FINAL PROPOSED RULE # 23P27

Final Proposed Filing - Coversheet

Instructions:

In accordance with Title 3 Chapter 25 of the Vermont Statutes Annotated and the "Rule on Rulemaking" adopted by the Office of the Secretary of State, this filing will be considered complete upon filing and acceptance of these forms with the Office of the Secretary of State, and the Legislative Committee on Administrative Rules.

All forms shall be submitted at the Office of the Secretary of State, no later than 3:30 pm on the last scheduled day of the work week.

The data provided in text areas of these forms will be used to generate a notice of rulemaking in the portal of "Proposed Rule Postings" online, and the newspapers of record if the rule is marked for publication. Publication of notices will be charged back to the promulgating agency.

PLEASE REMOVE ANY COVERSHEET OR FORM NOT REQUIRED WITH THE CURRENT FILING BEFORE DELIVERY!

Certification Statement: As the adopting Authority of this rule (see 3 V.S.A. § 801 (b) (11) for a definition), I approve the contents of this filing entitled:

Health Benefits Eligibility and Enrollment Rule, Special Rules for Medicaid Coverage of Long-Term Services and Supports - Eligibility and Post-Eligibility (Part 4)

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

(signature) (date)

Printed Name and Title:
Todd Daloz, Deputy Secretary, Agency of Human Services

RECEIVED BY: _____

- ☐ Coversheet
- ☐ Adopting Page
- ☐ Economic Impact Analysis
- ☐ Environmental Impact Analysis
- ☐ Strategy for Maximizing Public Input
- ☐ Scientific Information Statement (if applicable)
- ☐ Incorporated by Reference Statement (if applicable)
- ☐ Clean text of the rule (Amended text without annotation)
- ☐ Annotated text (Clearly marking changes from previous rule)
- ☐ ICAR Minutes
- ☐ Copy of Comments
- ☐ Responsiveness Summary

1. TITLE OF RULE FILING:
Health Benefits Eligibility and Enrollment Rule, Special Rules for Medicaid Coverage of Long-Term Services and Supports - Eligibility and Post-Eligibility (Part 4)

2. PROPOSED NUMBER ASSIGNED BY THE SECRETARY OF STATE
23P027

3. ADOPTING AGENCY:
Agency of Human Services (AHS)

4. PRIMARY CONTACT PERSON:
(A PERSON WHO IS ABLE TO ANSWER QUESTIONS ABOUT THE CONTENT OF THE RULE).

Name: Danielle Fuoco

Agency: Agency of Human Services

Mailing Address: 280 State Drive, Center Building, Waterbury, Vermont 054671-1000

Telephone: 802-585-4265 Fax: 802-241-0450

E-Mail: danielle.fuoco@vermont.gov

Web URL *(WHERE THE RULE WILL BE POSTED)*:
https://humanservices.vermont.gov/rules-policies/health-care-rules

5. SECONDARY CONTACT PERSON:
(A SPECIFIC PERSON FROM WHOM COPIES OF FILINGS MAY BE REQUESTED OR WHO MAY ANSWER QUESTIONS ABOUT FORMS SUBMITTED FOR FILING IF DIFFERENT FROM THE PRIMARY CONTACT PERSON).

Name: Jessica Ploesser

Agency: Agency of Human Services

Mailing Address: 280 State Drive, NOB 1 South, Waterbury, VT 05671

Telephone: 802-241-0454 Fax: 802-241-0450

E-Mail: jessica.ploesser@vermont.gov

6. RECORDS EXEMPTION INCLUDED WITHIN RULE:
(DOES THE RULE CONTAIN ANY PROVISION DESIGNATING INFORMATION AS CONFIDENTIAL; LIMITING ITS PUBLIC RELEASE; OR OTHERWISE, EXEMPTING IT FROM INSPECTION AND COPYING?) No

IF YES, CITE THE STATUTORY AUTHORITY FOR THE EXEMPTION:

N/A

PLEASE SUMMARIZE THE REASON FOR THE EXEMPTION:

N/A

7. LEGAL AUTHORITY / ENABLING LEGISLATION:
(THE SPECIFIC STATUTORY OR LEGAL CITATION FROM SESSION LAW INDICATING WHO THE ADOPTING ENTITY IS AND THUS WHO THE SIGNATORY SHOULD BE. THIS SHOULD BE A SPECIFIC CITATION NOT A CHAPTER CITATION).

3 V.S.A. 801(b)(11); 33 V.S.A. 1901(a)(1) and 1810

8. EXPLANATION OF HOW THE RULE IS WITHIN THE AUTHORITY OF THE AGENCY:
This rule amends an existing rule on eligibility and enrollment in the State of Vermont's health benefit programs. AHS's authority to adopt rules as identified above includes, by necessity, the authority to amend the rules to ensure continued alignment with federal and state guidance and law.

9. THE FILING HAS CHANGED SINCE THE FILING OF THE PROPOSED RULE.

10. THE AGENCY HAS INCLUDED WITH THIS FILING A LETTER EXPLAINING IN DETAIL WHAT CHANGES WERE MADE, CITING CHAPTER AND SECTION WHERE APPLICABLE.

11. SUBSTANTIAL ARGUMENTS AND CONSIDERATIONS WERE NOT RAISED FOR OR AGAINST THE ORIGINAL PROPOSAL.

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

13. THE AGENCY HAS NOT INCLUDED A LETTER EXPLAINING IN DETAIL THE REASONS FOR THE AGENCY'S DECISION TO REJECT OR ADOPT THEM.

14. CONCISE SUMMARY (**150 WORDS OR LESS**):

This proposed rulemaking amends Parts 1-5, and 7-8 of the 8-part Health Benefits Eligibility and Enrollment (HBEE) rule. Parts 1, 2, 3, 5, and 7 were last amended effective January 1, 2023. Part 4 was last amended effective January 15, 2019. Part 8 was last amended effective October 1, 2021. Substantive revisions include: implementing 12 months of Medicaid continuous eligibility for children; codifying ineligibility for Qualified Health Plan subsidy if failure to reconcile tax credits for 2 consecutive years; allowing self-attestation of income for Qualified Health Plan subsidies if no tax information is available through data sources; and codifying 2 new income and resource

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

15. EXPLANATION OF WHY THE RULE IS NECESSARY:

The changes align HBEE with federal and state guidance and law, provide clarification, correct information, improve clarity, and make technical corrections. Substantive revisions include those listed in the concise summary above.

16. EXPLANATION OF HOW THE RULE IS NOT ARBITRARY:

The rules are required to implement state and federal health care guidance and laws. Additionally, the rules are within the authority of the Secretary, are within the expertise of AHS, and are based on relevant factors including consideration of how the rules affect the people and entities listed below.

17. LIST OF PEOPLE, ENTERPRISES AND GOVERNMENT ENTITIES AFFECTED BY THIS RULE:

Medicaid applicants/enrollees;

Individuals who wish to purchase health coverage including those who apply for premium and cost-sharing assistance;

Health insurance issuers;

Eligibility and enrollment assisters, including agents and brokers;

Health care providers;

Health law, policy and related advocacy and community-based organizations and groups including the Office of the Health Care Advocate; and

Agency of Human Services including its departments.

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

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

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

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

Other changes in Parts 1-5 and 7-8 align the rule with federal and state guidance and law, provide clarification, correct information, improve clarity, and make technical corrections. These changes do not carry a specific economic impact on any person or entity.

19. A HEARING WAS HELD.

20. HEARING INFORMATION

(THE FIRST HEARING SHALL BE NO SOONER THAN 30 DAYS FOLLOWING THE POSTING OF NOTICES ONLINE).

IF THIS FORM IS INSUFFICIENT TO LIST THE INFORMATION FOR EACH HEARING, PLEASE ATTACH A SEPARATE SHEET TO COMPLETE THE HEARING INFORMATION.

Date: 10/6/2023

Time: 01:00 PM

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

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

Zip Code: 05671

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

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Date:

Time: AM

Street Address:

Zip Code:

URL for Virtual:

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

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

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

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

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

280 State Drive – Center Building
Waterbury, VT 05671-1000

OFFICE OF THE SECRETARY
TEL: (802) 241-0440
FAX: (802) 241-0450

JENNEY SAMUELSON
SECRETARY

TODD W. DALOZ
DEPUTY SECRETARY

STATE OF VERMONT
AGENCY OF HUMAN SERVICES

MEMORANDUM

TO: Jim Condos, Secretary of State

FROM: Jenney Samuelson, Secretary, Agency of Human Services

DATE: April 1, 2022

SUBJECT: Signatory Authority for Purposes of Authorizing Administrative Rules

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I hereby designate Deputy Secretary of Human Services Todd W. Daloz as signatory to fulfill the duties of the Secretary of the Agency of Human Services as the adopting authority for administrative rules as required by Vermont's Administrative Procedure Act, 3 V.S.A. § 801 et seq.

Cc: Todd W. Daloz

State of Vermont
Agency of Human Services
280 State Drive
Waterbury, VT 05671-1000
www.humanservices.vermont.gov

Jenney Samuelson, Secretary
[phone] 802-241-0440
[fax] 802-241-0450

MEMORANDUM

To: Sarah Copeland Hanzas, Secretary of State, Vermont Secretary of State Office
Rep. Trevor Squirrell, Chair. Legislative Committee on Administrative Rules (LCAR)

From: Adaline Strumolo, Deputy Commissioner, Department of Vermont Health Access

Cc: Todd Daloz, Deputy Secretary, Agency of Human Services
Charlene Dindo, Committee Assistant, Legislative Committee on Administrative Rules
Louise Corliss. APA Coordinator. Secretary of State's Office

Date: October 23, 2023

Re: Agency of Human Services Final Proposed Rule Filing

Enclosed are the final proposed rule filings for the following Health Benefits Eligibility and Enrollment (HBEE) rule parts:

Amended:

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

No public comments were received during the public comment period.

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

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

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

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

Adopting Page

Instructions:

This form must accompany each filing made during the rulemaking process:

Note: To satisfy the requirement for an annotated text, an agency must submit the entire rule in annotated form with proposed and final proposed filings. Filing an annotated paragraph or page of a larger rule is not sufficient. Annotation must clearly show the changes to the rule.

When possible, the agency shall file the annotated text, using the appropriate page or pages from the Code of Vermont Rules as a basis for the annotated version. New rules need not be accompanied by an annotated text.

1. TITLE OF RULE FILING:
   Health Benefits Eligibility and Enrollment Rule, Special Rules for Medicaid Coverage of Long-Term Services and Supports - Eligibility and Post-Eligibility (Part 4)
2. ADOPTING AGENCY:
   Agency of Human Services (AHS)
3. TYPE OF FILING (*PLEASE CHOOSE THE TYPE OF FILING FROM THE DROPDOWN MENU BASED ON THE DEFINITIONS PROVIDED BELOW*):

   - **AMENDMENT** - Any change to an already existing rule, even if it is a complete rewrite of the rule, it is considered an amendment if the rule is replaced with other text.
   - **NEW RULE** - A rule that did not previously exist even under a different name.
   - **REPEAL** - The removal of a rule in its entirety, without replacing it with other text.

   This filing is **AN AMENDMENT OF AN EXISTING RULE** .

4. LAST ADOPTED (*PLEASE PROVIDE THE SOS LOG#, TITLE AND EFFECTIVE DATE OF THE LAST ADOPTION FOR THE EXISTING RULE*):

   Part 1 - General Provisions and Definitions, SOS # 22P014, effective 1/1/2023; Part 2 - Eligibility Standards, SOS #22P015, effective 1/1/2023; Part 3 -

Nonfinancial Eligibility Requirements, SOS # 22P016, effective 1/1/2023; Part 4 - Special Rules for Medicaid Coverage of Long-Term Care Services and Supports - Eligibility and Post-Eligibility, SOS # 18P046, effective 1/15/2019; Part 5 - Financial Methodologies, SOS # 22P017, effective 1/1/2023; Part 7 - Eligibility and Enrollment Procedures, SOS # 22P018, effective 1/1/2023; Part 8 - State Fair Hearings and Expedited Eligibility Appeals, SOS # 21P008, effective 10/1/2021.

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

[phone] 802-828-3322

Kristin L. Clouser, Secretary

INTERAGENCY COMMITTEE ON ADMINISTRATIVE RULES (ICAR) MINUTES

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

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

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

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

Proposed Rule: Health Benefits Eligibility and Enrollment Rule, Special Rules for Medicaid Coverage of Long-Term Services and Supports - Eligibility and Post-Eligibility (Part 4)

Presented By: Robin Chapman and Danielle Fuoco

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

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

Economic Impact Analysis

Instructions:

In completing the economic impact analysis, an agency analyzes and evaluates the anticipated costs and benefits to be expected from adoption of the rule; estimates the costs and benefits for each category of people enterprises and government entities affected by the rule; compares alternatives to adopting the rule; and explains their analysis concluding that rulemaking is the most appropriate method of achieving the regulatory purpose. If no impacts are anticipated, please specify "No impact anticipated" in the field.

Rules affecting or regulating schools or school districts must include cost implications to local school districts and taxpayers in the impact statement, a clear statement of associated costs, and consideration of alternatives to the rule to reduce or ameliorate costs to local school districts while still achieving the objectives of the rule (see 3 V.S.A. § 832b for details).

Rules affecting small businesses (excluding impacts incidental to the purchase and payment of goods and services by the State or an agency thereof), must include ways that a business can reduce the cost or burden of compliance or an explanation of why the agency determines that such evaluation isn't appropriate, and an evaluation of creative, innovative or flexible methods of compliance that would not significantly impair the effectiveness of the rule or increase the risk to the health, safety, or welfare of the public or those affected by the rule.

1. TITLE OF RULE FILING:

   Health Benefits Eligibility and Enrollment Rule, Special Rules for Medicaid Coverage of Long-Term Services and Supports - Eligibility and Post-Eligibility (Part 4)

2. ADOPTING AGENCY:

   Agency of Human Services (AHS)

3. CATEGORY OF AFFECTED PARTIES:

   LIST CATEGORIES OF PEOPLE, ENTERPRISES, AND GOVERNMENTAL ENTITIES POTENTIALLY AFFECTED BY THE ADOPTION OF THIS RULE AND THE ESTIMATED COSTS AND BENEFITS ANTICIPATED:

   Categories of people, enterprises, and governmental entities that may be affected by these rules:

   Medicaid applicants/enrollees;

Individuals who wish to purchase health coverage including those who apply for premium and cost-sharing assistance;

Health insurance issuers (including standalone dental issuers);

Eligibility and enrollment assisters, including agents and brokers;

Health care providers;

Health law, policy and related advocacy and community-based organizations and groups including the Office of the Health Care Advocate; and

Agency of Human Services including its departments.

Anticipated costs and benefits of this rule:

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

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

Other changes in Parts 1-5 and 7-8 align the rule with federal and state guidance and law, provide clarification, correct information, improve clarity, and make technical corrections. These changes do not carry a specific economic impact on any person or entity.

4. IMPACT ON SCHOOLS:

INDICATE ANY IMPACT THAT THE RULE WILL HAVE ON PUBLIC EDUCATION, PUBLIC SCHOOLS, LOCAL SCHOOL DISTRICTS AND/OR TAXPAYERS CLEARLY STATING ANY ASSOCIATED COSTS:

No impact.

5. ALTERNATIVES: *CONSIDERATION OF ALTERNATIVES TO THE RULE TO REDUCE OR AMELIORATE COSTS TO LOCAL SCHOOL DISTRICTS WHILE STILL ACHIEVING THE OBJECTIVE OF THE RULE.*

   Not applicable.

6. IMPACT ON SMALL BUSINESSES:
   INDICATE ANY IMPACT THAT THE RULE WILL HAVE ON SMALL BUSINESSES (EXCLUDING IMPACTS INCIDENTAL TO THE PURCHASE AND PAYMENT OF GOODS AND SERVICES BY THE STATE OR AN AGENCY THEREOF):

   No impact.

7. SMALL BUSINESS COMPLIANCE: *EXPLAIN WAYS A BUSINESS CAN REDUCE THE COST/BURDEN OF COMPLIANCE OR AN EXPLANATION OF WHY THE AGENCY DETERMINES THAT SUCH EVALUATION ISN'T APPROPRIATE.*

   Not applicable.

