions have been applied (see § 29.08), the individual has not passed the resource test. An individual may become eligible for MABD by spending down or giving away excess resources as provided in § 30.00 subject

to transfer of resource rules (see § 25.00) for those seeking Medicaid coverage of long-term care services and supports.

(b) Determining countable resources for individuals other than children. The general rule in paragraph (a) above is followed to determine whether total resources, after exclusions, of an individual other than a child falls below the resource maximum for one.

(c) Determining countable resources for individuals with spouses and not in long-term care. The general rule in paragraph (a) above is followed to determine whether the total resources, after exclusions, of an individual living with their spouse and requesting MABD, other than Medicaid coverage of long-term care services and supports under MABD, falls below the resource maximum for two.

(d) Determining countable resources for children

(1) Unless otherwise specified in the coverage group rules at §§ 8.05 and 8.06, the countable resources of an eligible child are determined by:

(i) Combining the resources of the parents living with the child with the child's resources, until the child reaches the age of 18;

(ii) Subtracting the resource maximum for one, if one parent, or two, if two parents, from the parent's countable resources; and

(iii) Deeming and adding the remainder to the child's own countable resources.

(2) If the child's total countable resources fall below the resource maximum for one, the resource test is passed.

(e) Determining countable resources for individuals requesting Medicaid coverage of long term care services and supports under MABD who have spouses. For an individual requesting Medicaid coverage of long-term care services and supports under MABD who has a spouse, the resource evaluation process of assessment and allocation is performed as set forth in this paragraph at the beginning of the first continuous period of long-term care. An individual discharged from long-term care and readmitted later does not undergo these steps again; only the resources of, and any new transfers by, the readmitted individual are counted. An institutionalized spouse (sometimes referred to in this rule as the "IS") who receives additional resources after allocating less than the community spouse resource allocation (CSRA) maximum to their community spouse (sometimes referred to in this rule as the "CS") and being found eligible for Medicaid coverage of long-term care services and supports under MABD, may, until the first annual review of their eligibility, continue to transfer resources to the CS up to a combined total transfer of no more than the CSRA maximum. After the IS's first regularly-scheduled annual redetermination of eligibility, no further transfers are allowed even if the CSRA maximum has not been allocated to the CS; the rules regarding transfers apply after the IS's first regularly-scheduled annual redetermination (see § 25.00).

See Vermont's Medicaid Procedures Manual for the current CSRA maximum.

(1) Assessment of resources for individuals with community spouses. At the time of admission to long-term care and application for Medicaid coverage of long-term care services and supports under MABD, including long-term care services and supports in a home and community-based setting, AHS completes

an assessment of resources. An individual or their spouse may also request a resource assessment prior to admission to long-term care. AHS provides a copy of the assessment to each spouse and retains a copy. The assessment must include at least:

(i) The total value of countable resources in which either spouse has an ownership interest;

(ii) The basis for determining total value;

(iii) The spousal share or one-half the total;

(iv) Conclusion as to whether the IS would be eligible for MABD based on resources;

(v) The highest amount of resources the IS and CS may retain and still permit the IS to be eligible;

(vi) Information regarding the transfer of assets policy; and

(vii) The right of the IS or the CS to a fair hearing at the time of application for MABD.

(2) Allocation of resources for individuals with community spouses

(i) An allocation of resources is completed at the time of the IS's application for Medicaid coverage of long-term care services and supports under MABD, as follows:

(A) The total countable resources of the couple are determined at the time of the application for Medicaid coverage of long-term care services and supports under MABD, regardless of which spouse has an ownership interest in the resource;

(B) The greatest of the following is deducted:

(I) CSRA maximum;

(II) Amount set by a fair hearing, or

(III) Amount transferred from the IS to the CS under a court order.

(ii) The remaining resources allocated to the IS are compared to the resource maximum for one to determine whether or not the IS passes the MABD resource test. If the IS does not pass the resource test, see the spenddown provisions at § 30.00.

(iii) The resources of the CS are considered available to the IS until the month after the month in which the IS becomes eligible for Medicaid coverage of long-term care services and supports under MABD. If the CS fails to make the resources accessible to the IS, after AHS has determined that they are available, AHS may still grant the IS Medicaid coverage of long-term care services and supports under MABD if:

(A) The IS assigns any rights to support from the CS to AHS; or

(B) Denial of Medicaid coverage of long-term care services and supports would work an undue hardship, as specified in § 25.05.

(iv) The CS is provided with the amount determined to be the share of the CS (or to someone else for the sole benefit of the CS). Any transfer of resources from the IS to the CS must be completed by

the next review of eligibility of the IS. The transfer will be verified at the next regularly scheduled redetermination of the IS's eligibility.

(v) For purposes of allocation, an "assisted living" facility is considered a community setting and not an institution for long term care provided that the assisted living facility does not include 24-hour care, has privacy, a lockable door, and is a homelike setting. An IS is permitted to allocate income and resources to a CS when the CS resides in an assisted living facility.

29.11 Overview of income requirements (01/15/2017, GCR 16-098)

(a) Definition: Income. Any form of cash payment from any source received by an individual or by a member of the individual's financial responsibility group. Income is considered available and counted in the month it is received or credited to the individual with the exception of a lump sum receipt of earnings such as sale of crops or livestock. These receipts are only counted if received during the six-month accounting period and are averaged over the six-month period.

(b) Counting rules

(1) All earned and unearned income of an individual who is aged, blind or disabled and of the members of the individual's financial responsibility group is counted except income that is specifically excluded (see § 29.13) or deducted (see § 29.15). All countable income is verified.

(2) Countable income depends on the coverage group for which an individual is eligible. It is determined according to the rules at § 29.14 and compared to the highest applicable income standard. If total countable income for the Medicaid group exceeds the income standard for every coverage group in §§ 8.05 and 8.06, the individual is denied eligibility and given a spenddown (see § 30.00).

29.12 Types of income (01/15/2017, GCR 16-098)

(a) In general. This subsection describes the kinds of income considered when determining MABD eligibility.

(b) Earned income. Earned income includes the following:

(1) Gross salary, wages, commissions, bonuses, severance pay received as a result of employment.

(2) Income from self-employment (see (c) below for more information about self-employment income).

(3) Payments from Economic Opportunity Act of 1964 programs as recipients or employees, such as:

(i) Youth Employment Demonstration Act Programs;

(ii) Job Corps Program (Title I, Part A);

(iii) Work Training Programs (Title I, Part B);

(iv) Work Study Programs (Title I, Part C);

(v) Community Action Programs (Title II); and

(vi) Voluntary Assistance Program for Needy Children (Title II); and

(4) Income from:

(i) Employment under Title I of the Elementary and Secondary Education Act (e.g., as a teacher's aide, lunch room worker, etc.);

(ii) Wages from participation in the Limited Work Experience Program under the Workforce Investment Act of 1998 (29 U. S. C. §794d); and

(iii) Earnings from the Senior Community Service Employment (SCSE) program.

(c) Self-employment income

(1) Net earnings from self-employment are counted. Net earnings means gross income from any trade or business less the allowable deductions specified in § 29.15(a)(1).

(2) Tax forms are used to determine countable income from self-employment. An individual who states that the income on their tax forms is no longer reflective of their situation may submit alternate documentation.

(3) When the individual's business has been the same for several years, income reported on tax forms from the last year is used.

(4) When the individual's business was new in the previous or current year and the individual has business records, income reported on tax forms and other available business records is divided by the number of months the individual has had the business.

(5) When the individual's business has no records, is seasonal or has unusual income peaks, income reported on the individual's signed statement estimating annual income is included.

(d) Unearned income

(1) Any payment other than earned income from any source received by an individual or by a member of the individual's financial responsibility group. It is the gross payment, less allowable deductions at § 29.15(b). Periodic benefits received by an individual as unearned income are counted.

(2) Unearned income includes income from capital investments in which the individual is not actively engaged in managerial effort. This includes rent received for the use of real or personal property. Ordinary and necessary expenses of rental property such as interest on debts, state and local taxes, the expenses of managing or maintaining the property, etc. are deducted in determining the countable unearned income from this source. The deduction is permitted as of the date the expense is paid. Depreciation or depletion of property is not a deductible expense.

(3) Unearned income also includes, but is not limited to, the following:

(i) Social Security retirement, disability, SSI, or survivor benefits for surviving spouses, children of a decedent, and dependent parents;

(ii) Railroad Retirement;

(iii) Unemployment compensation;

(iv) Private pension plans;

(v) Annuities;

(vi) Interest earned on life insurance dividends;

(vii) Regular and predictable voluntary cash contributions received from friends or relatives;

(viii) Cash prizes or awards;

(ix) Withheld overpayments of unearned income, unless the overpayment was counted as income in determining Medicaid eligibility in the month received;

(x) Royalty payments to holders of patents or copyrights for which no past or present work was or is involved;

(xi) Retroactive Retirement, Survivors and Disability Insurance (RSDI) benefits for an individual with drug addiction or alcoholism (such benefits are treated as if they had all been received in a lump sum payment, even if paid in installments);

(xii) Veteran's Administration (VA) pension, compensation and educational payments that are not part of a VA program of vocational rehabilitation and do not include any funds which the veteran contributed;

(xiii) Interest payments received by the individual on an income-producing promissory note or contract (such as a property agreement or loan agreement) when the individual is the lender and the note or contract is excluded as a resource under § 29.08(d)(2).

(xiv) Alimony and support payments received; and

(xv) Death benefits received by an individual to the extent the benefits exceed what was paid by the individual for the expenses of the deceased person's last illness and burial.

29.13 Income exclusions[21] (01/15/2019, GCR 18-063)

(a) Earned income exclusions. The following are excluded from earned income:

(1) Support service payments made directly to the providers of services in the Limited Work Experience Program under the Workforce Investment Act of 1998 (29 USC § 794d) or needs-based payments of $10 per day made to participants in the program.

(2) The earned income of an individual under the age of 22 who is a student regularly attending school. This applies to wages received from regular employment, self-employment, or payments from the Neighborhood Youth Corps, Work Study and similar programs.

(3) Infrequent or irregular earned income received, not to exceed $30 per calendar quarter.

[21] See, also, § 29.08(i)(9) for income excluded by federal law.

(4) Any in-kind assistance received from others.

(5) Earned Income Tax Credit payments (both refunds and advance payments).

(6) Earned income of a working disabled individual when performing the second step of the categorically-needy eligibility test redetermining net income, set forth in § 8.05(d).

(7) Earned income of a child under the age of 18.

(8) Wages paid by the Census Bureau for temporary employment.

(b) Unearned income exclusions. Unearned income exclusions are limited to the following:

(1) Expenses incurred as a condition of receiving the unearned income. For example, guardianship fees may be deducted from unearned income if having a guardian is a requirement for receiving the income, or attorney fees and court costs may be deducted from unearned income if they were incurred in order to establish a right to the income.

(2) The following VA payments:

(i) Portion of pension or compensation payment for aid and attendance and housebound allowances, even when the provider is a spouse or a parent of the veteran;

(ii) Augmented portion of pensions, compensation or other benefits for a dependent of a veteran or a veteran's spouse;

(iii) $20 from educational benefits to the veteran funded by the government;

(iv) Educational benefits paid as either part of a plan of vocational rehabilitation or by withdrawals from the veteran's own educational fund;

(v) Clothing allowance; and

(vi) Payment adjustments for unusual medical expenses.

(3) Ordinary and necessary expenses of rental property and other capital investments except depreciation or depletion of property. This includes, but is not limited to, interest on debts, state and local taxes. The expenses of managing or maintaining the property, as of the date the expense is paid, are deductible.

(4) The first $20 per month of any unearned income unless all of the unearned income is from a source that gives assistance based on financial need.

(5) Any public agency's refund of taxes on food or real property.

(6) Infrequent or irregular unearned income received, not to exceed $60 per calendar quarter.

(7) Bills paid directly to vendors by a third party.

(8) Replacement of lost, stolen or destroyed income.

(9) Weatherization assistance.

(10) Receipts from the sale, exchange or replacement of a resource.

(11) Any assistance based on need which is funded wholly by the state, such as General Assistance.

(12) Public assistance benefits of any person who is living with the individual, as well as any income that was used to determine the amount of those benefits.

(13) Any portion of a grant, scholarship or fellowship used to pay tuition, fees or other necessary educational expenses.

(14) Home produce used for personal consumption.

(15) Assistance and interest earned on assistance for a catastrophe from the Disaster Relief and Emergency Assistance Act or other comparable assistance provided by the federal, state or local government.

(16) Irregular and unpredictable voluntary cash contributions or gifts received from friends or relatives.

(17) Payments for providing foster care for children or adults placed in the individual's home by a public or private non-profit placement agency.

(18) One-third of child support payments received for a child in the household of the individual. The remaining two-thirds of the support payments are considered the unearned income of the child received from the absent parent.

(19) Income paid for chore, attendant or homemaker services under a government program, such as Title XX personal services payments or the $90 VA Aid and Attendance payments to veterans in nursing homes.

(20) Any "in-kind" assistance received from others.

(21) Assistance provided in cash or in kind (including food, clothing, or shelter) under a government program that provides medical care or services (including vocational rehabilitation).

(22) That portion of a benefit intended to cover the financial need of other individuals, such as AABD-EP grants.

(23) Retroactive payments of SSI, AABD or OASDI benefits if the payments were included in determining financial eligibility for Medicaid in the month it was actually owed to the individual.

(24) Home energy assistance provided by a private nonprofit organization or a regulated supplier of home energy.

(25) State-administered victims' compensation payments.

(26) State or local government relocation payments.

(27) Payments occasioned by the death of another person to the extent that they are used to pay for the

deceased person's last illness and burial, including gifts and inheritances.

(28) Earned Income Tax Credit payments (both refunds and advance payments).

(29) Social security disability insurance benefits (SSDI) and veterans disability benefits provided to working disabled persons when determining categorically-needy eligibility, specified in § 8.05(d).

(30) Income from a home equity conversion plan in the month received.

(31) Dividends paid on life insurance policies.

(32) Payments made by someone other than the individual to a third-party trust for the benefit of the individual.

(33) Interest and dividend income from a countable resource or from a resource excluded under a federal statute other than § 1613 of the SSA.

(34) Any interest on an excluded burial space purchase agreement if left to accumulate as part of the value of the agreement.

(35) Any amount refunded on income taxes that the individual has already paid.

(36) Proceeds of a loan in the month received when the individual is the borrower because of the borrower's obligation to repay.

(37) Exclusions based on federal law as set forth in § 29.08(i)(9).

29.14 Determination of countable income (01/01/2018, GCR 17-047)

(a) In general

(1) The earned and unearned income of the members of the financial responsibility group is counted. Income is considered available and counted in the month it is received or credited to the member.

(2) The general approach AHS follows when it determines countable income for MABD is set forth below. These general rules apply to all individuals.

(i) Determine income of the financial responsibility group.

(ii) The income of all members of the financial responsibility group is combined, and the appropriate exclusions (see § 29.13) and standard deductions applied (see § 29.14).

(iii) Compare countable income to the applicable income standard.

(iv) An individual passes the income test when their Medicaid group's income does not exceed the appropriate PIL, or the applicable income maximum, whichever is higher. An individual with income greater than the applicable income standard may establish financial eligibility by incurring eligible medical expenses that at least equal the difference between their countable income and the applicable PIL.

(3) The following subsections specify how income is allocated and deemed based on the type of coverage sought and the size of the financial responsibility group.

(b) Financial responsibility group of one individual seeking MABD other than Medicaid coverage of long-term care services and supports under MABD. Common financial responsibility groups of one include a single adult, an individual residing in a residential care home, and a child seeking Katie Beckett coverage. AHS determines countable income for an individual seeking MABD, other than Medicaid coverage of long-term care services and supports under MABD, with a financial responsibility group of one as follows:

(1) Determine and combine the total countable unearned income of the individual.

(2) Subtract a $20 disregard (pursuant to § 29.13(b)(4)), if applicable.

(3) Deduct an allocation for each ineligible child in the household for whom the individual is financially responsible. The amount of each allocation is equal to the maximum allocation amount minus any countable income of the child. If the unearned income is not at least equal to the applicable allocation amount, any remaining allocation may be deducted from earned income.

(4) Deduct from unearned income amounts used to comply with the terms of court-ordered support or Title IV-D support payments (pursuant to § 29.15(b)), if applicable. If unearned income is insufficient, any remaining amounts may be deducted from earned income.

(5) Determine and combine the individual's countable earned income.

(6) Deduct any remaining amount of the $20 disregard, allocations for children and child support payments from the earned income.

(7) Deduct $65 from the remaining earned income.

(8) Deduct allowable work expenses for the disabled (§ 29.15(a)(3)).

(9) Deduct one-half of the remaining earned income.

(10) Deduct any allowable work expenses for the blind (§ 29.15(a)(2)).

(11) Combine the remaining earned income with any remaining unearned income.

(12) Deduct the amount of any income of a blind or disabled individual that is necessary for them to carry out a Plan to Achieve Self-Support (PASS), if applicable.

(13) The result is the individual's countable income for the month. For a child seeking Katie Beckett coverage, compare it to the institutional income standard (IIS). For all others, compare it to the protected income level (PIL) or the SSI/AABD payment standard for one, whichever is higher.

(c) Financial responsibility group of two seeking MABD other than Medicaid coverage of long-term care services and supports under MABD. Countable income for MABD for any individual with a financial responsibility group of two is determined according to the rules under paragraph (b) above, as well as the following additional rules:

(1) *Deem income at step (1)*. Earned and unearned income is deemed to the individual at step (1) from their ineligible spouse or ineligible parent, except no income is deemed to an individual from their ineligible children.

(2) *Allocate income at step (3)*. Income is allocated from the financial responsibility group to each member of the financial responsibility group who is not applying for MABD at step (3) in the following amounts:

(i) For a child, the difference between the SSI federal payment rate for one and the SSI federal payment rate for a couple is allocated. The allocation is reduced for ineligible children if they have income, unless the ineligible children are students with earned income. No allocation is made to children receiving public assistance.

(ii) For a parent in a one-parent financial responsibility group, the SSI federal payment for one is allocated.

(iii) For parents in two-parent financial responsibility groups, the SSI federal payment for two is allocated.

(3) *Count income at step (13) for an individual requesting MABD who has a spouse*. Countable income for an individual whose spouse is not requesting MABD is determined, according to the rules under paragraph (b) above, except at step (13) the countable income of the Medicaid group is compared to the PIL or the SSI/AABD payment standard for two, whichever is higher.

(d) Parent and child living together seeking MABD, other than Medicaid coverage of long-term care services and supports under MABD. These groups include a parent who is aged, blind, or disabled and a child who is blind or disabled. When a parent and a child in the same household both request MABD, countable income is determined as a financial responsibility group of two as follows:

(1) Determine the net income available to the parent following the steps under paragraph (b) if the parent is single, or under paragraph (c) if the parent has a spouse, except do not allocate any income to the eligible child. Compare the parent's income to the PIL for one or, if married, the SSI/AABD payment standard for two. If the parent's countable income is below the highest applicable income standard, the parent has passed the income test for eligibility. If the parent's income exceeds the highest applicable income standard, deem the amount of income in excess of the highest applicable income standard to the eligible child as unearned income.

(2) Determine the child's countable income by deeming any income from (1) above and then following the steps in paragraphs (e)(3)(iv) through (xiv). If the child's income is less than the PIL, both the parent and the child pass the income test for MABD eligibility.

(3) When both a parent and child have a spenddown requirement, the parent and child will pass the income test once the child's spenddown requirement has been met because the parent's excess income was deemed to the child. If the parent's spenddown requirement is less than the child's and the parent meets their spenddown requirement, the parent will become eligible. The child, however, will remain ineligible until the remainder of the child's spenddown is met. The parent's incurred eligible medical expenses are deducted from the spenddown requirements of both the parent and child because the parent's income was included in both income computations.

(e) Children seeking MABD, other than Medicaid coverage of long-term care services and supports under MABD (excluding Katie Beckett)

(1) The provisions of this paragraph generally apply when countable income for an eligible child is determined as a financial responsibility group of one. They do not apply in the following contexts:

(i) Katie Beckett (see paragraph (b) above);

(ii) A child whose parent also requests Medicaid (see paragraph (d) above); or

(iii) Medicaid coverage of long-term care services and supports under MABD (see paragraph (f) below).

(2) Since parents are financially responsible for their children, their income must be considered available to their child requesting MABD, until the child reaches the age of 18.

(3) AHS determines countable income in applicable cases as follows:

(i) Determine the total countable income, both earned and unearned, of the parents living with the child.

(ii) Deduct an allocation specified in paragraph (c)(2)(ii)(B) of (C) for the needs of the parents living in the household from the total countable income of the parents.

(iii) Deem the remaining amount to the child. If there is more than one blind or disabled child in the household, divide the remainder by the number of blind or disabled children and deem an equal portion to each. Do not deem more income to a child than the amount which, when combined with the child's own income, would bring their countable income to the PIL. If the share of parental income that would be deemed to a child makes that child ineligible because that child has other countable income, deem parental income to other blind and disabled children under age 18 in the household and no portion to the child.

(iv) Add the child's own unearned income. This is the total unearned income.

(v) Deduct the $20 disregard. This is the total countable unearned income.

(vi) Determine the earned income of the child.

(vii) Deduct the balance of the $20 disregard.

(viii) Deduct the $65 earned income exclusion from any earned income.

(ix) Deduct any allowable work expenses of a disabled child (§ 29.15(a)(3).

(x) Deduct one-half of the remaining earned income.

(xi) Deduct any allowable work expenses of a blind child (§ 29.15(a)(2).

(xii) Combine the remaining earned and unearned income.

(xiii) Deduct the amount of any income that is necessary to carry out a Plan to Achieve Self-Support (PASS), if applicable.

(xiv) The result is the child's countable income. Compare it to the PIL for one. A child with income below the PIL passes the income test.

(f) Individuals seeking Medicaid coverage of long-term care services and supports under MABD. Countable income for an individual requesting Medicaid coverage of long-term care services and supports under MABD is determined as follows:

(1) The countable income of the individual is compared to the applicable income standard for their coverage group beginning with the date of admission to long-term care.

(2) The institutional income standard (IIS) for an individual equals 300 percent of the maximum SSI federal payment to an individual living independently in the community. The IIS for a couple equals twice the IIS for an individual.

(3) When an individual is in a nursing facility and AHS has an indication that they will need long-term care for fewer than 30 days, AHS uses the PIL for the month of admission, and applies the rules for MABD other than the rules for Medicaid coverage of long-term care services and supports under MABD.

(g) Long-term care individuals in an institution

(1) Countable income for an individual seeking Medicaid coverage of long-term care services and supports under MABD in an institution is determined according to the rules under paragraph (b) above, except AHS:

(i) Allocates income to the individual's community spouse, other family members and for home upkeep, according to the rules in § 24.04;

(ii) Allocates a personal needs allowance to the individual; and

(iii) Compares the countable income of the Medicaid group to the IIS beginning with the date of admission to long-term care.

(2) For an individual whose gross income exceeds the IIS, AHS determines whether they may spend down their excess income to the PIL to establish their financial eligibility as medically needy, according to the rules at § 30.00. AHS determines whether the individual has incurred eligible medical expenses that equal the difference between their countable income and the PIL.

(h) Long-term care individuals seeking services in a home and community-based setting

(1) Countable income for an individual seeking Medicaid coverage of long-term care services and supports under MABD in a home and community-based setting is determined according to the rules under paragraph (b) above, except AHS:

(i) Allocates income to the individual's community spouse and other family members according to the rules in § 24.04; and

(ii) Allocates a community maintenance allowance to the individual; and

(iii) Approves income eligibility if the individual:

(A) Has gross income that does not exceed the IIS; or

(B) Passes the net income test for an individual working with disabilities (see § 8.05(d)).

(2) For an individual whose gross income exceeds the IIS, AHS determines whether they may spend down their excess income to the PIL to establish their income eligibility as medically needy using the rules at § 30.00. AHS determines whether the individual has incurred eligible medical expenses that equal the difference between their countable income and the PIL.

29.15 Income deductions (01/15/2017, GCR 16-098)

Deductions from earned income, including self employment, and from unearned income are allowed.

(a) Earned income deductions. A deduction of $65.00 and one-half of the remainder applies to all determinations of earned income.

(1) Business expenses. Deductions of business expenses from self-employment income are limited to the following:

(i) Operating costs necessary to produce cash receipts, such as office or shop rental; taxes on farm or business property; hired help; interest on business loans; cost of materials, livestock and equipment required for the production of income; and any business depreciation.

(ii) The cost of any meals provided to children for whom an individual provides day care in their own home, at the currently allowed rate per meal.

(iii) The actual operating expenses necessary to produce cash receipts for commercial boarding houses: an establishment licensed as a commercial enterprise that offers meals and lodging for compensation, or, in areas without licensing requirements, a commercial establishment that offers meals and lodging with the intention of making a profit.

(iv) Room and board, alone or as part of custodial care, provided that the amount shall not exceed the payment the household receives for room and board.

(v) Foster care payments made by AHS to licensed foster homes, including room and board of children in the custody of and placed by AHS when the Medicaid group includes a foster parent.

(vi) Ordinary and necessary expenses for active management of capital investments, like rental property. These may include fire insurance, water and sewer charges, property taxes, minor repairs which do not increase the value of the property, lawn care, snow removal, advertising for tenants and the interest portion of a mortgage payment.

(2) Work expenses of blind individuals. In addition to other allowable deductions, work expenses from income of a blind individual include the following[22]:

[22] Rates for mileage reimbursement are the rates established by the U.S. General Services Administration. The rates fluctuate periodically. For the current rate, refer to the U.S. General Services Administration's website at www.gsa.gov/mileage.

(i) Cost of purchasing and caring for a guide dog;

(ii) Work-related fees such as licenses, professional association dues or union fees;

(iii) Transportation to and from work including vehicle modifications;

(iv) Training to use an impairment-related item such as Braille or a work-related item such as a computer;

(v) Federal, state and local income taxes;

(vi) Social Security taxes and mandatory pension contributions;

(vii) Meals consumed during work hours;

(viii) Attendant care services;

(ix) Structural modifications to the home; and

(x) Medical devices such as wheelchairs.

(3) Work expenses of disabled individuals. In addition to other allowable deductions, work expenses from income of a disabled individual include the following[23]:

(i) Transportation to and from work, including vehicle modifications;

(ii) Impairment-related training;

(iii) Attendant care;

(iv) Structural modifications to the home; and

(v) Medical devices such as wheelchairs.

(b) Unearned income deduction

Amounts used to comply with the terms of court-ordered support or Title IV-D support payments are deducted from unearned income.

30.00 Spenddowns (01/15/2019, GCR 18-063)

(a) When the total countable income or, if applicable, resources of an individual exceeds the applicable income or resource standard for eligibility after allocations are made, and exclusions and disregards, if applicable, are applied, an individual requesting Medicaid, including Medicaid coverage of long-term care services and supports, may use the spenddown provisions set forth in this section to attain financial eligibility.

[23] Rates for mileage reimbursement are the rates established by the U.S. General Services Administration. The rates fluctuate periodically. For the current rate, refer to the U.S. General Services Administration's website at www.gsa.gov/mileage.

As stated in § 28.04(c), the income spenddown provisions under this section apply to an individual requesting MCA, including Medicaid coverage of long-term care services and supports under MCA, whose income exceeds the applicable income standard for eligibility for MCA and who is seeking MCA eligibility as medically needy and is subject to an income spenddown in order to be eligible. For this purpose, all references to "countable income" in this section shall mean the individual's MAGI-based income as described in § 28.03(d) adjusted, if applicable, by apportioning the income of financially responsible family members according to the requirements set forth in § 28.04(b). Since there is no resource test for MCA eligibility, none of the resource spenddown provisions under this section apply.

See § 7.03(a)(8)(i) for the individuals who may qualify for MCA as medically needy.

(b) Spending down is the process by which an individual incurs allowable expenses to be deducted from their income or spends resources to meet financial eligibility requirements.

(c) Spenddown is calculated using an accounting period of either one or six months, depending on the type of Medicaid services requested (see § 30.02). For purposes of calculating the spenddown for an individual requesting MCA eligibility as medically needy, other than Medicaid coverage of long-term care services and supports under MCA, a six month accounting period is used.

30.01 Definitions (01/15/2019, GCR 18-063)

(a) Accounting period. The one-month or six-month span of time used to budget the income of an individual requesting Medicaid.

(b) Community living arrangement

(1) A community living arrangement includes any residence, such as a house, apartment, residential care home, assisted living facility, boarding house, or rooming house. In a community living arrangement, the individual requesting Medicaid obtains and pays for basic maintenance items, such as food, shelter, clothing, personal needs, separately from medical care. The individual requesting Medicaid may live alone, as a member of a family, or with non-relatives.

(2) An individual requesting Medicaid coverage of long-term care services and supports is not considered to be in a community living arrangement.

(c) [Reserved]

(d) Long-term care living arrangement. An individual requesting Medicaid coverage of long-term care services and supports, including services and supports in a home and community-based setting, is considered to be in a long-term care living arrangement. Medicaid eligibility is determined according to the applicable long-term care Medicaid eligibility rules.

An individual receiving hospice services is considered to be in a long-term care living arrangement.[24] An individual receiving hospice services is:

[24] For information about hospice services, see Health Care Administrative Rules (HCAR) at § 4.227.

(1) Terminally ill;

(2) Would be eligible for Medicaid coverage of long-term care services and supports if they lived in a medical institution; and

(3) Needs additional interdisciplinary medical care and support services to enable them and their families to maintain personal involvement and quality of life in their choice of care setting and site of death.

(e) Income spenddown. The amount of qualifying medical expenses an individual must incur to reduce their excess income to the maximum applicable to their Medicaid coverage category.

(f) Resource spenddown. The amount an individual must spend to reduce their excess resources to the resource standard applicable to the appropriate Medicaid coverage category.

30.02 Accounting periods (01/15/2017, GCR 16-098)

(a) Accounting periods are based on living arrangements. The length of the accounting period used to compute spenddown requirements depends on the living arrangement of the individual requesting Medicaid. For the purposes of Medicaid eligibility, an individual may be in a community living arrangement or a long-term care living arrangement.

(b) Six-month accounting period for community living arrangement

(1) A six-month accounting period is used to determine spenddown requirements for an individual in a community living arrangement.

(2) The six-month period begins with the first month for which Medicaid is requested, usually the month of application. If Medicaid is requested for expenses incurred during any one or more of the three months preceding the month of application, the six-month period begins with the earliest of these three months in which expenses were incurred and the individual met all other eligibility requirements.

(3) To determine the amount of income an individual must spend down, AHS makes reasonable estimates of future income, subject to review and adjustment if the individual's circumstances change during the remainder of the six-month accounting period.

(c) One-month accounting period for long-term care living arrangement

(1) A one-month accounting period is used to determine spenddown requirements for an individual in a long-term care living arrangement.

