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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) (01/01/2024, GCR 23-083)

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 (01/01/2024, GCR 23-083)

(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 woman during pregnancy and the post partum period, as defined in the definition of pregnant woman in § 3.00, 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 during the retroactive period defined in § 70.01(b) and met all eligibility criteria. If she applies for Medicaid after her pregnancy ends, but was pregnant on or after April 1, 2023, and met all eligibility criteria at § 70.01(b), she may also be granted eligibility through the end of the month in which the post partum period ends.

(iii) Continuous eligibility:

An eligible pregnant woman who would lose eligibility because of a change in circumstances, including a change in household income, household composition or categorical eligibility, is deemed to continue to be eligible throughout the pregnancy and the post partum period without regard to a change in circumstances unless:

(A) The woman requests voluntary termination;

(B) The woman ceases to be a resident of Vermont;

(C) The woman dies; or

(D) AHS determines that eligibility was determined incorrectly at the most recent determination or redetermination of eligibility because of agency error or fraud, abuse, or perjury attributed to the woman.[6]

This provision applies to a medically-needy pregnant woman as follows: If the woman meets her spenddown while pregnant, her eligibility continues during the remainder of her pregnancy and post partum period. The woman does not have to meet a spenddown again until the end of her post partum period.

(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 children effective January 1, 2024:

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

(B) An individual who is determined to be eligible for Medicaid under this sub clause will remain eligible for Medicaid until the first to occur of:

(I) The end of the 12-month period that begins on the date of such determination;

[6] CMS SHO Letter No. 21-007 (December 7, 2021).

[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.

(II) The time that such individual attains the age of 19; or

(III) The date that such individual ceases to be a resident of Vermont.

This provision does not apply to medically-needy children or to children eligible for Medicaid on the basis of Transitional Medical Assistance.

(iii) 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:

(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]

[9] 42 CFR § 435.172.

[10] 42 CFR § 435.119.

[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).

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:

(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

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

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. 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.[15] 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 § 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.[16] 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.

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

[15] 42 CFR § 435.831.

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

(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) (01/01/2024, GCR 23-083)

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.[17]

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).

8.03 Categorical relationship to SSI (01/01/2024, GCR 23-083)

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.

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

(d) Definition: blind or disabled child; continuous eligibility for children.

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

(i) Under age 18, or

(ii) 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.

(2) Continuous eligibility for children. The continuous eligibility for children provision at § 7.03(a)(3)(ii) applies to individuals, who are under age 19, eligible for Medicaid under the MABD categorically-needy coverage groups.

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 (01/01/2024, GCR 23-083)

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

(a) Individual enrolled in SSI/AABD[18]

(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).

(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

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

(i) Have not applied for SSI/AABD[19]; or

(ii) Do not meet SSI/AABD requirements not applicable to Medicaid (e.g., participation in vocational rehabilitation or a substance abuse treatment program)[20].

[18] 42 CFR § 435.120.

[19] 42 CFR § 435.210.

[20] 42 CFR § 435.122.

(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[21] (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:

(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[22], and any veterans' disability benefits, and, if married, all income of the working disabled person's spouse[23], 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.

[21] 42 CFR § 435.120(c).

[22] 33 VSA § 1902(b).

[23] 33 VSA § 1902(b).

(ii) Has resources at the time of enrollment in the group that do not exceed $10,000.00[24] for a single individual and $15,000.00[25] 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.[26] 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:

(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:[27]

(i) The individual:

[24] 33 VSA § 1902(b).

[25] 33 VSA § 1902(b).

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

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

(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[28], 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 SSI/AABD maximum for the individual's Medicaid group; and

(iii) Meet the MABD nonfinancial criteria.

(g) Disabled adult child (DAC)[29]

(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

[28] 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).

[29] SSA § 1634(c).

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[30]

(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) Was 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.

(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.[31] 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

[30] Section 503 of P.L. 94-566; 42 CFR § 435.135(a)(3).

[31] 42 CFR §§ 435.131, 435.132 and 435.133.

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:[32]

(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[33]

(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

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

[33] 42 CFR § 435.134.

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[34]

(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 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.[35] 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));[36]

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

[34] 42 CFR § 435.211.

[35] 42 CFR § 435.236.

[36] 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)).

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

(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).[37] A disabled individual who:

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

(A) For purposes of § 8.05(k)(6):

(I) A "medical institution" means a hospital, skilled nursing facility, or intermediate care facility; and

(II) "Requires the level of care provided in a medical institution" means the individual is living at home but requires the level of care provided in a medical institution.

(B) AHS determines whether the individual requires the level of care provided in a medical institution. AHS may designate a standardized assessment tool which AHS will use whenever it determines whether an individual requires an institutional level of care.

(C) Level of care eligibility for DCHC may be reviewed by AHS annually, unless it is determined that the frequency of reviews should be altered due to the unique circumstances of the individual, or when there is a change in health or functional status of the individual.

[37] Social Security Act § 1902(e)(3); 42 CFR § 435.225.

