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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) (01/01/2024, GCR 23-082)

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 (01/01/2024, GCR 23-082)

(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. 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.[2] Vermont includes certain, but not all, optional categories of enrollees. Vermont has also elected to cover certain, but not all, optional services for which federal financial participation is available. It also operates health care programs permitted by research demonstration waiver authority under § 1115 of the Social Security Act.

Vermont is authorized to establish reasonable standards, consistent with the objectives of the Medicaid statute, for determining the extent of coverage in the optional categories[3] based on such criteria as medical necessity or utilization control.[4] 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.[5] Vermont may not limit services based upon diagnosis, type of illness, or condition.[6]

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

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

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

[3] 42 USC § 1396a(a)(17).

[4] 42 CFR § 440.230(d).

[5] 42 CFR § 440.230(b).

[6] 42 CFR § 440.230(c).

group (§ 7.03(a)(3)) apply with equal effect to an individual who is enrolled in CHIP.

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

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

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

Additionally, catastrophic plans are available to certain individuals.

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

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

Federal premium tax credits are available to eligible individuals and families with incomes up to 400 percent of the FPL to purchase insurance through VHC.[7]

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.[8]

(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.

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[7] 26 CFR 1.36B-2.

[8] See 26 CFR § 1.36B-2.

2.05 Administration of eligibility for health benefits (01-01-2024, GCR 23-082)

(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:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.00 Definitions (01/01/2024, GCR 23-082)

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

Adjusted monthly premium.[9] 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).[10] 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).[11] The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), as amended by the Three Percent Withholding Repeal and Job Creation Act (Pub. L. 112-56).

Aid to the Aged, Blind, or Disabled (AABD).[12] 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).[13] The period each year during which a qualified individual may enroll or change coverage in a QHP.

Applicable benchmark plan (ABP).[14] As defined in § 60.06, the second-lowest-cost silver plan offered through VHC.

Applicant[15]

(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.[16] 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

[9] 26 CFR § 1.36B-3(e).

[10] 42 CFR § 435.4; 45 CFR § 155.20; § 36B of the Code (as added by § 1401 of the ACA); 3 VSA § 1812.

[11] 26 CFR § 1.36B-1(j); 42 CFR § 435.4; 45 CFR § 155.20.

[12] 33 VSA § 1301 et seq.; AABD Rule 2700 et seq.

[13] 45 CFR § 155.20.

[14] 26 CFR § 1.36B-3(f).

[15] 42 CFR § 435.4; 45 CFR §§ 155.20 and 156.20.

[16] 42 CFR § 435.4; 45 CFR § 155.410(a).

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[17]

(a) Applicant;

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

(c) Authorized representative; or

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

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

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

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

Benefit year (or taxable year).[18] A calendar year for which a health plan provides coverage for health benefits.

Broker.[19] 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.

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[17] 42 CFR § 435.907; 45 CFR § 155.20.

[18] 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."

[19] 45 CFR § 155.20.

Caretaker relative[20]

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

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

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

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

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

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

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

Categorically needy.[21] 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.[22] 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

[20] 42 CFR § 435.4.

[21] 42 CFR § 435.4.

[22] 45 CFR § 156.155.

following exceptions:

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

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

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

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

Code. Internal Revenue Code.

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

Cost sharing.[23] 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).[24] 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.[25] See, § 60.02(b).

[23] 45 CFR §§ 155.20 and 156.20.

[24] 45 CFR §§ 155.20 and 156.20; 33 VSA § 1812.

[25] 26 CFR § 1.36B-3(b)(1).

Coverage group.[26] 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.[27] A month for which, as of the first day of the month:

(a) An individual is receiving coverage;

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

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

Date of application. See, application date.

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

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

Dependent child.[28] 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

(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-

[26] 42 CFR § 435.10(b).

[27] 26 CFR § 1.36B-3(c).

[28] 42 CFR § 435.4.

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

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

Eligible employer-sponsored plan[30]

(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[31] offered in a group market.

Eligibility determination.[32] 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.[33] 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.

[29] 42 CFR §§ 435.4 and 435.914.

[30] 26 CFR § 1.36-2(c)(3)(i); 26 USC § 5000A(f)(2).

[31] 26 USC § 5000A(f)(1)(D).

[32] 42 CFR § 435.4. *See also,* 42 CFR §§ 435.911 and 435.916; 45 CFR § 155.302.

