FINAL PROPOSED RULE # 22-P15

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, Eligibility Standards (Part 2)

/s/ Todd Daloz , on 10/12/22
(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

VERMONT

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

[phone] 802-241-0440
[fax] 802-241-0450

Jenney Samuelson, Secretary

Date: October 18, 2022

Re: Summary of Changes from proposed to final proposed rule filing for Health Benefits Eligibility and Enrollment (HBEE) rules (GCR 22-029 through 22-033)

In addition to the changes being made in response to public comments (see responsiveness summary), additional changes are being made to correct technical and typographical errors.

The following is a list of these additional changes and the reasons for them. All changes being made in HBEE rule are identified in gray highlight in the annotated version of the final proposed rule being filed contemporaneously herewith.

The changes, in order by section number, are as follows:

PART TWO

Section 8.05(k)(6)(iii) – To align more closely with federal law at 42 CFR § 435.225(b), add "the" before "appropriate" on the first line of text; replace "medical care in the community" with "institutional level of care outside of a medical institution;" add "and" before "the" on the second line of text; add "estimated Medicaid" before "cost" on the second line of text; replace "of which" with "of such care" after "cost" on the second line of text; add "Medicaid" before "cost" on the third line of text; replace "medical care in an appropriate medical institution" with "appropriate institutional care."

PART THREE

Section 17.03(c)(6) – To improve clarity, change "the" to "their" on the first line of text; to align with revisions being made in Section 3.00 (to definition of "pregnant woman") and Section 7.03(a)(2), delete "60-day" on the first line of text

Section 18.03(b) – To align with revisions being made in Section 3.00 (to definition of "pregnant woman") and Section 7.03(a)(2), change "60-day" to "post partum" on the fourth line of text; to improve clarity, add "," after "period" on the fourth line of text; to improve clarity, add "," after "delivery" on the fifth line of text

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MEMORANDUM

To: Jim Condos, Secretary of State, Vermont Secretary of State Office
Sen. Mark A. MacDonald, 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 18, 2022

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:

- 22P014 HBEE Part One – General Provisions and Definitions
- 22P015 HBEE Part Two – Eligibility Standards
- 22P016 HBEE Part Three – Nonfinancial Eligibility Requirements
- 22P017 HBEE Part Five – Financial Methodologies
- 22P018 HBEE Part Seven – Eligibility and Enrollment Procedures

Public comments were received on HBEE Part Two and HBEE Part Three during the public comment period. No comments were received for the other parts. One general comment was received that was out of the scope of this rulemaking.

HBEE Part Two and HBEE Part Three were amended in response to comments from Vermont Legal Aid, Inc. (VLA). Please see the State's Responsiveness Summary and Summary of Technical Changes at the end of each rule package for the list of changes from the propose rule.

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

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

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

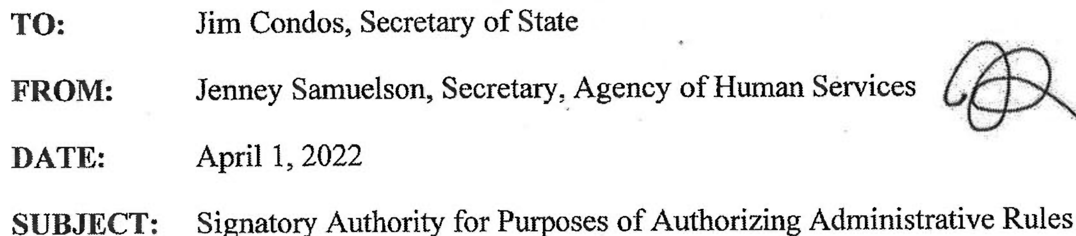
OFFICE OF THE SECRETARY
TEL: (802) 241-0440
FAX: (802) 241-0450

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

1. TITLE OF RULE FILING:
   Health Benefits Eligibility and Enrollment Rule, Eligibility Standards (Part 2)
2. PROPOSED NUMBER ASSIGNED BY THE SECRETARY OF STATE
   22P015
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 05671-1000

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 RAISED FOR OR AGAINST THE ORIGINAL PROPOSAL.