8. COMPARISON:
   COMPARE THE IMPACT OF THE RULE WITH THE ECONOMIC IMPACT OF OTHER ALTERNATIVES TO THE RULE, INCLUDING NO RULE ON THE SUBJECT OR A RULE HAVING SEPARATE REQUIREMENTS FOR SMALL BUSINESS:
   There are no alternatives to the adoption of this rule. The rule is required to implement state and federal law.

9. SUFFICIENCY: *DESCRIBE HOW THE ANALYSIS WAS CONDUCTED, IDENTIFYING RELEVANT INTERNAL AND/OR EXTERNAL SOURCES OF INFORMATION USED.*
   AHS has analyzed and evaluated the anticipated costs and benefits to be expected from the adoption of these rules including considering the costs and benefits for each category of persons and entities described above. There are no alternatives to the adoption of this rule; it is necessary to ensure continued alignment with federal and state guidance and law on eligibility and enrollment in health benefits programs.

Environmental Impact Analysis

Instructions:

In completing the environmental impact analysis, an agency analyzes and evaluates the anticipated environmental impacts (positive or negative) to be expected from adoption of the rule; compares alternatives to adopting the rule; explains the sufficiency of the environmental impact analysis. If no impacts are anticipated, please specify "No impact anticipated" in the field.

Examples of Environmental Impacts include but are not limited to:

- Impacts on the emission of greenhouse gases
- Impacts on the discharge of pollutants to water
- Impacts on the arability of land
- Impacts on the climate
- Impacts on the flow of water
- Impacts on recreation
- Or other environmental impacts

1. TITLE OF RULE FILING:

   Health Benefits Eligibility and Enrollment Rule, Special Rules for Medicaid Coverage of Long-Term Services and Supports - Eligibility and Post-Eligibility (Part 4)

2. ADOPTING AGENCY:

   Agency of Human Services (AHS)

3. GREENHOUSE GAS: *EXPLAIN HOW THE RULE IMPACTS THE EMISSION OF GREENHOUSE GASES (E.G. TRANSPORTATION OF PEOPLE OR GOODS; BUILDING INFRASTRUCTURE; LAND USE AND DEVELOPMENT, WASTE GENERATION, ETC.):*
   No impact.

4. WATER: *EXPLAIN HOW THE RULE IMPACTS WATER (E.G. DISCHARGE / ELIMINATION OF POLLUTION INTO VERMONT WATERS, THE FLOW OF WATER IN THE STATE, WATER QUALITY ETC.):*
   No impact.

5. LAND: *EXPLAIN HOW THE RULE IMPACTS LAND (E.G. IMPACTS ON FORESTRY, AGRICULTURE ETC.):*
   No impact.
6. RECREATION: *EXPLAIN HOW THE RULE IMPACTS RECREATION IN THE STATE:*
   No impact.
7. CLIMATE: *EXPLAIN HOW THE RULE IMPACTS THE CLIMATE IN THE STATE:*
   No impact.
8. OTHER: *EXPLAIN HOW THE RULE IMPACT OTHER ASPECTS OF VERMONT'S ENVIRONMENT:*
   No impact.
9. SUFFICIENCY: *DESCRIBE HOW THE ANALYSIS WAS CONDUCTED, IDENTIFYING RELEVANT INTERNAL AND/OR EXTERNAL SOURCES OF INFORMATION USED.*
   No impact.

Public Input Maximization Plan

Instructions:

Agencies are encouraged to hold hearings as part of their strategy to maximize the involvement of the public in the development of rules. Please complete the form below by describing the agency's strategy for maximizing public input (what it did do, or will do to maximize the involvement of the public).

This form must accompany each filing made during the rulemaking process:

1. TITLE OF RULE FILING:

   Health Benefits Eligibility and Enrollment Rule, Special Rules for Medicaid Coverage of Long-Term Services and Supports - Eligibility and Post-Eligibility (Part 4)

2. ADOPTING AGENCY:

   Agency of Human Services (AHS)

3. PLEASE DESCRIBE THE AGENCY'S STRATEGY TO MAXIMIZE PUBLIC INVOLVEMENT IN THE DEVELOPMENT OF THE PROPOSED RULE, LISTING THE STEPS THAT HAVE BEEN OR WILL BE TAKEN TO COMPLY WITH THAT STRATEGY:

   AHS consulted with key stakeholders on the development of policies in this rulemaking. AHS took input from the Office of the Health Care Advocate/Vermont Legal Aid, Qualified Health Plan issuers, members, and providers through the Medicaid & Exchange Advisory Committee.

   The proposed rule were posted on the AHS website for public comment, and a public hearing was held on October 6, 2023. No one attended the hearing. When the proposed rule was filed with the Office of the Secretary of State, AHS provided notice and access to the rule, through the Global Commitment Register, to stakeholders and all persons who subscribe to the Global Commitment Register.

   The public comment period ended October 13, 2023. No comments were received. Part 2 has been amended since the proposed filing with technical changes to improve

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

The Global Commitment Register is a database that provides notification of policy changes and clarification of existing Medicaid policy, including rulemaking, under Vermont's 1115 Global Commitment to Health waiver. Anyone can subscribe to the Global Commitment Register. Subscribers will receive email notification of the filing including hyperlinks to the documents posted on the Global Commitment Register and an explanation of how to be further involved in the rulemaking.

4. BEYOND GENERAL ADVERTISEMENTS, PLEASE LIST THE PEOPLE AND ORGANIZATIONS THAT HAVE BEEN OR WILL BE INVOLVED IN THE DEVELOPMENT OF THE PROPOSED RULE:

Agency of Human Services including its departments;

Agency of Administration;

Department of Financial Regulation;

Medicaid and Exchange Advisory Committee;

Representatives of Vermont's Health Insurance Industry, including the Qualified Health Plan issuers;

Health law, policy and related advocacy and community-based organizations and groups, including the Office of the Health Care Advocate at Vermont Legal Aid.

Table of Contents

Annotated Text

Table of Contents

Part Four
Special Rules for Medicaid Coverage of Long-Term Care Services and Supports - Eligibility and Post-Eligibility

24.00 Patient share payment for Medicaid coverage of long-term care services and supports (01/01/2024~~01/01/2018~~, GCR 23-085~~17-046~~)

24.01 In general (01/15/2017, GCR 16-097)

(a) Definition: patient share.[1] Once AHS determines that an individual is eligible for Medicaid coverage of long-term care services and supports, it computes how much of their income must be paid to the long-term care provider each month for the cost of their care (this is called the "patient share").

A patient share is computed for an individual who qualifies for Medicaid coverage of long-term care services and supports under MABD in a medical institution or in a home and community-based setting under a special income coverage group (see § 8.05(k)) or as medically needy (see § 8.06). An individual's patient share is determined at initial eligibility, eligibility redeterminations, and when changes in circumstances occur.

(b) Computation of patient share

(1) An individual's patient share is determined by computing a maximum patient share and deducting allowable expenses. § 24.03 describes how the maximum patient share is determined. § 24.04 describes allowable deductions from the patient share. The actual patient share payable by the individual is the lesser of:

(i) The balance of the individual's income remaining after computing the patient share; and

(ii) The cost of care remaining after third-party payment.

(2) In cases in which allowable deductions exceed the individual's income, the patient-share payment is reduced by the deductions, sometimes resulting in no patient-share obligation, for as many months needed to exhaust the deductions against the individual's available income. The month when the remaining deductions no longer exceed the individual's income, the balance is the patient share payment for that month. When monthly income and allowable deductions are stable, the patient-share amount remains constant. When income or allowable deductions fluctuate, the patient-share payment is likely to vary.

(c) Patient share payment. An individual owes their patient share by the last day of the month in which they receive the income. Payment is made either to the facility in which the individual resided or to the highest-paid provider of long-term care services and supports. Patient-share amounts and payments to long-term care providers may be adjusted when a patient transitions from one setting to another, as specified in § 24.05.

[1] 42 CFR §§ 435.725, 435.726 and 435.735

24.02 Long-term care residence period (01/01/2024~~01/15/2017~~, GCR 23-085~~16-097~~)

(a) In general. A patient share obligation is assessed in the month of admission to long-term care as long as the individual is expected to need long-term care services and supports for at least 30 consecutive days. If long-term care services and supports are expected to be needed for fewer than 30 consecutive days, no patient share is assessed. Instead, the individual's services are covered through Medicaid, other than Medicaid coverage of long-term care services and supports, if the individual meets medical necessity criteria (see HCAR~~Medicaid coverage rule §~~ 4.1017~~103~~) and relevant financial, nonfinancial and categorical eligibility criteria.

(b) Duration of the long-term care residence period

(1) Beginning of long-term care residence

(i) In a general hospital setting. A long-term care residence period in a general hospital setting begins with the first day that the utilization review committee finds acute hospital care is no longer medically necessary and skilled nursing care is medically necessary.

(ii) In other long-term care settings. A long-term care residence period in a long-term care setting, other than a general hospital, begins with the first day that the utilization review committee finds medical need for long-term care or the date of admission, whichever is later.

(2) Ending of long-term care residence period. A long-term care residence period ends with the earliest of:

(i) The individual's date of death;

(ii) The date of the individual's discharge from a long-term care living arrangement (as defined in § 30.01); or

(iii) The last day medical need for long-term care is established by the utilization review committee.

(3) Leave of absence or transfer. A long-term care residence period is not ended by a leave of absence from the current setting (see DVHA Rule 7604.1). A long-term care residence period also continues despite transfer from either:

(i) One long-term care setting to another long-term care setting;

(ii) A general hospital setting (where skilled nursing care has been continuously authorized while awaiting transfer) to another long-term care setting; or

(iii) A long-term care setting to a general hospital setting followed by return to the long-term care setting without an intervening residence period in a community living arrangement (as defined in § 30.01).

(4) Percentage of month in long-term care. The percentage of the month an individual is in long-term care is determined using the appropriate table below.

Percentage of Month in Long-Term Care: All months except February

Day of the month admitted to long-term care	Percentage of the month in long-term care	Day of the month admitted to long-term care	Percentage of the month in long-term care	Day of the month admitted to long-term care	Percentage of the month in long-term care
1	100%	11	67%	21	33%
2	97%	12	63%	22	30%
3	93%	13	60%	23	27%
4	90%	14	57%	24	23%
5	87%	15	53%	25	20%
6	83%	16	50%	26	17%
7	80%	17	47%	27	13%
8	77%	18	43%	28	10%
9	73%	19	40%	29	7%
10	70%	20	37%	30-31	3%

Percentage of Month in Long-Term Care: February

Day of the month admitted to long-term care	Percentage of the month in long-term care	Day of the month admitted to long-term care	Percentage of the month in long-term care	Day of the month admitted to long-term care	Percentage of the month in long-term care
1	100%	11	64%	21	29%
2	96%	12	61%	22	25%
3	93%	13	57%	23	21%
4	89%	14	54%	24	18%
5	86%	15	50%	25	14%
6	82%	16	46%	26	11%
7	79%	17	43%	27	7%
8	75%	18	39%	28	4%
9	71%	19	36%	29	0%
10	68%	20	32%		

24.03 Determining maximum patient share (01/15/2017, GCR 16-097)

To determine the maximum patient share, the individual's gross income less allowable deductions as specified in § 24.04 is considered. This is the most that an individual receiving Medicaid coverage of long-term care services and supports is obliged to pay toward the cost of their long-term care services and supports. If an individual was in long-term care for less than a full month, the maximum patient share is multiplied by the applicable percentage in the table set forth in § 24.02.

24.04 Allowable deductions from patient-share (01/01/2024~~01/01/2018~~, GCR 23-08~~517-046~~)

(a) Income deductions. When determining the actual patient share payable by an individual, the following are deducted from the individual's gross income:

(1) SSI/AABD, AABD only and Reach Up benefit payments still being received when the person first enters long-term care;

(2) SSI/AABD payments intended to be used to maintain the community residence of an individual temporarily (not to exceed 3 months) in an institution;

(3) Austrian Reparation Payments;

(4) German Reparation Payments;

(5) Japanese and Aleutian Restitution Payments;

(6) Payments from the Agent Orange Settlement Fund;

(7) Radiation Exposure Compensation; and

(8) VA payments for aid and attendance paid to a veteran residing in a nursing facility or to the veteran's surviving spouse residing in a nursing facility.

(b) Other deductions. The following items are then deducted from the individual's patient share in the following order:

(1) A personal-needs allowance (PNA) or community-maintenance allowance (CMA) (see paragraph (c) of this subsection);

(2) Home-upkeep expenses, if applicable (see paragraph (d) of this subsection);

(3) Allocations to a community spouse or maintenance needs of family members living in the community, if applicable (see paragraph (e) of this subsection); and

(4) Reasonable medical expenses incurred, if applicable (see §§ 30.05 and 30.06). For the purposes of this paragraph (b)(4), "reasonable medical expenses" do not include expenses for long-term care services and supports received during penalty periods for Medicaid coverage of long-term care services and supports.

(5) NOTE: Unpaid patient-share obligations may not be used to reduce a current patient share obligation.

(c) Personal-needs allowance and community-maintenance allowance. A reasonable amount for clothing and other personal needs of an individual is deducted from their monthly income, as follows:

(1) For an individual receiving Medicaid coverage of long-term care services and supports in an institutional setting, a standard personal needs deduction (PNA) is applied.

(2) For an individual receiving Medicaid coverage of long-term care services and supports in a home and community-based setting, a standard community maintenance deduction (CMA) is applied. (NOTE: Unlike the individual in the institutional setting whose room and board is covered by Medicaid, an individual receiving long-term care services and supports in a home and community-based setting has a higher deduction to provide a reasonable amount for food, shelter, and clothing to meet their personal needs.)

(d) Home-upkeep deduction

(1) Expenses from the monthly income of an individual receiving Medicaid coverage of long-term care services and supports in an institution or receiving enhanced residential care (ERC) services in a residential care home are deducted to help maintain their owned or rented home in the community. This deduction is allowed for six months. It is available for each separate admission to long-term care, as long as the criteria listed below are met. The home-upkeep standard deduction is three-fourths of the SSI/AABD payment level for a single individual living in the community.

(2) The home-upkeep deduction is granted when the individual has income equal to or greater than the standard home-upkeep deduction and greater than their PNA. An individual who has less income than the standard home-upkeep deduction may deduct an amount for home upkeep equal to the difference between the individual's income and the PNA.

(i) The home-upkeep deduction may be applied at any point during the individual's institutionalization or receipt of ERC services, as the case may be, as long as both of the following criteria for the deduction are met:

(A) No one resides in the individual's home and receives an allocation as a community spouse or other eligible family member; and

(B) The individual submits a doctor's statement before the six-month deduction period, stating that the individual is expected to be discharged from the institution or ERC setting within six months and to return home immediately after discharge.

(ii) If the situation changes during the period the individual is receiving the home-upkeep deduction, the individual's eligibility for the deduction is redetermined. The deduction is denied or ended when:

(A) The individual's home is sold or rented;

(B) The rented quarters of the individual are given up; or

(C) The individual's health requires the long-term care admission period to last longer than six months.

(e) Allocations to family members

(1) In general. An individual is allowed to allocate their income to certain family members as described in this paragraph.

(i) Allocation to community spouse

(A) If an individual receiving Medicaid coverage of long-term care services and supports (the institutionalized spouse) has a spouse living in the community (the community spouse), an allocation may be deducted from the institutionalized spouse's income for the needs of the community spouse. The term "community spouse" applies to the spouse of the institutionalized spouse even if the community spouse is also receiving Medicaid coverage of long-term care services and supports in a home and community-based setting. When one spouse is receiving Medicaid coverage of long-term care services and supports in an institutional setting and the other is receiving Medicaid coverage of long-term care services and supports in a home and community-based setting, the spouse receiving home and community-based services and supports may receive an allocation. When both spouses are receiving home and community-based services and supports, either may allocate to the other.

(B) "Assisted living" is considered a community setting and not an institutional setting provided that assisted living does not include 24-hour care, has privacy, a lockable door, and is a homelike setting. If the spouse of an institutionalized spouse is living in an assisted living setting, they are considered a community spouse for purposes of the community spouse income allocation.

(C) An institutionalized spouse may allocate less than the full amount of the allocation to their community spouse or may allocate nothing. The allocation is reduced by the gross income, if any, of the community spouse. A community spouse, as well as an institutionalized spouse, has a right to request a fair hearing on the amount of the allocation.