[33] 45 CFR § 155.20.

Enroll. To initiate coverage for an approved individual.

Enrollee.[34] 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)).[35] A state-managed entity through which individuals, qualified employees, and small businesses can compare, shop for, purchase, and enroll in QHPs; and individuals can apply for and enroll in health-benefits programs. In Vermont, the Exchange is known as Vermont Health Connect (VHC).

Exchange service area.[36] The area in which the Exchange (in Vermont, VHC) is certified to operate.

Family coverage.[37] Health insurance that covers more than one individual and provides coverage for essential health benefits.

Family size. See, § 28.02(a).

Federal poverty level (FPL).[38] 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.

[34] 42 CFR § 435.4.

[35] 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.

[36] 45 CFR § 155.20.

[37] 26 CFR § 1.36B-1(m).

[38] 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.

Grandfathered health plan coverage.[39] 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.[40] 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.[41] A program that is one of the following:

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

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

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

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

Health insurance coverage.[42] 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.[43] 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.[44] 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.

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[39] 45 CFR § 155.20; 45 CFR § 147.140.

[40] 45 CFR §§ 155.20 and 156.20; 45 CFR § 144.103; 45 CFR § 146.145(a).

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

[42] 45 CFR § 155.20; 45 CFR § 144.103.

[43] 45 CFR §§ 155.20 and 156.20; 45 CFR § 144.103; 18 VSA § 9402(8).

[44] 45 CFR § 155.20.

Indian.[45] A person who is a member of an Indian tribe.

Indian tribe.[46] 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.[47] An establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more individuals unrelated to the proprietor.

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

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

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

Lawfully present. See, § 17.01(g).

Level of coverage.[48] 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.

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[45] 25 CFR § 900.6.

[46] 25 CFR § 900.6.

[47] 42 CFR § 435.1010. This is the definition referred to in 42 CFR § 435.403(b) and 45 CFR § 155.305(a)(3). "Assisted living" is considered a community setting and not a medical institution or nursing facility because assisted living does not include 24-hour care, has privacy, a lockable door, and is a homelike setting. Former PP&D to Former Medicaid Rule 4201.

[48] 45 CFR § 156.20; § 1302(d)(2) of the ACA.

Long-term care services and supports.[49] A range of medical, personal, and social services that can help an individual with functional limitations live their life more independently. Supports range from daily living (e.g. grocery shopping and food preparation) to 24-hour medical care provided in nursing facilities. Examples of long-term care services and supports include nursing facility services; a level of care in any institution equivalent to nursing facility services; home and community-based services to qualifying individuals as specified in relevant waiver authorizations or in any related program regulations, to include:

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

(b) Traumatic brain injury services (TBI);

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

(d) Children's mental health services.

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

MAGI-based income.[50] 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.[51] Medical benefits funded through Medicaid as specified in related program rules and waiver authorizations.

Medical incapacity. See, § 64.09.

Medical institution.[52] An institution that:

[49] 42 CFR § 435.603(j)(4).

[50] 42 CFR §§ 435.4 and 435.603(e).

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

[52] 42 CFR § 435.1010.

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

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

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

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

Medically needy.[53] 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).[54] 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.[55] 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.[56] 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.[57] 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.

[53] 42 CFR § 435.4.

[54] 42 CFR § 435.4; 45 CFR § 155.20.

[55] 45 CFR § 155.300; 45 CFR § 156.145; 26 CFR §§ 1.36B-2(c)(3)(vi) and 1.36B-6.

[56] 45 CFR § 155.20; 33 VSA § 1807.

[57] 42 CFR § 435.4.

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

OASDI.[58] Old age, survivors, and disability insurance under Title II of the Act.

Optional state supplement.[59] A cash payment made by a state, under § 1616 of the Act, to an aged, blind, or disabled individual. *See*, AABD.

Patient share. See, § 24.00.

Physician's certificate. See, § 64.09.

Plan year.[60] 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.[61] 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.[62] A woman during pregnancy and the post partum period, which begins on the date the pregnancy ends and extends 12 months, and then ends on the last day of the month in which the 12-month period ends. The 12-month post partum period is extended to a woman who was still enrolled in Medicaid on April 1, 2023 and was pregnant or within 12 months of the end of a pregnancy on that date.