12. THE AGENCY HAS INCLUDED COPIES OF ALL WRITTEN SUBMISSIONS AND SYNOPSES OF ORAL COMMENTS RECEIVED.

13. THE AGENCY HAS 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, 2, 3, 5, and 7 of the 8-part Health Benefits Eligibility and Enrollment (HBEE) rule. Substantive revisions include: codifying the annual open enrollment period for qualified health plans from November 1 - January 15; adding a new income-based special enrollment period for qualified health plans that allows ongoing enrollment for those at or below 200% of the Federal Poverty Level (FPL); extending the Medicaid postpartum period for pregnant women from 60 days to 12 months; adding Compacts of Free Association (COFA) migrants as qualified non-citizens eligible for Medicaid and exempt from the 5-year bar; adding a reference to a standardized eligibility tool for Katie Beckett Medicaid; and expanding Medicaid eligibility for former

foster care children to include children aging out of foster care in another state. In response to comment, the rule also addresses the ACA's "family glitch" regarding affordability of employer coverage.

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;

Agency of Human Services including its departments; and Department of Financial Regulation.

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

AHS anticipates that some of the proposed changes to HBEE will have an economic impact on the State's budget, beginning in SFY2023. The estimated gross annualized budget impact of expanding postpartum Medicaid coverage for pregnant women from 60 days to 12 months is ~$2 million and accounted for in AHS's FY2023 budget. The estimated gross annualized budget impact of expanding Medicaid coverage to

children who age out of foster care in any state is $52,700. There is no anticipated impact from the addition of COFA migrants.

Changes related to Qualified Health Plan enrollment are not expected to have an economic impact except insofar as any opportunity to encourage enrollment and maintain VT's low uninsured rate is fiscally positive for VT.

Other changes in Parts 1, 2, 3, 5, & 7 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: 8/17/2022

Time: 02:00 PM

Street Address: Cherry A Conference Room

Waterbury State Office Complex, 280 State Drive, Waterbury, VT

OR Virtual Hearing - Phone or Microsoft Teams

Call in (audio only)

(802) 522-8456; Conference ID: 738063547#

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

Zip Code: 05671

Date:

Time: AM

Street Address:

Zip Code:

Date:

Time: AM

Street Address:

Zip Code:

Date:

Time: AM

Street Address:

Zip Code:

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

8/24/2022

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

HBEE

Health Benefits Eligibility and Enrollment

Vermont Health Connect

Exchange

Medicaid

QHP

Qualified Health Plan

Health Benefit

Pregnant

Foster Care

Special Enrollment Period

SEP

Annual Open Enrollment Period

AOEP

Post partum

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, Eligibility Standards (Part 2)
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 # 21P005, effective 10/1/2021; Part 2 - Eligibility Standards, SOS # 18P044, effective 1/15/2019; Part 3 - Nonfinancial Eligibility Requirements, SOS # 18P045, effective 1/15/2019; Part 5 - Financial Methodologies,

SOS # 21P006, effective 10/1/2021; Part 7 - Eligibility and Enrollment Procedures, SOS # 21P007, effective 10/1/2021.

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Kristin L. Clouser, Secretary

INTERAGENCY COMMITTEE ON ADMINISTRATIVE RULES (ICAR) MINUTES

Meeting Date/Location: June 13, 2022, virtually via Microsoft Teams
Members Present: Chair Douglas Farnham, Brendan Atwood, Jared Adler, Jennifer Mojo, Diane Sherman, Mike Obuchowski and Donna Russo-Savage
Members Absent: John Kessler and Diane Bothfeld
Minutes By: Melissa Mazza-Paquette