(D) The standard community spouse income allocation equals 150 percent of the FPL for two. The actual community spouse income allocation equals the standard allocation plus any amount by which actual shelter expenses of the community spouse exceed the standard allocation, up to a maximum amount. The maximum community spouse income allocation equals a maximum provided by the federal government each year by November 1st.

(E) The presumptions set forth below are applied to the ownership interests in income when determining a community spouse's community spouse income allocation unless the institutionalized spouse establishes by a preponderance of the evidence that the ownership interests are other than as presumed.

(I) Income paid in the name of one spouse is presumed available only to the named spouse.

(II) Income paid in the name of both spouses is presumed available in equal shares to each spouse.

(III) Income paid in the name of either spouse and any other person is presumed available to that spouse in proportion to their ownership interest.

(IV) Income paid in the name of both spouses and any other person is presumed available to each spouse in an amount of one-half of the joint interest.

(ii) Allocation to other family members

(A) A deduction from the individual's income is allowed for the maintenance needs of certain other family members. If the individual has no community spouse living in the home, the countable resources of any such family member cannot exceed the community spouse resource allocation (CSRA) minimum ~~(see Vermont's Medicaid Procedures Manual for the current CSRA minimum)~~.[2] If the individual has a community spouse living in the home, there is no limit on the amount of countable resources of any such family member.

For purposes of this deduction, a family member must be:

(I) A child of either the individual or the individual's spouse under age 18; or

(II) A dependent child, parent, or sibling of either the individual or the individual's spouse. For the purposes of this subparagraph, a family member is considered dependent if they meet each of the following three criteria:

(i) They have been or will be a member of the household of the individual or their spouse for at least one year;

(ii) More than one half of their total support is provided by the individual or the individual's spouse; and

(iii) They have gross annual income below $2,500 or are a child of the individual (or spouse) under age 19 or under age 24 and a full-time student during any five months of the tax year.

(B) *Deduction for family members living with the community spouse*. When family members live with the community spouse of the individual receiving Medicaid coverage of long-term care services and supports, the deduction equals the maintenance income standard reduced by the gross income of each family member and divided by three. The resulting amount is the maximum allocation that may be made to each family member.

(C) *Deduction for family members not living with the community spouse*. When family members do not live with the community spouse of the individual receiving Medicaid coverage of long-term care services and supports, the deduction equals the applicable PIL for the number of family members living in the same household, reduced by the gross income, if any, of the family members in the household.

(D) The family members described above may be required to apply for SSI, AABD or Reach Up, as long as this would not disadvantage them financially.

24.05 Transfer between settings (01/15/2017, GCR 16-097)

(a) In general. An individual receiving long-term care sometimes moves from one setting to another, such as from one nursing facility to another or from a nursing facility to a hospital and back to the same or another nursing facility. The patient share must be paid toward the cost of the individual's care from income received by the individual during each month of a continuous period of receiving Medicaid coverage of long-term care services and supports. As a general rule, the provider giving long-term care services and supports to the individual on

[2] For the current CSRA minimum, see Vermont's Eligibility Standards for Healthcare Programs on the Department of Vermont Health Access website.

the last day of the preceding month sends the individual a bill for the individual's share of the cost for that month. Payment is made to an institution if the individual was receiving Medicaid coverage of long-term care services and supports in the institution on the last day of the preceding month. Payment is made to the highest-paid provider of long-term care services and supports if the individual was receiving Medicaid coverage of long-term care services and supports in a home and community-based setting on the last day of the preceding month. If payment of a patient share results in a credit to the provider, then the provider sends the excess to AHS. Exceptions to this rule are specified in the paragraphs below.

(b) Hospital admission from nursing facility. An individual receiving Medicaid coverage of long-term care services and supports who is hospitalized continues to receive Medicaid coverage of long-term care services and supports, and their patient share amount is not redetermined. Payment of the patient share is allocated to the providers as follows:

(1) Acute care. The patient share is paid directly to AHS when the individual is hospitalized and receiving acute hospital care on the last day of the month preceding the month in which income is received. Failure to pay the patient share may result in closure of the individual's eligibility for Medicaid coverage of long-term care services and supports.

(2) Long-term care. The patient share is paid to the hospital when the individual is hospitalized and receiving Medicaid coverage of long-term care services and supports in the hospital on the last day of the month preceding the month in which income is received.

(c) Transfer from home and community-based setting to nursing facility

(1) Respite services. The patient share amount is not adjusted when an individual receiving Medicaid coverage of long-term care services and supports in a home and community-based setting enters an institution for respite services. The patient share is paid to the highest-paid provider of the long-term care services and supports, even if the individual is in an institution on the last day of the month.

(2) Other services. AHS adjusts the patient share amount when an individual receiving Medicaid coverage of long-term care services and supports in a home and community-based setting enters an institution for services other than respite services and has been in the institution for a full calendar month. The patient share is paid to the institution since the individual was receiving Medicaid coverage of long-term care services and supports in an institution on the last day of the month.

(d) Discharge from nursing facility to home and community-based setting. The patient share amount is adjusted when an individual is in an institution for more than one full calendar month and discharged to a home and community-based setting. After the patient-share amount is redetermined using the community maintenance allowance (see § 24.04(c)), the first month's patient share is paid to the institution because the individual resided in the institution on the last day of the previous month. Thereafter, the patient share it is paid to the highest paid provider.

(e) Discharge from long-term care. All income an individual receiving Medicaid coverage of long-term care services and supports receives during the month they are discharged from long-term care and any month after discharge when the individual leaves a long-term care living arrangement (see § 30.01) is excluded. A long-term care provider must refund any patient-share payment made by an individual when the individual pays their patient share from income received in the month of their discharge.

(f) Termination of eligibility for long-term care. An individual receiving Medicaid coverage of long-term care services and supports becomes fully responsible for the total cost of any care they receive when they remain institutionalized after a medical-review team decision that they no longer need skilled nursing or intermediate care, or they become ineligible for other reasons. The individual's responsibility begins after the effective date of the review team's decision. An individual usually must pay in advance for such care as a privately-paying patient. They incur no patient share obligation for the calendar month that the review team's decision takes effect. A long-term care provider must credit payment toward the cost of private care furnished after the effective date of the review team's decision to end Medicaid coverage of long-term care services and supports when an individual receiving Medicaid coverage of long-term care services and supports has already paid their patient share to the provider during the calendar month the review team's decision takes effect.

(g) Patient share in the month of death. Income received during the calendar month of the death of an individual receiving Medicaid coverage of long-term care services and supports is counted and applied to the cost of the care the individual received during the prior month. For example, if the individual dies on June 26th, the patient-share payment from income they received during June is due for care provided in May. If the individual dies on July 1st, the patient-share payment from income they received during July is due for care provided in June.

25.00 Income or resource transfers and eligibility for Medicaid coverage of long-term care services and supports (01/01/2024~~01/01/2018~~, GCR 23-085~~17-046~~)

25.01 In general (01/15/2017, GCR 16-097)

(a) AHS determines whether transfers of income or resources made by an individual requesting Medicaid coverage of long-term care services and supports are allowable transfers under the rules set forth in this section.

(1) This section applies to an individual:

(i) Who is requesting Medicaid coverage of long-term care services and supports in a medical institution under MABD or MCA.

(ii) Who is requesting Medicaid coverage of long-term care services and supports in a home and community-based setting under MCA.

(iii) Who is requesting Medicaid coverage of long-term care services and supports in a home and community-based setting under MABD and is in a special income coverage group under § 8.05(k)) or is medically needy (§ 8.06).

(2) This section also applies to the spouse of an individual described in (1) above.

If AHS determines that a transfer is not allowable, the individual requesting Medicaid coverage of long-term care services and supports will not be eligible for such coverage until a penalty period has expired. The start date of the penalty period is based on when the individual would, but for the disallowed transfer, be otherwise eligible for Medicaid coverage of long-term care services and supports, as explained in more detail in this section. The duration of the penalty period is based on the value of the disallowed transfer.

(b) AHS makes determinations concerning transfers occurring before the individual requests Medicaid coverage of

long-term care services and supports as part of its determination of the individual's initial eligibility. Once AHS has determined that a transfer is disallowed and has established a penalty period that transfer is not reconsidered unless AHS obtains new information about the transfer. If, after the initial determination, AHS discovers that the individual made an additional transfer (or transfers), AHS also determines whether the additional transfer (or transfers) is allowable, whether the date of the additional transfer (or transfers) is before or after the initial determination, and establishes a penalty period (or periods) as required. If the individual requesting Medicaid coverage of long-term care services and supports has a spouse (community spouse), after the month in which the individual is determined eligible for Medicaid coverage of long-term care services and supports, no resources of the community spouse shall be determined available to the individual (the institutionalized spouse). Accordingly, no transfers by the community spouse after the initial month of the institutionalized spouse's eligibility are considered for purposes of the institutionalized spouse's ongoing eligibility.

(c) § 25.03 specifies the criteria for allowable transfers, to which no penalty period applies, effective for all initial determinations of eligibility for Medicaid coverage of long-term care services and supports and all redeterminations. No other transfers are allowable.

25.02 Definitions (01/15/2017, GCR 16-097)

(a) Transfer of income or resources. For the purposes of this section, a transfer of income or resources is any action taken by the individual requesting Medicaid coverage of long-term care services and supports, by the spouse of such individual, or by any other person with lawful access to the income or resources of the individual or such individual's spouse that disposes of the income or resources. The date of the transfer is the date the action was taken. It also applies to certain income and resources to which the individual or such individual's spouse is entitled but does not have access because of an action taken by:

(1) The individual or such individual's spouse;

(2) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse; or

(3) A person, including a court or administrative body, acting at the direction or upon the request of the individual or such individual's spouse.

(b) Fair market value. Unless otherwise specified, fair market value is an amount equal to the price of an item on the open market in the individual's locality at the time of a transfer, or contract for sale, if earlier.

25.03 Allowable transfers (01/01/2024~~01/01/2018~~, GCR 23-085~~17-046~~)

(a) Transfers for fair-market value – in general. No penalty period is applied to income or resources transferred for fair market value.

AHS determines whether the individual requesting Medicaid coverage of long-term care services and supports, or the spouse of such individual, as the case may be, received fair market value for a transfer of income or resources by determining the difference, if any, between the fair market value of the income or resource reduced by any applicable deductions at the time of the transfer and the amount received for the income or resource. Any of the following deductions may be used to reduce fair market value:

(1) The amount of any legally enforceable liens or debts against the transferred income or resource at the time of transfer that reduced the transferor's equity in the income or resource;

(2) The reasonable and necessary costs of making the sale or transfer;

(3) The value of income or resources received by the transferor in exchange for the transferred income or resources;

(4) The value of income or resources returned to the transferor; and

(5) The following verified payments or in-kind support given to or on behalf of the transferor as compensation for receipt of the income or resources by the person who received the income or resources:

(i) Personal services;

(ii) Payments for medical care;

(iii) Funeral expenses of the individual's deceased spouse;

(iv) Taxes, mortgage payments, property insurance, or normal repairs, maintenance and upkeep on the transferred property; or

(v) Support and maintenance (*e.g.*, food, clothing, incidentals, fuel and utilities) provided in the transferor's own home or in the home of the person who received the income or resources from the transferor.

(b) Receipt of fair market value after the date of the transfer. If the value of a transferred resource is scheduled for receipt after the date of transfer, it is considered a transfer for fair market value only if the transferor can expect to receive the full fair-market value of the resource within their expected lifetime. Expected lifetime is determined as follows:

(1) When institutionalized individual is transferor. Expected lifetime of the institutionalized individual is measured at the time of the transfer as determined in accordance with actuarial publications of the Office of the Chief Actuary of the SSA (http://socialsecurity.gov/OACT/STATS/table4c6.html) ~~and set forth in Vermont's Medicaid Procedures Manual~~.

(2) When spouse of institutionalized individual is transferor. Expected lifetime of the spouse of the institutionalized individual is measured at the time of the transfer as determined in accordance with actuarial publications of the Office of the Chief Actuary of the SSA) (http://socialsecurity.gov/OACT/STATS/table4c6.html) ~~and set forth in Vermont's Medicaid Procedures Manual~~.

(3) Pursuant to the authority granted in Vermont Act 71 § 303(7)(2005), AHS may develop alternate actuarial tables that will be consistent with federal law and adopted by rule.

(c) Transfers for less than fair-market value – in general. A penalty period is not imposed for a transfer for less than fair market value that meets one or more of the following criteria:

(1) Time of transfer – beyond look-back period. The date of the transfer was more than 60 calendar months prior to the first month in which the individual both requests eligibility for Medicaid coverage of long-term care services and supports and meets all other requirements for eligibility.

(2) Transferred income or resources are returned. The transferred income or resources have been returned or otherwise remain available to the individual or the individual's spouse.

(3) Property transferred of a person other than the individual or their spouse. The action that constituted the transfer was the removal of the individual's (or spouse's) name from a joint account in a financial institution, and the individual (or spouse) has demonstrated, to AHS's satisfaction, that the funds in the account accumulated from the income and resources of another owner who is not the individual (or their spouse).

(4) Transfer of resource for a purpose other than creation or maintenance of eligibility for Medicaid coverage of long-term care services and supports. The transferor has documented to AHS's satisfaction convincing evidence that the resources were transferred exclusively for a purpose other than for the individual to become or remain eligible for Medicaid coverage of long-term care services and supports. A signed statement by the transferor is not, by itself, convincing evidence. Examples of convincing evidence are documents showing that:

(i) The transfer was not within the transferor's control (e.g., was ordered by a court);

(ii) The transferor could not have anticipated the individual's eligibility for Medicaid coverage of long-term care services and supports on the date of the transfer (e.g., the individual became disabled due to a traumatic accident after the date of transfer); or

(iii) A diagnosis of a previously undetected disabling condition leading to the individual's eligibility for Medicaid coverage of long-term care services and supports was made after the date of the transfer.

(5) Transfers of specified property for the benefit of certain family members. The transfer meets the criteria specified below for transfers involving trusts (see paragraph (d)), transfers of homes (see paragraph (e)), and transfers for the benefit of certain family members (see paragraph (g)).

(6) Intent to transfer for fair market value. The transferor has demonstrated to AHS's satisfaction that they intended to dispose of the income or resources either at fair market value, or for other valuable consideration.

(7) Transfer of excluded income or resources

(i) The transferor transferred excluded income or resources.

(ii) Penalties are imposed for the transfer for less than fair market value of any asset considered by the SSA's SSI program to be countable or excluded. For example, transfer of a home or of the proceeds of a loan are both subject to penalty.

(d) Allowable transfers involving trusts. A penalty period is not imposed for transfers involving trusts that meet one or more of the following criteria:

(1) The action that constituted the transfer was the establishment of an irrevocable trust that does not under any circumstances allow disbursements to or for the benefit of the individual, and the date of the transfer was more than 60 calendar months prior to the first month in which the individual requests Medicaid coverage of long-term care services and supports.

(2) The action that constituted the transfer was the establishment of a trust solely for the benefit of the individual if the individual was under age 65 when the trust was established and the trust meets all of the criteria at § 29.08(e)(1)(ii)(F).

(3) The action that constituted the transfer was the establishment of a pooled trust, as specified at § 29.08(e)(1)(ii)(G), unless the individual was age 65 or older when they established the trust. If so, the transfer is not exempted from the imposition of a transfer penalty period.

(4) The action that constituted the transfer was the establishment of a revocable trust. However, AHS considers any payment from the revocable trust to anyone other than the individual a transfer for less than fair-market value subject to penalty unless the payment is for their benefit.

(e) Allowable transfers of homes to family members. A penalty period is not imposed for the transfer of a home that meets the definition at § 29.08(a)(1) provided that title was transferred to one or more of the following persons:

(1) The spouse of the individual requesting Medicaid coverage of long-term care services and supports;

(2) The individual's child who was under age 21 on the date of the transfer;

(3) The individual's son or daughter who is blind or permanently and totally disabled, regardless of age;

(4) The brother or sister of the individual when:

(i) The brother or sister had an equity interest in the home on the date of the transfer; and

(ii) Was residing in the home continuously for at least one year immediately prior to the date the individual began to receive Medicaid coverage of long-term care services and supports, including services in a home and community-based setting; or

(5) The son or daughter of the individual provided that the son or daughter:

(i) Was residing in the home continuously for at least two years immediately prior to the date the individual (parent) began receiving Medicaid coverage of long-term care services and supports, including services in a home and community-based setting; and

(ii) Provided care to the individual during part or all of this period that allowed the individual to postpone receipt of Medicaid coverage of long-term care services and supports.