Premium

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

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

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

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

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

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[58] 42 CFR § 435.4.

[59] 42 CFR § 435.4.

[60] 45 CFR §§ 155.20 and 156.20.

[61] 45 CFR § 155.20. Incorporates meaning of this term given in § 1311(e)(3)(B) of the ACA.

[62] 42 CFR § 435.4.

Private facility. 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. Any institution meeting all of the following conditions:

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

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

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

Qualified Health Plan (QHP). A health plan certified by Vermont's Department of Financial Regulation (DFR) and offered by Vermont Health Connect.[63]

QHP issuer.[64] A health insurance issuer that offers a QHP in accordance with a certification from DFR.

Qualified individual.[65] 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.[66] 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.

[63] 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)."

[64] 45 CFR §§ 155.20 and 156.20.

[65] 45 CFR §§ 155.20 and 156.20.

[66] 45 CFR § 155.300.

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

Secure electronic interface.[67] An interface that allows for the exchange of data between information technology systems and adheres to the requirements in subpart C of 42 CFR part 433.

Self-only coverage.[68] Health insurance that covers one individual and provides coverage for essential health benefits.

Special enrollment period (SEP).[69] 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.[70] 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);

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[67] 42 CFR § 435.4.

[68] 26 CFR § 1.36B-1(l).

[69] 45 CFR § 155.20.

[70] 45 CFR § 155.300.

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

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

Tax dependent

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

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

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

4.00 General program rules (01/01/2024, GCR 23-082)

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 (01/01/2024, GCR 23-082)

(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.[71] 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

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

right, and will be afforded the opportunity without delay, to apply for benefits.

(g) Right to be assisted by others

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

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

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

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

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

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

(j) Right to interpreter services. Individuals will be informed of the availability of interpreter services. Unless the 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 (01/01/2024, GCR 23-082)

(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

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

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

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

(4) A QHP enrollee who did not request an eligibility determination for APTC or CSR, and is not receiving

APTC or CSR, need not report changes that affect eligibility for health-benefits programs.

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

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

4.04 Case records (01/01/2024, GCR 23-082)

(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. Case records are retained as required by federal and state requirements for audit and/or review.

4.05 Quality-control review (01/01/2024, GCR 23-082)

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

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

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

(d) When a case is selected for review, the individual must cooperate with the QC representative. Cooperation

includes, but is not limited to, participation in a personal interview and the furnishing of requested information. If the individual does not cooperate, eligibility for the individual's household may be closed and the individual members may be disenrolled.

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

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

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

(1) "[K]nowingly fails, by false statement, misrepresentation, impersonation, or other fraudulent means, to disclose a material fact used in making a determination as to the qualifications of that person to receive 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 . . . ;"[72] 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 . . . ."[73]

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

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

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

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

(2) Was the omission or incorrect representation an error or result of the individual's misunderstanding of eligibility requirements or the responsibility to provide information?

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

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[72] 33 VSA § 141(a).

[73] 33 VSA § 141(b).

(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[74] (01/15/2019, GCR 18-060)

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

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

(1)

[74] 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.

(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.[75] 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.[76] 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 (01/01/2024, GCR 23-082)

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

(a) In general.[77] AHS will provide assistance to any individual seeking help with the application or renewal process in person, over the telephone, and online, and in a manner that is accessible to individuals with disabilities and those who are limited English proficient. Eligibility and enrollment assistance that meets the accessibility standards in paragraph (c) of this subsection is provided, and referrals are made to assistance programs in the state when available and appropriate. These functions include assistance provided directly to any individual seeking help with the application or renewal process.

(b) Assistance tools

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[75] 45 CFR § 155.270(a).

[76] 45 CFR § 155.270(b).

[77] 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.

(1) Call center.[78] 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.[79] 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 assistance services, including the toll-free telephone number of the call center required in paragraph

[78] 42 CFR § 435.908; 45 CFR § 155.205(a).

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

(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[80]

(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[81]

(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

[80] 42 CFR § 435.905(b); 45 CFR § 155.205(c).

[81] 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.[82] 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).[83] 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.[84] 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[85] (01/01/2024, GCR 23-082)

(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

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

[83] All Programs Rule 2030.

[84] 42 USC § 18116; 45 CFR §§ 92.2 and 155.120(c)(1); 9 VSA § 4502.