- 2:01 p.m. meeting called to order, welcome and introductions.
- Committee discussion on process improvements is scheduled for the August meeting to allow for participation from all members.
- Review and approval of minutes from the May 9, 2022 meeting.
- No additions/deletions to agenda. Agenda approved as drafted.
- Note: An emergency rule titled 'Vital Records Emergency Rule', provided by the Agency of Human Services, Department of Health, was supported by ICAR Chair Farnham on May 16, 2022. This rulemaking implements a process for individuals to amend the marker on their birth certificate to reflect the individual's gender identity. Specifically, it does the following: 1) Defines the term "non-binary" to describe the additional gender identities that may be reflected on a birth certificate. 2) Creates a process for registrants to file their Affidavit of Gender Identity with the Department.
- One public comment made by Venn [Saint Wilder].
- Presentation of Proposed Rules on pages 2-10 to follow.
  1. 2021 Vermont Plumbing Rules, Department of Public Safety & Plumbers Examining Board, page 2
  2. Vital Records Rule, Agency of Human Services, Department of Health, page 3
  3. Rule 4.600 Definition of Electric Transmission Facility in 30 V.S.A. § 248, Public Utility Commission, page 4
  4. Health Benefits Eligibility and Enrollment Rule, General Provisions and Definitions (Part 1), Agency of Human Services, page 5
  5. Health Benefits Eligibility and Enrollment Rule, Eligibility Standards (Part 2), Agency of Human Services, page 6
  6. Health Benefits Eligibility and Enrollment Rule, Nonfinancial Eligibility Requirements (Part 3), Agency of Human Services, page 7
  7. Health Benefits Eligibility and Enrollment Rule, Financial Methodologies (Part 5), Agency of Human Services, page 8
  8. Health Benefits Eligibility and Enrollment Rule, Eligibility-and-Enrollment Procedures (Part 7), Agency of Human Services, page 9
  9. Administrative Rules of the Board of Nursing, Secretary of State, Office of Professional Regulation, page 10
- Next scheduled meeting is Monday, July 11, 2022 at 2:00 p.m.
- 3:25 p.m. meeting was paused for a 15-minute break
- Add discussion of strike-all rules for transparency at a future meeting as time allows.
- 3:50 p.m. meeting adjourned.

DRAFT

Proposed Rule: Health Benefits Eligibility and Enrollment Rule, Eligibility Standards (Part 2), Agency of Human Services

Presented By: Robin Chapman and Addie Strumolo

Motion made to accept the rule by Donna Russo-Savage, seconded by Jared Adler, and passed unanimously except for Brendan Atwood who abstained, with the following recommendations:

1. Proposed Filing Coversheet, #12: Spell out acronym 'QHP' and include acronym in parenthesis as it's the first time being used in the filing.
2. Public Input Maximization Plan, #4: Specify entities (not individuals) included in the 'Representatives of Vermont's Health Insurance Industry' and 'Health law, policy and related advocacy and community-based organizations and groups.'.
3. Annotated text, page 17 (C) and (D): Evaluate text for clarity/accuracy.

DRAFT

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.

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1. TITLE OF RULE FILING:

   Health Benefits Eligibility and Enrollment Rule, Eligibility Standards (Part 2)

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;

Agency of Human Services including its departments; and Department of Financial Regulation.

Anticipated costs and benefits of this rule:

The Agency of Human Services anticipates that some of the proposed changes to HBEE will have an economic impact on the State's gross annualized budget, beginning in fiscal year 2023. The estimated gross annualized budget impact of expanding postpartum Medicaid coverage for pregnant women from 60 days to 12 months is expected to be approximately $2 million and is accounted for in AHS's FY2023 budget. The estimated gross annualized budget impact of expanding Medicaid coverage to children who age out of foster care in any state is $52,700. There is no anticipated economic impact from the addition of Compacts of Free Association (COFA) migrants at this time, as this population is not currently present in Vermont Medicaid.

An extended open enrollment period for qualified health plans (QHP) could result in increased QHP enrollment which would have a financial impact on health insurance issuers. However, this rulemaking codifies current practice, and AHS does not expect it to result in a meaningful difference in enrollment.

Allowing for a continuous enrollment opportunity through the income-based special enrollment period

could result in increased enrollment as well as upward rate pressure due to adverse selection (signing up for health insurance when utilization is expected). However, AHS consulted with the QHP issuers on this point and neither indicated a need to increase rates in anticipation of this enrollment opportunity. Instead, they strongly support this policy change to encourage continuous coverage.

Households accessing this special enrollment period will be eligible for federal and state subsidies. The federal government may pay out more in federal subsidies because of the special enrollment period. However, there is unlikely to be a fiscal impact on the State. AHS expects that most households enrolling through this special enrollment period will have previously been covered by Vermont Medicaid. Therefore, any increase in state subsidy expenditures would be offset by Medicaid savings.