(f) Allowable transfers involving life-estate interests in another individual's home. A penalty period is not imposed for the purchase of a life-estate interest in another person's home when:

(1) It is the purchaser's residence; and

(2) The purchaser resides in the home for a period of at least one year after the purchase.

(g) Other allowable transfers. A penalty period is not imposed for transfers that meet any of the following criteria:

(1) The transfer was for the sole benefit of the individual requesting Medicaid coverage of long-term care services and supports.

(2) The income or resource was transferred by the institutionalized spouse to their community spouse before the initial determination of the institutionalized spouse's eligibility for Medicaid coverage of long-term care services and supports. This also applies to a transfer made to a third party for the sole benefit of the community spouse.

(3) The income or resource was transferred to the individual's son or daughter who is blind or permanently and totally disabled or to a trust for the sole benefit of such son or daughter regardless of their age.

(4) The income or resource was transferred to a trust, including a trust described in § 29.08(e)(1)(F) or § 29.08(e)(1)(G), established solely for the benefit of an individual under the age of 65 years who is disabled.

(h) Transfers involving annuities

(1) In general

(i) *Purchases.* Any annuity purchased by an individual requesting Medicaid coverage of long-term care services and supports, or, if married, their community spouse on or after February 8, 2006, must name Vermont Medicaid as the first remainder beneficiary of the annuity up to the amount of Medicaid payments, including payments for Medicaid coverage of long-term-care services and supports, made by the state on behalf of the individual. If there is a community spouse or a minor or disabled child, they may be named as a remainder beneficiary ahead of the state. Vermont Medicaid must then be named as the secondary remainder beneficiary. If Vermont Medicaid is not named as a remainder beneficiary in the correct position, the purchase of the annuity is considered a transfer for less than fair market value. When Vermont Medicaid is a remainder beneficiary of an annuity, the issuer of the annuity is required to notify Vermont Medicaid of any changes in the disbursement of income or principal from the annuity as well as any changes to the state's position as remainder beneficiary.

(ii) *Annuity-related transactions other than purchases.* In addition to the purchase of an annuity, certain transactions with respect to an annuity that occur on or after February 8, 2006, make an annuity, including one purchased before that date, subject to the provisions of this paragraph. Such transactions include any action taken by the individual requesting Medicaid coverage of long-term care services and supports or, if married, their community spouse that changes the course of payments to be made by the annuity or the treatment of the income or principal of the annuity. Routine changes and automatic events that do not require any action or decision are not considered transactions that would subject the annuity to this treatment.

(2) Additional requirements

(i) In addition to the requirement under paragraph (h)(1) that Vermont Medicaid be named as a remainder beneficiary in the correct position in order for the purchase of an annuity by an individual requesting Medicaid coverage of long-term care services and supports or, if married, their community spouse to not be considered a transfer for less than fair market value, if the purchase of the annuity is by the individual requesting Medicaid coverage of long-term care services and supports, the purchase must also meet one or more of the four alternatives described below in order for it to not be subject to a transfer penalty. To determine that an annuity is established under any of the various provisions of the Code that are referenced in (C) and (D) below, AHS relies on verification from the financial institution, employer or employer association that issued the annuity. The burden of proof is on the individual to produce this documentation. Absent such documentation, AHS considers the purchase of the annuity a transfer for less than fair-market value and, as such, subject to a penalty.

(ii) The four alternatives are as follows:

(A) The annuity meets the provisions of §§ 29.08(d)(1) or 29.09(d)(1).

(B) The annuity is:

(I) Irrevocable and nonassignable;

(II) Provides for payments to the individual in equal intervals and equal amounts with no deferral and no balloon payments made;

(III) Is actuarially sound because it does not exceed the life expectancy of the individual, as determined using the actuarial publications of the Office of the Chief Actuary of the SSA (http://socialsecurity.gov/OACT/STATS/table4c6.html) ~~and set forth in Vermont's Medicaid Procedures Manual~~; and

(IV) Returns to the individual at least the amount used to establish the contract and any additional payments plus earnings, as specified in the contract.

(C) The annuity is considered either:

(I) An individual retirement annuity (according to § 408(b) of the Code), or

(II) A deemed Individual Retirement Account (IRA) under a qualified employer plan (according to § 408(q) of the Code).

(D) The annuity is purchased with proceeds from one of the following:

(I) A traditional IRA (§ 408(a) of the Code);

(II) Certain accounts or trusts which are treated as traditional IRAs (§ 408(c) of the Code);

(III) A simplified retirement account (§ 408 (p) of the Code);

(IV) A simplified employee pension (§ 408 (k) of the Code); or

(V) A Roth IRA (§ 408A of the Code).

(3) Impermissible transfers. An annuity that does not meet the above criteria is assessed a transfer penalty based on its fair market value. The fair market value of an annuity equals the amount of money used to establish the annuity and any additional amounts used to fund the annuity, plus any earnings and minus any early withdrawals and surrender fees.

(i) Allowable transfers involving promissory notes and other income-producing resources

(1) Promissory notes or similar income-producing resources (contracts) are assessed a transfer penalty based on their fair market value unless they:

(i) Have a repayment term that is actuarially-sound as determined in accordance with actuarial publications of the Office of the Chief Actuary of the SSA (http://socialsecurity.gov/OACT/STATS/table4c6.html) ~~and set forth in Vermont's Medicaid Procedures Manual~~;

(ii) Provide for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

(iii) Prohibit the cancellation of the balance upon the death of the lender.

(2) Fair market value equals the amount of money used to establish the contract and any additional payments used to fund it, plus any earnings and minus any payments already received as of the date of the application for Medicaid coverage of long-term care services and supports.

(j) Transfers involving jointly-owned income or resources

(1) Joint-ownership established on or after January 1, 1994. For any joint-ownership established on or after January 1, 1994, the portion of the jointly-owned asset subject to the imposition of a penalty period is evaluated based on the specific circumstances of the situation. An individual is presumed to own a jointly-owned resource using the rules in § 29.09. In the case of a jointly-owned account in a financial institution, for example, since the account is presumed to be owned entirely by the individual (see § 29.09(c)(5)(ii)), a transfer penalty is imposed against the individual for any amount withdrawn from the account by another joint owner on the account. The individual may rebut the presumption of ownership by establishing to AHS's satisfaction that the amount withdrawn was, in fact, the sole property of and contributed to the account by the other joint owner (or owners), and thus did not belong to the individual.

(2) Joint-ownership established before January 1, 1994. For a joint ownership established before January 1, 1994, the date of the transfer is the date the other person (or persons) became a joint owner. The value of the transfer equals the amount that the resource available to the individual or, if married, the individual's spouse was reduced in value when the other person (or persons) became a joint owner.

25.04 Penalty period for disallowed transfers (01/15/2017, GCR 16-097)

(a) Definition: Otherwise eligible

(1) For purposes of determining the start date of the penalty period because of disallowed transfers, an individual is considered "otherwise eligible" for Medicaid coverage of long-term care services and

supports as of the earliest date they pass all eligibility criteria in the sequence listed below. They must also meet each of these criteria in any month for which they request retroactive eligibility:

(i) Clinical criteria (see definition of long-term care in § 3.00).

(ii) Citizenship and identity criteria (§ 17.00).

(iii) Category (§ 7.03 (MCA), §§ 8.05 and 8.06 (MABD)).

(iv) Residency (§ 21.00).

(v) Living arrangements (§ 20.00).

(vi) Resources (§ 29.07), if applicable.

(vii) Income (§§ 28.03 and 28.04 (MCA), § 29.11 (MABD) - for anyone with excess income, see explanation in (2) below).

(2) When an individual's income exceeds the income requirement for their applicable coverage group, the individual must spend down to the applicable PIL in the month of application or the next month. An individual with a penalty is subject to the penalty period start date beginning on the date the spenddown is met. If the spenddown is not met in the month of application or the next month, the individual is denied Medicaid coverage of long-term care services and supports. AHS then determines whether the person is eligible for Medicaid (other than Medicaid coverage of long-term care services and supports). If so, it assesses a 6-month spend down.

Examples:

(i) The individual applies in June for Medicaid coverage of long-term care services and supports under MABD and requests retroactive coverage as of April. The individual meets all eligibility criteria but their gross countable income exceeds the IIS and they have transfers that will result in a 38 day penalty period. The spenddown period is April – September. The individual meets their spenddown on April 23rd. April 23rd is the date the individual is considered to be "otherwise eligible." Their penalty period would be April 23rd – May 30th.

(ii) Same case as in (i), but no retroactive coverage is requested. The spenddown period is June-November. The spenddown is met June 23rd. June 23rd is the date the individual is considered to be "otherwise eligible." The penalty period is June 23rd – July 30th.

(b) Penalty period – in general. If a transfer is disallowed, a penalty period of restricted Medicaid coverage to an otherwise eligible individual is imposed. During this period, no Medicaid payments are made for the individual's long-term care services and supports. Payments are made for all other covered Medicaid services provided to the individual during the period of restricted coverage.

(c) Penalty date

(1) Transfers made in a single month. The penalty date is the beginning date of each penalty period imposed for a disallowed transfer. The penalty date starts on the first day in which the individual would have been otherwise eligible for Medicaid coverage of long-term care services and supports (see paragraph (a) of

this subsection for explanation of "otherwise eligible").

(2) Transfers occurring in different months. Penalty periods run consecutively rather than concurrently, in the order in which the transfers occurred. If, after establishing a penalty period for disallowed transfers, it is determined that additional disallowed transfers were made in a subsequent month but before the end of the first penalty period, the first day following the end of the first penalty period will be designated as the penalty date for the subsequent penalty period.

(d) Penalty period

(1) Calculation of penalty. The number of days in a penalty period are equal to the total value of all disallowed transfers made during a given calendar month divided by the average daily cost to a privately-paying patient of nursing facility services in the state as of the date of application or the date of discovery, if additional disallowed transfers are discovered after the initial determination of eligibility for Medicaid coverage of long-term care services and supports.

(2) Transfers in different calendar months. Penalty periods for transfers in different calendar months are consecutive and established in the order in which the disallowed transfers occurred.

(3) Continuous nature of penalty period. A penalty period runs continuously from the first date of the penalty period, even if the individual stops receiving long-term care services and supports.

(e) Penalty when both spouses request Medicaid coverage of long-term care services and supports

(1) In general. The following rules are applied to the assignment of penalty periods when both members of a couple are requesting or receiving Medicaid coverage of long-term care services and supports.

(2) Spouses eligible at same time. For spouses determined otherwise eligible for Medicaid coverage of long-term care services and supports at the same time, the value of the disallowed transfer is divided by two to determine the number of days of restricted coverage for each member of the couple.

(3) Penalty period for one spouse is running at the time the other requests Medicaid coverage of long-term care services and supports. If the penalty period established for one member of the couple has not yet expired when the other member of the couple requests and is determined otherwise eligible for Medicaid coverage of long-term care services and supports, the number of days remaining in the penalty period is divided by two to determine the number of days of restricted coverage for each member of the couple.

(4) Death of a spouse during penalty period. When the member of the couple for whom a penalty period has been established dies, the days remaining in that member's penalty period are not reassigned to their spouse if the spouse requests and is determined otherwise eligible for Medicaid coverage of long-term care services and supports.

(5) Penalty periods for transfer by second spouse to request Medicaid coverage of long-term care services and supports. When a penalty period is established for a disallowed transfer by the second member of the couple to request and be determined otherwise eligible for Medicaid coverage of long-term care services and supports, that penalty period is assigned to the spouse who made the transfer provided that it was made after the determination of disallowed transfers for the first spouse.

25.05 Undue Hardship (01/15/2017, GCR 16-097)

(a) In general. AHS does not establish a penalty period resulting from a disallowed transfer when it determines that restricted coverage will result in an undue hardship. Undue hardship is considered only in cases where AHS has first determined that a transfer has been made for less than fair market value and that no transfer exception applies (see § 25.03).

(b) Definition: Undue hardship

(1) For purposes of this subsection, undue hardship means depriving the individual of:

(i) Medical care, such that the individual's health or life would be endangered; or

(ii) Food, clothing, shelter, or other necessities of life.

(2) Undue hardship does not exist when the application of a transfer penalty merely causes an individual or the individual's family member(s) inconvenience or restricts their lifestyle. Undue hardship does not exist when the individual transferred the assets to their community spouse and the community spouse has countable or excluded resources in excess of the community spouse resource allocation (CSRA) standard (§ 29.10(e)).

(c) Undue hardship reasons. In determining the existence of undue hardship, all circumstances involving the transfer and the situation of the individual are considered. Undue hardship is established when one or more of the following circumstances, or any other comparable reasons, exist:

(1) Whether imposition of the transfer penalty would result in the individual's immediate family qualifying for SSI; Reach Up; AABD; General Assistance; 3SquaresVTs; or another public assistance program requiring a comparable showing of financial need.

(2) Whether funds can be made available for the cost of the individual's long-term care services and supports only if assets such as a family farm or other family business are sold, and the assets are the primary source of income for the individual's spouse, parents, children or siblings.

(3) Whether an agent under a power of attorney (POA) or a guardian of the individual transferred the asset, and the POA or guardian was not acting in the best interest of the individual when the transfer was made as determined by AHS or a court, or the transfer forms the basis for a report to AHS for investigation of abuse, neglect or exploitation.

(4) Whether the individual was deprived of an asset by exploitation, fraud or misrepresentation. Such claims must be documented by official police reports or civil or criminal action against the alleged perpetrator or substantiated by AHS or by a sworn statement to AHS attesting to the fact that the claim was reported to the police or to the AHS department responsible for substantiating such claims.

(5) Whether the individual cannot recover the assets due to loss, destruction, theft, or other similar circumstances.

(6) *Presumption of care and rebuttal of presumption.*

(i) *Presumption.* When the transfer is to a person, AHS presumes the recipient of the transferred asset could make arrangements for the individual's care and the care of dependent family members up to the value of the transfer unless the evidence submitted indicates that there is no reasonable way that the person can make any of these arrangements. The facts and verification required to determine if the recipient of the transferred asset can make other arrangements to pay or provide the care of the individual, or to provide for the needs of financially-dependent family members, may include the following, if applicable:

(A) A copy of the tax return for the preceding calendar year;

(B) All earnings pay stubs for the past 12 months;

(C) All bank books, stocks, bonds, certificates, life insurance policies (e.g. bank books must include those before and after receipt of the transferred asset); and

(D) All documents associated with the proceeds of the transferred asset which will show the value of any purchase of new assets from the sale proceeds of the transferred asset.

(E) When the transfer is made to a relative who is a minor, a family member with financial responsibility for the minor must be asked to provide the required facts and verification.

(ii) *Rebuttal.* If the individual rebuts the presumption and shows there is no reasonable way that the recipient of the transferred asset can make arrangements for the individual's care and the care of dependent family members up to the value of the transfer, AHS will consider whether the individual has exhausted all reasonable efforts to meet their needs from other available sources. This includes whether the individual has exhausted all reasonable efforts to obtain return of the asset transferred, and demonstrated that efforts to obtain return of the asset or adequate compensation would probably not succeed. AHS will take into consideration all excluded and countable assets above the protected resource standard and income above the monthly maintenance needs allowance. Burial funds (§ 29.08(c)) and the individual's principal place of residence (§ 29.08(a)(1)) will continue to be excluded.

(d) Authority of provider to file request for individual. For the purposes of this subsection, a long-term care provider may, with the consent of the individual or the personal representative of the individual, file a request for undue hardship on behalf of the individual.

(e) Process for reviewing undue hardship requests

(1) Notice of imposition of penalty period

(i) The individual will be informed of the right to request an undue hardship exception through written notice of a penalty period of ineligibility for Medicaid coverage of long-term care services and supports because of an impermissible asset transfer.

(ii) The notice will:

(A) Specify the factual and legal basis for the imposition of the penalty, and

(B) Explain how the individual may request an undue hardship exception.

(2) Timing of exception request. An individual may request an undue hardship exception within 20 days of receiving notification of the transfer penalty.

(3) Application requirements. To request an undue hardship exception, the individual must submit documentation supporting their claim of undue hardship.