(2) The one-month accounting period begins with the first calendar month during which the individual is in a long-term care living arrangement for any part of the month, applies for Medicaid coverage of long-term care services and supports for that month, and meets the general and categorical requirements for eligibility for Medicaid coverage of long-term care services and supports.

(3) The one-month accounting period ends with the last calendar month during which the individual is in a long-term care living arrangement for any part of the month and passes all other eligibility tests for Medicaid coverage of long-term care services and supports.

30.03 Spend down of excess resources and income – in general (01/15/2017, GCR 16-098)

An individual who passes all nonfinancial eligibility tests may qualify for Medicaid by spending down the income or resources, if applicable, that are in excess of the maximums applicable to them. The income and resource maximums for each MABD eligibility category are specified in the descriptions found in §§ 8.05 and 8.06. Income and resource maximums can also be found in Vermont's Medicaid Procedures Manual. The income maximums for the MCA categories are specified in the descriptions found in § 7.03(a).

30.04 Resource spenddowns (01/15/2017, GCR 16-098)

(a) Spending down excess resources

(1) An individual requesting MABD with excess resources is determined to have passed the resource test upon proof that the excess resources are no longer held as a resource and have actually been spent or given away. However, an individual with excess resources seeking Medicaid coverage of long-term care services and supports under MABD is subject to the transfer-of-resource provisions at § 25.00 if they spend or give away excess resources within the penalty period specified in § 25.04.

(2) MABD may be granted for the month of application if the resource test is passed at any point in the month and all other eligibility criteria are met. Resources may rise above the resource maximum, for example, due to interest added to bank accounts or failure to use the full monthly income amount protected for maintenance expenses during the month it is received. An individual enrolled in MABD may maintain MABD eligibility for any month in which resources exceed the resource maximum by taking any action that reduces the excess amount, including giving the excess to AHS to repay expenditures on the individual's care. As long as resources are reduced to the resource maximum before the end of the month during which resources exceed the limit, MABD continues without interruption.

(3) When a third party who handles any resources of an individual receiving MABD or of a member of the individual's financial responsibility group is unaware of a resource or its value, AHS provides uninterrupted MABD to the individual as long as the excess amount is paid to AHS as a recovery of Medicaid payments. Excess resources reimbursed to AHS in these situations will not result in ineligibility.

(b) Retroactive coverage. One or more of the following actions may be taken to reduce excess resources in order to qualify for MABD up to three months prior to the month of application as long as all other eligibility tests are passed:

(1) Set up a burial fund that meets the requirements specified in § 29.08 for an excluded resource.

(2) If countable income is less than the applicable PIL, spend resources on maintenance expenses, such as housing, food, clothing and fuel, up to a maximum per month of the difference between the countable income and the applicable PIL.

(3) Spend excess resources on covered or noncovered medical expenses.

30.05 Income spenddowns (01/15/2017, GCR 16-098)

(a) Spending down excess income on medical expenses. AHS determines that an individual requesting Medicaid with excess income has passed the income test upon proof that medical expenses have been paid or incurred

at least equal to the difference between the countable income and the applicable income maximum for the accounting period.

(b) Allowable uses of excess income. Medical expenses of any member of the individual's financial responsibility group, whether they are paid or incurred but not paid, may be used to meet the individual's income spenddown requirement; references in § 30.06 to the medical expenses of the "individual" include the medical expenses of any member of the individual's financial responsibility group.

(c) Income spenddown methodology

(1) An individual requesting Medicaid may spend their excess income down to the PIL on medical expenses following the methodology specified below to receive Medicaid as part of the medically-needy coverage group.

(2) The spenddown methodology is the same for all living arrangements, except that a one-month accounting period applies to an individual in a long-term care living arrangement and a six-month accounting period applies to an individual in a community living arrangement.

(d) Eligibility date

(1) An individual with excess income passes their income test on the first day within their accounting period that deductible medical expenses meet or exceed their spenddown requirement. Sometimes this allows for retroactive coverage.

(2) Eligibility becomes effective:

(i) On the first day of the month when a spenddown requirement is met using health insurance expenses and noncovered medical expenses.

(ii) Later than the first day of the month when a spenddown requirement is met using covered medical expenses.

(3) Special eligibility dates apply, as set forth in § 30.06, for an individual who meets their spenddown requirement using noncovered assistive community care services (ACCS).

(4) Medicaid pays for covered services on the first day that the individual's medical expenses exceed the amount of their spenddown requirement. Medicaid continues until the end of the accounting period unless the individual's situation or PIL changes.

(e) Continuing responsibility for medical expenses incurred before the eligibility date

(1) An individual remains responsible for medical expenses they incurred before the date of eligibility.

(2) When services are received from more than one provider on the day that Medicaid begins, the individual must decide which services they will be responsible for paying and which ones Medicaid will cover.

(f) Deduction sequence. Medical expenses are deducted from income in the following order:

(1) Health insurance expenses (see § 30.06(b)).

(2) Noncovered medical expenses (see § 30.06(c)).

(3) Covered medical expenses (see § 30.06(d)) that exceed limitations on amount, duration, or scope of services covered (see DVHA Rules 7201-7606).

(4) Covered medical expenses (see § 30.06(d)) that do not exceed limitations on amount, duration or scope of services covered. These must be deducted in chronological order of the date the service was received beginning with the oldest expense.

(g) Time frames for deductions

(1) Deductible medical expenses include medical expenses incurred:

(i) During the current accounting period, whether paid or unpaid;

(ii) Before the current accounting period and paid in the current accounting period, or

(iii) Before the current accounting period, remaining unpaid, and for which continuing liability can be established (see paragraph (i) of this § 30.06 for details on how to establish continuing liability).

(2) Deductible medical expenses also include medical expenses paid during the current accounting period by a state or local program other than a program that receives Medicaid funding.

(3) Medical expenses incurred before or during the accounting period and paid for by a bona fide loan, as described in (4) below, may be deducted if the expense has not been previously used to meet a spenddown requirement and the individual establishes continuing liability for the loan (see paragraph (i) of this § 30.05 for details on how to establish continuing liability) and documents that all or part of the principal amount of the loan remains outstanding at any time during the accounting period. Only the amount of the principal outstanding during the accounting period, including payments made on the principal during the accounting period, may be deducted.

(4) For purposes of this subsection, a “bona fide loan” is an obligation documented from its outset by a written contract and a specified repayment schedule.

(h) Predictable expenses. In general, an expense is incurred on the date liability for the expense begins. However, there are four types of predictable medical expenses that may be deducted before they are incurred, if it can be reasonably assumed that the expense will continue during the accounting period:

(1) Premiums on health insurance (see § 30.06(b));

(2) Medically necessary over-the-counter drugs and supplies (see § 30.06(c)(1));

(3) Ongoing, noncovered personal care services (see § 30.06(c)(3)); and

(4) ACCS provided to an individual residing in a level III residential care home which is either:

(i) Not enrolled as a Medicaid provider; or

(ii) With an admission agreement specifying the resident’s financial status as a privately-paying resident

(see § 30.06(c)(4)).

(i) Establishing continuing liability for prior medical expenses. Continuing liability for unpaid medical expenses, including liability on a bona fide loan used to pay medical expenses, incurred before the current accounting period is established when any of the following conditions is met. The liability was incurred:

(1) Within six months of the date of application or the first day of the accounting period, whichever is later.

(2) More than six months before the date of application or the first day of the accounting period, whichever is later, and there is a bill for the liability dated within 90 days of that date.

(3) More than six months before the date of application or the first day of the accounting period, whichever is later, and the service provider or lender has confirmed that the unpaid liability has not been forgiven and is not expected to be forgiven at any time within the current accounting period.

30.06 Allowable medical expenses (01/15/2017, GCR 16-098)

(a) In general

(1) Medical expenses that are the current liability of the individual and for which no third party is legally liable may be deducted from total excess income or resources for the accounting period.

(2) No medical expense may be used more than once to meet a spenddown requirement.

(3) A medical expense may be used to spend down either income or resources.

(4) If only a portion of a medical expense is used to meet the spenddown requirement for a given accounting period, that portion of the medical expense that was not used and remains a current liability may be applied toward a spenddown requirement in a future accounting period.

(5) Upon receiving coverage, the individual remains directly responsible to providers for expenses incurred before the spenddown was met.

(b) Health insurance expenses

(1) Health insurance is insurance that covers medical care and services, such as Medicare part B, and similar group or individual policies. A deduction is allowed for health insurance premiums paid by the individual if it can be reasonably assumed that health insurance coverage will continue during the accounting period. Deductions may also be allowed for other health insurance expenses, including enrollment fees and deductibles or coinsurance imposed by Medicare or other health insurance not subject to payment by a third party (such as another insurance policy). Health insurance coverage, the amount of the premium for the coverage, and any other deductible expense amounts must be verified.

(2) Premiums, or other expenses, for the following types of insurance are not deductible:

(i) Income protection or similar insurance plans designed to replace or supplement income lost due to sickness or accident; or

(ii) Automobile or other liability insurance, although these may include medical benefits for the insured

or their family.

(c) Expenses not covered by Medicaid. A deduction is allowed for necessary medical and remedial expenses recognized by state law but not covered by Medicaid in the absence of an exception for Medicaid coverage under DVHA Rule 7104. In determining whether a medical expense meets these criteria, AHS may require medical or other related information to verify that the service or item for which the expense was incurred was medically necessary and was a medical or remedial expense. The patient's physician shall verify medical necessity with a written statement or prescription specifying the need, quantity, and time period covered. Examples of medical expenses not covered by Medicaid include, but are not limited to, expenses for the services and items listed in (1) through (6) below. Any medical bills, including those incurred during a period of Medicaid eligibility, that are the current liability of the individual and have not been used to meet a previous spenddown requirement may be deducted from excess income. Generally, the individual is required to present a bill or receipt to verify that medical expenses have been incurred or paid.

(1) Over-the-counter drugs

(i) In general. Either standard deductions or actual costs, if greater, may be used to deduct noncovered over-the-counter drugs and supplies.

(ii) Documentation

(A) Documentation verifying medical necessity is not required when AHS determines that an over-the-counter drug or supply is a common remedy for the medical condition of the individual or of the member of the individual's financial responsibility group and the usage is within the maximum amount for common over-the-counter drugs and supplies.

(B) Documentation verifying medical necessity may be required whenever one or both of the following two situations apply:

(I) When the drug or supply is not a common remedy for the medical condition, or

(II) When the reported usage exceeds the maximum amount.

(iii) Amount deductible

(A) Instead of actual expenses, a reasonable estimate of ongoing expenses for over-the-counter drugs and supplies may be applied prospectively to the accounting period. Reasonable estimates of unit sizes, costs and maximums for common over-the-counter drugs and supplies used to meet the spenddown requirement are found in Vermont's Medicaid Procedures Manual.

(B) If an individual uses an ongoing expense to meet their spenddown requirement, they are not eligible to receive Medicaid coverage during that accounting period for the same expense.

(2) Transportation. Noncovered commercial and private transportation costs may be deducted.

(i) For commercial transportation, the actual cost of the transportation, verified by receipt, may be deducted.

(ii) For private transportation, either a standard deduction or the actual cost, if greater, may be used. The process set forth in Vermont's Medicaid Procedures Manual determines the deductible expense for private transportation.

(iii) The cost of transportation may be deducted without verification of medical necessity provided that:

(A) The transportation was essential to secure the medical service; and

(B) The individual was responsible for the cost and was charged an agreed-upon fee or purchased fuel to use a family-owned vehicle or other non-commercial vehicle.

(iv) Mileage reimbursement rates are the rates established by the U.S. General Services Administration. The rates fluctuate periodically. It is important to refer to the federal website in order to determine the current rate. The website is www.gsa.gov/mileage.

(3) Personal care services

(i) In general. A deduction for noncovered personal care services provided in an individual's own home or in a level IV residential care home is allowed when they are medically necessary in relation to an individual's medical condition.

(ii) Deductible personal care services. Deductible personal care services include the personal care services described in DVHA Rule 7406.2 and assistance with managing money. They also include general supervision of physical and mental well-being where a physician states such care is required due to a specific diagnosis, such as Alzheimer's disease or dementia or like debilitating diseases or injuries. Room and board is not a personal care service.

(iii) Qualified personal-care service providers

(A) Except as stated in (B) below, services may be deducted when performed by a home-health agency or other provider identified by the individual's physician as qualified to provide the service.

(B) When the service provider is living in the home, deductions may not be based on payments for personal care services provided to an individual:

(I) Under age 21 by the individual's parent, stepparent, or legal guardian, unless the individual is 18, 19, or 20 years old and payment for personal care services is made from and does not exceed the individual's own income or assets;

(II) By the individual's spouse;

(III) By the individual's sibling, child, or grandchild when the person providing the services is under age 18; or

(IV) By a parent of the individual's minor child.

(iv) Documentation

(A) To document the need for personal care services, the provider must submit:

(I) A plan of care;

(II) A list of the personal care services required;

(III) A statement that the services are necessary in relation to a particular medical condition; and

(IV) A statement that the level of care provided by the particular level IV residential care home is appropriate or, if the individual is not living in a level IV residential care home and the services are not provided by a home health agency, that the provider is qualified to provide the service.

(B) Upon the initial submission of a plan of care, it is assumed that the individual will continue to need the personal care services for the entire accounting period, unless the plan of care has specified a date by which the individual's need for services is expected to change.

A plan of care can be submitted to AHS using a form provided by AHS or using a statement, signed by the physician, that contains information sufficient, as determined by AHS, to document the individual's need for personal care services.

(C) A new plan must be submitted:

(I) Once every six months, when the provider has not specified an ongoing need for personal care services in the current plan; or

(II) Once every two years, when the physician has specified an ongoing need for personal care services in the current plan.

(D) A new plan must also be submitted:

(I) Whenever the service provider changes, unless the service is performed by a home health agency; and

(II) Whenever the need for services in relation to the individual's condition is expected to change, according to the current plan of care.

(v) Amount deductible

(A) Either standard deductions or actual costs, if greater, may be used for deducting personal-care services. Expenses that have not been incurred yet may be deducted if they are predictable and meet the requirements in § 30.05(h). Expenses also may be deducted if they have actually been incurred by the individual and are not subject to payment by Medicaid or any other third party.

(B) The standard monthly deduction for personal care services shall be deducted for each full or partial calendar month in the accounting period during which the plan of care documents the need for services. The actual documented costs of personal care services may be deducted if they exceed the monthly standard deduction. Deductions may be made for anticipated need through the end of the accounting period.

(C) All changes to these standards that result in lower standard deductions will be made via the Administrative Procedures Act.

(4) Assistive Community-Care Services (ACCS)

(i) Deductible assistive community-care services. A deduction for noncovered assistive community care services (ACCS) provided to an individual residing in a licensed level III residential care home is allowed. The individual may also deduct medically-necessary personal-care services included under the list at DVHA Rule 7406.2 but not part of the list at DVHA Rule 7411.4.

(ii) Qualified Service Providers

(A) Qualified service providers include all level III residential care homes licensed by AHS.

(B) When an individual that is a resident of a level III residential care home becomes eligible for Medicaid by projecting the cost of ACCS across part of the accounting period, the residential care home may agree to function as a Medicaid provider for ACCS with respect to that resident for the remainder of their accounting period. In these cases, the provider may bill for ACCS services no sooner than the ACCS coverage date given to the resident and the provider in a notice from AHS.

(C) When a privately-paying resident of a level III residential care home becomes eligible for Medicaid after having met a spenddown requirement by projecting the cost of ACCS across the entire accounting period, the residential care home shall not function as a Medicaid provider for ACCS with respect to that resident during the period when the resident is meeting the spenddown requirement.

(iii) Documentation

(A) Documentation verifying medical necessity is not required for ACCS. If an individual claims a deduction for medically-necessary personal-care services included under the list at DVHA Rule 7406.2 but not part of the list at DVHA Rule 7411.4 the individual's physician must submit:

(I) A plan of care (form 288B);

(II) A list of the personal care services required;

(III) A statement that the services are necessary in relation to a particular medical condition; and

(IV) A statement that the level of care provided by the particular level III residential care home is appropriate and that the provider is qualified to provide the service.

(B) Upon the initial submission of a plan of care, it is assumed that the individual will continue to need the personal care services for the entire accounting period, unless the plan of care has specified a date by which the individual's need for services is expected to change.

(C) An individual with an approved personal care services deduction must submit new plans at the same frequencies specified under paragraph (c)(3)(iv) of this subsection.

(iv) Amount deductible

(A) The deduction for ACCS may be used for the entire accounting period or part of it. Whether the standard daily or monthly deduction is used depends on the size of the spenddown requirement. The actual documented costs of ACCS may be deducted if they exceed the monthly standard deduction. Deductions may be made for anticipated need through the end of the accounting period. All changes in these standards that result in lower standard deductions will be made via the Administrative Procedures Act.

(B) If the individual's excess income and resources after deduction of all expenses for which Medicaid coverage is not available equal or exceed the deduction for ACCS for the entire accounting period, for the purposes of meeting a spenddown requirement, ACCS are projected and deducted as if they were not Medicaid-covered services for the entire accounting period. Medicaid eligibility for services other than ACCS becomes effective on the day the spenddown requirement is met. Expenses for which Medicaid coverage is not available are:

(I) Medical expenses excluded from coverage;

(II) Covered medical expenses incurred prior to the accounting period, not used to meet a previous spenddown requirement, and remaining unpaid; and

(III) Covered medical expenses incurred and paid during the current accounting period.

(C) If the individual's excess income and resources after deduction of all expenses for which Medicaid coverage is not available are less than the deduction for ACCS for the entire accounting period, ACCS expenses are not projected. Instead, they are deducted as covered expenses on a daily basis. In this case, Medicaid eligibility for all covered services other than ACCS becomes effective the first day of the accounting period. Medicaid coverage for ACCS begins later. It starts the day cumulative daily ACCS deductions exceed the individual's remaining excess income and resources. The individual is not responsible for payment of a portion of the ACCS expense on the first day of ACCS eligibility.

(D) In addition, the amount of the deduction for any services included under the list at DVHA rule 7406.2 but not part of the list at DVHA rule 7411.4 documented as medically necessary by the plan of care is determined based on the number of hours times minimum wage, or actual costs, if greater.

(5) Dental services. Dental services in excess of the allowable annual maximum may be deducted.

(6) Private-duty nursing services. Private-duty nursing services for an individual age 21 and older may be deducted.

(d) Expenses for covered medical services

(1) A covered medical service is any medical or remedial service that Medicaid would pay for if the individual were enrolled in Medicaid (see DVHA Rules 7201–7606).

(2) Deductions for covered medical services are not limited to the Medicaid reimbursement for the service. The actual cost paid or incurred is allowed. A standard deduction may be taken for ACCS (see DVHA Rule 7411.4), as set forth in Vermont's Medicaid Procedures Manual.

(e) Third-party coverage

(1) No deduction is allowed if the medical expense is subject to payment by a third party such as health insurance, worker's compensation, liability award, or other benefit program unless the third party is a state or local program other than Medicaid.

(2) When a third party is liable for all or some medical expenses, only the portion owed by the individual may be deducted. AHS is required to take reasonable measures to determine the legal liability of third parties to pay for incurred expenses. Estimates of payment by the third party may be used if actual third party liability cannot be ascertained within the period for determining Medicaid eligibility. An eligibility determination may not be delayed simply because actual third party liability cannot be ascertained or payment by the third party has not been received.

(3) If an individual is pursuing a liability award, but liability has not yet been established, a deduction is allowed. Eligibility must be based on AHS's estimate of the amount the individual owes for the bill.

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Part Six
Small Employer Health-Benefits Program Rules

31.00 Definitions (08/01/2016, 16-02)

	As used only in Part Six, the following terms have the following meanings:
Annual employee open enrollment period[1]	A period in which a qualified employee enrolling in a qualified health plan through Vermont Health Connect (VHC) may: (a) Create an account; (b) Select QHPs, and if offered by the employer, stand-alone dental coverage for himself/herself, and dependents, if the qualified employer offers coverage to dependents; (c) Complete the employee eligibility and enrollment application; (d) Receive assistance from VHC in completing the application; (e) Estimate whether the coverage offered by the employer meets applicable federal affordability standards, by (1) exiting the employee application; and (2) submitting an application for individual eligibility determination for affordability assistance to purchase coverage as a qualified individual; (f) Designate an authorized representative according to Section 5.02. The annual employee open enrollment period shall precede the end of the employer's current plan year and shall follow the annual employer election period.
Annual employer election period[2]	The employer election period comes before both the employee open enrollment period and the completion of the employer's current plan year. During the employer election period, the qualified employer may change its participation in VHC for the next plan year, and elect the following: (a) The employees to whom it will offer coverage; (b) Whether to offer coverage to the qualified employee's dependents, and the coverage tiers to offer, i.e., single, two-person, adult plus dependent, or family; (c) Whether to offer stand-alone dental coverage;

[1] 45 CFR § 155.725(e)

[2] 45 CFR § 155.725(c).

	(d) Whether the individual owners, partners, retirees, or others will participate in a plan offered to employees; (e) During the election period employers will be able to go on the VHC website and use the available tools for assistance in deciding whether to offer their employees group health coverage. (f) The method by which the qualified employer makes QHPs available to qualified employees (see: employer choice, section 34.00); and (g) The amount of its contribution towards the premium cost of each coverage tier for each class of participant.
Dependent	Any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a participant.[3]
Employee[4]	Any individual employed by an employer. An employee does not include an individual and his or her spouse with respect to a trade or business, whether incorporated or unincorporated, which is wholly owned by the individual or by the individual and his or her spouse, and does not include a partner in a partnership and his or her spouse.
Employer[5]	(a) The term "employer" means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan. (b) Such term includes employers with one or more employees, and (c) All persons treated as a single employer such as a controlled group of corporations; partnerships, proprietorships, etc., which are under common control; affiliated service groups; and other arrangements such as separate organizations and employee leasing arrangements.[6]
Full-time employee[7]	(a) An employee who is employed on average at least 30 hours of service per week, for effective plan years beginning on or after January 1, 2014. (b) For purposes of the definition of small employer, full-time employee does not include seasonal workers. (c) For purposes of the definition of qualified employer, full-time employee does not include

[3] 45 CFR § 144.103.

[4] 45 CFR § 155.20. [45 CFR §155.20 applies the definition in 42 U.S.C. 300gg-91(d)(6) which applies the definition in 29 U.S.C. §1002(6) explained at 29 CFR § 2510.3–3.]

[5] 45 CFR § 155.20. [Applies the definition in PHSA §2791, 42 U.S.C. 300gg-91(d)(5) which applies the definition in 29 U.S.C. §1002(5).]

[6] 45 CFR § 155.20 referencing 26 U.S.C. § 414.

[7] 45 CFR § 155.20.

	seasonal employees.
Qualified employee[8]	An employee made eligible to enroll in coverage through VHC through an offer of coverage from a qualified employer.
Qualified employer[9]	A qualified employer is a small employer that: (a) Has its principal place of business in Vermont, and elects to provide coverage for all full-time employees of such employer through VHC, regardless of where an employee resides; or (b) Elects to provide coverage through VHC for all of its full-time employees who are principally employed in Vermont, and if not principally employed in Vermont, to each full-time employee through the small business health options program (SHOP) serving that employee's primary worksite.
Seasonal employee[10]	The term seasonal employee means an employee who is hired into a position for which the customary annual employment is six months or less and the employee does not have any hour of service for the employer for a period of at least 13 consecutive weeks before resuming employment Customary means that by the nature of the position an employee in this position typically works for a period of six months or less, and that period should begin each calendar year in approximately the same part of the year, such as summer or winter.[11] In certain unusual instances, the employee can still be considered a seasonal employee even if the seasonal employment is extended in a particular year beyond its customary duration (regardless of whether the customary duration is six months or is less than six months). For example, if ski instructors at a resort have a customary period of annual employment of six months, but are asked in a particular year to work an additional month because of an unusually long or heavy snow season, they would still be considered seasonal employees.[12] Employers may but are not required to provide seasonal employees with coverage for purposes of being a qualified employer.

[8] 45 CFR §155.20.

[9] 33 V.S.A. §§1802, 1804; 45 CFR § 155.710, 26 U.S.C 4980H(c)(2)(B)(ii) provides that an employer shall not be considered to employ more than 50 full-time employees if the employer's workforce exceeds 50 full-time employees for 120 days or fewer during the calendar year, and the employees in excess of 50 employed during such 120-day period were seasonal workers.

[10] 45 CFR § 155. 20; 26 USC § 4980H(c)(4); 26 CFR § 54.4980H-1(a)(38) .

[11] Shared Responsibility for employers regarding health coverage, 79 FR 8544, 8593 (Feb. 12, 2014).

[12] Shared Responsibility for employers regarding health coverage, 79 FR 8544, (Feb. 12, 2014).

Seasonal worker[13]	An employee who performs labor or services on a seasonal basis, including ordinarily, when the employment pertains to or is of the kind exclusively performed at certain seasons or periods of the year and which, from its nature, may not be continuous or carried on throughout the year. A worker who moves from one seasonal activity to another, while employed in agriculture or performing agricultural labor, is employed on a seasonal basis even though she may continue to be employed during a major portion of the year. Seasonal workers include retail workers employed exclusively during holiday seasons. Seasonal workers are not counted when determining whether an employer is a small employer.
Small employer[14]	(a) For plan years beginning on or after January 1, 2014 through December 31, 2015, an entity which employed an average of at least 1 but not more than 50 full-time employees on working days during the preceding calendar year and who employs at least one employee on the first day of the plan year. (b) Beginning on January 1, 2016, an entity which employed an average of at least 1 but not more than 100 employees on working days during the preceding calendar year and which employs at least 1 employee on the first day of the plan year. The number of employees shall be calculated using the method set forth in section 4980H(c)(2) of the Internal Revenue Code; in general, by: (1) Counting each full-time employee as one employee; (2) Adding the number of hours worked by part-time employees in a month and dividing by 120; and (3) Excluding seasonal workers if the employer's workforce exceeds 50 full-time employees for 120 days or fewer during the calendar year.
32.00 Employer eligibility (08/01/2016, 16-02)	
(a) Employer's continuing eligibility[15]	A qualified employer which ceases to be a small employer solely because of an increase in the number of employees shall continue to be treated as a qualified employer until the qualified employer otherwise fails to meet eligibility criteria or elects to no longer purchase coverage for qualified employees through VHC.
(b) Employer eligibility requirements[16]	To the extent permitted by HHS: (1) VHC shall permit small employers to purchase QHPs directly from a health insurer under contract with VHC. (2) Upon request, VHC must provide a small employer with an eligibility determination as

[13] 33 V.S.A. § 1804, citing definition in 26 U.S. Code § 4980H, 26 CFR § 54.4980H-1(a)(39), citing 9 C.F.R § 500.20(s)(1).

[14] 26 U.S.C. § 4980H(c)(2); 42 U.S.C. § 18024(b); 45 CFR §155.20; 33 V.S.A. §§1804, 1811(a)(3).

[15] 45 CFR § 155.710(d).

[16] 33 V.S.A. § 1803(b)(4); 45 CFR § 155.710(b), § 155.715(a).

	to whether it is a qualified employer with a notice of approval or denial of eligibility and the employer's right to appeal such eligibility determination. VHC may accept an employer's attestation of eligibility as eligibility is defined in §§ 31.00 and 32.00(b) instead of determining the employer's eligibility.
(c) Employer application[17]	VHC must use a single application to determine employer eligibility and to collect information necessary for purchasing coverage. Such application must collect the following: (1) Employer name and address of employer's locations; (2) Number of full time employees; (3) Employer Identification Number (EIN); and (4) A list of qualified employees and their taxpayer identification numbers.
(d) Filing the application[18]	VHC must provide the tools to file an application (1) Via an Internet Web site; (2) By telephone through a call center; (3) By mail; and (4) In person, with reasonable accommodations for those with disabilities.
(e) Verification of eligibility[19]	For the purpose of verifying employer eligibility VHC: (1) May establish, in addition to or in lieu of reliance on the employer application or attestation, additional methods to verify the information provided by the employer on the application; and (2) Must collect only the minimum information necessary for verification of eligibility in accordance with the eligibility standards described in §§ 31.00, and 32.00(a).
(f) Eligibility adjustment period[20]	When the information submitted on the VHC employer application is inconsistent with the eligibility definitions and standards described in §§ 31.00, 32.00(b), and 33.00, VHC must: (1) Make a reasonable effort to identify and address the causes of such inconsistency, including as a result of typographical or other clerical errors; (i) A reasonable effort by VHC includes resolution of VHC errors, and

[17] 45 CFR § 155.730(b), (d), (e).

[18] 45 CFR § 155.405(c)

[19] 45 CFR § 155.715(c).

[20] 45 CFR § 155.715(d).

	(ii) VHC outreach to the employer contact, as necessary; (2) Issue a written notice to the employer if the inconsistency remains unresolved after reasonable efforts have been made by VHC to resolve the inconsistency; (3) Provide the employer with a period of 30 days from the date on which the notice described in paragraph (f)(2) of this section is sent to the employer to either present satisfactory documentary evidence to support the employer's application, or resolve the inconsistency; and (4) If, after the 30-day period described in paragraph (3) VHC has not received satisfactory documentary evidence, VHC must: (i) Notify the employer of its denial of eligibility in accordance with this subsection, 32.00(f), and of the employer's right to appeal such determination; and (ii) If the employer was enrolled pending the confirmation or verification of eligibility information, discontinue the employer's participation in VHC at the end of the month following the month in which the notice is sent.
(g) Notice of employer eligibility determination[21]	Upon request, VHC must provide a small employer with an eligibility determination as to whether it is a qualified employer and a notice of approval or denial of eligibility, and the employer's right to appeal such eligibility determination.
33.00 Employee eligibility (07/15/2015, 15-02)	
(a) Eligibility to enroll in VHC[22]	(1) A qualified employee is eligible to enroll in employer sponsored coverage through VHC if that employee receives an offer of coverage from a qualified employer. A qualified employee is eligible to enroll his or her dependents in coverage through VHC if the offer from the qualified employer includes an offer of dependent coverage. (2) An individual and his or her spouse with respect to a trade or business, whether incorporated or unincorporated, which is wholly owned by the individual and his or her spouse may participate and enroll in any qualified health plan that he or she is offering to at least one qualified employee. (3) A member of a partnership that is a qualified employer may participate and enroll in any qualified health plan that the partnership is offering to at least one qualified employee.
(b) Employee application[23]	VHC must use a single application for eligibility determination, QHP selection, and enrollment for qualified employees, and their dependents (if the employer offers dependent coverage).

[21] 45 CFR § 155.715(e).

[22] 45 CFR § 155.710(e), 77 FR 18399 (March 27, 2012).

[23] 45 CFR § 155.730(c), (d), (e).