Addressing the ACA's family glitch could result in more Vermonters becoming eligible for state and federal subsidies; however, AHS expects the population to be small and the subsidy costs to be borne primarily by the federal government.

Finally, any opportunity to encourage enrollment and maintain Vermont's low uninsured rate is fiscally positive for the State. It means less uncompensated care and a healthier risk pool to stabilize the insurance market.

The other changes in Parts 1, 2, 3, 5, and 7 align the rule with federal and state guidance and law, provide clarification, correct information, improve clarity, and make technical corrections. While these changes are made with a goal of reducing administrative burden on Vermonters and the State, they 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

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1. TITLE OF RULE FILING:

   Health Benefits Eligibility and Enrollment Rule, Eligibility Standards (Part 2)

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 IMPACT 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:

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1. TITLE OF RULE FILING:

   Health Benefits Eligibility and Enrollment Rule, Eligibility Standards (Part 2)

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. The Medicaid post partum extension was supported by the General Assembly and advocacy groups including the Office of the Health Care Advocate. AHS worked with the Department of Financial Regulation on the Qualified Health Plan changes. The open enrollment period and income-based special enrollment period are both modeled on changes made by the federal government. AHS discussed the proposals with the General Assembly, Office of the Health Care Advocate/Vermont Legal Aid, Medicaid & Exchange Advisory Committee, and Qualified Health Plan issuers, and took their input in rule development. AHS notified the Medicaid and Exchange Advisory Committee of this rulemaking ahead of filing, including the estimated timeframe for filing and the proposed revisions to the rule.

Public Input

The proposed rule was posted on the AHS website for public comment, and a public hearing was held on August 17, 2022. No one attended the hearing. When the 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 August 24, 2022. Comments were received from Vermont Legal Aid on Part 2 and Part 3 of the HBEE rule. A general comment was also received on a topic outside the scope of the HBEE rule. Part 2 and Part 3 have been amended since the proposed filing. The comments received, responsiveness summary, and a list of technical changes are included with this filing. There are no changes to Parts 1, 5, and 7 since the proposed filing.

The Global Commitment Register is a database that provides notification of policy changes and clarifications of existing Medicaid policy, including rulemaking, under Vermont's 1115 Global Commitment to Health waiver. Anyone can subscribe to the Global Commitment Register. Subscribers 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.

Comments on Rule 22P014
1557-Reg-Revision-QA-FINAL-2022.pdf

Hello, please Excuse my last submission as I was attempting to copy and paste this document.

On behalf of stakeholders, my family member included, I'd like the committee to allow a comprehensive service system that allows contracted supports which are not available at any designated agencies to follow this law. Currently, ABA providers must operate at a fiscal loss when providing a contracted service under HCAR rule of $30.11 cap. This is discriminatory in use of federal funding.

I'd appreciate a chance to discuss this issue further.
Thank you so much,
A parent of adult daughter with hcbs waiver

Submitted Electronically to:
Medicaid Policy Unit
AHS.MedicaidPolicy@vermont.gov

In re: GCR 22-029 to 22-033
Health Benefits Eligibility and Enrollment Rules Update

Dear Medicaid Policy Unit,

Thank you for the opportunity to comment on the proposed program changes to the Health Benefits Eligibility and Enrollment Rules.

The Office of the Health Care Advocate (HCA) and the Disability Law Project (DLP) at Vermont Legal Aid submit the following comments in response to the proposed HBEE changes:

Part Two:

Categorical Eligibility for Foster Children

The HCA and the DLP support the proposed changes in Rule 9.03(e) to expand categorical eligibility for foster children. The proposed rule expands eligibility for former foster children to include former foster children from other states. Under the current rule, this category had been limited to former foster children from Vermont. We strongly support this expansion.

We suggest some clarification to Rule 9.03 (e)(iii) that defines eligible former foster children. The rule currently reads,

"If the individual attained 18 years of age on or after January 1, 2023, . . ."