(4) Standard of proof. Undue hardship is established when the individual demonstrates by a preponderance of the evidence that denial of Medicaid coverage of long-term care services and supports will cause actual and not merely possible undue hardship.

(5) Nature of available relief. If the individual establishes undue hardship, AHS may waive all or a portion of the penalty period.

(6) Notice of decision on request. A notice of decision on the undue hardship exception request will be issued within 10 business days of receipt of all information determined by AHS as needed to evaluate the request. The notice will be in writing and will inform the individual of the right to request a fair hearing to appeal the decision.

(7) Notice of decision on eligibility for Medicaid coverage of long-term care services and supports. If no request for an undue hardship exception is received within 20 days after notification of the transfer penalty, or if the request is denied, an eligibility determination will be issued specifying the applicable penalty period. If the individual is receiving Medicaid coverage of long-term care services and supports, the notice will include the date the Medicaid coverage terminates and the right to request a fair hearing and continuing benefits.

(8) Exception: Request made within request for fair hearing. When an individual makes a request for an undue hardship exception for the first time at the same time they are requesting a fair hearing, the individual must raise all claims and submit all evidence permitting consideration of the undue hardship exception at least 10 business days in advance of the fair hearing. The undue hardship request must then be referred to AHS for consideration. AHS will then inform the fair hearings entity of its decision on the request within 10 business days of receiving it.

(9) Exception: Request made during penalty period on the basis of changed circumstances. A request for an undue hardship exception may be filed at any time during a penalty period if new circumstances leading to undue hardship arise during the duration of the penalty period. If granted, the request will be prospective from the date of the request.

(10) Limitation on obligation to pay for long-term care services and supports during penalty period. The state has no obligation to pay for cost of an individual's long-term care services and supports during the individual's penalty period unless an undue hardship exception has been granted or the individual prevails at a fair hearing.

(11) Extension of time period. The time periods specified in this paragraph (e) may be extended if AHS determines that extenuating circumstances require additional time.

26.00 [Reserved]

27.00 [Reserved]

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Part Four
Special Rules for Medicaid Coverage of Long-Term Care Services and Supports - Eligibility and Post-Eligibility

24.00 Patient share payment for Medicaid coverage of long-term care services and supports (01/01/2024, GCR 23-085)

24.01 In general (01/15/2017, GCR 16-097)

(a) Definition: patient share.[1] Once AHS determines that an individual is eligible for Medicaid coverage of long-term care services and supports, it computes how much of their income must be paid to the long-term care provider each month for the cost of their care (this is called the "patient share").

A patient share is computed for an individual who qualifies for Medicaid coverage of long-term care services and supports under MABD in a medical institution or in a home and community-based setting under a special income coverage group (see § 8.05(k)) or as medically needy (see § 8.06). An individual's patient share is determined at initial eligibility, eligibility redeterminations, and when changes in circumstances occur.

(b) Computation of patient share

(1) An individual's patient share is determined by computing a maximum patient share and deducting allowable expenses. § 24.03 describes how the maximum patient share is determined. § 24.04 describes allowable deductions from the patient share. The actual patient share payable by the individual is the lesser of:

(i) The balance of the individual's income remaining after computing the patient share; and

(ii) The cost of care remaining after third-party payment.

(2) In cases in which allowable deductions exceed the individual's income, the patient-share payment is reduced by the deductions, sometimes resulting in no patient-share obligation, for as many months needed to exhaust the deductions against the individual's available income. The month when the remaining deductions no longer exceed the individual's income, the balance is the patient share payment for that month. When monthly income and allowable deductions are stable, the patient-share amount remains constant. When income or allowable deductions fluctuate, the patient-share payment is likely to vary.

(c) Patient share payment. An individual owes their patient share by the last day of the month in which they receive the income. Payment is made either to the facility in which the individual resided or to the highest-paid provider of long-term care services and supports. Patient-share amounts and payments to long-term care providers may be adjusted when a patient transitions from one setting to another, as specified in § 24.05.

[1] 42 CFR §§ 435.725, 435.726 and 435.735

24.02 Long-term care residence period (01/01/2024, GCR 23-085)

(a) In general. A patient share obligation is assessed in the month of admission to long-term care as long as the individual is expected to need long-term care services and supports for at least 30 consecutive days. If long-term care services and supports are expected to be needed for fewer than 30 consecutive days, no patient share is assessed. Instead, the individual's services are covered through Medicaid, other than Medicaid coverage of long-term care services and supports, if the individual meets medical necessity criteria (see HCAR 4.101) and relevant financial, nonfinancial and categorical eligibility criteria.

(b) Duration of the long-term care residence period

(1) Beginning of long-term care residence

(i) In a general hospital setting. A long-term care residence period in a general hospital setting begins with the first day that the utilization review committee finds acute hospital care is no longer medically necessary and skilled nursing care is medically necessary.

(ii) In other long-term care settings. A long-term care residence period in a long-term care setting, other than a general hospital, begins with the first day that the utilization review committee finds medical need for long-term care or the date of admission, whichever is later.

(2) Ending of long-term care residence period. A long-term care residence period ends with the earliest of:

(i) The individual's date of death;

(ii) The date of the individual's discharge from a long-term care living arrangement (as defined in § 30.01); or

(iii) The last day medical need for long-term care is established by the utilization review committee.

(3) Leave of absence or transfer. A long-term care residence period is not ended by a leave of absence from the current setting (see DVHA Rule 7604.1). A long-term care residence period also continues despite transfer from either:

(i) One long-term care setting to another long-term care setting;

(ii) A general hospital setting (where skilled nursing care has been continuously authorized while awaiting transfer) to another long-term care setting; or

(iii) A long-term care setting to a general hospital setting followed by return to the long-term care setting without an intervening residence period in a community living arrangement (as defined in § 30.01).

(4) Percentage of month in long-term care. The percentage of the month an individual is in long-term care is determined using the appropriate table below.

Percentage of Month in Long-Term Care: All months except February

Day of the month admitted to long-term care	Percentage of the month in long-term care	Day of the month admitted to long-term care	Percentage of the month in long-term care	Day of the month admitted to long-term care	Percentage of the month in long-term care
1	100%	11	67%	21	33%
2	97%	12	63%	22	30%
3	93%	13	60%	23	27%
4	90%	14	57%	24	23%
5	87%	15	53%	25	20%
6	83%	16	50%	26	17%
7	80%	17	47%	27	13%
8	77%	18	43%	28	10%
9	73%	19	40%	29	7%
10	70%	20	37%	30-31	3%

Percentage of Month in Long-Term Care: February

Day of the month admitted to long-term care	Percentage of the month in long-term care	Day of the month admitted to long-term care	Percentage of the month in long-term care	Day of the month admitted to long-term care	Percentage of the month in long-term care
1	100%	11	64%	21	29%
2	96%	12	61%	22	25%
3	93%	13	57%	23	21%
4	89%	14	54%	24	18%
5	86%	15	50%	25	14%
6	82%	16	46%	26	11%
7	79%	17	43%	27	7%
8	75%	18	39%	28	4%
9	71%	19	36%	29	0%
10	68%	20	32%		

24.03 Determining maximum patient share (01/15/2017, GCR 16-097)

To determine the maximum patient share, the individual's gross income less allowable deductions as specified in § 24.04 is considered. This is the most that an individual receiving Medicaid coverage of long-term care services and supports is obliged to pay toward the cost of their long-term care services and supports. If an individual was in long-term care for less than a full month, the maximum patient share is multiplied by the applicable percentage in the table set forth in § 24.02.

24.04 Allowable deductions from patient-share (01/01/2024, GCR 23-085)

(a) Income deductions. When determining the actual patient share payable by an individual, the following are deducted from the individual's gross income:

(1) SSI/AABD, AABD only and Reach Up benefit payments still being received when the person first enters long-term care;

(2) SSI/AABD payments intended to be used to maintain the community residence of an individual temporarily (not to exceed 3 months) in an institution;

(3) Austrian Reparation Payments;

(4) German Reparation Payments;

(5) Japanese and Aleutian Restitution Payments;

(6) Payments from the Agent Orange Settlement Fund;

(7) Radiation Exposure Compensation; and

(8) VA payments for aid and attendance paid to a veteran residing in a nursing facility or to the veteran's surviving spouse residing in a nursing facility.

(b) Other deductions. The following items are then deducted from the individual's patient share in the following order:

(1) A personal-needs allowance (PNA) or community-maintenance allowance (CMA) (see paragraph (c) of this subsection);

(2) Home-upkeep expenses, if applicable (see paragraph (d) of this subsection);

(3) Allocations to a community spouse or maintenance needs of family members living in the community, if applicable (see paragraph (e) of this subsection); and

(4) Reasonable medical expenses incurred, if applicable (see §§ 30.05 and 30.06). For the purposes of this paragraph (b)(4), "reasonable medical expenses" do not include expenses for long-term care services and supports received during penalty periods for Medicaid coverage of long-term care services and supports.

(5) NOTE: Unpaid patient-share obligations may not be used to reduce a current patient share obligation.

(c) Personal-needs allowance and community-maintenance allowance. A reasonable amount for clothing and other personal needs of an individual is deducted from their monthly income, as follows:

(1) For an individual receiving Medicaid coverage of long-term care services and supports in an institutional setting, a standard personal needs deduction (PNA) is applied.

(2) For an individual receiving Medicaid coverage of long-term care services and supports in a home and community-based setting, a standard community maintenance deduction (CMA) is applied. (NOTE: Unlike the individual in the institutional setting whose room and board is covered by Medicaid, an individual receiving long-term care services and supports in a home and community-based setting has a higher deduction to provide a reasonable amount for food, shelter, and clothing to meet their personal needs.)

(d) Home-upkeep deduction

(1) Expenses from the monthly income of an individual receiving Medicaid coverage of long-term care services and supports in an institution or receiving enhanced residential care (ERC) services in a residential care home are deducted to help maintain their owned or rented home in the community. This deduction is allowed for six months. It is available for each separate admission to long-term care, as long as the criteria listed below are met. The home-upkeep standard deduction is three-fourths of the SSI/AABD payment level for a single individual living in the community.

(2) The home-upkeep deduction is granted when the individual has income equal to or greater than the standard home-upkeep deduction and greater than their PNA. An individual who has less income than the standard home-upkeep deduction may deduct an amount for home upkeep equal to the difference between the individual's income and the PNA.

(i) The home-upkeep deduction may be applied at any point during the individual's institutionalization or receipt of ERC services, as the case may be, as long as both of the following criteria for the deduction are met:

(A) No one resides in the individual's home and receives an allocation as a community spouse or other eligible family member; and

(B) The individual submits a doctor's statement before the six-month deduction period, stating that the individual is expected to be discharged from the institution or ERC setting within six months and to return home immediately after discharge.

(ii) If the situation changes during the period the individual is receiving the home-upkeep deduction, the individual's eligibility for the deduction is redetermined. The deduction is denied or ended when:

(A) The individual's home is sold or rented;

(B) The rented quarters of the individual are given up; or

(C) The individual's health requires the long-term care admission period to last longer than six months.

(e) Allocations to family members

(1) In general. An individual is allowed to allocate their income to certain family members as described in this paragraph.

(i) Allocation to community spouse

(A) If an individual receiving Medicaid coverage of long-term care services and supports (the institutionalized spouse) has a spouse living in the community (the community spouse), an allocation may be deducted from the institutionalized spouse's income for the needs of the community spouse. The term "community spouse" applies to the spouse of the institutionalized spouse even if the community spouse is also receiving Medicaid coverage of long-term care services and supports in a home and community-based setting. When one spouse is receiving Medicaid coverage of long-term care services and supports in an institutional setting and the other is receiving Medicaid coverage of long-term care services and supports in a home and community-based setting, the spouse receiving home and community-based services and supports may receive an allocation. When both spouses are receiving home and community-based services and supports, either may allocate to the other.

(B) "Assisted living" is considered a community setting and not an institutional setting provided that assisted living does not include 24-hour care, has privacy, a lockable door, and is a homelike setting. If the spouse of an institutionalized spouse is living in an assisted living setting, they are considered a community spouse for purposes of the community spouse income allocation.

(C) An institutionalized spouse may allocate less than the full amount of the allocation to their community spouse or may allocate nothing. The allocation is reduced by the gross income, if any, of the community spouse. A community spouse, as well as an institutionalized spouse, has a right to request a fair hearing on the amount of the allocation.

(D) The standard community spouse income allocation equals 150 percent of the FPL for two. The actual community spouse income allocation equals the standard allocation plus any amount by which actual shelter expenses of the community spouse exceed the standard allocation, up to a maximum amount. The maximum community spouse income allocation equals a maximum provided by the federal government each year by November 1st.

(E) The presumptions set forth below are applied to the ownership interests in income when determining a community spouse's community spouse income allocation unless the institutionalized spouse establishes by a preponderance of the evidence that the ownership interests are other than as presumed.

(I) Income paid in the name of one spouse is presumed available only to the named spouse.

(II) Income paid in the name of both spouses is presumed available in equal shares to each spouse.

(III) Income paid in the name of either spouse and any other person is presumed available to that spouse in proportion to their ownership interest.

(IV) Income paid in the name of both spouses and any other person is presumed available to each spouse in an amount of one-half of the joint interest.

(ii) Allocation to other family members

(A) A deduction from the individual's income is allowed for the maintenance needs of certain other family members. If the individual has no community spouse living in the home, the countable resources of any such family member cannot exceed the community spouse resource allocation (CSRA) minimum.[2] If the individual has a community spouse living in the home, there is no limit on the amount of countable resources of any such family member.

For purposes of this deduction, a family member must be:

(I) A child of either the individual or the individual's spouse under age 18; or

(II) A dependent child, parent, or sibling of either the individual or the individual's spouse. For the purposes of this subparagraph, a family member is considered dependent if they meet each of the following three criteria:

(i) They have been or will be a member of the household of the individual or their spouse for at least one year;

(ii) More than one half of their total support is provided by the individual or the individual's spouse; and

(iii) They have gross annual income below $2,500 or are a child of the individual (or spouse) under age 19 or under age 24 and a full-time student during any five months of the tax year.

(B) *Deduction for family members living with the community spouse.* When family members live with the community spouse of the individual receiving Medicaid coverage of long-term care services and supports, the deduction equals the maintenance income standard reduced by the gross income of each family member and divided by three. The resulting amount is the maximum allocation that may be made to each family member.

(C) *Deduction for family members not living with the community spouse.* When family members do not live with the community spouse of the individual receiving Medicaid coverage of long-term care services and supports, the deduction equals the applicable PIL for the number of family members living in the same household, reduced by the gross income, if any, of the family members in the household.

(D) The family members described above may be required to apply for SSI, AABD or Reach Up, as long as this would not disadvantage them financially.

24.05 Transfer between settings (01/15/2017, GCR 16-097)

(a) In general. An individual receiving long-term care sometimes moves from one setting to another, such as from one nursing facility to another or from a nursing facility to a hospital and back to the same or another nursing facility. The patient share must be paid toward the cost of the individual's care from income received by the individual during each month of a continuous period of receiving Medicaid coverage of long-term care services and supports. As a general rule, the provider giving long-term care services and supports to the individual on the last day of the preceding month sends the individual a bill for the individual's share of the cost for that

[2] For the current CSRA minimum, see Vermont's Eligibility Standards for Healthcare Programs on the Department of Vermont Health Access website.

month. Payment is made to an institution if the individual was receiving Medicaid coverage of long-term care services and supports in the institution on the last day of the preceding month. Payment is made to the highest-paid provider of long-term care services and supports if the individual was receiving Medicaid coverage of long-term care services and supports in a home and community-based setting on the last day of the preceding month. If payment of a patient share results in a credit to the provider, then the provider sends the excess to AHS. Exceptions to this rule are specified in the paragraphs below.

(b) Hospital admission from nursing facility. An individual receiving Medicaid coverage of long-term care services and supports who is hospitalized continues to receive Medicaid coverage of long-term care services and supports, and their patient share amount is not redetermined. Payment of the patient share is allocated to the providers as follows:

(1) Acute care. The patient share is paid directly to AHS when the individual is hospitalized and receiving acute hospital care on the last day of the month preceding the month in which income is received. Failure to pay the patient share may result in closure of the individual's eligibility for Medicaid coverage of long-term care services and supports.