(c) Employee application verification[24]	For the purpose of verifying employer and employee eligibility, VHC (1) Must verify that an individual applicant is identified by the employer as an employee to whom the qualified employer has offered coverage and must otherwise accept the information attested to within the application unless the information is inconsistent with the employer-provided information; (2) May establish, in addition to or in lieu of reliance on the application, additional methods to verify the information provided by the applicant on the application; and (3) Must collect only the minimum information necessary for verification of eligibility in accordance with the eligibility standards described in § 33.00(a)(1).
(d) Eligibility adjustment period.[25]	For an employee requesting eligibility to enroll in a QHP through VHC for whom VHC receives information on the application inconsistent with the employer provided information, VHC must— (1) Make a reasonable effort to identify and address the causes of such inconsistency, including as a result of typographical or other clerical errors; (2) Notify the individual of the inability to substantiate his or her employee status; (3) Provide the employee with a period of 30 days from the date on which the notice described in subsection (2) is sent to the employee to either present satisfactory documentary evidence to support the employee's application, or resolve the inconsistency; and (4) If, after the 30-day period described in subsection (3), VHC has not received satisfactory documentary evidence, VHC must notify the employee of its denial of eligibility in accordance with this subsection, 33.00(f).
(e) Employee information safeguarded[26]	VHC shall not provide to the employer any information collected on the employee application with respect to spouses or dependents other than the name, address, and birth date of the spouse or dependent.
(f) Notification of employee eligibility.[27]	For an employee requesting an eligibility determination as to whether the employee is a qualified employee, VHC must notify the employee and employer of the determination and the employee's right to appeal such eligibility determination.
34.00 Employer choice[28] (08/01/2016, 16-02)	

[24] 45 CFR § 155.715(c).

[25] 45 CFR § 155.715(d).

[26] 45 CFR § 155.730(g).

[27] 45 CFR § 155.715(f).

[28] 45 CFR § 155.705(b)(2), (b)(3).

Two models of employer choice	(a) Except as provided for in 34.00(c), a qualified employer may offer QHPs on VHC to its employees and at the employer's option to the employees' dependents[29] in one of the following ways: (1) Permitting the qualified employee to select any plan from among all QHPs offered on VHC; or (2) Permitting the qualified employee to select any QHP offered on VHC by one issuer of the employer's choice; (b) A qualified employer may choose to offer in addition to QHPs any stand-alone dental plans offered on VHC to its eligible employees and at the employer's option to their dependents.
35.00 Employee enrollment waiting periods[30] (07/15/2015, 15-02)	
	(a) A group health plan or health insurance issuer offering group health insurance coverage shall not apply any enrollment waiting period that exceeds 90 days. (b) Eligibility conditions that are based solely on the lapse of a time period are permissible for no more than 90 days. (c) [Reserved]
36.00 Rolling enrollment and short plan years[31] (07/15/2015, 15-02)	

[29] IRS Notice 2013-45. Applicable large employers may be subject to an assessable payment by the IRS for failing to offer its minimum essential coverage to their full-time employees and their employees' dependents which for purpose of the penalty does not mean spouses. Notice 2013-45 states that no employer shared responsibility payments will be assessed for 2014.

[30] 45 CFR § 147.116.

[31] 45 CFR § 155.725(b).

	(a) Qualified employers' plan years must be on a calendar year term beginning January 1, 2015. (b) VHC will permit a qualified employer to purchase coverage for its small group at any point during the year. The plan year will end on December 31 of the calendar year in which coverage first became effective. (c) In 2016, qualified employers with 51 to 100 employees will be eligible to enroll in a QHP for the first time and may experience a short plan year. (i) QHP issuers may provide transitional relief to employers renewing during the 2015 plan year which have a short subsequent plan year as a result of becoming a small employer, by extending cost share accumulators into the short 2016 plan year.
37.00 Employer election period (07/15/2015, 15-02)	
(a) Annual employer election period [32]	VHC will provide qualified employers with a standard election period prior to the completion of the employer's plan year and before the annual employee open enrollment period.
(b) Notice of election period[33]	VHC shall ensure that employers are notified of the annual election period in advance of the start of the employer election period.
38.00 Employee enrollment periods[34] (07/15/2015, 15-02)	
(a) Employee enrollment periods, generally	(1) Employees will have the opportunity to select qualified health plans, and a stand-alone dental plan if the employer offers dental coverage, verify and provide necessary personal information for enrollment of himself or herself and his or her dependents, if the employer offers coverage to employee dependents, and make changes to enrollment. (2) VHC may only permit a qualified employee to enroll in a QHP or an enrollee to change QHPs during initial, annual, or special open enrollment periods.
(b) Annual open enrollment period[35]	VHC will provide a standardized annual open enrollment period for qualified employees prior to the completion of the applicable qualified employer's plan year and after that employer's annual election period.
(c) Notice of annual	VHC must provide notification to a qualified employee of the annual open enrollment period in

[32] 45 CFR § 155.725(c).

[33] 45 CFR § 155.725(d).

[34] 45 CFR §155.410; §45 CFR §155.725.

[35] 45 CFR §155.725(e).

open enrollment period[36]	advance of the open enrollment period.
(d) Newly qualified employees enrollment period[37]	For an employee who becomes a qualified employee outside of the initial or annual open enrollment period, a 30-day enrollment period begins on the first day of becoming a qualified employee. The enrollment period must end no sooner than 15 days prior to the date that any applicable employee waiting period longer than 45 days would end if the employee made a plan selection on the first day of becoming eligible.
39.00 Employee special enrollment periods (08/01/2016, 16-02)	
(a) Events resulting in a special enrollment period[38]	(1) VHC must allow qualified employees or their dependents to enroll in or change from one QHP to another as a result of the following triggering events: (i) An event described in § 71.03(d)(1), (2), (4), (5), (7), (8), or (9); (ii) A qualified employee or dependent loses eligibility for coverage under a Medicaid plan under title XIX of the Social Security Act or a state child health plan under title XXI of the Social Security Act; or (iii) A qualified employee or dependent becomes eligible for premium assistance with a small employer plan under such Medicaid plan or a state child health plan (including any waiver or demonstration project conducted under or in relation to such a plan). (2) A dependent of a qualified employee is not eligible for a special enrollment period if the employer does not extend the offer of coverage to dependents.
(b) Duration of special enrollment periods[39]	A qualified employee or dependent of a qualified employee who experiences a qualifying event described above has 60 days from the date of a triggering event to select a QHP through VHC.
(c) Loss of minimum essential coverage.[40]	Loss of minimum essential coverage is determined using the provisions of § 71.03(e).
40.00 Enrollment (07/15/2015, 15-02)	

[36] 45 CFR §155.725(f).

[37] 45 CFR §155.725(g).

[38] 45 CFR §155.725(j).

[39] 45 CFR §155.725(j).

[40] 45 CFR §155.725(j); 45 CFR § 155.420(e); 26 CFR § 54.9801-6(a)(3)(i-iii).

(a) Generally	(1) VHC must ensure that employee coverage shall be effective for the coverage effective date selected by the employer on its application during the employer election period, if VHC receives all necessary enrollee information by the employee plan selection deadline, and payment is made in full. (2) Upon receipt of full payment, VHC must transfer enrollment information to issuers on or before the next non-holiday business day. (3) For employers choosing to direct enroll with the issuers, employee coverage shall be effective for the coverage effective date agreed upon by the employer and the issuer.
(b) New enrollments	(1) The effective date of coverage for a QHP selection received by VHC from a newly qualified employee being added to an employer's plan will be the first day of a month following plan selection, unless the employee is subject to a waiting period consistent with § 35.00, in which case the effective date may be on the first day of a later month, but in no case may the effective date fail to comply with § 35.00. (2) For plan selections received by VHC within the last five days of the month, VHC will transfer enrollment information and QHP issuer will effectuate coverage without undue delay and, if necessary, retroactive to the effective date in (1) of this subsection.

41.00 Coverage effective dates[41] (07/15/2015, 15-02)

(a) Generally	(1) Coverage will become effective on the employer selected date provided full payment is received by VHC by the due date on the invoice of the month before the coverage month, except that (2) When a qualified employee is eligible to make, and makes a plan selection during a special enrollment period, coverage will become effective under (c) of this section, and (3) Coverage for a newly qualified employee being added to an employer's plan will become effective under § 40.00(b).
(b) Coverage effective dates generally, for plan years beginning on or after January 1, 2015	(1) VHC shall ensure a coverage effective date of January 1st for a QHP selection received by VHC from a qualified employee on or before November 30 of the year before a plan year beginning January 1, 2015, and subsequent years as long as payment is received in accordance with (a) of this section. (2) For an employer choosing to direct enroll with a QHP issuer, an issuer may provide a January 1 coverage effective date for a plan selection made by a qualified employee after November 30.
(c) Employee special enrollment period	The effective dates of coverage are determined using the provisions of § 70.03(b)(2).

[41] 45 CFR § 155.725(h).

coverage effective dates[42]	
(d) Notification of effective date[43]	VHC must ensure that a QHP issuer notifies a qualified employee enrolled in a QHP of the effective date of coverage.
42.00 Renewal of employee coverage[44] (07/30/2014, 14-04)	
	If a qualified employee enrolled in a QHP through VHC remains eligible for coverage, such employee will remain in the QHP selected the previous year unless: (a) The qualified employee terminates coverage from such QHP; (b) The qualified employee enrolls in another QHP; or (c) The QHP is no longer available to the qualified employee.
43.00 Terminations[45] (07/15/2015, 15-02)	
(a) In general	The provisions of this section apply when enrollment in a QHP takes place through Vermont Health Connect.
43.01 Employer withdrawal from VHC[46] (08/01/2016, 16-02)	
(a) Employer withdrawal	A qualified employer may withdraw from coverage through VHC with advance notice in accordance with applicable state and federal law.

[42] 45 CFR §155.725(j)(5); 45 CFR § 155.420(b)

[43] 45 CFR §155.720(e).

[44] 45 CFR §155.725(i).

[45] 45 CFR § 155.735, 156.285(d).

[46] 45 CFR § 155.715(g), 155.735(b).

(b) Employee notice of termination	VHC will ensure that: (1) Each QHP issuer terminates the enrollment through VHC of the employer's qualified employees enrolled in the QHP through VHC. (2) Each of the employer's qualified employees enrolled in a QHP through VHC is notified of the termination of coverage prior to such termination. (i) Such notification provides information about other potential sources of coverage, including access to individual market coverage through VHC.
43.02 Termination of employer group for non-payment of premiums[47] (07/15/2015, 15-02)	
(a) Conditions under which QHP issuer may terminate coverage	(1) If premium payment is not received one month from the first of the coverage month, the QHP issuer may terminate the qualified employer for lack of payment provided notice requirements in 43.06 are met.
(b) Reinstatement	(1) The QHP issuer must reinstate the qualified employer in its previous coverage if the qualified employer: (i) Requests reinstatement within 30 days following its termination for non-payment, (ii) Pays all premiums owed including any prior premiums owed for coverage during the one month grace period, and (iii) Pays the premium for the next month's coverage. (2) Reinstatement is not allowed more than twice within a plan year. Upon a third instance of termination for non-payment, a qualified employer may not re-enroll until the following calendar year. (3) VHC will ensure that the employer's qualified employees enrolled in a QHP through VHC are notified of the group's reinstatement.
(c) Payment for COBRA Continuation Coverage	Nothing in this section modifies existing obligations related to the administration of coverage required under 29 U.S.C. 1161, *et seq.,* as described in 26 CFR part 54.

[47] 45 CFR §155.735(c), 156.285(d).

43.03 Termination of employee or dependent coverage[48] (07/15/2015, 15-02)	
(a) Termination due to loss of eligibility	(1) If a qualified employee or their dependent is no longer eligible for coverage under the employer's group health plan, VHC will notify the QHP issuer of the loss of eligibility.
(b) Employee voluntary termination	(1) To the extent permitted by the qualified employer and allowable under applicable state and federal law,[49] VHC will allow an employee to terminate his or her coverage in a QHP, including as a result of the employee obtaining other minimum essential coverage, with fourteen day notice to VHC. (2) VHC will: (i) Notify the employee's employer of employee termination.[50] (ii) Notify the QHP issuer of employee termination. (3) The last day of coverage is the last day of the month in which VHC receives notice in accordance with (1), unless employee requests and QHP issuer agrees to an earlier termination effective date.
43.04 Termination effective dates (07/15/2015, 15-02)	
(a) Other termination effective dates	The effective dates of termination resulting from events not described in this section are determined using the provisions of § 76.00(d).
43.05 Termination of coverage tracking and approval[51] (07/15/2015, 15-02)	
(a) Termination of coverage tracking and approval	VHC and QHP issuers must maintain records of termination of coverage in compliance with § 76.00(c).
43.06 Notice of Termination[52] (07/15/2015, 15-02)	
(a) Employee notice	(1) If a qualified employee or their dependent is terminated from coverage due to non-payment of premiums or due to a loss of eligibility to participate in VHC, including where an employee loses his or her eligibility because a qualified employer has lost its eligibility, VHC will ensure that the employee is notified of the termination.

[48] 45 CFR §155.735(d).

[49] See, e.g., 26 CFR § 1.125-4.

[50] 45 CFR § 155.720(h).

[51] 45 CFR §155.735(e).

[52] 45 CFR §155.735(g).

	(2) The notice will include the termination effective date, reason for termination, and information about other potential sources of coverage, including access to individual market coverage through VHC. (3) The notice will be sent within 3 business days of the determination to terminate coverage, if an electronic notice is sent, and within 5 business days if a mailed hard copy notice is sent.
(b) Employer notice	(1) If an employer group's coverage or enrollment through VHC is terminated due to non-payment of premiums or, where applicable, due to a loss of the qualified employer's eligibility to offer coverage through VHC, VHC will ensure that the employer is notified of the termination. (2) Such notice will include the termination effective date and reason for termination. (3) Such notice will be sent within 3 business days of the determination to terminate coverage, if an electronic notice is sent, and within 5 business days if a mailed hard copy notice is sent.
(c) Notices to dependents	When a primary subscriber and his or her dependents live at the same address, a separate termination notice need not be sent to each dependent at that address, provided that the notice sent to each primary subscriber at that address contains all required information about the termination for the primary subscriber and his or her dependents at that address.
44.00 Employer and employee eligibility appeals[53] (08/01/2016, 16-02)	
(a) Employer right to appeal	An employer may appeal: (1) A notice of denial of eligibility under § 32.00(g); or (2) A failure of the VHC to provide a timely eligibility determination or a timely notice of an eligibility determination in accordance with § 32.00(g).
(b) Employee right to appeal	An employee may appeal: (1) A notice of denial of eligibility under § 33.00(f); or (2) A failure of the VHC to provide a timely eligibility determination or a timely notice of an eligibility determination in accordance with § 33.00(f).
(c) Notices	Notices of the right to appeal a denial of eligibility must be written and include — (1) The reason for the denial of eligibility, including a citation to the applicable regulations; and (2) The procedure by which the employer or employee may request an appeal of the denial

[53] 45 CFR §155.740.

	of eligibility.
(d) Appeal request	VHC and AHS must: (1) Allow an employer to request an appeal within 90 days from the date of the notice of denial of eligibility. (2) Accept appeal requests submitted — (i) By telephone; (ii) By mail; or (iii) Via the Internet. (3) Assist the applicant or enrollee in making the appeal request, if requested. (4) Not limit or interfere with the applicant's right to make an appeal request; and (5) Consider an appeal request valid if it is submitted within 90 days from the date of the notice of denial of eligibility.
(e) Notice of appeal request	Upon receipt of a valid appeal request, AHS must — (1) Send timely acknowledgement to the employer of the receipt of the appeal request, including — (i) An explanation of the appeals process; and (ii) Instructions for submitting additional evidence for consideration by AHS. (2) Promptly notify VHC of the appeal, if the appeal request was not initially made to VHC. (3) Upon receipt of an appeal request that is not valid because it fails to meet the requirements of this section, AHS must — (i) Promptly and without undue delay, send written notice to the employer or employee that is appealing that — (A) The appeal request has not been accepted, (B) The nature of the defect in the appeal request; and (C) An explanation that the employer or employee may cure the defect and resubmit the appeal request within 90 days from the date of the notice of denial of eligibility, or within a reasonable timeframe established by AHS. (ii) Treat as valid an amended appeal request that meets the requirements of this section.
(f) Transmittal and receipt of records	(1) Upon receipt of a valid appeal request VHC must promptly transmit, via secure electronic interface, to AHS — (i) The appeal request, if the appeal request was initially made to VHC; and

	(ii) The eligibility record of the employer or employee that is appealing. (2) AHS must promptly confirm receipt to VHC of the records VHC transmitted.
(g) Dismissal of appeal	AHS: (1) Must dismiss an appeal if the employer that is appealing — (i) Withdraws the request in writing; or (ii) Fails to submit an appeal request 90 days from the date of the notice of denial of eligibility to AHS. (2) Must provide timely notice to the employer or employee that is appealing of the dismissal of the appeal request, including the reason for dismissal, and must notify VHC of the dismissal. (3) May vacate a dismissal if the employer or employee makes a written request within 30 days of the date of the notice of dismissal showing good cause why the dismissal should be vacated.
(h) Procedural rights of the employer and employee	AHS must provide the employer, or the employer and employee if an employee is appealing, the opportunity to submit relevant evidence for review of the eligibility determination.
(i) Adjudication of VHC appeals	Employer or employee appeals must: (1) Be reviewed *de novo* by one or more impartial officials who have not been directly involved in the employer or employee eligibility determination implicated in the appeal, and (2) Consider the information used to determine the employer or employee's eligibility as well as any additional relevant evidence submitted during the course of the appeal by the employer or employee.
(j) Appeal decisions	Appeal decisions must: (1) Be based solely on (i) The evidence referenced in (h)(2) of this section, and (ii) The employer and employee eligibility requirements for VHC. (2) State the decision, including a plain language description of the effect of the decision on the appellant's eligibility; (3) Summarize the facts relevant to the appeal; (4) Identify the legal basis, including the regulations that support the decision; (5) State the effective date of the decision; and (6) Be effective as follows:

	(i) If an employer is found eligible under the decision, then at the employer's option, the effective date of coverage or enrollment through VHC under the decision can either be made retroactive to the effective date of coverage or enrollment through VHC that the employer would have had if the employer had been correctly determined eligible, or prospective to the first day of the month following the date of the notice of the appeal decision. (ii) For employee appeal decisions only, if an employee is found eligible under the decision, then at the employee's option, the effective date of coverage or enrollment through VHC under the decision can either be made effective retroactive to the effective date of coverage or enrollment through VHC that the employee would have had if the employee had been correctly determined eligible, or prospective to the first day of the month following the date of the notice of the appeal decision. (iii) If the employer or employee is found ineligible under the decision, then the appeal decision is effective as of the date of the notice of the appeal decision.
(k) Notice of appeal decision	AHS must issue written notice of the appeal decision to the employer or to the employer and employee if an employee's eligibility is implicated, and to VHC within 90 days of the date the appeal request is received.
(l) Implementation of VHC appeal decisions	VHC must promptly implement the appeal decision upon receiving the notice of appeal decision under (j) of this section.
(m) Appeals record	(1) Subject to the requirements of all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information the appeal record must be accessible to the employer, or employer and employee if an employee's eligibility is implicated, in a convenient format and at a convenient time. (2) AHS must provide public access to all appeal records, subject to all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information.
45.00 Employer appeals of employee eligibility for APTC/CSR[54] (08/01/2016, 16-02)	
(a) Notice to an employer of employee's receipt of APTCs and CSRs	VHC will notify an employer that an employee has been determined eligible for advance payments of the premium tax credit and cost-sharing reductions and has enrolled in a qualified health plan through VHC in accordance with § 71.01(e).
(b) Employer Right to appeal	An employer may, in response to a notice of an employee's eligibility for advance payments of the premium tax credit and cost-sharing reductions to an employer, appeal a determination that the employer does not provide minimum essential coverage through an employer sponsored plan or that the employer does provide that coverage but it is not affordable coverage with

[54] 45 CFR § 155.555.

	respect to an employee. The employer will file the appeal with the HHS appeals entity or other entity as directed by VHC in the notice in (a) of this section.
46.00 Premium processing (07/30/2014, 14-04)	
(a) Premium aggregation	VHC must perform the following functions related to premium payment administration: (1) Provide each qualified employer with a bill on a monthly basis that identifies the employer contribution, the employee contribution, and the total amount that is due to the QHP issuers from the qualified employer; (2) Collect from each employer the total amount due and make payments to QHP issuers for all enrollees; and (3) Maintain books, records, documents, and other evidence of accounting procedures and practices of the premium aggregation program for each benefit year for at least 10 years.
(b) QHP issuers must accept VHC payments	QHP Issuer must accept payment from the VHC on behalf of a qualified employer or an enrollee.
47.00 [Reserved] (07/30/2014, 14-04)	
48.00 [Reserved] (07/30/2014, 14-04)	
49.00 [Reserved] (07/30/2014, 14-04)	
50.00 [Reserved] (07/30/2014, 14-04)	

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Part Seven
Eligibility-and-Enrollment Procedures

Part Seven sets forth the application processing and enrollment requirements for health benefits, including verification of eligibility factors, determination of premium assistance amounts, billing and collection of premiums, and periodic renewals of eligibility.

51.00 Automatic entitlement to Medicaid following a determination of eligibility under other programs[1] (01/15/2017, GCR 16-100)

A separate application for Medicaid is not required from an individual who receives SSI or AABD.

52.00 Application[2] (01/01/2018, GCR 17-048)

52.01 In general (01/15/2017, GCR 16-100)

An individual will be afforded the opportunity to apply for health benefits at any time, without delay.[3]

52.02 Application filing[4] (01/01/2018, GCR 17-048)

(a) The application. A single, streamlined application will be used to determine eligibility and to collect information necessary for:

(1) Enrollment in a QHP;

(2) APTC;

(3) CSR;

(4) Vermont Premium Reduction;

(5) Vermont Cost Sharing Reduction; and

(6) MAGI-based Medicaid. For Medicaid categories that are not based on MAGI methodologies, the single, streamlined application may be supplemented with a form (or forms) to collect additional information, or an appropriate, alternative application may be used.

[1] 42 CFR § 435.909.

[2] 42 CFR § 435.907; 45 CFR §§ 155.310(a) and 155.405.

[3] 42 CFR § 435.906; 45 CFR § 155.310(c).

[4] 42 CFR § 435.907; 45 CFR § 155.405.

(b) Filing the application. AHS will:

(1) Accept the application from an application filer; and

(2) Provide the tools to file an application:

(i) Via an internet website;

(ii) By telephone through a call center;

(iii) By mail;

(iv) Through other commonly available electronic means; and

(v) In person.

(c) Assistance.[5] AHS will provide assistance to any individual seeking help with the application or renewal process, in the manner prescribed in § 5.01.

(d) Application filers. An application will be accepted from:

(1) The applicant;

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

(3) An authorized representative; or

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

(e) Missing information[6]

(1) The applicant's eligibility for health benefits will not be determined before the applicant provides answers to all required questions on the application.

(2) If an incomplete application is received, the applicant will be sent a request for answers to all of the unanswered questions necessary to determine eligibility. The request will include a response due date, which will be no earlier than 15 days after the date the request is sent to the applicant.

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

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

[5] 42 CFR § 435.908.

[6] 45 CFR § 155.310(k).

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

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

(f) Limits on information.[7] An applicant will be required to provide only the information necessary to make an eligibility determination or for a purpose directly connected to the administration of health-benefits programs.

(g) Information collection from non-applicants.[8] Information regarding citizenship, status as a national, or immigration status will not be requested for an individual who is not seeking health benefits for themselves.

(h) Signature required. An initial application must be signed under penalty of perjury. Electronic, including telephonically-recorded, signatures and handwritten signatures transmitted via any other electronic transmission will be accepted.

(i) Accessibility. Any application or supplemental form must be accessible to individuals who are limited English proficient and individuals who have disabilities, consistent with the provisions of § 5.01.

53.00 Attestation and verification – in general (01/15/2017, GCR 16-100)

(a) Basis and scope. The income and eligibility verification requirements set forth in §§ 53.00 through 56.00 are based on §§ 1137, 1902(a)(4), 1902(a)(19), 1902(a)(46)(B), 1902(ee), 1903(r)(3), 1903(x), and 1943(b)(3) of the Act, and § 1413 of the ACA.

(b) In general. AHS will verify or obtain information as provided in §§ 53.00 through 56.00 before making a determination about an individual's eligibility for health benefits. Such information will be used in making the eligibility determination. See § 58.00 for details on the eligibility determination process.

(c) Attestation.[9] Except where the law requires other procedures (such as for citizenship and immigration-status information), attestation of information needed to determine the eligibility of an individual for health benefits will be accepted (either self-attestation by the individual or attestation by an adult who is in the individual's household, an authorized representative, or, if the individual is under age 18[10] or incapacitated, someone acting responsibly for the individual) without requiring further information (including documentation) from the

[7] 42 CFR § 435.907(e).

[8] 45 CFR § 155.310(a)(2).

[9] 42 CFR § 435.945(a).

[10] In its response to comments on its proposed rule, CMS indicated that "[s]tate law and regulation establish who may file an application for an insurance affordability program on behalf of a child under age 21, and nothing in the Affordable Care Act or these regulations alters State authority or flexibility on this matter." 77 FR 17,156 (March 23, 2012). In Vermont, the age of majority is 18. 1 VSA § 173.

individual.

(d) Use of federal electronic verification service.[11] To the extent that information related to determining eligibility for health benefits is available through an electronic service established by HHS, AHS will obtain the information through such service, unless AHS has secured HHS approval of alternative procedures described in (e) below.[12]

(e) Flexibility in information collection and verification. Subject to approval by HHS, AHS may request and use information from a source or sources alternative to those listed in § 56.01(b), or through a mechanism other than the electronic service described in (d) above, provided that such alternative source or mechanism will reduce the administrative costs and burdens on individuals and the state while maximizing accuracy, minimizing delay, and meeting applicable requirements relating to confidentiality, disclosure, maintenance, or use of information.

(f) Notice of intent to obtain and use information.[13] Before it requests information for an individual from another agency or program, AHS will inform the individual that it will obtain and use information available to it to verify income, resources (when applicable), and eligibility or for other purposes directly connected to the administration of a health-benefits program or to enrollment in a QHP.

(g) Security of electronic information exchanges.[14] Information exchanged electronically between AHS and any other agency or program will be sent and received via secure electronic interfaces, as specified in § 4.09. Any such exchange of data will be made pursuant to written agreements with such other agencies or programs, which will provide for appropriate safeguards limiting the use and disclosure of information as required by federal or state law or regulations.

(h) Limitation on scope of information requests

(1) An individual will not be required to provide information beyond the minimum necessary to support eligibility and enrollment processes.

(2) An individual will not be required to provide additional information or documentation unless information needed by AHS cannot be obtained electronically or the information obtained electronically is not reasonably compatible, as that term is defined in § 57.00(a), with information provided by or on behalf of the individual.

(i) Limitation on use of evidence of immigration status. Evidence of immigration status may not be used to determine that an individual is not a Vermont resident.

[11] 42 CFR § 435.949(b).

[12] 42 CFR § 435.945(k); 45 CFR § 155.315(h)

[13] 42 CFR § 435.945(f).

[14] 42 CFR § 435.945(i).

54.00 Attestation and verification of citizenship and immigration status (01/15/2019, GCR 18-064)

54.01 Definitions (01/15/2017, GCR 16-100)

For definitions relevant to citizenship and immigration status, see § 17.00.

54.02 Declaration of citizenship or immigration status (01/15/2017, GCR 16-100)

Except as provided in § 54.06 for certain individuals applying for Medicaid, and except for employees enrolling in a qualified employer-sponsored plan, an individual seeking health benefits must sign a declaration that they are:

(a) A citizen or national of the United States (§ 17.01(a) and (c));

(b) A qualified non-citizen (§ 17.01(d)); or

(c) Lawfully present in the United States (§ 17.01(g)).

For the effect that citizenship and immigration status has on eligibility for health benefits, see § 17.00.

54.03 Verification frequency (01/15/2019, GCR 18-064)

(a) Citizenship.[15] Verification or documentation of citizenship is a one-time activity; once an individual's citizenship is documented and recorded, subsequent changes in eligibility should not require repeating the documentation unless later evidence raises a question about the individual's citizenship.

(b) Immigration status.[16] Immigration status, including lawful presence, must be verified or documented at the time of initial application and, for a Medicaid enrollee, at the time of eligibility renewal. In verifying immigration status at the time of renewal, AHS will first rely on information provided at the time of initial application to determine ongoing eligibility. AHS will only require the individual to provide further documentation or to re-verify satisfactory status if it cannot verify continued eligibility based on the information already available to it.

54.04 Electronic verification[17] (01/01/2018, GCR 17-048)

(a) Verification with records from the SSA. For an individual who attests to citizenship and has a Social Security number, AHS will transmit their Social Security number and other identifying information to HHS, which will submit it to the SSA for verification.

(b) Verification with the records of DHS. For an individual who has documentation that can be verified through DHS and who either attests to lawful immigration status or lawful presence, or who attests to citizenship and for whom AHS cannot substantiate a claim of citizenship through SSA, AHS will transmit information from the

[15] 42 CFR § 435.956(a)(4)(ii).

[16] CMS SHO Letter No. 10-006 (July 1, 2010), p. 5.

[17] 42 CFR § 435.956; 45 CFR § 155.315(c).

individual's documentation and other identifying information to HHS, which will submit necessary information to DHS for verification.

54.05 Inconsistencies and inability to verify information[18] (01/01/2018, GCR 17-048)

(a) In general. Except as provided in § 54.06, with respect to citizenship, lawful presence or satisfactory immigration status which cannot be verified through SSA or DHS, AHS will:

(1) Follow the procedures specified in § 57.00 (inconsistencies), except that:

(i) The opportunity period described in § 57.00(c)(2)(ii) during which the individual must submit documentation or resolve the inconsistency begins with the date the notice described in § 57.00(c)(2)(i) is received by, rather than sent to, the individual and, for both QHP and Medicaid purposes, extends 90 days from that date. The date on which the notice is received is considered to be five days after the date on the notice, unless the individual demonstrates that they did not receive the notice within the five-day period.

(ii) The opportunity period may be extended beyond 90 days for QHP purposes, and for Medicaid purposes for individuals declaring to be in satisfactory immigration status, if the individual is making a good-faith effort to resolve any inconsistencies or AHS needs more time to complete the verification process.

(2) If the individual does not have a Social Security number, assist the individual in obtaining a Social Security number;[19]

(3) Attempt to resolve any inconsistencies, including typographical or other clerical errors, between information provided by the individual and data from an electronic data source, and resubmit corrected information to the electronic data source;

(4) Provide the individual with information on how to contact the source of the electronic data so they can attempt to resolve inconsistencies directly with such data source; and

(5) Permit the individual to provide other documentation of citizenship or immigration status.[20]

(b) Eligibility activities during opportunity period.[21] During the opportunity period described in paragraphs (a)(1)(i) and (ii) of this subsection, AHS will:

(1) Not delay, deny, reduce, or terminate benefits for an individual who is otherwise eligible for health

[18] 42 CFR § 435.956; 45 CFR 155.315(c)(3).