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

(iii) Can receive the appropriate institutional level of care outside of a medical institution and the estimated Medicaid cost of such care is no greater than the estimated Medicaid cost of appropriate institutional care;

(iv) Is age 18 or younger;

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

(vi) Has MABD resources (described at § 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 (01/01/2024, GCR 23-083)

(a) In general. 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 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 (01/01/2024, GCR 23-083)

(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 or medically-needy 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)[38]

(i) An individual is eligible for Medicaid payment of their Medicare Part A and Part B premiums, deductibles, and coinsurance, or coverage of premiums and cost sharing related to enrollment in Medicare Part B for coverage of immunosuppressive drugs, if the individual is a member of a Medicaid group (as defined in § 29.04) with MABD income at or below 100 percent of the FPL; and

(A) 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) for purposes of Medicaid payment of their Medicare Part A and Part B premiums, deductibles, and coinsurance as described in (i) above; or

(B) Enrolled under Medicare Part B for coverage of immunosuppressive drugs for purposes of coverage of premiums and cost sharing related to enrollment in Medicare Part B for coverage of immunosuppressive drugs as described in (i) above.

(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.

(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.[39]

[38] 42 CFR § 435.123.

[39] Vermont gives effect to this rule by estimating the new year's FPL levels in January of each year. Vermont applies the

(2) Specified Low-Income Medicare Beneficiaries (SLMB)[40]

(i) An individual is eligible for Medicaid payment of their Medicare Part B premiums if the individual is entitled to Medicare Part A, or coverage of the Part B premium related to enrollment in Medicare Part B for coverage of immunosuppressive drugs if the individual is enrolled under Medicare Part B for coverage of immunosuppressive drugs, 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.[41]

(3) Qualified Individuals (QI-1)[42]

(i) An individual is eligible for Medicaid payment of their Medicare Part B premiums if the individual is entitled to Medicare Part A, or coverage of the Part B premium related to enrollment in Medicare Part B for coverage of immunosuppressive drugs if the individual is enrolled under Medicare Part B for coverage of immunosuppressive drugs, if the individual:

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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.

[40] 42 CFR § 435.124.

[41] 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.

[42] 42 CFR § 435.125.

(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.[43]

(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 (01/01/2024, GCR 23-083)

[43] 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 (01/01/2024, GCR 23-083)

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

(b) Deemed newborn[44]

(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);[45]

(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.

[44] 42 CFR § 435.117.

[45] 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[46]

(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.

[46] 42 CFR § 435.145.

(d) Special needs adoption[47]

(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[48]

(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; and

(ii) If the individual attained 18 years of age prior to January 1, 2023:

(A) 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

(B) Was in foster care under the responsibility of Vermont and enrolled in Medicaid under the state's Medicaid State plan or 1115 demonstration upon attaining age 18; or

(iii) If the individual attained 18 years of age on or after January 1, 2023:

(A) Is not 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

(B) Was in foster care under the responsibility of any state and enrolled in Medicaid under a state's Medicaid State plan or 1115 demonstration upon attaining age 18 or such higher age as the state may have elected.

(3) Income standard. There is no Medicaid income standard that applies.

[47] 42 CFR § 435.227.

[48] 42 CFR § 435.150; SSA § 1902(a)(10)(A)(i)(IX).

(f) Individual with breast or cervical cancer[49]

(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:

(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);[50] 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

[49] 42 CFR § 435.213; CMS SHO Letter (January 4, 2001).

[50] 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.

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.

(g) Family planning services[51]

(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)

[51] 42 CFR § 435.214.

Eligibility for enrollment in a QHP.[52] 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:

(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[53] (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) (01/01/2024, GCR 23-083)

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[54] (01/01/2024, GCR 23-083)

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) for the full calendar month for which APTC would be paid, other than coverage in the individual market.

[52] 45 CFR § 155.305(a).

[53] 45 CFR § 155.305(b).

[54] See generally, 26 CFR § 1.36B-2 and 45 CFR § 155.305(f).

12.03 Applicable tax filer[55] (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.

(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.

[55] 26 CFR § 1.36B-2(b); 45 CFR § 155.305.

(d) Individual not lawfully present or incarcerated.[56] 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;

(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.[57] 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[58] (01/15/2017, GCR 16-095)

[56] 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).

[57] 26 CFR § 1.36B-2(b)(6).

[58] 45 CFR § 155.305(f)(3).

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[59] (01/01/2024, GCR 23-083)

AHS may not determine a tax filer eligible for APTC if HHS notifies AHS as part of the process described in § 56.03 that APTC payments were made on behalf of either the tax filer or spouse, if the tax filer is a married couple, for two consecutive years for which tax data would be utilized for verification of household income and family size in accordance with § 56.01(a), and the tax filer or their spouse did not comply with the requirement to file an income tax return for that year and for the previous year as required by 26 USC § 6011, 6012, and in 26 CFR chapter I, and reconcile APTC 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[60] (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[61] (01/15/2017, GCR 16-095)

[59] 45 CFR § 155.305(f)(4).

[60] 45 CFR § 155.305(g).

[61] 45 CFR § 155.305(g)(2).

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 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[62] (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;

[62] 45 CFR § 155.305(g)(3).

(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).

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[63] (01/01/2018, GCR 17-044)

An individual is eligible for enrollment in a catastrophic plan[64] 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)).

[63] 45 CFR § 155.305(h).

[64] 45 CFR § 156.155.