(2) Long-term care. The patient share is paid to the hospital when the individual is hospitalized and receiving Medicaid coverage of long-term care services and supports in the hospital on the last day of the month preceding the month in which income is received.

(c) Transfer from home and community-based setting to nursing facility

(1) Respite services. The patient share amount is not adjusted when an individual receiving Medicaid coverage of long-term care services and supports in a home and community-based setting enters an institution for respite services. The patient share is paid to the highest-paid provider of the long-term care services and supports, even if the individual is in an institution on the last day of the month.

(2) Other services. AHS adjusts the patient share amount when an individual receiving Medicaid coverage of long-term care services and supports in a home and community-based setting enters an institution for services other than respite services and has been in the institution for a full calendar month. The patient share is paid to the institution since the individual was receiving Medicaid coverage of long-term care services and supports in an institution on the last day of the month.

(d) Discharge from nursing facility to home and community-based setting. The patient share amount is adjusted when an individual is in an institution for more than one full calendar month and discharged to a home and community-based setting. After the patient-share amount is redetermined using the community maintenance allowance (see § 24.04(c)), the first month's patient share is paid to the institution because the individual resided in the institution on the last day of the previous month. Thereafter, the patient share it is paid to the highest paid provider.

(e) Discharge from long-term care. All income an individual receiving Medicaid coverage of long-term care services and supports receives during the month they are discharged from long-term care and any month after discharge when the individual leaves a long-term care living arrangement (see § 30.01) is excluded. A long-term care provider must refund any patient-share payment made by an individual when the individual pays their patient share from income received in the month of their discharge.

(f) Termination of eligibility for long-term care. An individual receiving Medicaid coverage of long-term care services and supports becomes fully responsible for the total cost of any care they receive when they remain institutionalized after a medical-review team decision that they no longer need skilled nursing or intermediate care, or they become ineligible for other reasons. The individual's responsibility begins after the effective date of the review team's decision. An individual usually must pay in advance for such care as a privately-paying patient. They incur no patient share obligation for the calendar month that the review team's decision takes effect. A long-term care provider must credit payment toward the cost of private care furnished after the effective date of the review team's decision to end Medicaid coverage of long-term care services and supports when an individual receiving Medicaid coverage of long-term care services and supports has already paid their patient share to the provider during the calendar month the review team's decision takes effect.

(g) Patient share in the month of death. Income received during the calendar month of the death of an individual receiving Medicaid coverage of long-term care services and supports is counted and applied to the cost of the care the individual received during the prior month. For example, if the individual dies on June 26th, the patient-share payment from income they received during June is due for care provided in May. If the individual dies on July 1st, the patient-share payment from income they received during July is due for care provided in June.

25.00 Income or resource transfers and eligibility for Medicaid coverage of long-term care services and supports (01/01/2024, GCR 23-085)

25.01 In general (01/15/2017, GCR 16-097)

(a) AHS determines whether transfers of income or resources made by an individual requesting Medicaid coverage of long-term care services and supports are allowable transfers under the rules set forth in this section.

(1) This section applies to an individual:

(i) Who is requesting Medicaid coverage of long-term care services and supports in a medical institution under MABD or MCA.

(ii) Who is requesting Medicaid coverage of long-term care services and supports in a home and community-based setting under MCA.

(iii) Who is requesting Medicaid coverage of long-term care services and supports in a home and community-based setting under MABD and is in a special income coverage group under § 8.05(k)) or is medically needy (§ 8.06).

(2) This section also applies to the spouse of an individual described in (1) above.

If AHS determines that a transfer is not allowable, the individual requesting Medicaid coverage of long-term care services and supports will not be eligible for such coverage until a penalty period has expired. The start date of the penalty period is based on when the individual would, but for the disallowed transfer, be otherwise eligible for Medicaid coverage of long-term care services and supports, as explained in more detail in this section. The duration of the penalty period is based on the value of the disallowed transfer.

(b) AHS makes determinations concerning transfers occurring before the individual requests Medicaid coverage of

long-term care services and supports as part of its determination of the individual's initial eligibility. Once AHS has determined that a transfer is disallowed and has established a penalty period that transfer is not reconsidered unless AHS obtains new information about the transfer. If, after the initial determination, AHS discovers that the individual made an additional transfer (or transfers), AHS also determines whether the additional transfer (or transfers) is allowable, whether the date of the additional transfer (or transfers) is before or after the initial determination, and establishes a penalty period (or periods) as required. If the individual requesting Medicaid coverage of long-term care services and supports has a spouse (community spouse), after the month in which the individual is determined eligible for Medicaid coverage of long-term care services and supports, no resources of the community spouse shall be determined available to the individual (the institutionalized spouse). Accordingly, no transfers by the community spouse after the initial month of the institutionalized spouse's eligibility are considered for purposes of the institutionalized spouse's ongoing eligibility.

(c) § 25.03 specifies the criteria for allowable transfers, to which no penalty period applies, effective for all initial determinations of eligibility for Medicaid coverage of long-term care services and supports and all redeterminations. No other transfers are allowable.

25.02 Definitions (01/15/2017, GCR 16-097)

(a) Transfer of income or resources. For the purposes of this section, a transfer of income or resources is any action taken by the individual requesting Medicaid coverage of long-term care services and supports, by the spouse of such individual, or by any other person with lawful access to the income or resources of the individual or such individual's spouse that disposes of the income or resources. The date of the transfer is the date the action was taken. It also applies to certain income and resources to which the individual or such individual's spouse is entitled but does not have access because of an action taken by:

(1) The individual or such individual's spouse;

(2) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse; or

(3) A person, including a court or administrative body, acting at the direction or upon the request of the individual or such individual's spouse.

(b) Fair market value. Unless otherwise specified, fair market value is an amount equal to the price of an item on the open market in the individual's locality at the time of a transfer, or contract for sale, if earlier.

25.03 Allowable transfers (01/01/2024, GCR 23-085)

(a) Transfers for fair-market value – in general. No penalty period is applied to income or resources transferred for fair market value.

AHS determines whether the individual requesting Medicaid coverage of long-term care services and supports, or the spouse of such individual, as the case may be, received fair market value for a transfer of income or resources by determining the difference, if any, between the fair market value of the income or resource reduced by any applicable deductions at the time of the transfer and the amount received for the income or resource. Any of the following deductions may be used to reduce fair market value:

(1) The amount of any legally enforceable liens or debts against the transferred income or resource at the time of transfer that reduced the transferor's equity in the income or resource;

(2) The reasonable and necessary costs of making the sale or transfer;

(3) The value of income or resources received by the transferor in exchange for the transferred income or resources;

(4) The value of income or resources returned to the transferor; and

(5) The following verified payments or in-kind support given to or on behalf of the transferor as compensation for receipt of the income or resources by the person who received the income or resources:

(i) Personal services;

(ii) Payments for medical care;

(iii) Funeral expenses of the individual's deceased spouse;

(iv) Taxes, mortgage payments, property insurance, or normal repairs, maintenance and upkeep on the transferred property; or

(v) Support and maintenance (*e.g.*, food, clothing, incidentals, fuel and utilities) provided in the transferor's own home or in the home of the person who received the income or resources from the transferor.

(b) Receipt of fair market value after the date of the transfer. If the value of a transferred resource is scheduled for receipt after the date of transfer, it is considered a transfer for fair market value only if the transferor can expect to receive the full fair-market value of the resource within their expected lifetime. Expected lifetime is determined as follows:

(1) When institutionalized individual is transferor. Expected lifetime of the institutionalized individual is measured at the time of the transfer as determined in accordance with actuarial publications of the Office of the Chief Actuary of the SSA (http://socialsecurity.gov/OACT/STATS/table4c6.html).

(2) When spouse of institutionalized individual is transferor. Expected lifetime of the spouse of the institutionalized individual is measured at the time of the transfer as determined in accordance with actuarial publications of the Office of the Chief Actuary of the SSA) (http://socialsecurity.gov/OACT/STATS/table4c6.html).

(3) Pursuant to the authority granted in Vermont Act 71 § 303(7)(2005), AHS may develop alternate actuarial tables that will be consistent with federal law and adopted by rule.

(c) Transfers for less than fair-market value – in general. A penalty period is not imposed for a transfer for less than fair market value that meets one or more of the following criteria:

(1) Time of transfer – beyond look-back period. The date of the transfer was more than 60 calendar months prior to the first month in which the individual both requests eligibility for Medicaid coverage of long-term

care services and supports and meets all other requirements for eligibility.

(2) Transferred income or resources are returned. The transferred income or resources have been returned or otherwise remain available to the individual or the individual's spouse.

(3) Property transferred of a person other than the individual or their spouse. The action that constituted the transfer was the removal of the individual's (or spouse's) name from a joint account in a financial institution, and the individual (or spouse) has demonstrated, to AHS's satisfaction, that the funds in the account accumulated from the income and resources of another owner who is not the individual (or their spouse).

(4) Transfer of resource for a purpose other than creation or maintenance of eligibility for Medicaid coverage of long-term care services and supports. The transferor has documented to AHS's satisfaction convincing evidence that the resources were transferred exclusively for a purpose other than for the individual to become or remain eligible for Medicaid coverage of long-term care services and supports. A signed statement by the transferor is not, by itself, convincing evidence. Examples of convincing evidence are documents showing that:

(i) The transfer was not within the transferor's control (e.g., was ordered by a court);

(ii) The transferor could not have anticipated the individual's eligibility for Medicaid coverage of long-term care services and supports on the date of the transfer (e.g., the individual became disabled due to a traumatic accident after the date of transfer); or

(iii) A diagnosis of a previously undetected disabling condition leading to the individual's eligibility for Medicaid coverage of long-term care services and supports was made after the date of the transfer.

(5) Transfers of specified property for the benefit of certain family members. The transfer meets the criteria specified below for transfers involving trusts (see paragraph (d)), transfers of homes (see paragraph (e)), and transfers for the benefit of certain family members (see paragraph (g)).

(6) Intent to transfer for fair market value. The transferor has demonstrated to AHS's satisfaction that they intended to dispose of the income or resources either at fair market value, or for other valuable consideration.

(7) Transfer of excluded income or resources

(i) The transferor transferred excluded income or resources.

(ii) Penalties are imposed for the transfer for less than fair market value of any asset considered by the SSA's SSI program to be countable or excluded. For example, transfer of a home or of the proceeds of a loan are both subject to penalty.

(d) Allowable transfers involving trusts. A penalty period is not imposed for transfers involving trusts that meet one or more of the following criteria:

(1) The action that constituted the transfer was the establishment of an irrevocable trust that does not under any circumstances allow disbursements to or for the benefit of the individual, and the date of the transfer

was more than 60 calendar months prior to the first month in which the individual requests Medicaid coverage of long-term care services and supports.

(2) The action that constituted the transfer was the establishment of a trust solely for the benefit of the individual if the individual was under age 65 when the trust was established and the trust meets all of the criteria at § 29.08(e)(1)(ii)(F).

(3) The action that constituted the transfer was the establishment of a pooled trust, as specified at § 29.08(e)(1)(ii)(G), unless the individual was age 65 or older when they established the trust. If so, the transfer is not exempted from the imposition of a transfer penalty period.

(4) The action that constituted the transfer was the establishment of a revocable trust. However, AHS considers any payment from the revocable trust to anyone other than the individual a transfer for less than fair-market value subject to penalty unless the payment is for their benefit.

(e) Allowable transfers of homes to family members. A penalty period is not imposed for the transfer of a home that meets the definition at § 29.08(a)(1) provided that title was transferred to one or more of the following persons:

(1) The spouse of the individual requesting Medicaid coverage of long-term care services and supports;

(2) The individual's child who was under age 21 on the date of the transfer;

(3) The individual's son or daughter who is blind or permanently and totally disabled, regardless of age;

(4) The brother or sister of the individual when:

(i) The brother or sister had an equity interest in the home on the date of the transfer; and

(ii) Was residing in the home continuously for at least one year immediately prior to the date the individual began to receive Medicaid coverage of long-term care services and supports, including services in a home and community-based setting; or

(5) The son or daughter of the individual provided that the son or daughter:

(i) Was residing in the home continuously for at least two years immediately prior to the date the individual (parent) began receiving Medicaid coverage of long-term care services and supports, including services in a home and community-based setting; and

(ii) Provided care to the individual during part or all of this period that allowed the individual to postpone receipt of Medicaid coverage of long-term care services and supports.

(f) Allowable transfers involving life-estate interests in another individual's home. A penalty period is not imposed for the purchase of a life-estate interest in another person's home when:

(1) It is the purchaser's residence; and

(2) The purchaser resides in the home for a period of at least one year after the purchase.

(g) Other allowable transfers. A penalty period is not imposed for transfers that meet any of the following criteria:

(1) The transfer was for the sole benefit of the individual requesting Medicaid coverage of long-term care services and supports.

(2) The income or resource was transferred by the institutionalized spouse to their community spouse before the initial determination of the institutionalized spouse's eligibility for Medicaid coverage of long-term care services and supports. This also applies to a transfer made to a third party for the sole benefit of the community spouse.

(3) The income or resource was transferred to the individual's son or daughter who is blind or permanently and totally disabled or to a trust for the sole benefit of such son or daughter regardless of their age.

(4) The income or resource was transferred to a trust, including a trust described in § 29.08(e)(1)(F) or § 29.08(e)(1)(G), established solely for the benefit of an individual under the age of 65 years who is disabled.

(h) Transfers involving annuities

(1) In general

(i) *Purchases*. Any annuity purchased by an individual requesting Medicaid coverage of long-term care services and supports, or, if married, their community spouse on or after February 8, 2006, must name Vermont Medicaid as the first remainder beneficiary of the annuity up to the amount of Medicaid payments, including payments for Medicaid coverage of long-term-care services and supports, made by the state on behalf of the individual. If there is a community spouse or a minor or disabled child, they may be named as a remainder beneficiary ahead of the state. Vermont Medicaid must then be named as the secondary remainder beneficiary. If Vermont Medicaid is not named as a remainder beneficiary in the correct position, the purchase of the annuity is considered a transfer for less than fair market value. When Vermont Medicaid is a remainder beneficiary of an annuity, the issuer of the annuity is required to notify Vermont Medicaid of any changes in the disbursement of income or principal from the annuity as well as any changes to the state's position as remainder beneficiary.

(ii) *Annuity-related transactions other than purchases*. In addition to the purchase of an annuity, certain transactions with respect to an annuity that occur on or after February 8, 2006, make an annuity, including one purchased before that date, subject to the provisions of this paragraph. Such transactions include any action taken by the individual requesting Medicaid coverage of long-term care services and supports or, if married, their community spouse that changes the course of payments to be made by the annuity or the treatment of the income or principal of the annuity. Routine changes and automatic events that do not require any action or decision are not considered transactions that would subject the annuity to this treatment.

(2) Additional requirements

(i) In addition to the requirement under paragraph (h)(1) that Vermont Medicaid be named as a remainder beneficiary in the correct position in order for the purchase of an annuity by an individual

requesting Medicaid coverage of long-term care services and supports or, if married, their community spouse to not be considered a transfer for less than fair market value, if the purchase of the annuity is by the individual requesting Medicaid coverage of long-term care services and supports, the purchase must also meet one or more of the four alternatives described below in order for it to not be subject to a transfer penalty. To determine that an annuity is established under any of the various provisions of the Code that are referenced in (C) and (D) below, AHS relies on verification from the financial institution, employer or employer association that issued the annuity. The burden of proof is on the individual to produce this documentation. Absent such documentation, AHS considers the purchase of the annuity a transfer for less than fair-market value and, as such, subject to a penalty.

(ii) The four alternatives are as follows:

(A) The annuity meets the provisions of §§ 29.08(d)(1) or 29.09(d)(1).

(B) The annuity is:

(I) Irrevocable and nonassignable;

(II) Provides for payments to the individual in equal intervals and equal amounts with no deferral and no balloon payments made;

(III) Is actuarially sound because it does not exceed the life expectancy of the individual, as determined using the actuarial publications of the Office of the Chief Actuary of the SSA (http://socialsecurity.gov/OACT/STATS/table4c6.html); and

(IV) Returns to the individual at least the amount used to establish the contract and any additional payments plus earnings, as specified in the contract.

(C) The annuity is considered either:

(I) An individual retirement annuity (according to § 408(b) of the Code), or

(II) A deemed Individual Retirement Account (IRA) under a qualified employer plan (according to § 408(q) of the Code).