[19] 42 CFR § 435.910.

[20] 42 CFR §§ 435.956(b)(1)(iii), 435.406 and 435.407.

[21] 42 CFR § 435.956(a)(5); 45 CFR § 155.315(f)(4).

benefits.

(2) Begin to furnish Medicaid benefits to otherwise eligible individuals effective on the date of the application containing the declaration of citizenship or immigration status by or on behalf of the individual.

(3) If relevant, proceed with respect to QHP enrollment, APTC, and CSR, as provided for in § 57.00(c)(4).[22]

(c) Failure to complete verification during opportunity period. If, by the end of the opportunity period described in paragraphs (a)(1)(i) and (ii) of this subsection, the individual's citizenship or immigration status has not been verified in accordance with paragraph (a) of this subsection, AHS will:

(1) With regard to the individual's eligibility for Medicaid, take action within 30 days to terminate eligibility.[23]

(2) With regard to the individual's eligibility for enrollment in a QHP, APTC and CSR, proceed in accordance with the provisions of § 57.00(c)(4)(ii).[24]

(d) Records of verification. AHS will maintain a record of having verified citizenship or immigration status for each individual in a case record or electronic database.

54.06 Individuals not required to document citizenship or national status for Medicaid[25] (01/01/2018, GCR 17-048)

The following individuals are not required to document citizenship or national status as a condition of receipt of Medicaid benefits:

(a) An individual receiving SSI benefits under Title XVI of the Act;

(b) An individual entitled to or enrolled in any part of Medicare;

(c) An individual receiving Social Security disability insurance benefits under § 223 of the Act or monthly benefits under § 202 of the Act, based on the individual's disability (as defined in § 223(d) of the Act);

(d) An individual who is in foster care and who is assisted under Title IV-B of the Act, and an individual who is a recipient of foster-care maintenance or adoption assistance payments under Title IV-E of the Act; and

(e) A child born in the United States on or after April 1, 2009, who was deemed eligible for Medicaid as a newborn

[22] 45 CFR § 155.315(c)(3).

[23] 42 CFR § 435.956(b)(3).

[24] 45 CFR § 155.315(f)(5).

[25] 42 CFR § 435.406(a)(1)(iii).

(§ 9.03(b)).[26]

54.07 Documentary evidence of citizenship and identity (01/01/2018, GCR 17-048)

(a) Definition: available. Document exists and can be obtained within the period of time specified in § 54.05.

(b) Standalone evidence of citizenship.[27] The following will be accepted as sufficient documentary evidence of citizenship:

(1) A U.S. passport, including a U.S. Passport Card issued by the Department of State, without regard to any expiration date as long as such passport or Card was issued without limitation.

(2) A Certificate of Naturalization.

(3) A Certificate of U.S. Citizenship.

(4) A valid state-issued driver's license if the state issuing the license requires proof of U.S. citizenship, or obtains and verifies a Social Security number from the applicant who is a citizen before issuing such license.

(5) Tribal documents:

(i) Documentary evidence issued by a federally-recognized Indian tribe, as published in the Federal Register by the Bureau of Indian Affairs within the U.S. Department of the Interior, and including tribes located in a State that has an international border, which:

(A) Identifies the federally-recognized Indian tribe that issued the document;

(B) Identifies the individual by name; and

(C) Confirms the individual's membership, enrollment, or affiliation with the tribe.

(ii) Documents described in paragraph (b)(5)(i) of this subsection include, but are not limited to:

(iii) A tribal enrollment card;

(iv) A Certificate of Degree of Indian Blood;

(v) A tribal census document;

(vi) Documents on tribal letterhead, issued under the signature of the appropriate tribal official, that meet the requirements of paragraph (b)(5)(i) of this subsection.

[26] Section 1903(x) of the Act.

[27] 42 CFR § 435.407(a).

(6) A data match with the Social Security Administration.

(c) Other evidence of citizenship.[28] If an applicant does not provide documentary evidence from the list in paragraph (b) of this subsection, the following must be accepted as satisfactory evidence to establish citizenship if also accompanied by an identity document listed in paragraph (d) of this subsection:

(1) A U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam, the Virgin Islands of the U.S., American Samoa, Swain's Island, or the Commonwealth of the Northern Mariana Islands (CNMI) (if born after November 4, 1986, (CNMI local time)). The birth record document may be issued by a State, Commonwealth, Territory, or local jurisdiction. If the document shows the individual was born in Puerto Rico or the CNMI before the applicable date referenced in this paragraph, the individual may be a collectively naturalized citizen. The following will establish U.S. citizenship for collectively naturalized individuals:

(i) Puerto Rico: Evidence of birth in Puerto Rico and the applicant's statement that they were residing in the U.S., a U.S. possession, or Puerto Rico on January 13, 1941.

(ii) CNMI (formerly part of the Trust Territory of the Pacific Islands (TTPI)):

(A) Evidence of birth in the CNMI, TTPI citizenship and residence in the CNMI, the U.S., or a U.S. Territory or possession on November 3, 1986, (CNMI local time) and the applicant's statement that they did not owe allegiance to a foreign state on November 4, 1986 (CNMI local time);

(B) Evidence of TTPI citizenship, continuous residence in the CNMI since before November 3, 1981 (CNMI local time), voter registration before January 1, 1975, and the applicant's statement that they did not owe allegiance to a foreign state on November 4, 1986 (CNMI local time).

(C) Evidence of continuous domicile in the CNMI since before January 1, 1974, and the applicant's statement that they did not owe allegiance to a foreign state on November 4, 1986 (CNMI local time). Note: If a person entered the CNMI as a nonimmigrant and lived in the CNMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.

(2) At state option, a cross-match with a state vital statistics agency documenting a record of birth.

(3) A Certification of Report of Birth, issued to U.S. citizens who were born outside the U.S.

(4) A Report of Birth Abroad of a U.S. Citizen.

(5) A Certification of birth in the United States.

(6) A U.S. Citizen I.D. card.

(7) A Northern Marianas Identification Card, issued by DHS (or predecessor agency).

(8) A final adoption decree showing the child's name and U.S. place of birth, or if an adoption is not final, a

[28] 42 CFR § 435.407(b).

statement from a state-approved adoption agency that shows the child's name and U.S. place of birth.

(9) Evidence of U.S. Civil Service employment before June 1, 1976.

(10) U.S. Military Record showing a U.S. place of birth.

(11) A data match with the Systematic Alien Verification for Entitlements (SAVE) Program or any other process established by DHS to verify that an individual is a citizen.

(12) Documentation that a child meets the requirements of § 101 of the Child Citizenship Act of 2000 (8 USC § 1431).

(13) Medical records, including, but not limited to, hospital, clinic, or doctor records or admission papers from a nursing facility, skilled care facility, or other institution that indicate a U.S. place of birth.

(14) Life, health, or other insurance record that indicates a U.S. place of birth.

(15) Official religious record recorded in the U.S. showing that the birth occurred in the U.S.

(16) School records, including pre-school, Head Start and daycare, showing the child's name and U.S. place of birth.

(17) Federal or State census record showing U.S. citizenship or a U.S. place of birth.

(18) If the individual does not have one of the documents listed in paragraphs (b) or (c)(1) through (17) of this subsection, they may submit an affidavit signed by another individual under penalty of perjury who can reasonably attest to the individual's citizenship, and that contains the individual's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized.

(d) Evidence of identity[29]

(1) The following will be accepted as proof of identity, provided such document has a photograph or other identifying information sufficient to establish identity, including, but not limited to, name, age, sex, race, height, weight, eye color, or address:

(i) Identity documents listed at 8 CFR § 274a.2(b)(1)(v)(B)(1), except a driver's license issued by a Canadian government authority.

(ii) Driver's license issued by a State or Territory.

(iii) School identification card.

(iv) U.S. military card or draft record.

[29] 42 CFR § 435.407(c).

(v) Identification card issued by the federal, state, or local government.

(vi) Military dependent's identification card.

(vii) U.S. Coast Guard Merchant Mariner card.

(viii) A finding of identity from an Express Lane agency, as defined in § 1902(e)(13)(F) of the Act.

(2) For children under age 19, a clinic, doctor, hospital, or school record, including preschool or day care records.

(3) Two documents containing consistent information that corroborates an individual's identity. Such documents include, but are not limited to, employer identification cards, high school and college diplomas (including high school equivalency diplomas), marriage certificates, divorce decrees, and property deeds or titles.

(4) AHS will accept as proof of identity:

(i) A finding of identity from a federal agency or another state agency, including but not limited to a public assistance, law enforcement, internal revenue or tax bureau, or corrections agency, if the agency has verified and certified the identity of the individual.

(ii) [Reserved]

(5) If the individual does not have any document specified in paragraphs (d)(1) through (d)(3) of this subsection and identity is not verified under paragraph (d)(4) of this subsection, the individual may submit an affidavit signed, under penalty of perjury, by another person who can reasonably attest to the individual's identity. Such affidavit must contain the individual's name and other identifying information establishing identity, as describe in paragraph (d)(1) of this subsection. The affidavit does not have to be notarized.

(e) Verification of citizenship by a federal agency or another state.[30] AHS may rely, without further documentation of citizenship or identity, on a verification of citizenship made by a federal or state agency, if such verification was done on or after July 1, 2006.

(f) Assistance.[31] AHS will assist individuals who need assistance to secure satisfactory documentary evidence of citizenship in a timely manner.

(g) Documentary evidence.[32] A photocopy, facsimile, scanned, or other copy of a document will be accepted to the same extent as an original document under this subsection, unless information on the submitted document is inconsistent with other information available to AHS, or AHS otherwise has reason to question the validity of

[30] 42 CFR § 435.407(d).

[31] 42 CFR § 435.407(e).

[32] 42 CFR § 435.407(f).

the document or the information on the document.

54.08 Documentation of immigration status for qualified non-citizens (01/15/2017, GCR 16-100)

If verification of immigration status cannot be obtained through the process described in § 54.04, a non-citizen individual seeking health benefits as a qualified non-citizen must provide United States Citizenship and Immigration Services (USCIS) documents to establish immigration status, as specified below:

(a) Lawful Permanent Resident

(1) USCIS Form I-551; or

(2) For recent arrivals, a temporary I-551 stamp on a foreign passport or on Form I-94.

(3) Note: Forms I-151, AR-3 and AR-3A have been replaced by USCIS. If presented as evidence of status, contact USCIS to verify status by filing a G-845 with a copy of the old form. Refer the individual to USCIS to apply for a replacement card.

(b) Refugee

(1) The following documents may be used to document refugee status:

(i) USCIS Form I-94 endorsed to show entry as refugee under § 207 of INA and date of entry to the United States;

(ii) USCIS Form I-688B annotated “274a.12(a)(3)”;

(iii) Form I-766 annotated ”A3”; or

(iv) Form I-571.

(2) Refugees usually change to Lawful Permanent Resident status after 12 months in the United States, but for the purposes of health-benefits eligibility are still considered refugees. They are identified by Form I-551 with codes RE-6, RE-7, RE-8, or RE-9.

(3) The following documents may be used to document that the individual is a “Cuban or Haitian entrant”:

(i) An I-94 Arrival/departure card with a stamp showing parole into the United States on or after April 21, 1980. I-94 may refer to §212(d)(5). I-94 may refer to humanitarian or public interest parole. I-94 may be expired.

(ii) An I-94 Arrival/departure card with a stamp showing parole at any time as a "Cuban/Haitian Entrant (Status Pending)." I-94 may refer to §212(d)(5). I-94 may be expired.

(iii) CH6 adjustment code on the I-551. Even after a Cuban/Haitian Entrant (Status Pending) becomes a permanent resident, they technically retain the status Cuban/Haitian Entrant (Status Pending). I-551 may be expired.

(iv) A Cuban or Haitian passport with a §212(d)(5) stamp dated after October 10, 1980. Passport may

be expired.

(c) Asylee

(1) USCIS Form I-94 annotated with stamp showing grant of asylum under § 208 of the INA;

(2) A grant letter from the Asylum Office of the USCIS;

(3) Form I-688B annotated “274a.12(a)(5)”;

(4) Form I-766 annotated “A5”; or

(5) An order of the Immigration Judge granting asylum. If a court order is presented, file a G-845 with the local USS district office attaching a copy of the document to verify that the order was not overturned on appeal.

(d) American Indian born outside of the United States

(1) Documentation of LPR status (See I-313.1);

(2) Birth or baptismal certificate issued on a reservation;

(3) Membership card or other tribal records;

(4) Letter from the Canadian Department of Indian Affairs;

(5) School records; or

(6) Contact with the tribe in question.

(e) Non-citizen granted parole for at least one year by the USCIS. USCIS Form I-94 endorsed to show grant of parole under § 212(d)(5) of the INA and a date showing granting of parole for at least one year.

(f) Non-citizen granted conditional entry under the immigration law in effect before April 1, 1980

(1) USCIS Form I-94 with stamp showing admission under § 203(a)(7) of the INA, refugee-conditional entry;

(2) Form I-688B annotated “274a.12 (a)(3)”; or

(3) Form I-766 annotated “A-3.”

(g) Non-citizen who has had deportation withheld under § 243(h) of the INA

(1) Order of an Immigration Judge showing deportation withheld under § 243(h) of the INA and date of the grant;

(2) USCIS Form I-688B annotated “247a.12(a)(10)”; or

(3) Form I-766 annotated "A10."

54.09 Documentation of entry date for determining the Medicaid five-year bar for qualified non-citizens (01/15/2017, GCR 16-100)

(a) The following are the documents that may be used to determine the Medicaid five-year bar for qualified non-citizens (§ 17.03):

(1) Form I-94. The date of admission should be found on the refugee stamp. If missing, AHS will contact USCIS to verify the date of admission by filing a G-845 with a copy of the document;

(2) If an individual presents Forms I-688B or I-766 (Employment Authorization Documents), and I-57 (refugee travel document), AHS will ask the individual to present Form I-94. If not available, AHS will contact USCIS by filing a G-845 with a copy of the document presented; or

(3) Grant letters or court orders. AHS will derive the date status is granted from the date of the letter or court order. If missing, AHS will contact USCIS to verify date of grant by filing a G-845 with a copy of the document.

(b) If an individual presents a receipt indicating that they have applied to USCIS for a replacement document for one of the documents identified above, AHS will contact the USCIS to verify status by filing a G-845 with the local USCIS district office with a copy of the receipt. AHS will contact the USCIS any time there is a reason to question the authenticity of a document presented or the information on the document is insufficient to determine whether non-citizen status requirements are met.

54.10 Ineligible non-citizens and non-immigrants (01/15/2017, GCR 16-100)

Some non-citizens may be lawfully admitted but only for a temporary or specified period of time as legal non-immigrants. These non-citizens are never qualified non-citizens. Because of the temporary nature of their admission status, they generally will be unable to establish residency and are not eligible for health benefits as qualified non-citizens. For example, a non-citizen in possession of a student visa is not a qualified non-citizen. In rare instances, an ineligible non-citizen may be able to establish residency and meet all other Medicaid eligibility criteria and therefore be eligible for treatment of emergency medical conditions only (see § 17.02(d)).

54.11 Visitors, tourists, and some workers and diplomats ineligible for Medicaid (01/15/2017, GCR 16-100)

For purposes of Medicaid eligibility, visitors, tourists, and some workers and diplomats are also ineligible non-citizens and non-immigrants. These non-citizens would have the following types of documentation:

(a) Form I-94 Arrival-Departure Record;

(b) Form I-185 Canadian Border Crossing Card;

(c) Form I-186 Mexican Border Crossing Card;

(d) Form SW-434 Mexican Border Visitor's Permit; or

(e) Form I-95A Crewman's Landing Permit.

55.00 Attestation and verification of other nonfinancial information[33] (01/15/2019, GCR 18-064)

55.01 Attestation only (01/15/2017, GCR 16-100)

Unless information from an individual is not reasonably compatible with other information provided or otherwise available to AHS, as described in § 57.00(b)(3), attestation of information needed to determine the following eligibility requirements will be accepted without requiring further information from the individual:

(a) Residency;

(b) Age;

(c) Date of birth; and

(d) Pregnancy.

55.02 Verification of attestation (01/15/2019, GCR 18-064)

An individual's attestations of information needed to determine the following eligibility requirements will be verified by AHS:

(a) Social Security number[34]

(1) The Social Security number furnished by an individual will be verified with SSA to insure the Social Security number was issued to that individual, and to determine whether any other Social Security numbers were issued to that individual.

(2) For any individual who provides a Social Security number, AHS will transmit the number and other identifying information to HHS, which will submit it to SSA.

(3) To the extent that an individual's Social Security number is not able to be verified through the SSA, or the SSA indicates that the individual is deceased, the procedures specified in § 57.00 will be followed, except that, for purposes of QHP eligibility:

(i) The individual will be provided with a period of 90 days from the date on which the notice described in § 57.00(c)(2)(i) is received, rather than sent, for the individual to provide satisfactory documentary evidence or resolve the inconsistency with the SSA.

(ii) The date on which the notice is received means five days after the date on the notice, unless the

[33] 42 CFR § 435.956; 45 CFR §§ 155.315 and 155.320.

[34] 42 CFR §§ 435.910 and 435.956(d); 45 CFR § 155.315(b).

individual demonstrates that they did not receive the notice within the five-day period.

For more information about Social Security numbers and eligibility for health benefits, see § 16.00.

(b) Incarceration status.[35] When determining an individual's eligibility for enrollment in a QHP, the individual's attestation regarding incarceration status will be verified by:

(1) Relying on any electronic data sources that are available to AHS; or

(2) If an approved data source is unavailable, accepting the individual's attestation, except as provided in (3) below.

(3) To the extent that an individual's attestation is not reasonably compatible with information from available data sources described in (1) above or other information provided by the individual or in AHS's records, AHS will follow the procedures specified in § 57.00.

(c) Eligibility for MEC other than through an eligible employer-sponsored plan.[36] When determining eligibility for APTC and CSR:

(1) AHS will verify whether an individual is eligible for MEC other than through an eligible employer-sponsored plan or Medicaid, using information obtained by transmitting identifying information specified by HHS to HHS.

(2) AHS will also verify whether an individual already has been determined eligible for coverage through Medicaid within the state.

(d) Enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan[37]

(1) General requirement. When determining eligibility for APTC and CSR, AHS will verify whether an individual reasonably expects to be enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested.

(2) Data. AHS will:

(i) Obtain data about enrollment in and eligibility for an eligible employer-sponsored plan from any electronic data sources that are available to it and which have been approved by HHS, based on evidence showing that such data sources are sufficiently current, accurate, and minimize administrative burden.

[35] 45 CFR § 155.315(e).

[36] 45 CFR § 155.320(b).

[37] 45 CFR § 155.320(d).

(ii) Obtain any available data regarding enrollment in employer-sponsored coverage or eligibility for qualifying coverage in an eligible employer-sponsored plan based on federal employment by transmitting identifying information specified by HHS to HHS for HHS to provide the necessary verification using data obtained by HHS.

(iii) Utilize data regarding small-group enrollment in QHPs.

(3) Verification procedures

(i) Except as specified in paragraphs (d)(3)(ii) or (iii) of this subsection, an individual's attestation regarding the verification specified in paragraph (d)(1) of this subsection will be accepted without further verification.

(ii) If an individual's attestation is not reasonably compatible with the information obtained by AHS as specified in paragraphs (d)(2)(i) through (d)(2)(iii) of this subsection, other information provided by the individual or by the application filer on the individual's behalf, or other information in AHS's records, the procedures specified in § 57.00 will be followed.

(iii) Except as specified in (iv) below, for any benefit year for which AHS does not reasonably expect to obtain sufficient verification data as described in paragraphs (d)(2)(i) through (d)(2)(iii) of this subsection, AHS will follow the alternative procedures described in this paragraph (d)(3)(iii). AHS reasonably expects to obtain sufficient verification data for any benefit year when, for the benefit year, AHS is able to obtain data about enrollment in and eligibility for qualifying coverage in an eligible employer-sponsored plan from at least one electronic data source that is available to AHS and that has been approved by HHS, based on evidence showing that the data source is sufficiently current, accurate, and minimizes administrative burden, as described under paragraph (d)(2)(i) of this subsection. AHS will select a statistically significant random sample of all such individuals for whom AHS does not have any of the information specified in paragraphs (d)(2)(i) through (d)(2)(iii) of this subsection and:

(A) Provide notice to the selected individuals indicating that AHS will be contacting any employer identified on the application for the individual and the members of their household to verify whether the individual is enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested;

(B) Proceed with all other elements of eligibility determination using the individual's attestation, and provide eligibility for enrollment in a QHP to the extent that an individual is otherwise qualified;

(C) Ensure that APTC and CSR are provided on behalf of an individual who is otherwise qualified for such payments and reductions, if the tax filer for the individual attests that they understand that any APTC paid on their behalf is subject to reconciliation;

(D) Make reasonable attempts to contact any employer identified on the application for the individual and the members of their household, to verify whether the individual is enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested;

(E) If AHS receives any information from an employer relevant to the individual's enrollment in an eligible employer-sponsored plan or eligibility for qualifying coverage in an eligible employer-

sponsored plan, AHS will determine the individual's eligibility based on such information and in accordance with the effective dates specified in § 73.06, and if such information changes their eligibility determination, notify the individual and their employer or employers of such determination;

(F) If, after a period of 90 days from the date on which the notice described in paragraph (d)(3)(iii)(A) of this subsection is sent to the individual, AHS is unable to obtain the necessary information from an employer, the individual's eligibility will be determined based on their attestation regarding coverage provided by that employer.

(G) In order to carry out the process described in paragraph (d)(3)(iii) of this subsection, AHS will only disclose an individual's information to an employer to the extent necessary for the employer to identify the employee.

(iv) For benefit years specified in federal law, AHS may establish an alternative process approved by HHS.

56.00 Attestation and verification of financial information[38] (01/15/2019, GCR 18-064)

56.01 Data (01/15/2017, GCR 16-100)

(a) Tax data[39]

(1) For all individuals whose income is counted in making a health-benefits eligibility determination, and for whom Social Security numbers are available, AHS will request tax return data regarding income and family size from the Secretary of the Treasury and data regarding Social Security benefits from the Commissioner of Social Security by transmitting identifying information specified by HHS to HHS.

(2) If the identifying information for one or more individuals does not match a tax record on file with the Secretary of the Treasury that may be disclosed, AHS will proceed in accordance with the provisions in § 57.00(c)(1).

(b) Non-tax data. For all individuals whose income is counted in making a health-benefits eligibility determination, AHS will request non-tax data from other agencies in the state and other state and federal programs, as follows:

(1) To the extent that AHS determines such information is useful to verifying the financial eligibility of an

[38] Generally, the ACA's provisions regarding modernization of Medicaid eligibility procedures (*e.g.,* application, renewal, attestation, electronic verification, submission modes, etc.) apply to determination of MAGI- and non-MAGI based eligibility decisions. See, CMS response to comments on proposed rule, 77 FR 17,143 (March 23, 2012). Accordingly, the provisions in this section apply in determining MABD income. However, as the concept of "family size" does not apply in the context of MABD (that program utilizes the concepts of "financial responsibility group" and "Medicaid group" in determining the countable non-MAGI-based income), provisions in this section that refer to "family size" apply only to MAGI-related Medicaid eligibility.

[39] 42 CFR § 435.948; 45 CFR § 155.320(c).

individual, the following will be requested:

(i) Information related to wages, net earnings from self-employment, and unearned income and resources from:

(A) The State Wage Information Collection Agency (SWICA);

(B) The IRS;

(C) The SSA;

(D) The State of Vermont's new-hire database;

(E) The agency or agencies administering the state unemployment compensation laws;

(F) The state-administered supplementary payment program under § 1616(a) of the Act (AABD, See AABD Rule 2700); and

(G) Any state program administered under a plan approved under Titles I, X, XIV, or XVI of the Act;

(ii) Information related to eligibility or enrollment from the 3SquaresVt Program, the Reach Up Program, other health-benefits programs, and other public-assistance programs that are administered by the State of Vermont; and

(iii) Any other information source bearing upon the individual's financial eligibility.

(2) To the extent that the information identified in this subsection is available through the federal electronic verification service (§ 53.00(d)), the information will be obtained through such service.

(3) The information will be requested by Social Security number, or if a Social Security number is not available, using other personally-identifying information in the individual's account, if possible.

56.02 Verification process for Medicaid (01/01/2018, GCR 17-048)

In determining an individual's eligibility for Medicaid:

(a) Family size.[40] For purposes of MAGI-based Medicaid eligibility, attestation of information needed to determine family size in accordance with the procedure set forth in § 55.01 will be accepted (attestation only).

(b) Income[41]

(1) Except as stated in paragraph (b)(2) of this subsection, income will be verified by comparing the individual's attestations with tax- and non-tax data obtained pursuant to § 56.01. If the attestations are not reasonably compatible, as that term is defined in § 57.00(a)(2), with such data or if such data is not

[40] 42 CFR § 435.956(f); 45 CFR § 155.320(c)(2)(i).

[41] 42 CFR §§ 435.945, 435.948, and 435.952; 45 CFR § 155.320(c)(2)(ii).

available, AHS will proceed in accordance with the provisions in § 57.00(c).

(2) For purposes of MAGI-based Medicaid eligibility, an individual's attestation that their income is above the highest income standard under which they may be determined eligible will be accepted without further verification.

(c) Resources. For purposes of MABD (non-MAGI-based Medicaid) eligibility, resources will be verified by comparing the individual's attestations with available data sources. If the attestations are not compatible with such sources, or if no such sources exist, or if sources exist but are not available, AHS will proceed in accordance with the provisions in § 57.00(c).

56.03 Verification process for APTC and CSR – general procedures (01/15/2017, GCR 16-100)

An individual must be eligible for APTC and have household income at or below 300% of the FPL in order for the individual to be eligible for the Vermont Premium Reduction and Vermont CSR. To receive the federal and Vermont CSR, an individual who is not an Indian must be enrolled in a silver-level QHP.

In determining eligibility for APTC and CSR:

(a) Family size[42]

(1) The individual must attest to the persons that comprise a tax filer's family size.

(2) To the extent that the individual attests that the tax data described in § 56.01(a) represent an accurate projection of a tax filer's family size for the benefit year for which coverage is requested, the individual's attestation will be accepted without further verification.

(3) To the extent that tax data are unavailable, or the individual attests that a change in circumstances has occurred or is reasonably expected to occur, and so they do not represent an accurate projection of a tax filer's family size for the benefit year for which coverage is requested, the tax filer's family size will be verified by accepting the individual's attestation without further verification, except as specified in paragraph (a)(4) of this subsection.

(4) If the individual's attestation to a tax filer's family size is not reasonably compatible, as that term is defined in § 57.00(a)(1), with other information provided by the individual or in AHS's records, data obtained through other electronic data sources will be used to verify the attestation. If such data sources are unavailable or information in such data sources is not reasonably compatible with the individual's attestation, additional documentation will be requested to support the attestation within the procedures specified in § 57.00.

(5) *Verification regarding APTC and CSR*. AHS will verify that neither APTC nor CSR is being provided on behalf of an individual by using information obtained by transmitting identifying information specified by

[42] 45 CFR § 155.320(c)(3)(i).

HHS to HHS.[43]

(b) Basic verification process for annual household income[44]

(1) The individual must attest to the tax filer's projected annual household income.

(2) AHS will compute annual household income based on the tax data described in § 56.01(a) (tax-based income calculation), if available.

(3) To the extent that the individual's attestation indicates that the tax-based income calculation under paragraph (b)(2) of this subsection represents an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the tax filer's eligibility for APTC and CSR will be determined based on that calculation.

(4) To the extent the tax data described in § 56.01(a) are unavailable or the individual attests that a change in circumstances has occurred or is reasonably expected to occur, and so they do not represent an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, AHS will require the individual to attest to the tax filer's projected household income for the benefit year for which coverage is requested.

(c) Verification process for increases in household income

(1) Except as specified in paragraphs (c)(2) or (3) of this subsection, the individual's attestation for the tax filer's household will be accepted without further verification if:

(i) The individual attests that the tax filer's annual household income has increased or is reasonably expected to increase from the tax-based income calculation under paragraph (b)(2) of this subsection; and

(ii) AHS has not verified the individual's income through the process specified in § 56.02(b) to be within the applicable Medicaid income standard.

(2) If the non-tax data available to AHS, as described in § 56.01(b), indicate that a tax filer's projected annual income is in excess of their attestation by more than twenty-five percent, AHS will proceed in accordance with § 57.00(c)(1)-(4)(i).

(3) If other information provided by the individual indicates that a tax filer's projected annual household income is in excess of the individual's attestation by more than twenty-five percent, the non-tax data will be used to verify the attestation. If such data are unavailable or information in such data is not reasonably compatible with the individual's attestation, AHS will proceed in accordance with § 57.00(c)(1)-(4)(i).

[43] 45 CFR § 155.320.

[44] 45 CFR § 155.320(c)(3)(ii).

56.04 Eligibility for alternate APTC and CSR verification procedures (01/01/2018, GCR 17-048)

Eligibility for alternate verification procedures for decreases in annual household income and situations in which tax data are unavailable.[45] AHS will determine a tax filer's annual household income for purposes of APTC and CSR based on the alternate APTC and CSR verification procedures described in §§ 56.05 through 56.07 if:

(a) An individual attests to the tax filer's projected annual household income;

(b) The tax filer does not meet the criteria specified in § 56.03(c) (attestation of increase in household income);

(c) The individuals in the tax filer's household have not established income through the process specified in § 56.02(b) (verification of income for Medicaid) that is within the applicable Medicaid income standard; and

(d) One of the following conditions is met:

(1) The Secretary of the Treasury does not have tax data that may be disclosed under § 6103(l)(21) of the Code for the tax filer that are at least as recent as the calendar year two years prior to the calendar year for which APTC or CSR would be effective;

(2) The individual attests that:

(i) The tax filer's applicable family size has changed or is reasonably expected to change for the benefit year for which the individuals in the tax filer's household are requesting coverage; or

(ii) The members of the tax filer's household have changed or are reasonably expected to change for the benefit year for which the individuals in their household are requesting coverage;

(3) The individual attests that a change in circumstances has occurred or is reasonably expected to occur, and so the tax filer's annual household income has decreased or is reasonably expected to decrease from the tax data described in § 56.01(a) for the benefit year for which the individuals in the tax filer's household are requesting coverage;

(4) The individual attests that the tax filer's filing status has changed or is reasonably expected to change for the benefit year for which the individual(s) in tax filer's household are requesting coverage; or

(5) An individual in the tax filer's household has filed an application for unemployment benefits.

[45] 45 CFR § 155.320(c)(3)(iv).

56.05 Alternate APTC and CSR verification procedure: small decrease in projected household income[46] (01/01/2018, GCR 17-048)

If a tax filer qualifies for an alternate APTC and CSR verification process and the individual's attestation to the tax filer's projected annual household income is no more than twenty-five percent below the tax-based income calculation (§ 56.03(b)(2)), the individual's attestation will be accepted without further verification.