[85] 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.[86] 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.[87] Upon presentment of a valid document of appointment, a judicially-appointed legal guardian or representative may act on an individual's behalf.

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

(a) General requirements.[88] 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.[89] 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;

[86] 42 CFR § 435.907(a); 45 CFR § 155.20.

[87] All Programs Rule 2014.

[88] 45 CFR § 155.210(a); 33 VSA § 1807.

[89] 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.[90] 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.[91] 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;

[90] 45 CFR § 155.210(c).

[91] 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.[92] 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;

[92] 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.[93] An entity that serves as a Navigator must carry out at least the following duties:

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

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

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

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

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

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

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

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

[93] 45 CFR § 155.210(e); 33 V.S.A. § 1807.

(9) Ensure that individuals:

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

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

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

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

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

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

(i) Understanding the process of filing eligibility appeals;

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

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

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

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

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

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

(a) General rule.[94] A broker may:

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

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

[94] 45 CFR § 155.220(a); 33 V.S.A. § 1805(17).

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.[95] 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.[96] 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[97] (01/01/2024, GCR 23-082)

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

(b) Certification

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

(2) To be certified, application counselors must:

[95] 45 CFR § 155.220(d); 33 V.S.A. § 1805(17).

[96] 33 V.S.A. § 1805(17).

[97] 42 CFR § 435.908; 45 CFR § 155.225.

(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.[98] Notwithstanding the non-discrimination provisions of § 5.01(g), an organization that receives federal funds to provide services to a defined population under the terms of federal legal authorities that participates in the certified application counselor program may limit its provision of certified application counselor services to the same defined population, but must comply with § 5.01(g) with respect to the provision of certified application counselor services to that defined population, If the organization limits its provision of certified application

[98] 45 CFR § 155.120(c)(2).

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 (01/01/2025, GCR 24-075)

(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); and

(5) Living-arrangement requirements (§ 20.00).

(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) (01/01/2025, GCR 24-075)

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 (01/01/2025, GCR 24-075)

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); and

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

7.03 Categorical and financial criteria (01/01/2025, GCR 24-075)

(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:

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.

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[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.

(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;

(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.

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[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.

(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]

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

[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).

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

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 1 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 12-month extension. For a parent or caretaker relative to remain eligible for the initial 12-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.

(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

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

[15] 42 CFR § 435.831.

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.

(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) (01/01/2025, GCR 24-075)

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 (01/01/2025, GCR 24-075)

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); and

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

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:

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

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

(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; 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

[18] 42 CFR § 435.120.

(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].

(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

[19] 42 CFR § 435.210.

[20] 42 CFR § 435.122.

[21] 42 CFR § 435.120(c).

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.

(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

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[22] 33 VSA § 1902(b).

[23] 33 VSA § 1902(b).

[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.

(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:

(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.

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

[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).

(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 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

[29] SSA § 1634(c).

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

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 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

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

[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.

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 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

[33] 42 CFR § 435.134.

[34] 42 CFR § 435.211.

[35] 42 CFR § 435.236.

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 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):

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[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)).

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

(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.

(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 (01/01/2025, GCR 24-075)

(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 and any dividend or interest income earned on resources is disregarded.

(iii) Benefits become effective on the first day of the calendar month immediately following the month

[38] 42 CFR § 435.123.

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]

(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 and any dividend or interest income earned on resources is disregarded.

(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

[39] 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.

[40] 42 CFR § 435.124.

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:

(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 and any dividend or interest income earned on resources is disregarded.

(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;

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[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.

[43] CMS State Medicaid Manual, § 3492.

(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 (01/01/2025, GCR 24-075)

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 (01/01/2025, GCR 24-075)

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); and

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

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

[44] 42 CFR § 435.117.

(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.

(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,

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

[46] 42 CFR § 435.145.

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.

(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:

[47] 42 CFR § 435.227.

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

(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.

(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

[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.

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.

(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)

[51] 42 CFR § 435.214.

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.[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)

[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).

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.

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

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

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.[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

[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).

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)

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

[58] 45 CFR § 155.305(f)(3).

[59] 45 CFR § 155.305(f)(4).

[60] 45 CFR § 155.305(g).

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)

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%

[61] 45 CFR § 155.305(g)(2).

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;

(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)).

[62] 45 CFR § 155.305(g)(3).

[63] 45 CFR § 155.305(h).

[64] 45 CFR § 156.155.