(D) The annuity is purchased with proceeds from one of the following:

(I) A traditional IRA (§ 408(a) of the Code);

(II) Certain accounts or trusts which are treated as traditional IRAs (§ 408(c) of the Code);

(III) A simplified retirement account (§ 408 (p) of the Code);

(IV) A simplified employee pension (§ 408 (k) of the Code); or

(V) A Roth IRA (§ 408A of the Code).

(3) Impermissible transfers. An annuity that does not meet the above criteria is assessed a transfer penalty based on its fair market value. The fair market value of an annuity equals the amount of money used to establish the annuity and any additional amounts used to fund the annuity, plus any earnings and minus

any early withdrawals and surrender fees.

(i) Allowable transfers involving promissory notes and other income-producing resources

(1) Promissory notes or similar income-producing resources (contracts) are assessed a transfer penalty based on their fair market value unless they:

(i) Have a repayment term that is actuarially-sound as determined in accordance with actuarial publications of the Office of the Chief Actuary of the SSA (http://socialsecurity.gov/OACT/STATS/table4c6.html);

(ii) Provide for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

(iii) Prohibit the cancellation of the balance upon the death of the lender.

(2) Fair market value equals the amount of money used to establish the contract and any additional payments used to fund it, plus any earnings and minus any payments already received as of the date of the application for Medicaid coverage of long-term care services and supports.

(j) Transfers involving jointly-owned income or resources

(1) Joint-ownership established on or after January 1, 1994. For any joint-ownership established on or after January 1, 1994, the portion of the jointly-owned asset subject to the imposition of a penalty period is evaluated based on the specific circumstances of the situation. An individual is presumed to own a jointly-owned resource using the rules in § 29.09. In the case of a jointly-owned account in a financial institution, for example, since the account is presumed to be owned entirely by the individual (see § 29.09(c)(5)(ii)), a transfer penalty is imposed against the individual for any amount withdrawn from the account by another joint owner on the account. The individual may rebut the presumption of ownership by establishing to AHS's satisfaction that the amount withdrawn was, in fact, the sole property of and contributed to the account by the other joint owner (or owners), and thus did not belong to the individual.

(2) Joint-ownership established before January 1, 1994. For a joint ownership established before January 1, 1994, the date of the transfer is the date the other person (or persons) became a joint owner. The value of the transfer equals the amount that the resource available to the individual or, if married, the individual's spouse was reduced in value when the other person (or persons) became a joint owner.

25.04 Penalty period for disallowed transfers (01/15/2017, GCR 16-097)

(a) Definition: Otherwise eligible

(1) For purposes of determining the start date of the penalty period because of disallowed transfers, an individual is considered "otherwise eligible" for Medicaid coverage of long-term care services and supports as of the earliest date they pass all eligibility criteria in the sequence listed below. They must also meet each of these criteria in any month for which they request retroactive eligibility:

(i) Clinical criteria (see definition of long-term care in § 3.00).

(ii) Citizenship and identity criteria (§ 17.00).

(iii) Category (§ 7.03 (MCA), §§ 8.05 and 8.06 (MABD)).

(iv) Residency (§ 21.00).

(v) Living arrangements (§ 20.00).

(vi) Resources (§ 29.07), if applicable.

(vii) Income (§§ 28.03 and 28.04 (MCA), § 29.11 (MABD) - for anyone with excess income, see explanation in (2) below).

(2) When an individual's income exceeds the income requirement for their applicable coverage group, the individual must spend down to the applicable PIL in the month of application or the next month. An individual with a penalty is subject to the penalty period start date beginning on the date the spenddown is met. If the spenddown is not met in the month of application or the next month, the individual is denied Medicaid coverage of long-term care services and supports. AHS then determines whether the person is eligible for Medicaid (other than Medicaid coverage of long-term care services and supports). If so, it assesses a 6-month spend down.

Examples:

(i) The individual applies in June for Medicaid coverage of long-term care services and supports under MABD and requests retroactive coverage as of April. The individual meets all eligibility criteria but their gross countable income exceeds the IIS and they have transfers that will result in a 38 day penalty period. The spenddown period is April – September. The individual meets their spenddown on April 23rd. April 23rd is the date the individual is considered to be "otherwise eligible." Their penalty period would be April 23rd – May 30th.

(ii) Same case as in (i), but no retroactive coverage is requested. The spenddown period is June-November. The spenddown is met June 23rd. June 23rd is the date the individual is considered to be "otherwise eligible." The penalty period is June 23rd – July 30th.

(b) Penalty period – in general. If a transfer is disallowed, a penalty period of restricted Medicaid coverage to an otherwise eligible individual is imposed. During this period, no Medicaid payments are made for the individual's long-term care services and supports. Payments are made for all other covered Medicaid services provided to the individual during the period of restricted coverage.

(c) Penalty date

(1) Transfers made in a single month. The penalty date is the beginning date of each penalty period imposed for a disallowed transfer. The penalty date starts on the first day in which the individual would have been otherwise eligible for Medicaid coverage of long-term care services and supports (see paragraph (a) of this subsection for explanation of "otherwise eligible").

(2) Transfers occurring in different months. Penalty periods run consecutively rather than concurrently, in the order in which the transfers occurred. If, after establishing a penalty period for disallowed transfers, it is

determined that additional disallowed transfers were made in a subsequent month but before the end of the first penalty period, the first day following the end of the first penalty period will be designated as the penalty date for the subsequent penalty period.

(d) Penalty period

(1) Calculation of penalty. The number of days in a penalty period are equal to the total value of all disallowed transfers made during a given calendar month divided by the average daily cost to a privately-paying patient of nursing facility services in the state as of the date of application or the date of discovery, if additional disallowed transfers are discovered after the initial determination of eligibility for Medicaid coverage of long-term care services and supports.

(2) Transfers in different calendar months. Penalty periods for transfers in different calendar months are consecutive and established in the order in which the disallowed transfers occurred.

(3) Continuous nature of penalty period. A penalty period runs continuously from the first date of the penalty period, even if the individual stops receiving long-term care services and supports.

(e) Penalty when both spouses request Medicaid coverage of long-term care services and supports

(1) In general. The following rules are applied to the assignment of penalty periods when both members of a couple are requesting or receiving Medicaid coverage of long-term care services and supports.

(2) Spouses eligible at same time. For spouses determined otherwise eligible for Medicaid coverage of long-term care services and supports at the same time, the value of the disallowed transfer is divided by two to determine the number of days of restricted coverage for each member of the couple.

(3) Penalty period for one spouse is running at the time the other requests Medicaid coverage of long-term care services and supports. If the penalty period established for one member of the couple has not yet expired when the other member of the couple requests and is determined otherwise eligible for Medicaid coverage of long-term care services and supports, the number of days remaining in the penalty period is divided by two to determine the number of days of restricted coverage for each member of the couple.

(4) Death of a spouse during penalty period. When the member of the couple for whom a penalty period has been established dies, the days remaining in that member's penalty period are not reassigned to their spouse if the spouse requests and is determined otherwise eligible for Medicaid coverage of long-term care services and supports.

(5) Penalty periods for transfer by second spouse to request Medicaid coverage of long-term care services and supports. When a penalty period is established for a disallowed transfer by the second member of the couple to request and be determined otherwise eligible for Medicaid coverage of long-term care services and supports, that penalty period is assigned to the spouse who made the transfer provided that it was made after the determination of disallowed transfers for the first spouse.

25.05 Undue Hardship (01/15/2017, GCR 16-097)

(a) In general. AHS does not establish a penalty period resulting from a disallowed transfer when it determines that

restricted coverage will result in an undue hardship. Undue hardship is considered only in cases where AHS has first determined that a transfer has been made for less than fair market value and that no transfer exception applies (see § 25.03).

(b) Definition: Undue hardship

(1) For purposes of this subsection, undue hardship means depriving the individual of:

(i) Medical care, such that the individual's health or life would be endangered; or

(ii) Food, clothing, shelter, or other necessities of life.

(2) Undue hardship does not exist when the application of a transfer penalty merely causes an individual or the individual's family member(s) inconvenience or restricts their lifestyle. Undue hardship does not exist when the individual transferred the assets to their community spouse and the community spouse has countable or excluded resources in excess of the community spouse resource allocation (CSRA) standard (§ 29.10(e)).

(c) Undue hardship reasons. In determining the existence of undue hardship, all circumstances involving the transfer and the situation of the individual are considered. Undue hardship is established when one or more of the following circumstances, or any other comparable reasons, exist:

(1) Whether imposition of the transfer penalty would result in the individual's immediate family qualifying for SSI; Reach Up; AABD; General Assistance; 3SquaresVTs; or another public assistance program requiring a comparable showing of financial need.

(2) Whether funds can be made available for the cost of the individual's long-term care services and supports only if assets such as a family farm or other family business are sold, and the assets are the primary source of income for the individual's spouse, parents, children or siblings.

(3) Whether an agent under a power of attorney (POA) or a guardian of the individual transferred the asset, and the POA or guardian was not acting in the best interest of the individual when the transfer was made as determined by AHS or a court, or the transfer forms the basis for a report to AHS for investigation of abuse, neglect or exploitation.

(4) Whether the individual was deprived of an asset by exploitation, fraud or misrepresentation. Such claims must be documented by official police reports or civil or criminal action against the alleged perpetrator or substantiated by AHS or by a sworn statement to AHS attesting to the fact that the claim was reported to the police or to the AHS department responsible for substantiating such claims.

(5) Whether the individual cannot recover the assets due to loss, destruction, theft, or other similar circumstances.

(6) *Presumption of care and rebuttal of presumption.*

(i) *Presumption.* When the transfer is to a person, AHS presumes the recipient of the transferred asset could make arrangements for the individual's care and the care of dependent family members up to

the value of the transfer unless the evidence submitted indicates that there is no reasonable way that the person can make any of these arrangements. The facts and verification required to determine if the recipient of the transferred asset can make other arrangements to pay or provide the care of the individual, or to provide for the needs of financially-dependent family members, may include the following, if applicable:

(A) A copy of the tax return for the preceding calendar year;

(B) All earnings pay stubs for the past 12 months;

(C) All bank books, stocks, bonds, certificates, life insurance policies (e.g. bank books must include those before and after receipt of the transferred asset); and

(D) All documents associated with the proceeds of the transferred asset which will show the value of any purchase of new assets from the sale proceeds of the transferred asset.

(E) When the transfer is made to a relative who is a minor, a family member with financial responsibility for the minor must be asked to provide the required facts and verification.

(ii) *Rebuttal.* If the individual rebuts the presumption and shows there is no reasonable way that the recipient of the transferred asset can make arrangements for the individual's care and the care of dependent family members up to the value of the transfer, AHS will consider whether the individual has exhausted all reasonable efforts to meet their needs from other available sources. This includes whether the individual has exhausted all reasonable efforts to obtain return of the asset transferred, and demonstrated that efforts to obtain return of the asset or adequate compensation would probably not succeed. AHS will take into consideration all excluded and countable assets above the protected resource standard and income above the monthly maintenance needs allowance. Burial funds (§ 29.08(c)) and the individual's principal place of residence (§ 29.08(a)(1)) will continue to be excluded.

(d) Authority of provider to file request for individual. For the purposes of this subsection, a long-term care provider may, with the consent of the individual or the personal representative of the individual, file a request for undue hardship on behalf of the individual.

(e) Process for reviewing undue hardship requests

(1) Notice of imposition of penalty period

(i) The individual will be informed of the right to request an undue hardship exception through written notice of a penalty period of ineligibility for Medicaid coverage of long-term care services and supports because of an impermissible asset transfer.

(ii) The notice will:

(A) Specify the factual and legal basis for the imposition of the penalty, and

(B) Explain how the individual may request an undue hardship exception.

(2) Timing of exception request. An individual may request an undue hardship exception within 20 days of receiving notification of the transfer penalty.

(3) Application requirements. To request an undue hardship exception, the individual must submit documentation supporting their claim of undue hardship.

(4) Standard of proof. Undue hardship is established when the individual demonstrates by a preponderance of the evidence that denial of Medicaid coverage of long-term care services and supports will cause actual and not merely possible undue hardship.

(5) Nature of available relief. If the individual establishes undue hardship, AHS may waive all or a portion of the penalty period.

(6) Notice of decision on request. A notice of decision on the undue hardship exception request will be issued within 10 business days of receipt of all information determined by AHS as needed to evaluate the request. The notice will be in writing and will inform the individual of the right to request a fair hearing to appeal the decision.

(7) Notice of decision on eligibility for Medicaid coverage of long-term care services and supports. If no request for an undue hardship exception is received within 20 days after notification of the transfer penalty, or if the request is denied, an eligibility determination will be issued specifying the applicable penalty period. If the individual is receiving Medicaid coverage of long-term care services and supports, the notice will include the date the Medicaid coverage terminates and the right to request a fair hearing and continuing benefits.

(8) Exception: Request made within request for fair hearing. When an individual makes a request for an undue hardship exception for the first time at the same time they are requesting a fair hearing, the individual must raise all claims and submit all evidence permitting consideration of the undue hardship exception at least 10 business days in advance of the fair hearing. The undue hardship request must then be referred to AHS for consideration. AHS will then inform the fair hearings entity of its decision on the request within 10 business days of receiving it.

(9) Exception: Request made during penalty period on the basis of changed circumstances. A request for an undue hardship exception may be filed at any time during a penalty period if new circumstances leading to undue hardship arise during the duration of the penalty period. If granted, the request will be prospective from the date of the request.

(10) Limitation on obligation to pay for long-term care services and supports during penalty period. The state has no obligation to pay for cost of an individual's long-term care services and supports during the individual's penalty period unless an undue hardship exception has been granted or the individual prevails at a fair hearing.

(11) Extension of time period. The time periods specified in this paragraph (e) may be extended if AHS determines that extenuating circumstances require additional time.

26.00 [Reserved]

27.00 [Reserved]

Special Rules for Medicaid Coverage of Long-Term Care Services and Supports – Eligibility and Post Eligibility

The Vermont Statutes Online

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

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Title 3 : Executive

Chapter 025 : Administrative Procedure

Subchapter 001 : General Provisions

(Cite as: 3 V.S.A. § 801)

§ 801. Short title and definitions

(a) This chapter may be cited as the "Vermont Administrative Procedure Act."

(b) As used in this chapter:

(1) "Agency" means a State board, commission, department, agency, or other entity or officer of State government, other than the Legislature, the courts, the Commander in Chief, and the Military Department, authorized by law to make rules or to determine contested cases.

(2) "Contested case" means a proceeding, including but not restricted to rate-making and licensing, in which the legal rights, duties, or privileges of a party are required by law to be determined by an agency after an opportunity for hearing.

(3) "License" includes the whole or part of any agency permit, certificate, approval, registration, charter, or similar form of permission required by law.

(4) "Licensing" includes the agency process respecting the grant, denial, renewal, revocation, suspension, annulment, withdrawal, or amendment of a license.

(5) "Party" means each person or agency named or admitted as a party, or properly seeking and entitled as of right to be admitted as a party.

(6) "Person" means any individual, partnership, corporation, association, governmental subdivision, or public or private organization of any character other than an agency.

(7) "Practice" means a substantive or procedural requirement of an agency, affecting one or more persons who are not employees of the agency, that is used by the

agency in the discharge of its powers and duties. The term includes all such requirements, regardless of whether they are stated in writing.

(8) "Procedure" means a practice that has been adopted in writing, either at the election of the agency or as the result of a request under subsection 831(b) of this title. The term includes any practice of any agency that has been adopted in writing, whether or not labeled as a procedure, except for each of the following:

(A) a rule adopted under sections 836-844 of this title;

(B) a written document issued in a contested case that imposes substantive or procedural requirements on the parties to the case;

(C) a statement that concerns only:

(i) the internal management of an agency and does not affect private rights or procedures available to the public;

(ii) the internal management of facilities that are secured for the safety of the public and the individuals residing within them; or

(iii) guidance regarding the safety or security of the staff of an agency or its designated service providers or of individuals being provided services by the agency or such a provider;

(D) an intergovernmental or interagency memorandum, directive, or communication that does not affect private rights or procedures available to the public;

(E) an opinion of the Attorney General; or

(F) a statement that establishes criteria or guidelines to be used by the staff of an agency in performing audits, investigations, or inspections, in settling commercial disputes or negotiating commercial arrangements, or in the defense, prosecution, or settlement of cases, if disclosure of the criteria or guidelines would compromise an investigation or the health and safety of an employee or member of the public, enable law violators to avoid detection, facilitate disregard of requirements imposed by law, or give a clearly improper advantage to persons that are in an adverse position to the State.