56.06 Alternate APTC and CSR verification procedure: large decrease in projected household income and situations where tax data are unavailable[47] (01/15/2019, GCR 18-064)

(a) In general. AHS will attempt to verify the individual's attestation of the tax filer's projected annual household income with the process specified in paragraph (b) of this subsection and in §§ 56.07 and 56.08 if the tax filer qualifies for an alternate APTC and CSR verification process under § 56.04 and:

(1) The individual's attestation to the tax filer's projected annual household income is greater than twenty-five percent below the tax-based income calculation (§ 56.03(b)(2)); or

(2) The tax data described in § 56.01(a) are unavailable.

(b) Applicable process. The alternate APTC and CSR verification process is as follows:

(1) *Data*. Data from non-tax income sources, as described in § 56.01(b), will be annualized (non-tax-based income calculation).

(2) *Eligibility*. To the extent that the individual's attestation indicates that the non-tax-based income calculation under paragraph (b)(1) of this subsection represents an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the tax filer's eligibility for APTC and CSR will be determined based on such data.

(3) If the individual's attestation indicates that the tax filer's projected annual household income is more than twenty-five percent below the non-tax-based income calculation under paragraph (b)(1) of this subsection, AHS will request additional documentation using the procedures specified in § 57.00(c)(1) through (4)(i). If, following the 90-day period described in § 57.00(c)(2)(ii), the individual has not responded to the request for documentation or AHS remains unable to verify the individual's attestation, AHS will follow the applicable procedures described in § 56.08.

56.07 Alternate APTC and CSR verification procedure: Increases in household income when tax

[46] 45 CFR § 155.320(c)(3)(v).

[47] 45 CFR § 155.320(c)(3)(vi).

data are unavailable[48] (01/15/2017, GCR 16-100)

(a) Attestation sufficient. Except as provided in paragraph (b) of this subsection, the individual's attestation for the tax filer's household will be accepted without further verification if:

(1) The individual's attestation indicates that a tax filer's annual household income has increased or is reasonably expected to increase from the non-tax-based income calculation (§ 56.06(b)(1)); and

(2) AHS has not verified the individual's income through the process specified in § 56.02(b) to be within the applicable Medicaid income standard.

(b) Additional verification required. Additional documentation will be requested using the procedures specified in § 57.00 if AHS finds that an individual's attestation of a tax filer's annual household income is not reasonably compatible with other information provided by the individual or the non-tax data available to AHS under § 56.01(b).

56.08 Alternate APTC and CSR verification procedure: following 90-day period (01/15/2017, GCR 16-100)

(a) Individual does not respond to request/data indicate individual's income within Medicaid standard. If, following the 90-day period described in § 57.00(c)(2)(ii) as required by § 56.06(b)(3), an individual has not responded to a request for additional information and the tax data or non-tax data indicate that an individual in the tax filer's household is eligible for Medicaid, the application for a health-benefits program (for example, Medicaid, APTC or CSR) will be denied.

(b) Attestation cannot be verified/tax data available. If, following the 90-day period described in § 57.00(c)(2)(ii) as required by § 56.06(b)(3), AHS remains unable to verify the individual's attestation, AHS will determine the individual's eligibility based on AHS's tax-based income calculation (§ 56.03(b)(2)), notify the individual of such determination, and implement such determination in accordance with the effective dates specified in § 73.06.

(c) Attestation cannot be verified/tax data unavailable. If, following the 90-day period described in § 57.00(c)(2)(ii) as required by § 56.06(b)(3), AHS remains unable to verify the individual's attestation for the tax filer and tax data necessary for a tax-based income calculation (§ 56.03(b)(2)) are unavailable, AHS will determine the tax filer ineligible for APTC and CSR, notify the individual of such determination, and discontinue any APTC or CSR in accordance with the effective dates specified in § 73.06.

56.09 Verification related to eligibility for enrollment in a catastrophic plan[49] (01/15/2017, GCR 16-100)

(a) AHS will verify an individual's attestation that they meet the requirements of § 14.00 (eligibility for enrollment in a catastrophic plan) by:

[48] 45 CFR § 155.320(c)(3)(vi)(C).

[49] 45 CFR § 155.315(j).

(1) Verifying the individual's attestation of age as follows:

(i) Except as provided in paragraph (a)(1)(iii) of this subsection, accepting their attestation without further verification; or

(ii) Examining electronic data sources that are available and which have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently current and accurate, and minimize administrative costs and burdens.

(iii) If information regarding age is not reasonably compatible with other information provided by the individual or in AHS's records, examining information in data sources that are available and which have been approved by HHS for this purpose based on evidence showing that such data sources are sufficiently current and accurate.

(2) Verifying that an individual has a certificate of exemption in effect as described in § 14.00(b).

(b) To the extent that AHS is unable to verify the information required to determine eligibility for enrollment in a catastrophic plan as described in paragraphs (a)(1) and (2) of this subsection, the procedures specified in § 57.00, except for § 57.00(c)(4) (eligibility for APTC and CSR), will be followed.

56.10 Education and assistance (01/15/2017, GCR 16-100)

Education and assistance will be provided to an individual regarding the processes specified in this section.

57.00 Inconsistencies (01/01/2018, GCR 17-048)

(a) Reasonable compatibility[50]

(1) For purposes of QHP, information obtained through electronic data sources, other information provided by the individual, or other information in AHS's records will be considered reasonably compatible with an individual's attestation when the difference or discrepancy does not impact the eligibility of the individual or the benefits to which the individual may be entitled, including the APTC amount and CSR category.

(2) For purposes of Medicaid, income information obtained through an electronic data match shall be considered reasonably compatible with income information provided by or on behalf of an individual if both are either above or at or below the applicable income standard or other relevant income threshold. For eligibility criteria other than income, an individual's attestation will be considered reasonably compatible with information obtained through electronic data sources, other information provided by the individual, or other information in AHS's records if the discrepancy does not affect eligibility for a specific Medicaid category.

(b) Applicability of reasonable-compatibility procedures. Except as otherwise specified in this rule, the procedures outlined in this section will be used when:

(1) Information needed in accordance with §§ 53.00 through 56.00 is not available electronically and

[50] 42 CFR § 435.952(c); 45 CFR § 155.300(d).

establishing a data match would not be effective, considering such factors as the administrative costs associated with establishing and using the data match, compared with the administrative costs associated with relying on paper documentation, and the impact on program integrity in terms of the potential for ineligible individuals to be approved as well as for eligible individuals to be denied coverage;

(2) AHS cannot verify information required to determine eligibility for health benefits, including when:

(i) Electronic data sources are required but data for individuals relevant to the eligibility determination are not included in such data sources; or

(ii) Electronic data from IRS, DHS and SSA are required but it is not reasonably expected that data sources will be available within one day of the initial request to the data source, except that an individual's attestation of residency or, for purposes of QHP, eligibility for MEC, may be accepted, and the procedures outlined in this section will not be used, when verification of those criteria would otherwise be required and the electronic data to support the attestation are not reasonably expected to be available within one day of the initial request to the data source; or

(3) Attested information that would not otherwise be verified is not reasonably compatible with other information that is provided by the application filer or that is otherwise available to AHS.

(c) Procedures for determining reasonable compatibility. In circumstances described in paragraph (b) of this section, AHS will:

(1) Make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the application filer to confirm the accuracy of the information submitted by the application filer, and by allowing the individual, or the application filer on the individual's behalf, the opportunity to provide AHS with a statement that reasonably explains the discrepancy.

(2) If unable to resolve the inconsistency as provided in paragraph (c)(1) of this section:

(i) Provide notice to the individual regarding the inconsistency; and

(ii) Provide the individual with an opportunity period, as described in this paragraph (c)(2)(ii), from the date on which such notice is sent to the individual to either present satisfactory documentary evidence via the channels available for the submission of an application, (except for by telephone through a call center), or otherwise resolve the inconsistency.[51] If, because of evidence submitted by the individual, one or more requests for additional evidence is necessary, such additional evidence must be submitted by the individual within the same opportunity period that begins with the first verification request.

(A) For purposes of QHP, the individual's opportunity period is 90 days.

[51] The opportunity period described in this paragraph (c)(2)(ii) does not apply to an inconsistency related to citizenship or immigration status. For the opportunity period for citizenship and immigration status, see § 54.05(a)(1).

(B) For purposes of Medicaid, the individual's opportunity period is as follows:

(I) If the individual is a new Medicaid applicant, the opportunity period is 20 days, communicated in the form of two separate and sequential notices permitting the individual 10 days within which to respond.

(II) If the individual is a Medicaid enrollee, the opportunity period is 10 days.

(3) Extend the opportunity period described in paragraph (c)(2)(ii) of this section if the individual demonstrates that a good-faith effort has been made to obtain the required documentation during the period.

(4) In connection with the verification of an attestation for QHP eligibility:

(i) During the opportunity period described in paragraph (c)(2)(ii) of this section:

(A) Proceed with all other elements of eligibility determination using the individual's attestation, and provide eligibility for enrollment in a QHP to the extent that an individual is otherwise qualified; and

(B) Ensure that APTC, the Vermont Premium Reduction, and federal and state CSR are provided on behalf of an individual within this period who is otherwise qualified for such payments and reductions, if the tax filer attests that they understand that any APTC paid on their behalf is subject to reconciliation.

(ii) After the period described in paragraph (c)(2)(ii) of this section, determine whether the individual is eligible to enroll in a QHP using the information available from the data sources specified above, if any, if AHS remains unable to verify the attestation. AHS will notify the individual of such determination, including notice that AHS is unable to verify the attestation. For an individual determined eligible for enrollment in a QHP who is seeking financial assistance (APTC/CSR):

(A) If AHS can determine the individual is not eligible for Medicaid based on available information, determine whether the individual is eligible for APTC, the Vermont Premium Reduction, and federal and state CSR based on the information available from the data sources specified above, and notify the individual of such determination, including notice that AHS is unable to verify the attestation.

(B) If AHS cannot determine, based on available information, that the individual is ineligible for Medicaid, deny the application for or terminate the individual's APTC, Vermont Premium Reduction and federal and state CSR on the basis that there is insufficient information to determine the individual's eligibility for Medicaid.[52]

(C) If an individual is determined ineligible for financial assistance, the individual would still be eligible for enrollment in a QHP without financial assistance.

(5) In connection with the verification of an attestation for Medicaid eligibility, if, after the opportunity period

[52] It is a condition of eligibility for APTC and CSR that the individual is not eligible for government-sponsored MEC; 26 CFR § 1.36B-2(a)(2). In this case, the individual's failure to respond to the verification request precludes the determination of this condition of eligibility.

described in paragraph (c)(2)(ii) of this section, the individual has not responded to a request for additional information or has not provided information sufficient to resolve the inconsistency, or AHS otherwise remains unable to verify the attestation, deny the application or disenroll the individual on the basis that there is insufficient information to determine the individual's eligibility for Medicaid. Medicaid coverage cannot begin for a new Medicaid applicant until verification of the attestation is received, unless the verification is for purposes of establishing citizenship or immigration status as described in § 54.05(b).

(d) Exception for special circumstances[53]

(1) Except for an inconsistency related to citizenship or immigration status, AHS will provide an exception, on a case-by-case basis, to accept an individual's attestation as to the information which cannot otherwise be verified, because such documentation:

(i) Does not exist; or

(ii) Is not reasonably available.

(2) To receive such an exception:

(i) The inconsistency must not be able to be otherwise resolved; and

(ii) The individual must provide an adequate explanation of the circumstances as to why they cannot obtain the documentation needed to resolve the inconsistency.

(e) Pursuit of additional information in cases where verification data are not reasonably compatible with information provided for or on behalf of an individual.[54] Eligibility will not be denied or terminated nor benefits reduced for any individual on the basis of verification information received in accordance with this part Seven unless additional information from the individual has been sought in accordance with this section, and proper notice and hearing rights have been provided to the individual.

58.00 Determination of eligibility for health-benefits programs[55] (01/01/2018, GCR 17-048)

58.01 In general[56] (01/01/2018, GCR 17-048)

(a) MAGI screen.[57] For each individual who has submitted an application for a health- benefits program (i.e., health benefits other than enrollment in a QHP without APTC or CSR), or whose eligibility is being renewed, and who meets the nonfinancial requirements for eligibility (or for whom AHS is providing an opportunity to

[53] 42 CFR § 435.952(c)(3); 45 CFR § 155.315(g).

[54] 42 CFR § 435.952(d).

[55] 42 CFR § 435.911; 45 CFR § 155.310; 45 CFR § 155.345.

[56] 42 CFR §§ 435.911(c) and 435.1200(e).

[57] 42 CFR § 435.911(c).

verify citizenship or immigration status), AHS will do the following:

(1) Promptly and without undue delay, consistent with timeliness standards established under § 61.00, furnish MAGI-based Medicaid to each such individual whose household income is at or below the applicable MAGI-based standard.

(2) For each individual described in paragraph (c) of this subsection (individuals subject to determination of Medicaid eligibility on a basis other than the applicable MAGI-based income standard), collect such additional information as may be needed to determine whether such individual is eligible for Medicaid on any basis other than the applicable MAGI-based income standard, and furnish Medicaid on such basis.

(3) For an individual who submits an application or renewal form which includes sufficient information to determine Medicaid eligibility, or whose eligibility is being renewed pursuant to a change in circumstance, and whom AHS determines is not eligible for Medicaid, promptly and without undue delay, determine eligibility for other health benefits.

(b) MAGI-based income standards for certain individuals enrolled for Medicare benefits.[58] In the case of an individual who has attained at least age 65 and an individual who has attained at least age 19 and who is entitled to or enrolled for Medicare benefits under part A or B or Title XVIII of the Act, non-MAGI-based income standards will be used, except that in the case of such an individual:

(1) Who is also pregnant, the applicable MAGI-based standard is the standard established under § 7.03(a)(2); and

(2) Who is also a parent or caretaker relative (as defined in § 3.00), the applicable MAGI-based standard is the standard established under § 7.03(a)(1).

(c) Individuals subject to determination of Medicaid eligibility on basis other than the applicable MAGI-based income standard.[59] For purposes of paragraph (a)(2) of this subsection, an individual includes:

(1) An individual who is identified, on the basis of information contained in an application or renewal form, or on the basis of other information available, as potentially eligible on a basis other than the applicable MAGI-based standard; and

(2) An individual who otherwise requests a determination of eligibility on a basis other than the applicable MAGI-based standard.

(d) Individuals requesting additional screening.[60] AHS will notify an applicant of the opportunity to request a full determination of eligibility for Medicaid on a basis other than the applicable MAGI-based income standard, and will provide such an opportunity. Such notification will also be made to an enrollee, and such opportunity

[58] 42 CFR § 435.911(b)(2).

[59] 42 CFR § 435.911(d).

[60] 45 CFR § 155.345(c).

provided in any redetermination of eligibility.

(e) Determination of eligibility for Medicaid on a basis other than the applicable MAGI-based income standard.[61] If an individual is identified as potentially eligible for Medicaid on a basis other than the applicable MAGI-based income standard or an individual requests a full determination for Medicaid under paragraph (d) of this subsection, and the individual provides all additional information needed to determine eligibility for such benefits, eligibility will be determined promptly and without undue delay, as provided in this section.

(f) Eligibility for APTC and CSR, pending determination of eligibility for Medicaid.[62] An individual who is described in paragraph (e) of this subsection and has not been determined eligible for Medicaid based on MAGI-based income standards will be considered as ineligible for Medicaid for purposes of eligibility for APTC or CSR until the individual is determined eligible for Medicaid.

58.02 Special rules relating to APTC eligibility[63] (01/15/2017, GCR 16-100)

(a) An individual may accept less than the full amount of APTC for which the individual is determined eligible.

(b) Before APTC on behalf of a tax filer may be authorized, the tax filer must provide necessary attestations, including, but not limited to, attestations that:

(1) They will file an income tax return for the benefit year, in accordance with 26 USC §§ 6011 and 6012, and implementing regulations;

(2) If married (within the meaning of 26 CFR § 1.7703-1), they will file a joint tax return for the benefit year unless they meet the exception criteria defined in § 12.03(b) (victim of domestic abuse or spousal abandonment);[64]

(3) No other tax filer will be able to claim them as a tax dependent for the benefit year; and

(4) They will claim a personal exemption deduction on their tax return for the individuals identified as members of their household, including the tax filer and their spouse, in accordance with § 56.03(a).[65]

[61] 42 CFR § 435.911(c); 45 CFR § 155.345(d).

[62] 45 CFR § 155.345(e).

[63] 45 CFR § 155.310(d)(2)(i) and (ii).

[64] Federal tax law does not recognize civil unions. Therefore, a Vermont couple in a civil union may not file a joint tax return; they may qualify for APTC by filing separate returns.

[65] 45 CFR § 155.320(c)(3)(i).

59.00 Special QHP eligibility standards and process for Indians[66] (01/01/2018, GCR 17-048)

59.01 Eligibility for CSR (01/15/2017, GCR 16-100)

(a) An individual who is an Indian, as defined in § 3.00, will be determined eligible for CSR if they:

(1) Meet the requirements specified in §§ 11.00 and 12.00; and

(2) Are expected to have household income, using MAGI methodologies for purposes of determining eligibility for APTC and CSR, that does not exceed 300 percent of the FPL for the benefit year for which coverage is requested.

(b) CSR may be provided to an individual who is an Indian only if they are enrolled in a QHP through VHC.

59.02 Special cost-sharing rule for Indians regardless of income (01/15/2017, GCR 16-100)

AHS must determine an individual eligible for the special cost-sharing rule described in § 1402(d)(2) of the ACA (items or services furnished through Indian health providers) if the individual is an Indian, without requiring the individual to request an eligibility determination for health-benefits programs in order to qualify for this rule.

59.03 Verification related to Indian status[67] (01/15/2017, GCR 16-100)

To the extent that an individual attests that they are an Indian, such attestation will be verified by:

(a) Utilizing any relevant documentation verified in accordance with § 53.00;

(b) Relying on any electronic data sources that are available and which have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently accurate and offer less administrative complexity than paper verification; or

(c) To the extent that approved data sources are unavailable, an individual is not represented in available data sources, or data sources are not reasonably compatible with an individual's attestation, following the procedures specified in § 57.00 and verifying documentation provided by the individual in accordance with the standards for acceptable documentation provided in § 54.07(b)(5).

[66] 45 CFR § 155.350.

[67] 45 CFR § 155.350.

60.00 Computing the premium-assistance credit amount[68] (01/01/2018, GCR 17-048)

60.01 In general[69] (01/01/2018, GCR 17-048)

This section explains the calculation of the federal and state premium assistance of QHPs. A tax filer's federal premium assistance credit amount for a benefit year is the sum of the premium-assistance amounts determined under § 60.04 for all coverage months for individuals in the tax filer's household.

State premium assistance, referred to throughout this rule as Vermont Premium Reduction, is defined in § 3.00 as a state subsidy paid directly to the QHP issuer to reduce monthly premiums for an eligible individual enrolled in a QHP through VHC. Vermont Premium Reduction is calculated using the same methodology as advance payment of the federal premium assistance credit and, as described in § 60.07, results in the premium contribution from an eligible individual being reduced by 1.5 percent.

60.02 Definition[70] (01/15/2017, GCR 16-100)

For purposes of this section:

Coverage family. The term “coverage family” means, in each month, the members of the tax filer's household for whom the month is a coverage month.

60.03 Coverage month[71] (01/01/2018, GCR 17-048)

(a) In general. A month is a coverage month for an individual if:

(1) As of the first day of the month, the individual is enrolled in a QHP;

(2) The tax filer pays the tax filer's share of the premium for the individual's coverage under the plan for the month by the unextended due date for filing the tax filer's income tax return for that benefit year, or the full premium for the month is paid by APTC and the Vermont Premium Reduction; and

(3) The individual is not eligible for the full calendar month for MEC other than coverage in the individual market.

(b) Certain individuals enrolled during a month. If an individual enrolls in a QHP and the enrollment is effective on the date of the individual’s birth, adoption or placement for adoption or in foster care, or on the effective date of a court order, the individual is treated as enrolled as of the first day of that month for purposes of this subsection.

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[68] 26 CFR § 1.36B-3.

[69] 26 CFR § 1.36B-3(a); 33 VSA § 1812(a).

[70] 26 CFR § 1.36B-3(b).

[71] 26 CFR § 1.36B-3(c).

(c) Premiums paid for a tax filer. Premiums another person pays for coverage of the tax filer, tax filer's spouse, or tax dependent are treated as paid by the tax filer.

(d) Appeals of coverage eligibility. A tax filer who is eligible for APTC pursuant to an eligibility appeal decision for coverage of a member of the tax filer's coverage family who, based on the appeal decision, retroactively enrolls in a QHP is considered to have met the requirement in (a)(2) of this subsection for a month if the tax filer pays the tax filer's share of the premiums for coverage under the plan for the month on or before the 120th day following the date of the appeal decision.

(e) Examples. The following examples illustrate the provisions of this § 60.03:

(1) Example 1: Tax filer M is single with no tax dependents

(i) In December 2013, M enrolls in a QHP for 2014 and AHS approves APTC. M pays M's share of the premiums. On May 15, 2014, M enlists in the U.S. Army and is eligible immediately for government-sponsored MEC.

(ii) Under paragraph (a) of this subsection, January through May 2014 are coverage months for M. June through December 2014 are not coverage months because M is eligible for other MEC for those months. Thus, under § 60.01, M's premium assistance credit amount for 2014 is the sum of the premium-assistance amounts for the months January through May.

(2) Example 2: Tax filer N has one tax dependent S

(i) S is eligible for government-sponsored MEC. N is not eligible for MEC other than through VHC. N enrolls in a QHP for 2014 and AHS approves APTCs. On August 1, 2014, S loses eligibility for government-sponsored MEC. N terminates enrollment in the QHP that covers only N and enrolls in a QHP that covers N and S for August through December 2014. N pays all premiums not covered by APTCs.

(ii) Under paragraph (a) of this subsection, January through December of 2014 are coverage months for N and August through December are coverage months for N and S. N's premium assistance credit amount for 2014 is the sum of the premium-assistance amounts for these coverage months.

(3) Example 3: O and P are the divorced parents of T

(i) Under the divorce agreement between O and P, T resides with P and P claims T as a tax dependent. However, O must pay premiums for health insurance for T. P enrolls T in a QHP for 2014. O pays the portion of T's QHP premiums not covered by APTCs.

(ii) Because P claims T as a tax dependent, P (and not O) may claim a premium tax credit for coverage for T. See § 1.36B-2(a) of the Code. Under paragraph (c) of this subsection, the premiums that O pays for coverage for T are treated as paid by P. Thus, the months when T is covered by a QHP and not eligible for other MEC are coverage months under paragraph (a) of this subsection in computing P's premium tax credit under § 60.01.

(4) Example 4: Q, an American Indian, enrolls in a QHP for 2014. Q's tribe pays the portion of Q's QHP premiums not covered by APTCs. Under paragraph (c) of this subsection, the premiums that Q's tribe

pays for Q are treated as paid by Q. Thus, the months when Q is covered by a QHP and not eligible for other MEC are coverage months under paragraph (c) of this subsection in computing Q's premium tax credit under § 60.01.

60.04 Federal premium-assistance amount[72] (01/01/2018, GCR 17-048)

(a) Premium assistance amount. The premium assistance amount for a coverage month is the lesser of:

(1) The premiums for the month, reduced by any amounts that were refunded, for one or more QHPs in which a tax filer or a member of the tax filer's household enrolls (enrollment premiums); or

(2) The excess of the monthly premium for the applicable benchmark plan (ABP) (benchmark plan premium) (§ 60.06) over 1/12 of the product of a tax filer's household income and the applicable percentage for the benefit year (the tax filer's contribution amount).

(b) Examples. The following examples illustrate the rules of paragraph (a):

(1) Example 1.

Taxpayer Q is single and has no dependents. Q enrolls in a QHP with a monthly premium of $400. Q's monthly benchmark plan premium is $500, and his monthly contribution amount is $80. Q's premium assistance amount for a coverage month is $400 (the lesser of $400, Q's month enrollment premium, and $420, the difference between Q's monthly benchmark plan premium and Q's contribution amount).

(2) Example 2.

(i) Tax filer R is single and has no dependents. R enrolls in a QHP with a monthly premium of $450. The difference between R's benchmark plan premium and contribution amount for the month is $420. R's premium assistance amount for a coverage month with a full month of coverage is $420 (the lesser of $450 and $420).

(ii) The issuer of R's QHP is notified that R died on September 20. The issuer terminates coverage as of that date and refunds the remaining portion of the September enrollment premiums ($150) for R's coverage.

(iii) R's premium assistance amount for each coverage month from January through August is $420 (the lesser of $450 and $420). Under paragraph (a), R's premium assistance amount for September is the lesser of the enrollment premiums for the month, reduced by any amounts that were refunded ($300 ($450 - $150)) or the difference between the benchmark plan premium and the contribution amount for the month ($420). R's premium assistance amount for September is $300, the lesser of $420 and $300.

(3) Example 3.

The facts are the same as in Example 2 of this paragraph (b), except that the QHP issuer does not refund

[72] 26 CFR § 1.36B-3(d).

any enrollment premiums for September. Under paragraph (a), R's premium assistance amount for September is $420, the lesser of $450 and $420.

60.05 Monthly premium for ABP[73] (01/15/2017, GCR 16-100)

The monthly premium for an ABP is the premium an issuer would charge for the ABP to cover all members of the tax filer's coverage family. The monthly premium is determined without regard to any premium discount or rebate under the wellness discount demonstration project under § 2705(d) of the PHS Act (42 USC §§ 300gg-4(d)) and may not include any adjustments for tobacco use. The monthly premium for an ABP for a coverage month is determined as of the first day of the month.

60.06 Applicable benchmark plan (ABP)[74] (01/01/2018, GCR 17-048)

(a) In general. The ABP helps determine the total amount of premium assistance. The ABP is the QHP from which the product of the applicable percentage and household income is subtracted to obtain the subsidy amount that will be provided on behalf of the qualified individual. Except as otherwise provided in this subsection, the ABP for each coverage month is the second-lowest-cost silver plan offered to the tax filer's coverage family through VHC for:

(1) Self-only coverage for a tax filer:

(i) Who computes tax under § 1(c) of the Code (unmarried individuals other than surviving spouses and heads of household) and is not allowed a deduction under § 151 of the Code for a tax dependent for the benefit year;

(ii) Who purchases only self-only coverage for one individual; or

(iii) Whose coverage family includes only one individual; and

(2) Family coverage for all other tax filers.

(b) Family coverage. The ABP for family coverage is the second-lowest-cost silver plan that would cover the members of the tax filer's coverage family (such as a plan covering two adults if the members of a tax filer's coverage family are two adults).

(c) Silver-level plan not covering pediatric dental benefits. [Reserved]

(d) Family members residing in different locations. If members of a tax filer's coverage family reside in different locations, the tax filer's benchmark plan premium is the sum of the premiums for the ABPs for each group of coverage family members residing in different locations, based on the plans offered to the group through the Exchange where the group resides. If all members of a tax filer's coverage family reside in a single location that is different from where the tax filer resides, the tax filer's benchmark plan premium is the premium for the ABP for the coverage family, based on the plans offered through the Exchange to the tax filer's coverage

[73] 26 CFR § 1.36B-3(e).

[74] 26 CFR § 1.36B-3(f).

family for the rating area where the coverage family resides.

(e) Single or multiple policies needed to cover the family

(1) *Policy covering a tax filer's family*. If a silver-level plan or a stand-alone dental plan offers coverage to all members of a tax filer's coverage family who reside in the same location under a single policy, the premium (or allocable portion thereof, in the case of a stand-alone dental plan) taken into account for the plan for purposes of determining the ABP under paragraphs (a), (b) and (c) of this subsection is the premium for this single policy.

(2) *Policy not covering a tax filer's family*. If a silver-level QHP or a stand-alone dental plan would require multiple policies to cover all members of a tax filer's coverage family who reside in the same location (for example, because of the relationships within the family), the premium (or allocable portion thereof, in the case of a stand-alone dental plan) taken into account for the plan for purposes of determining the ABP under paragraphs (a), (b), and (c) of this subsection is the sum of the premiums (or allocable portion thereof, in the case of a stand-alone dental plan) for self-only policies under the plan for each member of the coverage family who resides in the same location.

(f) Plan not available for enrollment. A silver-level QHP or a stand-alone dental plan that is not open to enrollment by a tax filer or family member at the time the tax filer or family member enrolls in a QHP is disregarded in determining the ABP.

(g) Benchmark plan terminates or closes to enrollment during the year. A silver-level QHP or a stand-alone dental plan that is used for purposes of determining the ABP under this subsection for a tax filer does not cease to be the ABP for a benefit year solely because the plan or a lower cost plan terminates or closes to enrollment during the benefit year.

(h) Only one silver-level plan offered to the coverage family. [Reserved]

(i) Examples[75]

60.07 Applicable percentage[76] (01/01/2018, GCR 17-048)

(a) In general. The applicable percentage multiplied by a tax filer's household income determines the tax filer's required share of premiums for the ABP. This required share is subtracted from the monthly premium for the ABP when computing the premium-assistance amount. The applicable percentage is computed by first determining the percentage that the tax filer's household income bears to the FPL for the tax filer's family size. The resulting FPL percentage is then compared to the income categories described in the table in paragraph (b) of this subsection (or successor tables). An applicable percentage within an income category increases on a sliding scale in a linear manner and is rounded to the nearest one-hundredth of one percent. For taxable years beginning after December 31, 2014, the applicable percentages in the table will be adjusted by the ratio of premium growth to growth in income for the preceding calendar year and may be further adjusted to reflect

[75] Examples to illustrate the rules of this subsection can be found at 26 CFR § 1.36B-3(f)(9).

[76] 26 CFR § 1.36B-3(g).

changes to the data used to compute the ratio of premium growth to income growth for the 2014 calendar year or the data sources used to compute the ratio of premium growth to income growth. Premium growth and income growth will be determined in accordance with IRS-published guidance. In addition, the applicable percentages in the table may be adjusted to taxable years beginning after December 31, 2018, to reflect rates of premium growth relative to growth in the consumer price index.

(b) Applicable percentage table for APTC[77]

Household income percentage of FPL	2014 initial percentage	2014 final percentage
Less than 133%	2.0	2.0
At least 133% but less than 150%	3.0	4.0
At least 150% but less than 200%	4.0	6.3
At least 200% but less than 250%	6.3	8.05
At least 250% but less than 300%	8.05	9.5
At least 300% but not more than 400%	9.5	9.5

(c) Applicable percentage table with the Vermont Premium Reduction.[78] The State reduces the APTC's applicable percentage by 1.5% for an individual expected to have household income, as defined in § 28.05(c), that does not exceed 300 percent of the FPL for the benefit year for which coverage is requested.

Household income percentage of FPL	2014 initial percentage	2014 final percentage
Less than 133%	0.5	0.5
At least 133% but less than 150%	1.5	2.5

[77] For taxable years after 2014, the applicable percentages in the table will be updated in accordance with IRS-published guidance, available at: www.irs.gov. For example, the applicable percentage table for 2015 is located at: http://www.irs.gov/pub/irs-drop/rp-14-37.pdf.

[78] For updated applicable percentage tables with the Vermont Premium Reduction for taxable years after 2014, go to: http://info.healthconnect.vermont.gov/Thresholds.

At least 150% but less than 200%	2.5	4.8
At least 200% but less than 250%	4.8	6.55
At least 250% but not more than 300%	6.55	8.0
More than 300% but not more than 400%	9.5	9.5

(d) Examples. The following examples illustrate the rules of this subsection with respect to the applicable percentage for federal premium assistance:

(1) Example 1. A's household income is 275 percent of the FPL for A's family size for that benefit year. In the table in paragraph (b) of this subsection, the initial percentage for a tax filer with household income of 250 to 300 percent of the FPL is 6.55 and the final percentage is 8.0. A's FPL percentage of 275 percent is halfway between 250 percent and 300 percent. Thus, rounded to the nearest one-hundredth of one percent, A's applicable percentage is 7.28, which is halfway between the initial percentage of 6.55 and the final percentage of 8.0.

(2) Example 2

(i) B's household income is 210 percent of the FPL for B's family size. In the table in paragraph (b) of this subsection, the initial percentage for a tax filer with household income of 200 to 250 percent of the FPL is 4.8 and the final percentage is 6.55. B's applicable percentage is 5.15, computed as follows.

(ii) Determine the excess of B's FPL percentage (210) over the initial household income percentage in B's range (200), which is 10. Determine the difference between the initial household income percentage in the tax filer's range (200) and the ending household income percentage in the tax filer's range (250), which is 50. Divide the first amount by the second amount:

210-200 = 10

250-200 = 50

10/50 = .20.

(iii) Compute the difference between the initial premium percentage (4.8) and the second premium percentage (6.55) in the tax filer's range; 6.55 -4.8 = 1.75.

(iv) Multiply the amount in the first calculation (.20) by the amount in the second calculation (1.75) and add the product (.35) to the initial premium percentage in B's range (4.8), resulting in B's applicable percentage of 6.65:

.20 x 1.75 = .35

4.8 + .35 = 5.15.

60.08 Plan covering more than one household[79] (01/15/2017, GCR 16-100)

(a) In general. If a QHP covers more than one household under a single policy, each applicable tax filer covered by the plan may claim a premium tax credit, if otherwise allowable. Each tax filer computes the credit using that tax filer's applicable percentage, household income, and the ABP that applies to the tax filer under § 60.06. In determining whether the amount computed under § 60.04(a) (the premiums for the QHP in which the tax filer enrolls) is less than the amount computed under § 60.04(b) (the benchmark plan premium minus the product of household income and the applicable percentage), the premiums paid are allocated to each tax filer in proportion to the premiums for each tax filer's ABP.

(b) Example: Tax filers A and B enroll in a single policy under a QHP. The following example illustrates the rules of this subsection:

(1) B is A's 25-year old child who is not A's tax dependent. B has no tax dependents. The plan covers A, B, and A's two additional children who are A's dependents. The premium for the plan in which A and B enroll is $15,000. The premium for the second-lowest-cost silver family plan covering only A and A's tax dependents is $12,000 and the premium for the second-lowest-cost silver plan providing self-only coverage to B is $6,000. A and B are applicable tax filers and otherwise eligible to claim the premium tax credit.

(2) Under paragraph (a) of this subsection, both A and B may claim premium tax credits. A computes her credit using her household income, a family size of three, and a benchmark plan premium of $12,000. B computes his credit using his household income, a family size of one, and a benchmark plan premium of $6,000.

(3) In determining whether the amount in § 60.04(a) (the premiums for the QHP A and B purchase) is less than the amount in § 60.04(b) (the benchmark plan premium minus the product of household income and the applicable percentage), the $15,000 premiums paid are allocated to A and B in proportion to the premiums for their ABPs. Thus, the portion of the premium allocated to A is $10,000 ($15,000 x $12,000/$18,000) and the portion allocated to B is $5,000 ($15,000 x $6,000/$18,000).

60.09 [Reserved] (01/15/2017, GCR 16-100)

60.10 Additional benefits[80] (01/15/2017, GCR 16-100)

(a) In general. If a QHP offers benefits in addition to the essential health benefits a QHP must provide, the portion of the premium for the plan properly allocable to the additional benefits is excluded from the monthly premiums under § 60.04(a) or (b). Premiums are allocated to additional benefits before determining the ABP.

(b) Method of allocation. The portion of the premium properly allocable to additional benefits is determined under

[79] 26 CFR § 1.36B-3(h).

[80] 26 CFR § 1.36B-3(j).

guidance issued by the Secretary of HHS.[81]

(c) Examples. The following examples illustrate the rules of this subsection:

(1) Example 1

(i) Tax filer B enrolls in a QHP that provides benefits in addition to the essential health benefits the plan must provide (additional benefits). The monthly premiums for the plan in which B enrolls are $370, of which $35 is allocable to additional benefits. B's benchmark plan premium (determined after allocating premiums to additional benefits for all silver level plans) is $440, of which $40 is allocable to additional benefits. B's monthly contribution amount, which is the product of B's household income and the applicable percentage, is $60.

(ii) Under this subsection, B's enrollment premiums and the benchmark plan premium are reduced by the portion of the premium that is allocable to the additional benefits provided under that plan. Therefore, B's monthly enrollment premiums are reduced to $335 ($370 - $35) and B's benchmark plan premium is reduced to $400 ($440 - $40). B's premium assistance amount for a coverage month is $335, the lesser of $335 (B's enrollment premiums, reduced by the portion of the premium allocable to additional benefits) and $340 (B's benchmark plan premium, reduced by the portion of the premium allocable to additional benefits ($400), minus B' $60 contribution amount).

(2) Example 2. The facts are the same as in Example 1, except that the plan in which B enrolls provides no benefits in addition to the essential health benefits required to be provided by the plan. Thus, under this subsection, B's benchmark plan premium ($440) is reduced by the portion of the premium allocable to the additional benefits provided under that plan ($40). B's enrollment premiums ($370) are not reduced under this subsection. B's premium assistance amount for a coverage month is $340, the lesser of $370 (B's enrollment premiums) and $340 (B's benchmark plan premium, reduced by the portion of the premium allocable to additional benefits ($400), minus B's 60 contribution amount).

60.11 Pediatric dental coverage[82] (01/15/2017, GCR 16-100)

(a) In general. For purposes of determining the amount of the monthly premium a tax filer pays for coverage under § 60.04(a), if an individual enrolls in both a QHP and a stand-alone dental plan, the portion of the premium for the stand-alone dental plan that is properly allocable to pediatric dental benefits that are essential benefits required to be provided by a QHP is treated as a premium payable for the individual's QHP.

(b) Method of allocation. The portion of the premium for a stand-alone dental plan properly allocable to pediatric dental benefits is determined under guidance issued by the Secretary of HHS.

(c) Example. The following example illustrates the rules of this subsection:

[81] See § 36B(b)(3)(D) of the Code.

[82] 26 CFR § 1.36B-3(k).

(1) Tax filer C and C's tax dependent, R, enroll in a QHP. The premium for the plan in which C and R enroll is $7,200 ($600/month) (Amount 1). The plan does not provide dental coverage. C also enrolls in a stand-alone dental plan covering C and R. The portion of the premium for the dental plan allocable to pediatric dental benefits that are essential health benefits is $240 ($20 per month). The excess of the premium for C's ABP over C's contribution amount (the product of C's household income and the applicable percentage) is $7,260 ($605/month) (Amount 2).

(2) Under this subsection, the amount C pays for premiums (Amount 1) for purposes of computing the premium-assistance amount is increased by the portion of the premium for the stand-alone dental plan allocable to pediatric dental benefits that are essential health benefits. Thus, the amount of the premiums for the plan in which C enrolls is treated as $620 for purposes of computing the amount of the premium tax credit. C's premium-assistance amount for each coverage month is $605 (Amount 2), the lesser of Amount 1 (increased by the premiums allocable to pediatric dental benefits) and Amount 2.

60.12 Households that include individuals who are not lawfully present[83] (01/15/2017, GCR 16-100)

(a) In general. If one or more individuals for whom a tax filer is allowed a deduction under § 151 of the Code are not lawfully present (see § 17.01(g) for definition of lawfully present), the percentage a tax filer's household income bears to the FPL for the tax filer's family size for purposes of determining the applicable percentage under § 60.07 is determined by excluding individuals who are not lawfully present from family size and by determining household income in accordance with paragraph (b) of this subsection.

(b) Revised household income computation

(1) Statutory method. For purposes of (a) of this subsection, household income is equal to the product of the tax filer's household income (determined without regard to this paragraph (b)) and a fraction:

(i) The numerator of which is the FPL for the tax filer's family size determined by excluding individuals who are not lawfully present; and

(ii) The denominator of which is the FPL for the tax filer's family size determined by including individuals who are not lawfully present.

(2) Comparable method. The IRS Commissioner may describe a comparable method in additional published guidance.[84]

61.00 Timely determination of eligibility[85] (01/15/2019, GCR 18-064)

(a) In general

[83] 26 CFR § 1.36B-3(l).

[84] See § 601.601(d)(2) of chapter one of the Code.

[85] 42 CFR § 435.912; 45 CFR § 155.310(e).

(1) AHS strives to complete eligibility determinations for health-benefits programs and QHP enrollment promptly and without undue delay. The amount of time needed to complete such determinations will necessarily vary, depending on such factors as:

(i) The capabilities and cost of generally-available systems and technologies;

(ii) The general availability of electronic data matching and ease of connections to electronic sources of authoritative information to determine and verify eligibility; and

(iii) The needs of an individual, including:

(A) Individual preferences for mode of application (such as through an internet Website, telephone, mail, in-person, or other commonly available electronic means); and

(B) The relative complexity of adjudicating the eligibility determination based on household, income or other relevant information.

(2) An eligibility determination is complete once AHS sends written notice of decision to the individual.

(b) Real-time determination of eligibility. When an individual files a complete, accurate and web-based application and relevant data can be fully verified through the use of available electronic means, an individual can expect a real-time or near-real-time eligibility determination.

(c) Normal maximum time for determining eligibility.[86] In cases involving such factors as described in paragraph (a) of this section, eligibility determinations may require additional time to complete. In any event, a decision on a health-benefits application will be made as soon as possible, but no later than:

(1) 90 days after the application date, if the application is based on a person's disability; or

(2) 45 days after the application date for any other health-benefits application.

(d) Extenuating circumstances. A determination may take longer in unusual situations, such as:

(1) An individual delays providing needed verification or other information;

(2) An examining physician delays sending a necessary report; or

(3) An unexpected emergency or administrative problem outside the control of AHS delays action on applications.

(e) Notice of timeliness standards. Individuals will be informed of the timeliness standards set forth in this section.

62.00 Interviews (01/15/2017, GCR 16-100)

An in-person interview will not be required as part of the application process for a determination of eligibility using MAGI-based income. However, an interview may be required for eligibility determinations for which MAGI-based

[86] 42 CFR § 435.912(c)(3).

methods do not apply or when an individual is applying for Medicaid coverage of long-term care services and supports.

63.00 Individual choice (01/15/2017, GCR 16-100)

(a) Choice of Medicaid category.[87] If an individual would be eligible under more than one Medicaid category, the individual may choose to have eligibility determined for the category of the individual's choosing.

(b) Choice to determine eligibility for health-benefits programs.[88] An individual may request only an eligibility determination for enrollment in a QHP without APTC or CSR. However, if the individual is requesting an eligibility determination for a health-benefits program, the individual may not request an eligibility determination for less than all of the health-benefits programs. For example, if an individual seeks a subsidy to help pay for the cost of QHP coverage, they may not limit their application to APTC or CSR. Rather, they must likewise submit to a determination of eligibility for Medicaid.

64.00 Premiums (01/15/2019, GCR 18-064)

64.01 In general (01/15/2017, GCR 16-100)

(a) Scope. An individual who is enrolled in a QHP, as well as some individuals enrolled in Medicaid's Dr. Dynasaur program, are required to pay monthly premiums.

(b) Medicaid premium methodologies and amounts. The Vermont legislature sets Medicaid premium methodologies and amounts. Premium schedules are made publicly available via website.

(c) Determination of premium obligation for Medicaid eligibility; premium recalculation for Medicaid and QHP

(1) As a part of the health-benefits application, redetermination, and renewal processes:

(i) AHS will determine whether an individual eligible for Medicaid will be required to pay monthly premiums.

(ii) AHS will determine the premium amount due from an individual enrolled in a QHP based on the individual's plan selection and any financial assistance amount credited.

(A) An amount will be credited for the amount of APTC for which the individual has been determined eligible and which the individual has selected to be applied toward the QHP premium(s) due.

(B) An amount will be credited for the amount of the Vermont Premium Reduction for which the individual has been determined eligible.

(2) AHS will recalculate the premium amount for an individual enrolled in Medicaid or enrolled in a QHP receiving premium assistance when:

[87] 42 CFR § 435.404.

[88] 45 CFR 155.310(b).

(i) AHS is informed of a change in income, family size, or health-insurance status, or

(ii) An adjustment is made in premium amounts or calculation methodologies.

(3) A change that increases the premium amount will appear on the next regularly-scheduled monthly bill, created after the premium amount is recalculated.

(d) Premium calculation for Medicaid

(1) The premium calculation for an individual on Medicaid will be based on the MAGI-based income of the individual's Medicaid household following the MAGI methodology described in § 28.03, as established on the most recently approved version of eligibility on the case record at the time that the premium bill is generated. If a premium obligation is calculated for an individual and if that individual is living together with, and under the same premium payer account as, one or more other individuals for whom a premium obligation is also calculated, only one premium bill will be generated for those individuals. The bill will be for the highest premium obligation that is calculated.

Example. If A and B live together and are under the same premium payer account, and if A's calculated premium is $60.00 based on A's Medicaid household income and B's calculated premium is $15.00 based on B's Medicaid household income, AHS will not generate separate bills for A and B. Rather, AHS will generate one premium bill for a total of $60.00 and, when paid, the premium payment will cover eligibility for both A and B.

(2) Prior to the start of the coverage month pertaining to the bill in question, the individual may notify AHS to show that, due to changed household circumstances, the individual is eligible for Medicaid without a premium obligation or a lower premium amount.

(i) If the showing indicates that the individual is eligible for Medicaid without a premium obligation for the coverage month, the individual will be enrolled in Medicaid effective the first day of such coverage month.

(ii) If the showing indicates that the individual is eligible for a lower premium amount, the premium amount billed for that coverage month will be adjusted.

(3) No premium adjustments will be made for the coverage month if the individual has already paid the premium for the coverage month and the individual notifies AHS after the start of that coverage month that the individual is eligible for Medicaid without a premium obligation or for a lower premium amount. If the individual is entitled to a premium change, the change will be applied to the following coverage month.

(e) Aggregate limits for Medicaid premiums[89]

(1) Subject to paragraph (e)(2) of this subsection, any Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household may not exceed an aggregate limit of five percent of the family's income applied on a quarterly basis.

[89] 42 CFR § 447.56(f).

(2) If an individual incurs out-of-pocket expenses in excess of the aggregate limit described in paragraph (e)(1) of this subsection, AHS will refund that excess amount to the individual.

(3) An individual may request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium.

(f) Notice of change in premium amount. An individual will be notified as provided in § 67.00 each time a premium amount is recalculated based on a reported change, whether or not the recalculation results in a change in the premium amount. In other cases (e.g., periodic system-generated recalculations), the individual will be notified only in cases where there is a change in the premium amount.

(g) Prospective billing and payment[90]

(1) Premiums are billed, and payments are due, prior to the start of a coverage month. For purposes of Medicaid, premium bills will be sent to the person identified on the application as the primary contact or application filer. That person will be responsible for payment of the Medicaid premium (referred to in this rule as the premium payer). AHS will establish an account for the premium payer.

(2) Except as provided in paragraph (g)(3) of this subsection, an individual enrolled in a QHP may pay any applicable premium owed by such individual directly to the QHP issuer.

(3) If an individual owes premiums for a QHP and for Medicaid, they may:

(i) Pay all such premiums in a combined payment transaction directly to AHS; or

(ii) Pay such premiums due for Medicaid directly to AHS in one transaction and such premiums due for a QHP in a separate transaction directly to the QHP issuer.

(h) Conditions of eligibility and enrollment

(1) For purposes of Medicaid, timely payment of a premium is required as a condition of initial enrollment and ongoing eligibility and enrollment.

(2) For purposes of QHP, timely payment of a premium is required as a condition of initial and ongoing enrollment.

(i) Premium requirement for partial coverage month

(1) The full amount due must be paid to obtain coverage for all or a part of a month.

(2) The premium for QHP coverage lasting less than one month must equal the product of:

(i) The premium for one month of coverage divided by the number of days in the month; and

[90] 45 CFR § 155.240(a).

(ii) The number of days for which coverage is being provided that month.[91]

(3) If APTC and the Vermont Premium Reduction are received for a partial coverage month consistent with § 73.06, APTC and the Vermont Premium Reduction amounts are prorated using the methodology in (2) above.

(j) Premiums are nonrefundable. Premium payments are generally nonrefundable. See § 64.11 for exceptions related to Medicaid premiums. With respect to QHPs, premiums may be refundable in certain cases, including death, overpayment (including retroactive adjustment of APTC), and invoicing errors.

(k) [Reserved]

(l) Dr. Dynasaur retroactive island. If an individual advises AHS that they have unpaid medical bills incurred during one or more of the three months prior to their application, they may be able to obtain an island of retroactive coverage for any or all of those months (called a "Dr. Dynasaur retroactive island"). If so, AHS will bill the individual for the premium applicable to the Dr. Dynasaur retroactive island. Premium payments for Dr. Dynasaur retroactive islands are subject to allocation as provided under § 64.05(b).

64.02 Public-notice requirements for Medicaid[92] (01/15/2017, GCR 16-100)

(a) Schedule of Medicaid premiums and cost-sharing requirements. A public schedule will be available describing current Medicaid premiums and cost-sharing requirements containing the following information:

(1) The group or groups of individuals who are subject to premiums and cost-sharing requirements and the current amounts;

(2) Mechanisms for making payments for required premiums and cost-sharing charges;

(3) The consequences for an individual who does not pay a premium or cost-sharing charge;

(4) A list of hospitals charging cost sharing for non-emergency use of the emergency department; and

(5) A list of preferred drugs or a mechanism to access such a list, including the state's health-benefits website.

(b) Schedule availability. The public schedule will be available to the following in a manner that ensures that affected individuals and providers are likely to have access to the notice:

(1) Enrollees, at the time of their enrollment and reenrollment after a redetermination of eligibility, and, when premiums, cost-sharing charges or aggregate limits are revised, notice to enrollees will be in accordance with § 5.01(d);

[91] 45 CFR § 155.240(e).

[92] 42 CFR § 447.57.

(2) Applicants, at the time of application;

(3) All participating providers; and

(4) The general public.

(c) [Reserved]

64.03 [Reserved] (01/15/2017, GCR 16-100)

64.04 Ongoing premium billing and payment (01/15/2017, GCR 16-100)

(a) After enrollment, ongoing premiums are billed and premium payments are due for an individual enrolled in Medicaid or a QHP as follows:

(1) A monthly bill for ongoing premiums will be sent by the 5th day of the month or the first non-holiday business day thereafter immediately preceding the month for which the premium covers. Payment is due on or before the last day of the month in which the bill is sent.

(2) For example, a premium bill for coverage in July 2014 will be sent by June 5, 2014. Payment of the premium will be due on or before June 30, 2014.

(b) If the full premium payment is received by the premium payment due date, coverage will continue without further notice.

(c) If the premium payment is made by mail, the payment will be considered received as of the date it is postmarked.

(d) AHS periodically publishes an operational document describing enrollment and premium billing timelines for QHPs.

64.05 Partial payment (01/15/2017, GCR 16-100)

(a) Single-premium obligation. When there is only a single premium obligation, payment of the full amount due is required to maintain coverage and eligibility. A payment of less than the full amount due will be considered by AHS as nonpayment.

(b) Allocation of partial payments when multiple-premium obligations

(1) Basic rule

(i) Except as provided in paragraph (b)(2) of this subsection, when a payment covers at least one, but fewer than all, of the premiums due, the payment will be applied as payment of one or more premiums in full rather than as a partial payment of any billed premium or premiums. The payment will be allocated by AHS in the following order:

(A) Dr. Dynasaur.

(B) VPharm.

(C) QHP.

(D) Stand-alone dental plan.

(E) Dr. Dynasaur retroactive island (see § 64.01(I) for definition).

(ii) Coverage will only continue for those for whom the full premium amount due has been received.

(2) Exception. An individual who wishes to specify a different payment allocation for the premiums due may do so by calling AHS at the number listed on the bill. The individual must make such a request prior to the time the payment is received by AHS.

64.06 Late payment/grace period (01/15/2019, GCR 18-064)

(a) Grace Period

(1) An individual enrolled in a QHP, with or without APTC, or in Dr. Dynasaur is entitled to a premium grace period as described in this paragraph (1) if the individual has not paid their monthly premium by its due date.

(i) For an individual enrolled in a QHP with APTC, the grace period is three consecutive months.

(ii) For an individual enrolled in a QHP without APTC, the grace period is one month.

(iii) For an individual enrolled in Dr. Dynasaur, the grace period is 60 days; it starts the day after the due date, extends 60 days, and then ends on the last day of the month in which the 60-day period ends.[93]

(2) During the grace period for an individual enrolled in a QHP with APTC, the QHP issuer:

(i) Will pay all appropriate claims for services rendered to the individual during the first month of the grace period; and

(ii) May pend claims for services rendered to the individual in the second and third months of the grace period.

(3) During the grace period for an individual enrolled in a QHP without APTC, the QHP issuer will pay all appropriate claims for services rendered to the individual during the grace period.

(4) During the grace period for an individual enrolled in Dr. Dynasaur, Medicaid will pay all appropriate claims

[93] Because of the length of the grace period for an individual enrolled in Dr. Dynasaur, the individual can be in more than one Dr. Dynasaur grace period at the same time. For example, if an individual does not pay their Dr. Dynasaur premium 2 months in a row, they will still be in a grace period for the first unpaid month when the grace period for the second unpaid month starts.

for services rendered to the individual.

(b) Notice of premium nonpayment and reinstatement

(1) In the case of an individual enrolled in a QHP:

(i) If the full premium payment is not received on or before the premium due date:

(A) The QHP issuer will notify the individual of:

(I) The payment delinquency;

(II) The grace period and the consequences of being in that status;

(III) The effect of premium nonpayment on their eligibility for APTC and CSR, if applicable, and their eligibility for future enrollment in a QHP;

(IV) The actions the individual must take to resume good standing; and

(V) The consequences of exhausting the grace period without paying all outstanding premiums.

(B) The QHP issuer will also:

(I) Notify HHS of the nonpayment as required by federal law; and

(II) With respect to an individual enrolled in a QHP with APTC, notify providers of the possibility for denied claims when the enrollee is in the second and third months of the grace period.

(ii) Except in the following circumstances, the individual will generally not be reinstated following termination for non-payment of premium at the end of the grace period:

(A) In the case of erroneous termination.

(B) If the individual is enrolled in a QHP without APTC, the individual may request reinstatement of coverage after termination for non-payment of premium once per benefit year. The individual must request reinstatement, and pay all premiums due, on or before the fifteenth day of the second month following the termination effective date. For example, if an individual is terminated for non-payment effective March 31, on or before May 15, they must request reinstatement and pay all premiums due. If the request is made in April, the customer must pay premiums for March, April and May to be reinstated. If the request is made in May, the customer must pay premiums for March, April, May and June to be reinstated.

(2) In the case of an individual enrolled in Dr. Dynasaur:

(i) If a full premium payment is not received by AHS on or before the premium due date, before the fifth business day of the grace period, AHS will send a notice advising that the individual is in a grace period status. The notice will also advise the individual:

(A) Of the Dr. Dynasaur disenrollment protection as provided under § 64.07;

(B) Of the consequences of being in a grace status;

(C) The actions the individual must take to resume good standing; and

(D) The consequences of exhausting the grace period without paying all outstanding premiums.

(ii) At least 11 days before the end of the grace period, AHS will send the individual a closure notice advising that enrollment will terminate at the end of the grace period.

(iii) Subject to the payment allocation described in (iv) below, if AHS receives at least a full premium payment for the grace period on or before the end of the grace period:

(A) The payment will first be applied to cover the premium due for the grace period;

(B) The individual will be reinstated; and

(C) The individual will be reenrolled for coverage in the month following the grace period.

(iv) *Payment allocation*. If an individual is in grace period status for more than one unpaid premium when AHS receives payment and the payment covers the premium due for at least one, but fewer than all, of the grace periods, the payment will be applied as payment of one or more premiums in full and allocated in chronological order beginning with the oldest grace period.

(v) If AHS receives a full premium payment for the grace period after the end of the grace period, the individual will not be reinstated or reenrolled, and will need to re-apply.

64.07 Dr. Dynasaur disenrollment protection[94] (01/15/2017, GCR 16-100)

(a) Prior to closure, an individual enrolled in Dr. Dynasaur who has received a grace period notice as provided under § 64.06(b)(2)(i) may contact AHS to show that, due to changed household circumstances, the individual is eligible for Medicaid without a premium obligation or with a lower premium amount.

(b) If the showing indicates that the individual is eligible for Medicaid without a premium obligation, AHS will reinstate and reenroll the individual and waive all outstanding premiums.

(c) If the showing indicates that the individual is obligated to pay a premium, but at a lower amount, any outstanding premium amounts due will be adjusted. If the individual pays the adjusted premium amount prior to closure, AHS will reinstate and reenroll the individual.

64.08 [Reserved] (01/15/2017, GCR 16-100)

64.09 Medical incapacity for VPharm (01/15/2017, GCR 16-100)

(a) “Medical incapacity” means a serious physical or mental infirmity to the health of an individual enrolled in VPharm (§ 10.01) that prevented the individual from paying the premium timely, as verified in a physician's

[94] 42 CFR § 457.570(b) provides CHIP enrollees an opportunity to show that their income has declined before coverage is terminated for non-payment of premium. Vermont has elected to extend this protection to all of the state’s premium-based Dr. Dynasaur coverage groups.

certificate furnished to AHS. Notice by telephone or otherwise by the physician that such certificate will be forthcoming will have the effect of receipt, provided that the certificate is in fact received within seven days.

(b) If an individual's VPharm coverage is terminated solely because of nonpayment of the premium, and the reason is medical incapacity as defined in (a) of this subsection, the individual's representative may request coverage for the period between the day coverage ended and the last day of the month in which they requested coverage. AHS will provide this coverage if it has received verification of medical incapacity and all premiums due for the period of non-coverage. The individual is responsible for all bills incurred during the period of non-coverage until AHS receives the required verification and premium amounts due.

(c) If the health condition related to this medical incapacity is expected to continue or recur, AHS will encourage the individual to sign up for automatic withdrawal of their premium or designate an authorized representative to receive and pay future premiums for as long as the anticipated duration of the condition.

64.10 Medicaid premium payment balances (01/15/2017, GCR 16-100)

Medicaid premium payment balances that result from partial payments or overpayments will be credited to the premium payer's account and will be applied to subsequent Medicaid premium bills.

64.11 Refund of prospective Medicaid premium payments (01/15/2017, GCR 16-100)

(a) Basic rule for Medicaid premiums. A paid Medicaid premium will automatically be refunded to the premium payer when, prior to the beginning of the coverage month associated with the premium payment, no one under the premium payer's account is subject to a premium obligation.

(b) Exception. A paid Medicaid premium will not be refunded if a change occurs after the beginning of the coverage month associated with the premium payment.

64.12 [Reserved] (01/15/2017, GCR 16-100)

64.13 Appeal of Medicaid or QHP premium amount (01/15/2017, GCR 16-100)

(a) *Medicaid.*

If an individual subject to a premium appeals a decision by AHS that ends their Medicaid eligibility, reduces their benefits or services, or increases the amount of their Medicaid premium, the individual must continue to pay the premium amount in effect prior to the decision that resulted in their appeal in order to have their Medicaid coverage continue pending the outcome of their appeal.

AHS may recover from the individual the difference between the premium level that would have become effective had the individual not appealed AHS's decision and the premium level actually paid during the fair hearing period when the individual withdraws the fair hearing request before the decision is made or following a final disposition of the matter in favor of AHS.

(b) *QHP.*

An individual who appeals the amount of their QHP premium must pay the billed amount until the appeal is

decided for coverage to continue. If the individual wins the appeal, any overpayment will be refunded.

65.00 [Reserved] (01/15/2019, GCR 18-064)

66.00 Presumptive Medicaid eligibility determined by hospitals[95] (01/01/2018, GCR 17-048)

66.01 Basis (01/15/2017, GCR 16-100)

This section implements § 1902(a)(47)(B) of the Act.

66.02 In general (01/15/2017, GCR 16-100)

(a) Basic rule. Medicaid will be provided during a presumptive eligibility period to an individual who is determined by a qualified hospital, on the basis of preliminary information, to be presumptively eligible in accordance with the policies and procedures established by AHS consistent with this section.

(b) Qualified hospital. A qualified hospital is a hospital that:

(1) Participates as a Medicaid provider; notifies AHS of its election to make presumptive eligibility determinations under this section; and agrees to make presumptive eligibility determinations consistent with state policies and procedures;

(2) Assists individuals in completing and submitting the full Medicaid application and understanding any documentation requirements; and

(3) Has not been disqualified by AHS in accordance with paragraph (d) of this subsection.

(c) Scope of authority to make determinations of presumptive eligibility. Hospitals may only make determinations of presumptive eligibility under this section based on income for:

(1) Children under § 7.03(a)(3);

(2) Pregnant women under § 7.03(a)(2);

(3) Parents and caretaker relatives under § 7.03(a)(1);

(4) Adults under § 7.03(a)(5);

(5) Former foster children under § 9.03(e);

(6) Individuals receiving breast and cervical cancer treatment under § 9.03(f); and

(7) Individuals receiving family planning services under § 9.03(g).

[95] 42 CFR § 435.1110.

(d) Disqualification of hospitals

(1) AHS may establish standards for qualified hospitals related to the proportion of individuals determined presumptively eligible for Medicaid by the hospital who:

(i) Submit a regular application before the end of the presumptive eligibility period; or

(ii) Are determined eligible for Medicaid based on such application.

(2) AHS will take action, including, but not limited to, disqualification of a hospital as a qualified hospital under this section, if it determines that the hospital is not:

(i) Making, or is not capable of making, presumptive eligibility determinations in accordance with applicable state policies and procedures; or

(ii) Meeting the standard or standards established under paragraph (d)(1) of this section.

(3) AHS may disqualify a hospital as a qualified hospital under this paragraph only after it has provided the hospital with additional training or taken other reasonable corrective action measures to address the issue.