(9) "Rule" means each agency statement of general applicability that implements, interprets, or prescribes law or policy and that has been adopted in the manner provided by sections 836-844 of this title.

(10) "Incorporation by reference" means the use of language in the text of a regulation that expressly refers to a document other than the regulation itself.

(11) "Adopting authority" means, for agencies that are attached to the Agencies of Administration, of Commerce and Community Development, of Natural Resources, of Human Services, and of Transportation, or any of their components, the secretaries of those agencies; for agencies attached to other departments or any of their components,

the commissioners of those departments; and for other agencies, the chief officer of the agency. However, for the procedural rules of boards with quasi-judicial powers, for the Transportation Board, for the Vermont Veterans' Memorial Cemetery Advisory Board, and for the Fish and Wildlife Board, the chair or executive secretary of the board shall be the adopting authority. The Secretary of State shall be the adopting authority for the Office of Professional Regulation.

(12) "Small business" means a business employing no more than 20 full-time employees.

(13)(A) "Arbitrary," when applied to an agency rule or action, means that one or more of the following apply:

(i) There is no factual basis for the decision made by the agency.

(ii) The decision made by the agency is not rationally connected to the factual basis asserted for the decision.

(iii) The decision made by the agency would not make sense to a reasonable person.

(B) The General Assembly intends that this definition be applied in accordance with the Vermont Supreme Court's application of "arbitrary" in Beyers v. Water Resources Board, 2006 VT 65, and In re Town of Sherburne, 154 Vt. 596 (1990).

(14) "Guidance document" means a written record that has not been adopted in accordance with sections 836-844 of this title and that is issued by an agency to assist the public by providing an agency's current approach to or interpretation of law or describing how and when an agency will exercise discretionary functions. The term does not include the documents described in subdivisions (8)(A) through (F) of this section.

(15) "Index" means a searchable list of entries that contains subjects and titles with page numbers, hyperlinks, or other connections that link each entry to the text or document to which it refers. (Added 1967, No. 360 (Adj. Sess.), § 1, eff. July 1, 1969; amended 1981, No. 82, § 1; 1983, No. 158 (Adj. Sess.), eff. April 13, 1984; 1985, No. 56, § 1; 1985, No. 269 (Adj. Sess.), § 4; 1987, No. 76, § 18; 1989, No. 69, § 2, eff. May 27, 1989; 1989, No. 250 (Adj. Sess.), § 88; 2001, No. 149 (Adj. Sess.), § 46, eff. June 27, 2002; 2017, No. 113 (Adj. Sess.), § 3; 2017, No. 156 (Adj. Sess.), § 2.)

The Vermont Statutes Online

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Title 33 : Human Services

Chapter 019 : Medical Assistance

Subchapter 001 : Medicaid

(Cite as: 33 V.S.A. § 1901)

§ 1901. Administration of program

(a)(1) The Secretary of Human Services or designee shall take appropriate action, including making of rules, required to administer a medical assistance program under Title XIX (Medicaid) and Title XXI (SCHIP) of the Social Security Act.

(2) The Secretary or designee shall seek approval from the General Assembly prior to applying for and implementing a waiver of Title XIX or Title XXI of the Social Security Act, an amendment to an existing waiver, or a new state option that would restrict eligibility or benefits pursuant to the Deficit Reduction Act of 2005. Approval by the General Assembly under this subdivision constitutes approval only for the changes that are scheduled for implementation.

(3) [Repealed.]

(4) A manufacturer of pharmaceuticals purchased by individuals receiving State pharmaceutical assistance in programs administered under this chapter shall pay to the Department of Vermont Health Access, as the Secretary's designee, a rebate on all pharmaceutical claims for which State-only funds are expended in an amount that is in proportion to the State share of the total cost of the claim, as calculated annually on an aggregate basis, and based on the full Medicaid rebate amount as provided for in Section 1927(a) through (c) of the federal Social Security Act, 42 U.S.C. § 1396r-8.

(b) [Repealed.]

(c) The Secretary may charge a monthly premium, in amounts set by the General Assembly, per family for pregnant women and children eligible for medical assistance under Sections 1902(a)(10)(A)(i)(III), (IV), (VI), and (VII) of Title XIX of the Social Security Act, whose family income exceeds 195 percent of the federal poverty level, as permitted

under section 1902(r)(2) of that act. Fees collected under this subsection shall be credited to the State Health Care Resources Fund established in section 1901d of this title and shall be available to the Agency to offset the costs of providing Medicaid services. Any co-payments, coinsurance, or other cost sharing to be charged shall also be authorized and set by the General Assembly.

(d)(1) To enable the State to manage public resources effectively while preserving and enhancing access to health care services in the State, the Department of Vermont Health Access is authorized to serve as a publicly operated managed care organization (MCO).

(2) To the extent permitted under federal law, the Department of Vermont Health Access shall be exempt from any health maintenance organization (HMO) or MCO statutes in Vermont law and shall not be considered to be an HMO or MCO for purposes of State regulatory and reporting requirements. The MCO shall comply with the federal rules governing managed care organizations in 42 C.F.R. Part 438. The Vermont rules on the primary care case management in the Medicaid program shall be amended to apply to the MCO except to the extent that the rules conflict with the federal rules.

(3) The Agency of Human Services and Department of Vermont Health Access shall report to the Health Care Oversight Committee about implementation of Global Commitment in a manner and at a frequency to be determined by the Committee. Reporting shall, at a minimum, enable the tracking of expenditures by eligibility category, the type of care received, and to the extent possible allow historical comparison with expenditures under the previous Medicaid appropriation model (by department and program) and, if appropriate, with the amounts transferred by another department to the Department of Vermont Health Access. Reporting shall include spending in comparison to any applicable budget neutrality standards.

(e) [Repealed.]

(f) The Secretary shall not impose a prescription co-payment for individuals under age 21 enrolled in Medicaid or Dr. Dynasaur.

(g) The Department of Vermont Health Access shall post prominently on its website the total per-member per-month cost for each of its Medicaid and Medicaid waiver programs and the amount of the State's share and the beneficiary's share of such cost.

(h) To the extent required to avoid federal antitrust violations, the Department of Vermont Health Access shall facilitate and supervise the participation of health care professionals and health care facilities in the planning and implementation of payment reform in the Medicaid and SCHIP programs. The Department shall ensure that the process and implementation include sufficient State supervision over these entities to comply with federal antitrust provisions and shall refer to the Attorney General for appropriate action the activities of any individual or entity that the Department determines, after notice and an opportunity to be heard, violate State or federal antitrust

laws without a countervailing benefit of improving patient care, improving access to health care, increasing efficiency, or reducing costs by modifying payment methods. (Added 1967, No. 147, § 6; amended 1997, No. 155 (Adj. Sess.), § 21; 2005, No. 159 (Adj. Sess.), § 2; 2005, No. 215 (Adj. Sess.), § 308, eff. May 31, 2006; 2007, No. 74, § 3, eff. June 6, 2007; 2009, No. 156 (Adj. Sess.), § E.309.15, eff. June 3, 2010; 2009, No. 156 (Adj. Sess.), § I.43; 2011, No. 48, § 16a, eff. Jan. 1, 2012; 2011, No. 139 (Adj. Sess.), § 51, eff. May 14, 2012; 2011, No. 162 (Adj. Sess.), § E.307.6; 2011, No. 171 (Adj. Sess.), § 41c; 2013, No. 79, § 23, eff. Jan. 1, 2014; 2013, No. 79, § 46; 2013, No. 131 (Adj. Sess.), § 39, eff. May 20, 2014; 2013, No. 142 (Adj. Sess.), § 98; 2017, No. 210 (Adj. Sess.), § 3, eff. June 1, 2018.)

§ 1901l. Medication for opioid use disorder

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

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

The Vermont Statutes Online

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Title 33 : Human Services

Chapter 018 : Public-Private Universal Health Care System

Subchapter 001 : Vermont Health Benefit Exchange

(Cite as: 33 V.S.A. § 1810)

§ 1810. Rules

The Secretary of Human Services may adopt rules pursuant to 3 V.S.A. chapter 25 as needed to carry out the duties and functions established in this subchapter. (Added 2011, No. 48, § 4.)

VERMONT

Proposed Rules Postings
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Deadline For Public Comment

Deadline: Oct 13, 2023

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

Rule Details

Rule Number:	23P027
Title:	Health Benefits Eligibility and Enrollment Rule, Special Rules for Medicaid Coverage of Long-Term Services and Supports - Eligibility and Post-Eligibility (Part 4).
Type:	Standard
Status:	Final Proposed
Agency:	Agency of Human Services
Legal Authority:	3 V.S.A. 801(b)(11); 33 V.S.A. 1901(a)(1) and 1810
Summary:	These proposed filings amend Parts 1-5, and 7-8 of the 8-part Health Benefits Eligibility and Enrollment (HBEE) rules. Parts 1, 2, 3, 5, and 7 were last

	amended effective January 1, 2023. Part 4 was last amended effective January 15, 2019. Part 8 was last amended effective October 1, 2021. Substantive revisions include: implementing 12 months of Medicaid continuous eligibility for children; codifying ineligibility for Qualified Health Plan subsidy if failure to reconcile tax credits for 2 consecutive years; allowing self-attestation of income for Qualified Health Plan subsidies if no tax information is available through data sources; and codifying 2 new income and resource exclusions for purposes of Medicaid eligibility for the Aged, Blind, and Disabled (MABD).
Persons Affected:	Medicaid applicants/enrollees; Individuals who wish to purchase health coverage including those who apply for premium and cost-sharing assistance; Health insurance issuers; Eligibility and enrollment assisters, including agents and brokers; Health care providers; Health law, policy and related advocacy and community-based organizations and groups including the Office of the Health Care Advocate; and Agency of Human Services including its departments.
Economic Impact:	The Agency of Human Services (AHS) anticipates that one proposed change to HBEE will have an economic impact on the State's budget, beginning in SFY2024. The estimated gross annualized budget impact of implementing 12 months of Medicaid continuous eligibility for children is $2.8 million. Federal law requires state Medicaid agencies to implement this change. There is no anticipated impact from the new income and resource exclusions for MABD eligibility. Changes related to eligibility for Qualified Health Plan (QHP) subsidies stem from federal rule changes. These federal rule changes make it easier for certain individuals to get and maintain federal subsidies. The fiscal impact for changes related to eligibility for QHP subsidies will be carried by the federal government. Other changes in Parts 1-5 and 7-8 align the rule with federal and state guidance and law, provide clarification, correct information, improve clarity, and make technical corrections. These changes do not carry a specific economic impact on any person or entity.
Posting date:	Sep 06,2023

Hearing Information

Hearing date:	10-06-2023 1:00 PM ADD TO YOUR CALENDAR
Location:	Virtual Hearing via Microsoft Teams
Address:	Meeting ID: 212 780 018 243 Passcode: iGPmNH
City:	Call in (audio only) 1+(802) 522-8456; Conference ID: 700 267 252#
State:	VT
Zip:	n/a
Hearing Notes:	For Teams Link, view Public Notice in Global Commitment Register on AHS 9c02-70edcc7559c62522252c2522Oid2522253a2522beb0dd2a-7ce6-4285-9l e79977845027252257d&data057C017CSOS.StatutoryFilings40vermont.go

Contact Information

Information for Primary Contact

PRIMARY CONTACT PERSON - A PERSON WHO IS ABLE TO ANSWER QUE ABOUT THE CONTENT OF THE RULE.

Level:	Primary
Name:	Danielle Fuoco
Agency:	Agency of Human Services
Address:	280 State Drive, Center Building
City:	Waterbury
State:	VT
Zip:	05671
Telephone:	802-585-4265
Fax:	802-241-0450
Email:	danielle.fuoco@vermont.gov SEND A COMMENT
Website Address:	https://humanservices.vermont.gov/rules-policies/health-care-rules/ VIEW WEBSITE

Information for Secondary Contact

SECONDARY CONTACT PERSON - A SPECIFIC PERSON FROM WHOM COPI FILINGS MAY BE REQUESTED OR WHO MAY ANSWER QUESTIONS ABOUT SUBMITTED FOR FILING IF DIFFERENT FROM THE PRIMARY CONTACT PER

Level:	Secondary
Name:	Jessica Ploesser
Agency:	Agency of Human Services
Address:	280 State Drive, NOB 1 South
City:	Waterbury
State:	VT
Zip:	05671

Telephone: 802-241-0454
Fax: 802-241-0450
Email: jessica.ploesser@vermont.gov
SEND A COMMENT

Keyword Information

Keywords:

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

Back

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	The Caledonian Record Julie Poutré (adv@caledonian-record.com)	Tel: 748-8121 FAX: 748-1613
	Times Argus / Rutland Herald Melody Hudson (classified.ads@rutlandherald.com) Elizabeth Marrier elizabeth.marrier@rutlandherald.com)	Tel: 802-747-6121 ext 2238 FAX: 802-776-5600
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	The Chronicle (ads@bartonchronicle.com)	Tel: 525-3531 FAX: 880-1040
	Herald of Randolph (ads@ourherald.com)	Tel: 728-3232 FAX: 728-9275 Attn: Brandi Comette
	Newport Daily Express (jlafoe@newportvermontdailyexpress.com)	Tel: 334-6568 FAX: 334-6891 Attn: Jon Lafoe
	News & Citizen (mike@stowereporter.com) Irene Nuzzo (irene@newsandcitizen.com and ads@stowereporter .com removed from distribution list per Lisa Stearns.	Tel: 888-2212 FAX: 888-2173 Attn: Bryan
	St. Albans Messenger Legals (legals@samessenger.com)	Tel: 524-9771 ext. 117 FAX: 527-1948 Attn: Legals
	The Islander (islander@vermontislander.com)	Tel: 802-372-5600 FAX: 802-372-3025
	Vermont Lawyer (hunter.press.vermont@gmail.com)	Attn: Will Hunter

FROM: APA Coordinator, VSARA **Date of Fax:** September 6, 2023

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

PAGES INCLUDING THIS COVER MEMO: **2**

***NOTE* 8-pt font in body. 12-pt font max. for headings - single space body. Please include dashed lines where they appear in ad copy. Otherwise minimize the use of white space. Exceptions require written approval.**

If you have questions, or if the printing schedule of your paper is disrupted by holiday etc. please contact VSARA at 802-828-3700, or E-Mail sos.statutoryfilings@vermont.gov, Thanks.

PROPOSED STATE RULES

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By law, public notice of proposed rules must be given by publication in newspapers of record. The purpose of these notices is to give the public a chance to respond to the proposals. The public notices for administrative rules are now also available online at https://secure.vermont.gov/SOS/rules/ . The law requires an agency to hold a public hearing on a proposed rule, if requested to do so in writing by 25 persons or an association having at least 25 members.

To make special arrangements for individuals with disabilities or special needs please call or write the contact person listed below as soon as possible.

To obtain further information concerning any scheduled hearing(s), obtain copies of proposed rule(s) or submit comments regarding proposed rule(s), please call or write the contact person listed below. You may also submit comments in writing to the Legislative Committee on Administrative Rules, State House, Montpelier, Vermont 05602 (802-828-2231).

NOTE: The seven rules below have been promulgated by the Agency of Human Services who has requested the notices be combined to facilitate a savings for the agency. When contacting the agency about these rules please note the title and rule number of the proposed rule(s) you are interested in.

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

AGENCY: Agency of Human Services

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

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

FOR FURTHER INFORMATION, CONTACT: Danielle Fuoco Agency of Human Services 280 State Drive, Waterbury, VT 05671-1000; Tel: 802-585-4265; Fax: 802-241-0450; E-mail: danielle.fuoco@vermont.gov; URL: https://humanservices.vermont.gov/rules-policies/health-care-rules/.

FOR COPIES: Jessica Ploesser, Agency of Human Services, 280 State Drive, NOB 1 South, Waterbury, VT 05671 Tel: 802-241-0454 Fax: 802-241-0450 E-Mail: jessica.ploesser@vermont.gov.