66.03 Procedures (01/15/2017, GCR 16-100)

(a) In general.[96] AHS will provide Medicaid services to an individual during the presumptive-eligibility period that follows a determination by a qualified hospital that, on the basis of preliminary information, the individual has gross income at or below the Medicaid income standard established for the individual.

(b) AHS's responsibilities.[97] AHS will:

(1) Provide qualified hospitals with application forms for Medicaid and information on how to assist individuals in completing and filing such forms;

(2) Establish oversight mechanisms to ensure that presumptive-eligibility determinations are being made consistent with applicable laws and rules; and

(3) Allow determinations of presumptive eligibility to be made by qualified hospitals on a statewide basis.

(c) Qualified hospital's responsibilities[98]

(1) On the basis of preliminary information, a qualified hospital must determine whether the individual is

[96] 42 CFR § 435.1102(a).

[97] 42 CFR § 435.1102(b).

[98] 42 CFR § 435.1102(b)(2), as applied to hospital determination of presumptive eligibility by 42 CFR § 435.1110(a).

presumptively eligible under this rule.

(2) For the purpose of the presumptive eligibility determination, a qualified hospital must accept self-declaration of the presumptive-eligibility criteria.

(3) If the individual is presumptively eligible, a qualified hospital must:

(i) Approve presumptive coverage for the individual;

(ii) Notify the individual within twenty-four hours of the eligibility determination, in writing or orally, if appropriate:

(A) That the individual is eligible for presumptive coverage;

(B) The presumptive eligibility determination date;

(C) That the individual is required to make application for ongoing Medicaid by not later than the last day of the following month; and

(D) That failure to cooperate with the standard eligibility determination process will result in denial of ongoing Medicaid and termination of presumptive coverage on the date described in § 66.04;

(iii) Notify AHS of the presumptive eligibility determination within five working days after the date on which determination is made;

(iv) Provide the individual with a Medicaid application form;

(v) Advise the individual that:

(A) If a Medicaid application on behalf of the individual is not filed by the last day of the following month, the individual's presumptive eligibility will end on that last day; and

(B) If a Medicaid application on behalf of the individual is filed by the last day of the following month, the individual's presumptive eligibility will end on the day that a decision is made on the Medicaid application; and

(vi) Take all reasonable steps to help the individual complete an application for ongoing Medicaid or make contact with AHS.

(4) If the individual is not presumptively eligible, a qualified hospital must notify the individual at the time the determination is made, in writing and orally if appropriate:

(i) Of the reason for the determination;

(ii) That their ineligibility for presumptive coverage does not necessarily mean that they are ineligible for other categories of Medicaid; and

(iii) That the individual may file an application for Medicaid with AHS, and that, if they do so, that the individual's eligibility for other categories of Medicaid will be reviewed.

(5) A qualified hospital may not delegate the authority to determine presumptive eligibility to another entity.[99]

(d) Required attestations.[100] For purposes of making a presumptive eligibility determination under this section, an individual (or another person having reasonable knowledge of the individual's status) must attest to the individual being a:

(1) Citizen or national of the United States or in satisfactory immigration status; and

(2) Resident of the state.

(e) Limitation on other conditions[101]

(1) The conditions specified in this subsection are the only conditions that apply in the case of a presumptive-eligibility determination.

(2) Verification of the conditions that apply for presumptive eligibility is not required.

66.04 Presumptive coverage[102] (01/01/2018, GCR 17-048)

(a) Effective dates

(1) Presumptive coverage begins on the date the individual is determined to be presumptively eligible.

(2) Presumptive coverage ends with the earlier of (and includes):

(i) The date that the individual is determined to be eligible or ineligible for ongoing Medicaid.

(ii) If the individual has not applied for ongoing Medicaid, the last day of the month following the month in which the individual was determined to be presumptively eligible.

(b) No retroactive coverage. No retroactive coverage may be provided as a result of a presumptive eligibility determination.

(c) Frequency. An individual may receive only one presumptive Medicaid eligibility period in a calendar year. A pregnant woman may receive only one presumptive Medicaid eligibility period for each pregnancy, even if she has not yet otherwise received a presumptive Medicaid eligibility period during the current calendar year.

[99] 42 CFR § 435.1102(b), as applied to hospital determination of presumptive eligibility by 42 CFR § 435.1110(a).

[100] 42 CFR § 435.1102(d)(1), as applied to hospital determination of presumptive eligibility by 42 CFR § 435.1110(a).

[101] 42 CFR § 435.1102(d)(2), as applied to hospital determination of presumptive eligibility by 42 CFR § 435.1110(a).

[102] 42 CFR § 435.1101, as applied to hospital determination of presumptive eligibility by 42 CFR § 435.1110(a).

66.05 Notice and fair hearing rules[103] (01/15/2017, GCR 16-100)

Notice and fair hearing regulations in Part Eight of this rule do not apply to determinations of presumptive eligibility under this section.

67.00 General notice standards[104] (01/01/2018, GCR 17-048)

(a) General requirement. Any notice required to be sent by AHS must be written and include clear statements of the following:

(1) An explanation of the action reflected in the notice, including the effective date of the action.

(2) Any relevant factual findings.

(3) Citations to, or identification of, the relevant regulations.

(4) Contact information for available customer service resources.

(5) An explanation of appeal rights, if applicable.

(b) Accessibility and plain language. All applications, forms, and notices, including the single, streamlined application and notices of decision, will conform to the accessibility and plain language standards outlined in § 5.01(c).

67.01 Use of electronic notices[105] (01/01/2018, GCR 17-048)

(a) Choice of notice format. An individual will be provided with a choice to receive notices and information required under these rules in electronic format or by regular mail. If the individual elects to receive communications electronically, AHS will:

(1) Confirm by regular mail the individual's election to receive notices electronically;

(2) Inform the individual of their right to change such election, at any time, to receive notices through regular mail;

(3) Post notices to the individual's electronic account within one business day of notice generation;

(4) Send an email or other electronic communication alerting the individual that a notice has been posted to

[103] 42 CFR § 435.1102(e), as applied to hospital determination of presumptive eligibility by 42 CFR § 435.1110(a).

[104] 45 CFR § 155.230.

[105] 42 CFR § 435.918; 45 CFR § 155.230. See, also, 45 CFR § 155.230(d)(3) allowing select required notices to be sent through standard mail, even if an election has been made to receive such notices electronically, in the event that an Exchange is unable to send these notices electronically due to technical limitations.

his or her account. Confidential information will not be included in the email or electronic alert;

(5) Send a notice by regular mail within three business days of the date of a failed electronic communication if an electronic communication is undeliverable; and

(6) At the individual's request, provide through regular mail any notice posted to the individual's electronic account.

(b) Limitation on use of electronic notices and other communications. Notice or other communications will be provided electronically only if the individual:

(1) Has affirmatively elected to receive electronic communications in accordance with paragraph (a) of this subsection; and

(2) Is permitted to change such election at any time.

68.00 Notice of decision and appeal rights (01/15/2019, GCR 18-064)

68.01 Notice of decision concerning eligibility[106] (01/15/2019, GCR 18-064)

(a) In general. AHS will send timely notice of any decision affecting eligibility in accordance with federal and state laws. A notice regarding QHP premium non-payment issued by a QHP issuer under § 64.06(b)(1) is not a notice of decision.

In general, a notice of a decision that adversely affects an enrollee's eligibility will be sent in advance of its effective date. A notice of a decision that adversely affects a Medicaid enrollee's eligibility, including a notice of termination, reduction, suspension of eligibility, or increase in liability, will comply with the advance notice requirements under § 68.02.

(b) Content of eligibility notice

(1) In general. Any notice of decision will contain clear statements of the following:

(i) AHS's decision and its basis;

(ii) The effective date of the decision, if applicable;

(iii) The specific reasons supporting the decision;

(iv) The specific regulations that support, or the change in federal or state law that requires, the decision;

(v) An explanation of the individual's appeal rights, including the right to request a fair hearing and an explanation of the circumstances under which the individual has the right to an expedited

[106] 42 CFR § 435.917; 45 CFR §§ 155.310(g) and 155.355.

administrative appeal pursuant to § 80.07;

(vi) A description of the methods by which the individual may appeal;

(vii) The time frame in which AHS must make a final administrative decision in a fair hearing and an expedited administrative appeal;

(viii) Information on the individual's right to represent themselves at a fair hearing or use legal counsel, a relative, a friend or other spokesperson;

(ix) In cases of a decision based on a change in law, an explanation of the circumstances under which a fair hearing will be granted;

(x) An explanation of the circumstances under which the individual's eligibility for QHP, APTC or CSR or their Medicaid will be continued pending a fair hearing decision; and

(xi) In connection with eligibility for a QHP, an explanation that a fair hearing decision for one household member may result in a change in eligibility for other household members and that change may be handled as a redetermination.

(2) Notice of approved eligibility. In addition to the information in paragraph (b)(1) of this subsection, a notice of approval of eligibility will contain clear statements of the following:

(i) The basis and effective date of the eligibility;

(ii) The circumstances under which the individual must report, and the methods for reporting, any changes that may affect their eligibility;

(iii) For an individual approved for Medicaid, basic information on the level of Medicaid benefits and services approved, including, if applicable, a description of any premiums and cost-sharing required, an explanation of how to request additional detailed information on benefits and financial responsibility, and the right to appeal the level of benefits and services approved; and

(iv) For an individual approved for Medicaid subject to a spenddown, the amount of medical expenses which must be incurred to establish eligibility.

(3) Medicaid notices of decision based on income at or below MAGI-based standard.[107] Whenever an approval, denial or termination of eligibility is based on an individual having a household income at or below the applicable MAGI-based income standard, the eligibility notice will contain clear statements of the following:

(i) Information regarding bases of eligibility other than the MAGI-based income standard and the benefits and services available to individuals eligible on such other bases, sufficient to enable the individual to make an informed choice as to whether to request a determination on such other bases; and

[107] 42 CFR § 435.917(c).

(ii) Information on how to request a determination on such other bases.

(c) Timing of notification of appeal rights.[108] AHS will provide notice of appeal rights as described in paragraph (b)(1) of this subsection:

(1) At the time that the individual applies for health benefits; and

(2) At the time AHS makes a decision affecting the individual's eligibility.

68.02 Advance notice of Medicaid adverse action decision[109] (01/01/2018, GCR 17-048)

(a) In general. AHS will send a notice of a decision that adversely affects an enrollee's Medicaid eligibility, including a notice of termination, reduction, suspension of eligibility, or increase in liability, as described at § 68.01(a), (adverse action) at least 11 days before the date the adverse action is to take effect (date of adverse action), except as permitted under paragraph (b) of this subsection.

(b) Exception.[110] A notice may be sent not later than the date of adverse action if:

(1) There is factual information confirming the death of an enrollee;

(2) A clear written statement signed by an enrollee is received that:

(i) The enrollee no longer wishes eligibility; or

(ii) Gives information that requires termination or reduction of eligibility and indicates that the enrollee understands that this must be the result of supplying that information;

(3) The enrollee has been admitted to an institution where they are ineligible;

(4) The enrollee's whereabouts are unknown and the post office returns mail directed to the enrollee indicating no forwarding address; or

(5) AHS establishes the fact that the enrollee has been accepted for Medicaid eligibility by another state, territory, or commonwealth.

(c) Exception: probable fraud.[111] The period of advance notice may be shortened to 5 days before the date of adverse action if:

(1) There are facts indicating that adverse action should be taken because of probable fraud by the enrollee;

[108] 42 CFR § 431.206(c).

[109] 42 CFR § 431.211.

[110] 42 CFR § 431.213.

[111] 42 CFR § 431.214.

and

(2) The facts have been verified, if possible, through secondary sources.

69.00 Corrective action[112] (01/15/2017, GCR 16-100)

Corrective payments will be promptly made, retroactive to the date an incorrect action was taken if:

(a) A fair hearing decision is favorable to an individual; or

(b) An issue is decided in an individual's favor before a fair hearing.

70.00 Medicaid enrollment (01/01/2018, GCR 17-048)

70.01 Enrollment when no premium obligation (01/15/2017, GCR 16-100)

(a) Prospective enrollment. Except when a spenddown is necessary, an individual approved for Medicaid without a premium obligation will be enrolled in Medicaid on the first day of the month within which their application is received by AHS provided they are eligible for that month.

(b) Retroactive eligibility[113]

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

(i) Eligibility is determined and a budget computed separately for each of the three months;

(ii) A medical need exists; and

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

(2) An individual may be eligible for the retroactive period (or any single month(s) of the retroactive period) even though ineligible for the prospective period.

(3) If an individual, at the time of application, declares that they incurred medical expenses during the retroactive period and eligibility is not approved, the individual's case record must contain documentation of the reason the individual was not eligible in one or more months of the retroactive period.

70.02 Premium obligation; initial billing and payment (01/01/2018, GCR 17-048)

(a) Initial billing. An individual who is approved for Medicaid with a premium obligation will be notified of the premium obligation and premium amount in a bill that will be sent at the time of approval. The individual will not

[112] 42 CFR § 431.246.

[113] § 1902(a)(34) of the Act; 42 CFR § 435.915.

be enrolled in Medicaid until AHS receives payment of the initial premium. The bill will include payment instructions. If the premium payment is made by mail, the payment will be considered received as of the date it is postmarked.

(b) Initial premium bill amount

(1) The initial bill will include premium charges for the month in which the individual's application was received (the application month) and the month following the application month if eligibility is approved in the same month as the application month. The premium due date is the last day of the month following the application month. If the month eligibility is approved is different than the application month, the initial bill will include the application month, the approval month, any month (or months) between the application month and the approval month, and the month following the approval month. The premium due date is the last day of the month following the approval month.

(2) If the individual is eligible for, and requests, retroactive coverage at the time of their initial application, the initial bill will include premium charges for each month of retroactive coverage. See § 70.01(b) for details on the requirements that must be met for retroactive eligibility.

(c) Payment allocation. When a premium payment is made for the initial months of coverage, and the payment covers the premiums due for at least one, but fewer than all, of the months included in the bill, the payment will be allocated in reverse chronological order, beginning with the latest month included in the bill and extending back as follows: (1) each month between the latest month and the application month, (2) the application month, and (3) any retroactive coverage months included in the bill.

Coverage will begin on the first day of the earliest month for which a full premium has been paid in accordance with the allocation method described above.

Once an individual is in an ongoing billing cycle due to the issuance of a bill for a subsequent month not included in the bill for the initial months, payments will be applied to the coverage month for which the latest bill was issued and to future coverage months. See § 64.04 for a description of the ongoing billing and payment process.

(d) Coverage islands; premiums paid after enrollment

(1) Individuals who initially pay the premiums due for fewer than all of the months included in the initial bill may subsequently obtain coverage islands for any or all of the remaining months (a "coverage island" is a period of eligibility with specific beginning and end dates).

(2) To obtain one or more coverage islands, the individual must pay the full premium amount that was initially billed for each of the desired months of coverage.

(3) Payments of coverage islands will be allocated in the order specified in paragraph (c) of this § 70.02.

71.00 Enrollment of qualified individuals in QHPs[114] (01/15/2019, GCR 18-064)

71.01 In general (01/01/2018, GCR 17-048)

(a) General requirements.[115] AHS will accept a QHP selection from an individual who is determined eligible for enrollment in a QHP in accordance with § 11.00, and will:

(1) Notify the issuer of the individual's selected QHP; and

(2) Transmit information necessary to enable the QHP issuer to enroll the individual.

(b) Timing of data exchange.[116] AHS will:

(1) Send eligibility and enrollment information to QHP issuers and HHS promptly and without undue delay;

(2) Establish a process by which a QHP issuer acknowledges the receipt of such information; and

(3) Send updated eligibility and enrollment information to HHS promptly and without undue delay, in a manner and timeframe specified by HHS.

(c) Records.[117] Records of all enrollments in QHPs will be maintained.

(d) Reconcile files.[118] AHS will reconcile enrollment information with QHP issuers and HHS no less than on a monthly basis.

(e) Notice of employee's receipt of APTCs and CSRs to an employer.[119] AHS will notify an employer that an employee has been determined eligible for advance payments of the premium tax credit and cost-sharing reductions and has enrolled in a qualified health plan through VHC within a reasonable timeframe following a determination that the employee is eligible for advance payments of the premium tax credit and cost-sharing reductions and enrollment by the employee in a qualified health plan through VHC. Such notice must:

(1) Identify the employee;

(2) Indicate that the employee has been determined eligible for advance payments of the premium tax credit

[114] 45 CFR § 155.400.

[115] 45 CFR § 155.400(a).

[116] 45 CFR § 155.400(b).

[117] 45 CFR § 155.400(c).

[118] 45 CFR § 155.400(d).

[119] 45 CFR § 155.310(h).

and cost-sharing reductions and has enrolled in a qualified health plan through VHC;

(3) Indicate that, if the employer has 50 or more full-time employees, the employer may be liable for the payment assessed under § 4980H of the Code; and

(4) Notify the employer of the right to appeal the determination and where to file the appeal as described in § 45.00(b).

(f) Premium payment.[120] In accordance with § 64.01(h)(2), initial payment of the full invoiced premium is a condition of enrollment. AHS will not enroll an applicant into coverage without full initial payment. Initial payment is due no later than twenty-one (21) days from the invoice date. An applicant's failure to pay timely will result in cancellation of a plan selection and will not implicate the grace period and noticing provisions for enrollees at § 64.06.

71.02 Annual open enrollment periods[121] (01/15/2017, GCR 16-100)

(a) General requirements[122]

(1) Annual open enrollment periods (AOEPs) will be provided consistent with this subsection, during which qualified individuals may enroll in a QHP and enrollees may change QHPs.

(2) A qualified individual may only be permitted to enroll in a QHP or an enrollee to change QHPs during the AOEP specified in paragraph (e) of this subsection, or a special enrollment period (SEP) described in § 71.03 for which the qualified individual has been determined eligible.

(b) [Reserved]

(c) [Reserved]

(d) Notice of AOEP.[123] AHS will provide a written AOEP notification to each enrollee no earlier than the first day of the month before the open enrollment period begins and no later than the first day of the open enrollment period.

(e) AOEP.[124] The AOEP will be in accordance with federal law.

[120] See, 45 CFR § 155.400(e).

[121] 45 CFR § 155.410.

[122] 45 CFR § 155.410(a).

[123] 45 CFR § 155.410(d).

[124] 45 CFR § 155.410(e).

(f) Coverage effective dates during the AOEP[125]

(1) Coverage will be effective January 1, for a QHP selection received on or before December 15.

(2) To the extent the AOEP extends beyond December 15, for a QHP selection received:

(i) Between the first and the fifteenth day of a month during the AOEP, coverage will be effective on the first day of the following month.

(ii) Between the sixteenth and the last day of a month during the AOEP, coverage will be effective on the first day of second following month.

(iii) For example, coverage will be effective February 1 for a QHP selection received from December 16 through January 15.

71.03 Special enrollment periods (SEP)[126] (01/15/2019, GCR 18-064)

(a) General requirements[127]

(1) AHS will provide SEP consistent with this subsection, during which qualified individuals may enroll in QHPs and enrollees may change QHPs.

(2) For the purpose of this subsection, “dependent” has the same meaning as it does in 26 CFR § 54.9801-2, referring to any individual who is or who may become eligible for coverage under the terms of a QHP because of a relationship to a qualified individual or enrollee.

(3) The requirement to have coverage in the 60 days prior to a triggering event is met if the qualified individual either had minimum essential coverage as described in § 23.00 for one or more days during the 60 days preceding the date of the triggering event; lived in a foreign country or in a United States territory for one or more days during the 60 days preceding the date of the triggering event; or meets other criteria established under federal law.[128]

(b) Effective dates[129]

(1) Regular effective dates. Except as specified in paragraphs (b)(2) and (3) of this subsection, for a QHP selection received by AHS from a qualified individual:

[125] 45 CFR § 155.410(f).

[126] 45 CFR § 155.420.

[127] 45 CFR § 155.420.

[128] See, e.g., 45 CFR §§ 155.420(a)(5) and 155.420(d)(6)(iv).

[129] 45 CFR § 155.420(b).

(i) Between the first and the fifteenth day of any month, the coverage effective date will be the first day of the following month; and

(ii) Between the sixteenth and the last day of any month, the coverage effective date will be the first day of the second following month.

(2) Special effective dates

(i) In the case of birth, adoption, placement for adoption, or placement in foster care, coverage is effective for a qualified individual or enrollee on the date of birth, adoption, placement for adoption, or placement in foster care or, if elected by the qualified individual or enrollee, in accordance with paragraph (b)(1) of this subsection.

(ii) In the case of marriage, as described in paragraph (d)(2) of this subsection, coverage is effective for a qualified individual or enrollee on the first day of the month following plan selection.

(iii) In the case of a qualified individual or enrollee eligible for a special enrollment period as described in paragraphs (d)(4), (d)(5), (d)(9), (d)(10), (d)(11), (d)(12), or (d)(13) of this subsection, coverage is effective on an appropriate date based on the circumstances of the special enrollment period.

(iv) In a case where an individual loses coverage as described in paragraph (d)(1) or (d)(6)(iii) of this subsection, if the plan selection is made before or on the day of the loss of coverage, the coverage effective date is on the first day of the month following the loss of coverage. If the plan selection is made after the loss of coverage, the coverage is effective on the first day of the following month.

(v) In the case of a court order as described in paragraph (d)(2)(i) of this subsection, coverage is effective for a qualified individual or enrollee on the date the court order is effective.

(vi) In a case where an enrollee or their dependent dies as described in paragraph (d)(2)(ii) of this subsection, coverage is effective on the first day of the month following the plan selection.

(vii) In a case where an individual gains access to a new QHP as described in paragraph (d)(7) of this subsection or becomes newly eligible for enrollment in a QHP through VHC in accordance with § 19.01 as described in paragraph (d)(3) of this subsection, if the plan selection is made on or before the date of the triggering event, coverage is effective on the first day of the month following the date of the triggering event. If the plan selection is made after the date of the triggering event, coverage is effective in accordance with paragraph (b)(1) of this subsection.

(viii) In a case where an individual becomes pregnant as described in paragraph (d)(14) of this subsection, coverage is effective on the first day of the month following plan selection.

(3) Option for earlier effective dates. Subject to demonstrating to HHS that all of the participating QHP issuers agree to effectuate coverage in a timeframe shorter than discussed in paragraph (b)(1) or (b)(2)(ii) of this subsection, one or both of the following may be done for all applicable individuals:

(i) For a QHP selection received from a qualified individual in accordance with the dates specified in paragraph (b)(1) or (b)(2)(ii) of this section, a coverage effective date for a qualified individual may be provided earlier than specified in such paragraphs.

(ii) For a QHP selection received from a qualified individual on a date set by the state after the fifteenth of the month, a coverage effective date of the first of the following month may be provided.

(4) APTC and CSR. Notwithstanding the standards of this subsection, APTC, Vermont Premium Reduction and federal and state CSR will adhere to the effective dates specified in § 73.06.

(c) Availability and length of SEP[130]

(1) *General rule*. Unless specifically stated otherwise herein, a qualified individual or enrollee has 60 days from the date of a triggering event to select a QHP.

(2) *Advanced availability*.

A qualified individual or their dependent who is described in one of the following paragraphs of this subsection has 60 days before and after the date of the triggering event to select a QHP:

(i) (d)(1);

(ii) (d)(3) if they become newly eligible for enrollment in a QHP through VHC because they newly satisfy the requirements under § 19.01;

(iii) (d)(6)(iii); or

(iv) (d)(7).

(3) *Special rule*. In the case of a qualified individual or enrollee who is eligible for an SEP as described in paragraphs (d)(4), (d)(5), or (d)(9) of this subsection, AHS may define the length of the SEP as appropriate based on the circumstances of the SEP, but in no event will the length of the SEP exceed 60 days.

(d) SEPs.[131] AHS will allow a qualified individual or enrollee, and, when specified below, their dependent, to enroll in or change from one QHP to another if one of the following triggering events occur:

(1) The qualified individual or their dependent either:

(i) Loses MEC. The date of the loss of coverage is the last day the individual would have coverage under their previous plan or coverage;

(ii) Is enrolled in any non-calendar year group health plan or individual health insurance coverage, even if the qualified individual or their dependent has the option to renew such coverage. The date of the loss of coverage is the last day of the plan or policy year; or

[130] 45 CFR § 155.420(c).

[131] 45 CFR § 155.420(d).

(iii) Loses medically needy coverage only once per calendar year. The date of the loss of coverage is the last day the individual would have medically needy coverage.

(2) *Gain or loss of dependent*

(i) The qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order.[132] In the case of marriage, at least one spouse must have had coverage for one or more days during the 60 days preceding the date of marriage, as described in paragraph (a)(3) of this subsection.

(ii) The enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by state law in the state in which the divorce or legal separation occurs, or if the enrollee or their dependent dies.

(3) The qualified individual, or their dependent, becomes newly eligible for enrollment in a QHP through VHC because they newly satisfy the requirements under § 17.02 (citizenship, status as a national, lawful presence) or § 19.01 (incarceration);

(4) The qualified individual's or their dependent's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct or inaction of an officer, employee, or agent of AHS or HHS, its instrumentalities, or an individual or entity authorized by AHS to provide enrollment assistance or conduct enrollment activities, as evaluated and determined by AHS. For purposes of this provision, misconduct includes, but is not limited to, the failure to comply with applicable standards under this rule or other applicable federal or state laws, as determined by AHS. In such cases, AHS may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, misconduct or inaction. See § 76.00(e)(3) regarding correction of an erroneous termination or cancellation of coverage;

(5) The enrollee or their dependent adequately demonstrates to AHS that the QHP in which they are enrolled substantially violated a material provision of its contract in relation to the enrollee;

(6) *Newly eligible or ineligible for APTC, or change in eligibility for CSR.*

(i) The enrollee is determined newly eligible or newly ineligible for APTC or has a change in eligibility for CSR;

(ii) The enrollee's dependent enrolled in the same QHP is determined newly eligible or newly ineligible for APTC or has a change in eligibility for CSR; or

(iii) A qualified individual or their dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for APTC based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan, including as a result of their employer discontinuing or changing available coverage within the next 60 days, provided that such individual

[132] See, 8 VSA § 4100b.

is allowed to terminate existing coverage.

(7) The qualified individual or enrollee, or their dependent, gains access to new QHPs as a result of a permanent move and had coverage for one or more days during the 60 days preceding the date of the permanent move, as described in paragraph (a)(3) of this subsection.

(8) The qualified individual:

(i) Who gains or maintains status as an Indian, as defined by § 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month; or

(ii) Who is or becomes a dependent of an Indian, as defined by § 4 of the Indian Health Care Improvement Act and is enrolled or is enrolling in a QHP through VHC on the same application as the Indian, may change from one QHP to another one time per month, at the same time as the Indian;

(9) The qualified individual or enrollee, or their dependent, demonstrates to AHS, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as AHS may provide.[133]

(10) The qualified individual or enrollee is a victim of domestic abuse or spousal abandonment as described in § 12.03(b). This special enrollment period is available to any member of a household who is a victim of domestic abuse, including unmarried and dependent victims within the household, as well as victims of spousal abandonment, including their dependents.

(11) The qualified individual or their dependent applies for coverage during the AOEP or due to a triggering event, is assessed as potentially eligible for Medicaid, and is determined ineligible for Medicaid either after the AOEP has ended or more than 60 days after the triggering event.

(12) The qualified individual or enrollee, or their dependent, adequately demonstrates to AHS that a material error related to plan benefits, service area, or premium influenced the qualified individual's or enrollee's decision to purchase a QHP.

(13) The qualified individual whose enrollment in a QHP through VHC has been terminated based on a citizenship or immigration status inconsistency submits sufficient documentation of citizenship or immigration status.[134]

(14) The qualified individual, who is not an enrollee, becomes pregnant. Any individual who is eligible for coverage under the terms of the health benefit plan because of a relationship to the pregnant individual may enroll through this SEP provided the pregnant individual does so. This SEP is available at any time

[133] See Vermont Health Connect's website for more information on these triggering events.

[134] See, § 11.02 regarding QHP eligibility and § 57.00(c)(4)(ii) regarding eligibility determination as a result of an inconsistency.

after the commencement of the pregnancy for the duration of the pregnancy.[135]

(15) The qualified individual is in possession of a certificate of exemption as described in § 23.06 and

(i) Is notified by HHS that they are no longer eligible for the exemption; or

(ii) Is eligible for enrollment in a QHP that is a catastrophic plan as described in § 14.00(b). When this triggering event occurs, the individual may only enroll in a catastrophic plan.

(e) Loss of coverage[136]

(1) Loss of coverage described in paragraph (d)(1) of this subsection includes those circumstances described in paragraphs (d)(1)(ii) and (iii) of this subsection and in paragraphs (3)(i) through (iii) below. Loss of coverage does not include voluntary termination of coverage or other loss due to:

(i) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; or

(ii) Termination of an individual's coverage for cause (which could include, but not be limited to, termination because of an action by the individual that constituted fraud or because the individual made an intentional misrepresentative of a material fact).[137]

(2) Eligibility for COBRA when the qualified individual or their dependent loses coverage does not disqualify the individual or their dependent from a special enrollment period under this subsection.

(3) The following conditions also qualify an employee for a special enrollment period under (d)(1) of this subsection:[138]

(i) *Loss of eligibility for coverage*. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time the coverage is terminated as a result of loss of eligibility. Loss of eligibility under this paragraph does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage under this paragraph includes (but is not limited to):

(A) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of

[135] 33 VSA § 1811(l).

[136] 45 CFR § 155.420(e).

[137] See, 45 CFR § 147.128.

[138] 26 CFR § 54.9801-6(a)(3)(i) through (iii).

employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;

(B) In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);

(C) In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, loss of coverage because an individual no longer resides, lives or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual; and

(D) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals [139]that includes the individual.

(ii) *Termination of employer contributions*. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent.

(iii) *Exhaustion of COBRA continuation coverage*.[140] In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions are satisfied at the time the COBRA continuation coverage is exhausted. An individual who satisfies the conditions of paragraph (e)(3)(i) of this subsection, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions of this paragraph.

72.00 Duration of QHP eligibility determinations without enrollment[141] (01/01/2018, GCR 17-048)

To the extent that an individual who is determined eligible for enrollment in a QHP does not select a QHP within their enrollment period, or is not eligible for an enrollment period, in accordance with § 71.00, and seeks a new enrollment period prior to the date on which their eligibility is redetermined in accordance with § 75.00 (annual redetermination), AHS will require the individual to attest as to whether information affecting their eligibility has changed since their most recent eligibility determination before determining their eligibility for a special enrollment period, and will process any changes reported in accordance with the procedures specified in § 73.00 (mid-year redetermination).

[139] See, 26 CFR § 54.9802-1(d).

[140] See, also, 26 CFR § 54.9801-2.

[141] 45 CFR § 155.310(j).

73.00 Eligibility redetermination during a benefit year[142] (01/01/2018, GCR 17-048)

73.01 General requirement (01/15/2017, GCR 16-100)

AHS must redetermine the eligibility of an individual in a health-benefits program or for enrollment in a QHP during the benefit year if it receives and verifies new information reported by the individual or identifies updated information through the data matching described in § 73.04, and such new information may affect eligibility.

73.02 Verification of reported changes (01/15/2017, GCR 16-100)

In general.[143] AHS will:

(a) Verify any information reported by an individual in accordance with the processes specified in §§ 53.00 through 56.00 prior to using such information in an eligibility redetermination; and

(b) Provide periodic electronic notifications regarding the requirements for reporting changes and an individual's opportunity to report any changes as described in § 4.03(b), to an individual who has elected to receive electronic notifications, unless the individual has declined to receive notifications under this paragraph (b).

73.03 Reestablishment of annual renewal date for Medicaid enrollees[144] (01/15/2017, GCR 16-100)

(a) If a redetermination is made during a benefit year for a Medicaid enrollee because of a change in the individual's circumstances and, subject to the limitation under (b) of this subsection, there is enough information available to renew eligibility with respect to all eligibility criteria, a new 12-month renewal period may begin.

(b) *Limitation on AHS's ability to request additional information*. For renewal of a Medicaid enrollee whose financial eligibility is determined using MAGI-based income, any requests by AHS for additional information from the individual will be limited to information relating to such change in circumstance.

73.04 Periodic examination of data sources[145] (01/01/2018, GCR 17-048)

AHS will periodically examine the available data sources described in § 56.01.

For QHP enrollees:

(a) This periodic examination will be to identify the following changes:

[142] 42 CFR § 435.916(d); 45 CFR § 155.330.

[143] 42 CFR § 435.916(d); 45 CFR § 155.330(c).

[144] 42 CFR § 435.916(d)(1)(ii).

[145] 45 CFR § 155.330(d)(1).

(1) Death; and

(2) For an individual on whose behalf APTC or CSR is being provided, eligibility for or enrollment in Medicare or Medicaid.

(b) AHS may make additional efforts to identify and act on other changes that may affect an individual's eligibility for enrollment in a health-benefits program or in a QHP, provided that such efforts:

(1) Would reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delay, and that applicable requirements with respect to the confidentiality, disclosure, maintenance, or use of such information will be met; and

(2) Comply with the standards specified in § 73.05(b).[146]

73.05 Redetermination and notification of eligibility[147] (01/01/2018, GCR 17-048)

(a) Enrollee-reported data.[148] If AHS verifies updated information reported by an individual, AHS will:

(1) Promptly redetermine the individual's eligibility in accordance with eligibility standards;

(2) Notify the individual regarding the redetermination in accordance with the requirements specified in § 68.00; and

(3) Notify the individual's employer, as applicable, in accordance with § 71.01(e).

(b) Data matching[149]

(1) For QHP enrollees:

(i) Except as provided in (iii) below, if AHS identifies updated information regarding death, in accordance with § 73.04(a)(1), or regarding any factor of eligibility not regarding income, family size, family composition, or tax filing status AHS will:

(A) Notify the individual regarding the updated information, as well as the individual's projected eligibility determination after considering such information;

(B) Allow the individual 30 days from the date of the notice to notify AHS that such information is inaccurate; and

(C) If the individual responds contesting the updated information, proceed in accordance with §

[146] 45 CFR § 155.330(d)(2).

[147] 45 CFR § 155.330(e).

[148] 45 CFR § 155.330(e)(1).

[149] 45 CFR § 155.330(e)(2).

57.00 (inconsistencies).

(D) If the individual does not respond within the 30-day period, proceed in accordance with paragraphs (a)(1) and (2) of this subsection.

(ii) If AHS identifies updated information regarding income, family size or family composition, with the exception of information regarding death, AHS will:

(A) Follow procedures described in paragraphs (b)(1)(i)(A) and (B) of this subsection; and

(B) If the individual responds confirming the updated information, proceed in accordance with paragraphs (a)(1) and (2) of this subsection.

(C) If the individual does not respond within the 30-day period, maintain the individual's existing eligibility determination without considering the updated information.

(D) If the individual provides more up-to-date information, proceed in accordance with § 73.02.

(iii) If AHS receives information from the Secretary of the Treasury that the tax filer for the enrollee's household or the tax filer's spouse did not comply with the requirements described in § 12.05, AHS when redetermining and providing notification of eligibility for advance payments of the premium tax credit will:

(A) Follow the procedures specified in paragraph (a) of this subsection.

(B) After a redetermination under this subsection, allow a tax filer to re-attest to compliance with the requirements described in § 12.05 and request a redetermination of eligibility.

(2) For Medicaid enrollees, if AHS identifies updated information regarding any factor of eligibility, AHS will proceed in accordance with the provisions of § 57.00(c).

73.06 Effective dates for QHP eligibility redeterminations[150] (01/15/2017, GCR 16-100)

(a) Except as specified in paragraphs (b) through (e) of this subsection, AHS will implement changes for QHP eligibility redeterminations as follows:

(1) Resulting from a redetermination under this section, on the first day of the month following the date of the notice described in § 73.05(a)(2); or

(2) Resulting from an appeal decision, on the date specified in the appeal decision; or

(3) Affecting enrollment or premiums only, on the first day of the month following the date on which AHS is notified of the change;

(b) Except as specified in paragraphs (c) through (e) of this subsection, AHS may determine a reasonable point in a month after which a change described in paragraph (a) of this subsection will not be effective until the first day of the month after the month specified in paragraph (a). Such reasonable point in a month must be no

[150] 45 CFR § 155.330(f).

earlier than the 15th of the month.

(c) Except as specified in paragraphs (d) and (e) of this subsection, AHS will implement a change described in paragraph (a) of this subsection that results in a decreased amount of APTC or a change in the level of CSR and for which the date of the notices described in paragraphs (a) (1) and (2) of this subsection, or the date on which AHS is notified in accordance with paragraph (a)(3) of this subsection is after the 15th of the month, on the first day of the month after the month specified in (a) of this subsection.

(d) AHS will implement a change associated with the events described in § 71.03(b)(2)(i) and (ii) on the coverage effective dates described in § 71.03(b)(2)(i) and (ii), respectively.

(e) Notwithstanding paragraphs (a) through (d) of this subsection, AHS will provide the effective date of a change associated with the events described in § 71.03(d)(4), (d)(5) and (d)(9) based on the specific circumstances of each situation.

73.07 Recalculation of APTC/CSR[151] (01/01/2018, GCR 17-048)

(a) When an eligibility redetermination in accordance with this section results in a change in the amount of APTC for the benefit year, AHS will recalculate the amount of APTC in such a manner as to:

(1) Account for any APTC made on behalf of the tax filer for the benefit year for which information is available to AHS, such that the recalculated APTC is projected to result in total advance payments for the benefit year that correspond to the tax filer's total projected premium tax credit for the benefit year, calculated in accordance with § 60.00, and

(2) Ensure that the APTC provided on the tax filer's behalf is greater than or equal to zero and is calculated in accordance with § 60.03.

(b) When an eligibility redetermination in accordance with this section results in a change in CSR, AHS will determine an individual eligible for the category of CSR that corresponds to their expected annual household income for the benefit year (subject to the special rule for family policies under § 13.03).

74.00 [Reserved] (01/15/2017, GCR 16-100)

75.00 Eligibility renewal[152] (01/15/2019, GCR 18-064)

75.01 In general (01/15/2017, GCR 16-100)

(a) Renewal occurs annually. Except as specified in §§ 75.02(k) and 75.02(l), eligibility of an individual in a health-benefits program or for enrollment in a QHP will be renewed on an annual basis.

(b) Updated income and family size information. In the case of an individual who requested an eligibility

[151] 45 CFR § 155.330(g).

[152] 42 CFR § 435.916(a) and (b); 45 CFR § 155.335.

determination for a health-benefits program (i.e., health benefits other than enrollment in a QHP without APTC or CSR), AHS will request updated tax return information, if the individual has authorized the request of such tax return information, data regarding Social Security benefits, and data regarding income (as described in § 56.01) for use in the individual's eligibility renewal.

(c) Authorization of the release of tax data to support annual redetermination[153]

(1) AHS must have authorization from an individual in order to obtain updated tax return information described in paragraph (b) of this subsection for purposes of conducting an annual redetermination.

(2) AHS is authorized to obtain the updated tax return information described in paragraph (b) of this subsection for a period of no more than five years based on a single authorization, provided that:

(i) An individual may decline to authorize AHS to obtain updated tax return information; or

(ii) An individual may authorize AHS to obtain updated tax return information for fewer than five years; and

(iii) AHS must allow an individual to discontinue, change, or renew his or her authorization at any time.

75.02 Renewal procedures for QHP enrollment (01/15/2019, GCR 18-064)

(a) Alternative procedures for annual renewals. AHS will conduct annual renewals of QHPs using one of the following:

(1) The procedures described in this section;

(2) Alternative procedures specified by HHS for the applicable benefit year; or

(3) Alternative procedures approved by HHS based on a showing by AHS that the alternative procedures would facilitate continued enrollment in coverage for which the individual remains eligible, provide clear information about the process to the individual (including regarding any action by the individual necessary to obtain the most accurate redetermination of eligibility), and provide adequate program integrity protections.

(b) Continuation of coverage. An individual who is enrolled in a QHP and whose QHP remains available will not be required to reapply or take other actions to renew coverage for the following year.

(c) Notice to enrollee.[154] For renewal of an individual's eligibility for enrollment in a QHP, AHS will provide an annual renewal notice to an individual, including the following:

(1) [Reserved]

[153] 45 CFR § 155.335(k).

[154] 45 CFR § 155.335(c).

(2) [Reserved]

(3) The individual's projected eligibility determination for the following year, after considering any updated information described in § 75.01(b), including, if applicable, the amount of any APTC and the level of any CSR or eligibility for Medicaid.

(d) Timing[155]

(1) The notice provisions of paragraph (c) of this subsection and § 71.02(d) may be satisfied through a single, coordinated notice.

(2) The notice specified in paragraph (c) of this subsection may be sent separately from the notice of annual open enrollment specified in § 71.02(d), provided that:

(i) The notice specified in paragraph (c) of this subsection is sent no earlier than the date of the notice of annual open enrollment specified in § 71.02(d); and

(ii) The timing of the notice specified in paragraph (c) of this subsection allows a reasonable amount of time for the individual to review the notice, provide a timely response, and for any changes in coverage elected during the AOEP to be implemented.

(e) Changes reported by enrollees[156]

(1) An individual must report any changes for the information listed in the notice described in paragraph (c) of this subsection within 30 days from the date of the notice.

(2) An individual, or an application filer, on behalf of the individual, may report changes via the channels available for the submission of an application, as described in § 52.02(b).

(f) Verification of reported changes.[157] Any information reported by an individual under paragraph (e) of this subsection will be verified by AHS using the processes specified in §§ 53.00 through 56.00, including the relevant provisions in those subsections regarding inconsistencies, prior to using such information to determine eligibility.

(g) Response to redetermination notice[158]

(1) An individual, or an application filer, on behalf of the individual, must sign and return the notice described in paragraph (c) of this subsection.

[155] 45 CFR § 155.335(d).

[156] 45 CFR § 155.335(e).

[157] 45 CFR § 155.335(f).

[158] 45 CFR § 155.335(g).

(2) To the extent that an individual does not sign and return the notice described in paragraph (c) of this subsection within the 30-day period specified in paragraph (e) of this subsection, AHS will proceed in accordance with the procedures specified in paragraph (h)(1) of this subsection.

(h) Redetermination and notification of eligibility[159]

(1) After the 30-day period specified in paragraph (e) of this subsection has elapsed, AHS will:

(i) Promptly redetermine the individual's eligibility in accordance with eligibility standards using the information provided to the individual in the notice specified in paragraph (c), as supplemented with any information reported by the individual and verified by AHS in accordance with paragraphs (e) and (f) of this subsection;

(ii) Notify the individual regarding the redetermination in accordance with the requirements specified in § 68.00; and

(iii) Notify the individual's employer, as applicable, in accordance with § 71.01(e).

(2) If an individual reports a change for the information provided in the notice specified in paragraph (c) of this subsection that has not been verified as of the end of the 30-day period specified in paragraph (e) of this subsection, AHS will redetermine the individual's eligibility after completing verification, as specified in paragraph (f) of this subsection.

(i) Effective date of annual redetermination.[160] A determination under this section is effective on the first day of the coverage year following the year in which the notice in paragraph (c) of this subsection was provided, or in accordance with the rules specified in § 73.06 regarding effective dates, whichever is later.

(j) Renewal of coverage.[161] If an individual remains eligible for coverage in a QHP upon annual redetermination, such individual will remain in the QHP selected the previous year unless such individual terminates coverage from such plan, including termination of coverage in connection with enrollment in a different QHP, in accordance with § 76.00.

(k) Limitation on redetermination.[162] To the extent that a qualified individual has requested an eligibility determination for a health-benefits program in accordance with § 63.00(b) and AHS does not have an active authorization to obtain tax data as a part of the annual redetermination process, AHS will redetermine the qualified individual's eligibility only for enrollment in a QHP and notify the enrollee in accordance with the timing described in paragraph (d) of this subsection. AHS will not proceed with a redetermination for a health-benefits program until such authorization has been obtained or the qualified individual continues their request

[159] 45 CFR § 155.335(h).

[160] 45 CFR § 155.335(i).

[161] 45 CFR § 155.335(j).

[162] 45 CFR § 155.335(l).

for an eligibility determination for a health-benefits program.

(l) Special rule.[163] A qualified individual's eligibility will not be redetermined in accordance with this subsection if the qualified individual's eligibility was redetermined under this subsection during the prior year, and the qualified individual was not enrolled in a QHP at the time of such redetermination, and has not enrolled in a QHP since such redetermination.

75.03 Renewal procedures for Medicaid (01/15/2017, GCR 16-100)

(a) Renewal on basis of available information

(1) A redetermination of eligibility for Medicaid will be made without requiring information from the individual if AHS is able to do so based on reliable information contained in the individual's account or other more current information available, including but not limited to information accessed through any data bases.

(2) If eligibility can be renewed based on such information, the individual will be notified:

(i) Of the eligibility determination, and basis; and

(ii) That the individual must inform AHS if any of the information contained in such notice is inaccurate, but that the individual is not required to sign and return such notice if all information provided on such notice is accurate.

(b) Eligibility renewal using pre-populated renewal form. If eligibility cannot be renewed in accordance with paragraph (a)(2) of this subsection, AHS will:

(1) Provide the individual with:

(i) A renewal form containing information available to AHS that is needed to renew eligibility;

(ii) At least 30 days from the date of the renewal form to respond and provide any necessary information through any of the modes of submission specified in § 52.02(b), and to sign the renewal form in a manner consistent with § 52.02(h);

(iii) Notice in a timely manner of the decision concerning the renewal of eligibility in accordance with the requirements specified in § 68.00;

(2) Verify any information provided by the individual in accordance with §§ 53.00 through 56.00;

(3) Reconsider in a timely manner the eligibility of an individual who is terminated for failure to submit the renewal form or necessary information, if the individual subsequently submits the renewal form within 90 days after the date of termination without requiring a new application;

(4) Not require an individual to complete an in-person interview as part of the renewal process; and

[163] 45 CFR § 155.335(m).

(5) Include in its renewal forms its toll-free customer service number and a request that individuals call if they need assistance.

(c) Medicaid continues for all individuals until they are found to be ineligible. When a Medicaid enrollee has done everything they were asked to do, Medicaid will not be closed even though a decision cannot be made within the required review frequency.[164]

76.00 Termination of QHP enrollment or coverage[165] (01/15/2019, GCR 18-064)

(a) General requirements. AHS will determine the form and manner in which enrollment in a QHP may be terminated.

(b) Termination events[166]

(1) Enrollee-initiated terminations

(i) An individual will be permitted to terminate their coverage or enrollment in a QHP, including as a result of the individual obtaining other MEC, with appropriate notice to AHS.

(ii) An individual will be provided an opportunity at the time of plan selection to choose to remain enrolled in a QHP if they become eligible for other MEC and the individual does not request termination in accordance with paragraph (b)(1)(i) of this section. If an individual does not choose to remain enrolled in a QHP in such a situation, AHS will initiate termination of their enrollment upon completion of the redetermination process specified in § 73.00.

(iii) AHS will establish a process to permit individuals, including enrollees' authorized representatives, to report the death of an enrollee for purposes of initiating termination of the enrollee's enrollment. AHS may require the reporting party to submit documentation of the death.

(iv) AHS will permit an enrollee to retroactively terminate or cancel their coverage or enrollment in a QHP in the following circumstances:

(A) The enrollee demonstrates to AHS that they attempted to terminate their coverage or enrollment in a QHP and experienced a technical error that did not allow the enrollee to terminate their coverage or enrollment through VHC, and requests retroactive termination within 60 days after they discovered the technical error.

(B) The enrollee demonstrates to AHS that their enrollment in a QHP through VHC was unintentional, inadvertent, or erroneous and was the result of the error or misconduct of an officer, employee, or agent of AHS or HHS, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities. Such enrollee must request cancellation within 60 days of discovering the unintentional, inadvertent or erroneous enrollment.

[164] Former Medicaid Rule 4142.

[165] 45 CFR § 155.430.

[166] 45 CFR § 155.430(b).

For purposes of this paragraph, misconduct includes the failure to comply with applicable standards under this rule or other applicable federal or state laws, as determined by AHS.

(C) The enrollee demonstrates to AHS that they were enrolled in a QHP without their knowledge or consent by any third party, including third parties who have no connection with AHS, and requests cancellation within 60 days of discovering of the enrollment.

(2) AHS or issuer-initiated termination. AHS may initiate termination of an individual's enrollment in a QHP, and must permit a QHP issuer to terminate such coverage or enrollment, in the following circumstances:

(i) The individual is no longer eligible for coverage in a QHP;

(ii) Non-payment of premiums for coverage of the individual, and

(A) The 3-month grace period required for individuals who when first failing to timely pay premiums are receiving APTC has been exhausted as described in § 64.06; or

(B) Any other grace period not described in paragraph (b)(2)(ii)(A) of this section has been exhausted;

(iii) The individual's coverage is rescinded;

(iv) The QHP terminates or is decertified;

(v) The individual changes from one QHP to another during an AOEP or SEP in accordance with § 71.02 or § 71.03; or

(vi) The enrollee was enrolled in a QHP without their knowledge or consent by a third party, including a third party with no connection with AHS.

(c) Termination of coverage or enrollment tracking and approval.[167] AHS will:

(1) Establish mandatory procedures for QHP issuers to maintain records of termination of enrollment;

(2) Send termination information to the QHP issuer and HHS, promptly and without undue delay, at such time and in such manner as HHS may specify;

(3) Require QHP issuers to make reasonable accommodations for all individuals with disabilities (as defined by the ADA) before terminating enrollment of such individuals; and

(4) Retain records in order to facilitate audit functions.

(d) Effective dates for termination of coverage or enrollment[168]

[167] 45 CFR § 155.430(c).

[168] 45 CFR § 155.430(d).

(1) For purposes of this section:

(i) Reasonable notice is defined as at least fourteen days from the requested effective date of termination; and

(ii) Changes in eligibility for APTC and CSR, including terminations, must adhere to the effective dates specified in § 73.06.

(2) In the case of a termination in accordance with paragraph (b)(1) of this section, the last day of enrollment is the last day of the month during which the termination is requested by the individual, unless the individual requests a different termination date. If an individual requests a different termination date, the last day of enrollment is:

(i) The termination date specified by the individual, if the individual provides reasonable notice.

(ii) If the individual does not provide reasonable notice, fourteen days after the termination is requested by the individual.

(iii) If the individual is newly eligible for Medicaid or other MEC, and the individual so requests, the last day of the month prior to the month during which the termination is requested by the individual, subject to the determination of the individual's QHP issuer.

(3) In the case of a termination in accordance with paragraph (b)(2)(i) of this section, the last day of enrollment is the last day of eligibility, as described in § 73.06, unless the individual requests an earlier termination effective date per paragraph (b)(1)(i) of this section.

(4) In the case of a termination in accordance with paragraph (b)(2)(ii)(A) of this section, the last day of enrollment will be the last day of the first month of the 3-month grace period.

(5) In the case of a termination in accordance with paragraph (b)(2)(ii)(B) of this section, the last day of enrollment should be consistent with existing State laws regarding grace periods.

(6) In the case of a termination in accordance with paragraph (b)(2)(v) of this section, the last day of coverage in an individual's prior QHP is the day before the effective date of coverage in their new QHP, including any retroactive enrollments.

(7) In the case of termination due to death, the last day of enrollment is the date of death.

(8) In cases of retroactive termination dates, AHS will ensure that appropriate actions are taken to make necessary adjustments to APTC, CSR, premiums and claims.

(9) In case of a retroactive termination in accordance with paragraph (b)(1)(iv)(A) of this section, the termination date will be no sooner than 14 days after the date that the enrollee can demonstrate they contacted AHS to terminate their coverage or enrollment through VHC, unless the issuer agrees to an earlier effective date as set forth in paragraph (d)(2)(iii) of this section.

(10) In case of a retroactive cancellation or termination in accordance with paragraph (b)(1)(iv)(B) or (C) of this section, the cancellation date or termination date will be the original coverage effective date or a later

date, as determined appropriate by AHS, based on the circumstances of the cancellation or termination.

(11) In the case of cancellation in accordance with paragraph (b)(2)(vi) of this section, AHS may cancel the enrollee's enrollment upon its determination that the enrollment was performed without the enrollee's knowledge or consent and following reasonable notice to the enrollee (where possible). The termination date will be the original coverage effective date.

(12) In the case of retroactive cancellations or terminations in accordance with paragraphs (b)(1)(iv)(A), (B) and (C) of this section, such terminations or cancellations for the preceding coverage year must be initiated within a timeframe established by AHS based on a balance of operational needs and consumer protection. This timeframe will not apply to cases adjudicated through the appeals process.

(e) Termination, cancellation, reinstatement defined

(1) *Termination*. A termination is an action taken after a coverage effective date that ends an enrollee's enrollment through VHC for a date after the original coverage effective date, resulting in a period during which the individual was enrolled in coverage through VHC.

(2) *Cancellation*. A cancellation is specific type of termination action that ends a qualified individual's enrollment on the date such enrollment became effective resulting in enrollment never having been effective.

(3) *Reinstatement*. A reinstatement is a correction of an erroneous termination or cancellation action and results in restoration of an enrollment with no break in coverage.

77.00 Administration of APTC and CSR[169] (01/01/2018, GCR 17-048)

(a) Requirement to provide information to enable APTC and CSR.[170] In the event that a tax filer is determined eligible for APTC and the Vermont Premium Reduction, if applicable, or an individual is eligible for federal or state CSR, or that such eligibility for such programs has changed, AHS will, simultaneously:

(1) Transmit eligibility and enrollment information to HHS necessary to enable HHS to begin, end, or change APTC or federal CSR; and

(2) Notify and transmit information necessary to enable the issuer of the QHP to implement, discontinue the implementation, or modify the level of APTC, the Vermont Premium Reduction or federal or state CSR, as applicable, including:

(i) The dollar amount of the advance payment including the Vermont Premium Reduction; and

(ii) The CSR eligibility category.

[169] 45 CFR § 155.340.

[170] 45 CFR § 155.340(a).

(b) Requirement to provide information related to employer responsibility[171]

(1) AHS will transmit the individual's name and tax filer identification number to HHS in the event that it determines that an individual is eligible for APTC or CSR based in part on a finding that an individual's employer:

(i) Does not provide MEC;

(ii) Provides MEC that is unaffordable, within the standard of § 23.02; or

(iii) Provides MEC that does not meet the minimum value requirement specified in § 23.03.

(2) If an individual for whom APTC are made or who is receiving CSR notifies AHS that they have changed employers, AHS must transmit the individual's name and tax filer identification number to HHS.

(3) In the event that an individual for whom APTC are made or who is receiving CSR terminates coverage from a QHP during a benefit year, AHS will:

(i) Transmit the individual's name and tax filer identification number, and the effective date of coverage termination, to HHS, which will transmit it to the Secretary of the Treasury; and

(ii) Transmit the individual's name and the effective date of the termination of coverage to their employer.

(c) Requirement to provide information related to reconciliation of APTC.[172] AHS will comply with the requirements of § 78.00 regarding reporting to the IRS and to tax filers.

(d) Timeliness standard.[173] All information required in accordance with paragraphs (a) and (b) of this section will be transmitted promptly and without undue delay.

(e) Allocation of APTC and the Vermont Premium Reduction among policies.[174] If one or more advance payments of the premium tax credit, including the Vermont Premium Reduction, if applicable, are to be made on behalf of a tax filer (or two tax filers covered by the same plan(s)), and individuals in the tax filers' households are enrolled in more than one QHP or stand-alone dental plan, then that portion of the APTC, including the Vermont Premium Reduction, that is less than or equal to the aggregate monthly premiums, as defined in § 60.05, for the QHP policies properly allocated to essential health benefits must be allocated among the QHP policies based on the number of enrollees covered under the QHP.

[171] 45 CFR § 155.340(b).

[172] 45 CFR § 155.340(c).

[173] 45 CFR § 155.340(d).

[174] 45 CFR § 155.340(e).

(f) Reduction of individual's portion of premium to account for APTC and the Vermont Premium Reduction.[175] If a tax filer is eligible for APTC including the Vermont Premium Reduction, if applicable, AHS will:

(1) Reduce the portion of the premium for the policy collected from the individual for the applicable month(s) by the amount of the APTC including the Vermont Premium Reduction, if applicable; and

(2) Include in each billing statement, as applicable, to the individual the amount of the APTC and the Vermont Premium Reduction for the applicable month(s) and the remaining premium owed for the policy.

(g) Failure to reduce individual's premiums to account for APTC and the Vermont Premium Reduction.[176] If AHS discovers that it did not reduce an individual's premium by the amount of the APTC including the Vermont Premium Reduction, if applicable, AHS will notify the individual of the improper reduction within 45 calendar days of discovering the improper reduction and refund the individual any excess premium paid by or for the individual as follows:

(1) Unless a refund is requested by or for the individual, AHS will, within 45 days of discovering the error, apply the excess premium paid by or for the individual to the individual's portion of the premium (or refund the amount directly). If any excess premium remains, AHS will then apply the excess premium to the individual's portion of the premium for each subsequent month for the remainder of the period of enrollment or benefit year until the excess premium is fully refunded (or refund the remaining amount directly). If any excess premium remains at the end of the period of enrollment or benefit year, AHS will refund any excess premium within 45 calendar days of the end of the period of enrollment or benefit year, whichever comes first.

(2) If a refund is requested by or for the individual, the refund will be provided within 45 calendar days of the date of the request.

78.00 Information reporting by AHS[177] (01/15/2017, GCR 16-100)

(a) Information required to be reported[178]

(1) *Information reported annually*.

AHS will report to the IRS the following information for each QHP:

(i) The name, address and taxpayer identification number (TIN), or date of birth if a TIN is not available, of the tax filer or responsible adult (an individual on behalf of whom APTC is not paid);

[175] 45 CFR § 155.340(g).

[176] 45 CFR § 155.340(h)

[177] 26 CFR § 1.36B-5.

[178] 26 CFR § 1.36B-5(c).

(ii) The name and TIN, or date of birth if a TIN is not available, of a tax filer's spouse;

(iii) The amount of advance credit payments paid for coverage under the plan each month;

(iv) For plans for which advance credit payments are made, the premium (excluding the premium allocated to benefits in excess of essential health benefits) for the ABP for purposes of computing advance credit payments;

(v) For plans for which advance credit payments are not made, the premium (excluding the premium allocated to benefits in excess of essential health benefits) for the ABP that would apply to all individuals enrolled in the QHP if advance credit payments were made for the coverage;

(vi) The name and TIN, or date of birth if a TIN is not available, and dates of coverage for each individual covered under the plan;

(vii) The coverage start and end dates of the QHP;

(viii) The monthly premium for the plan in which the individuals enroll, excluding the premium allocated to benefits in excess of essential health benefits:

(ix) The name of the QHP issuer;

(x) The AHS-assigned policy identification number;

(xi) AHS's unique identifier; and

(xii) Any other information required in published guidance.

(2) *Information reported monthly*.

For each calendar month, AHS will report to the IRS for each QHP, the information described in (1) above and the following information:

(i) For plans for which advance credits are made:

(A) The names, TINs, or dates of birth if no TIN is available, of the individuals enrolled in the QHP who are expected to be the tax filer's dependent; and

(B) Information on employment (to the extent this information is provided to AHS) consisting of:

(I) The name, address and employer identification number (EIN) of each employer of the tax filer, the tax filer's spouse, and each individual covered by the plan; and

(II) An indication of whether an employer offered affordable minimum essential coverage that provided minimum value, and, if so, the amount of the employee's required contribution for self-only coverage;

(ii) The unique identifying number AHS uses to report data that enables the IRS to associate the data with the proper account from month to month;

(iii) The issuer's EIN; and

(iv) Any other information specified in published guidance.

(b) Time for reporting. AHS will submit the annual report required under § 78.00(a)(1) on or before January 31 of the year following the calendar year of coverage. AHS will submit the monthly reports required under § 78.00(a)(2) as required by federal law.

(c) Annual statement to be furnished to individuals. On or before January 31 of the year following the calendar year of coverage, AHS will furnish to each tax filer or responsible adult a written statement showing the name and address of the recipient and the information described in (a)(1) of this section.

(d) Manner of reporting. AHS will comply with all guidance published by the Commissioner of the IRS[179] for the manner of reporting under this section.

79.00 [Reserved] (01/15/2017, GCR 16-100)

[179] See § 601.601(d)(2) of chapter one of the Code.

Table of Contents

Part Eight
State fair hearings/expedited eligibility appeals

80.00 State fair hearings and expedited eligibility appeals[1] (07/01/2019, GCR 18-126)

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 (07/01/2019, GCR 18-126)

(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 eligibility in accordance with § 7.03(a)(8) or § 8.06;

(2) A determination of income for the purposes of imposing 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.

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

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

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

(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 (07/01/2019, GCR 18-126)

(a) AHS Secretary's decision[9]

(1) The Secretary of AHS will:

[7] 45 CFR § 155.520(a).

[8] 42 CFR § 431.221(e).

[9] 3 VSA § 3091(h).

(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;

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

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

[11] 45 CFR § 155.520(c).

(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.

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.

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

[12] 45 CFR § 155.545(c).

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

(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).

(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.

(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.

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

[15] 45 CFR 155.540(b)(2)

[16] 42 CFR 431.224(b)

(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.

(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;

(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.

[17] 45 CFR 155.540

[18] 42 CFR 431.224

(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.

(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.

[19] 42 CFR 431.242(a)

[20] 42 CFR 431.244(f)(3)(i)

[21] 42 CFR 431.244(f)(4)(i)

(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.

(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 made on the appeal, provided the SSA's determination of "not disabled" is the only basis on which they might

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

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)