In approximately half the states in the country, foster care has been extended beyond age eighteen. (*See* Extending Foster Care Beyond 18 (ncsl.org)) The proposed rule should not be read in a limited way that would define this category to include only foster children who leave foster care at eighteen. It should be interpreted to also include foster children who leave foster after age eighteen.

Disabled Child Home Care Eligibility

The HCA and the DLP oppose the proposed eligibility changes to 8.05(k)(6) Disabled Child in Home Care (DCHC, Katie Beckett).

We have two concerns with this proposed rule change:

1. "Institutional level of care" is an evolving standard. In 1965 when the federal Medicaid program began, many children with serious medical conditions lived in institutions. Institutionalized medical services for children continued through 1981, when the Katie Beckett Medicaid Waiver was passed under President Ronald Reagan. It was through the advocacy of parents and Olmstead litigation that our medical system moved towards providing care so that children with serious medical conditions could live at home.

   The rule references skilled nursing facilities and intermediate care facilities as two of the three standards. Yet, Vermont does not have these institutions for children. Children are also explicitly excluded from the Choices for Care program which provides coverage for nursing facility care. Even when Vermont had an ICF-DD, this facility, too, had exclusion criteria for admission that made it inaccessible to children. It is better for children's development, and it is fiscally prudent for children to live at home, when medically advised. Vermont has worked hard to increase the amount of care that children can receive at home.

   Requiring eligibility tied to modern standards of admissions for institutions that do not exist in Vermont will make it almost impossible to for children to be found eligible for Katie Beckett Medicaid. Furthermore, to require proof that "without the receipt of institutional level of care in the home, the individual would be required to continue to reside in an institution," as described in (6)(i)(B)(II), is another standard that is impossible to meet.

   Parents have shared with us that they would rather lose everything they have, any savings, their jobs, and their homes, than send their child to an out of state institution, even if supports are inadequate at home. In other words, it is not without severe stress and financial burdens that parents can care for their medically needy children at home. It is financially better for the Vermont Medicaid program to have children receive medical care at home. To enable this to continue, DVHA needs to use the institutional standard of 1965.

   We urge DVHA to delete 8.05 (6)(1)(A and B).

2. No information exists that supports the proposition that a standardized level of care tool is necessary or helpful for these eligibility determinations. It is unclear what problem DVHA is trying to solve by use of a standardized tool. Proposing an as-yet-unidentified tool without any stakeholder input leads us to conclude that DVHA

believes too many children are mistakenly found eligible for Katie Beckett Medicaid.

In our experience, children are frequently found ineligible for coverage either on a first application or at a continuing eligibility review. We have seen no evidence given the regular stream of children and families with meritorious cases in need of assistance with denials and terminations that the current process for Katie Beckett eligibility is erroneously generous.

Furthermore, in representing dozens of children in appeals in Katie Beckett cases, the medical needs and interventions are extremely individualized. We have not seen a pattern or "type" of case that would be amenable to fitting into the standards of a tool. We have not seen a draft of any tool, so it is hard to envision how the diverse experiences of a
small number of medically needy children can be standardized.

We urge DVHA to not change the rule to require a tool. There has been no community conversation or consensus on the value of a standardized tool, or the contents of a standardized tool. It is possible that DVHA may find that no tool is either helpful or practical. Research and community engagement should precede any potential change to this rule.

We urge DVHA to cut sections (A-C).

Part Three

The HCA suggests that HBEE Rule 23.02 be amended to mirror the proposed federal rules that address the "family glitch." The Department of Treasury and the IRS have released proposed rules on this issue, and the HBEE rules should mirror the proposed federal rules. The proposed rules will change how affordability is calculated for family members when one member of the household has an offer of employer insurance.

Under current regulations employer-based health insurance is defined as "affordable" if the coverage solely for the employee, and not for family members, meets the affordability requirements. That means that affordability is calculated based on what it would cost for the employee to purchase a self-only plan. If the cost of the employee only plan meets the current affordability test, the employee *and their family members* are not eligible for Advance Premium Tax Credit (APTC). This is called the "family glitch" because it makes family members ineligible for APTC, even though the cost of a *family plan* with the employer is not "affordable." The proposed rule change would allow for two separate calculations: one for the employee and the other for family members. Under the proposed federal rules, if the cost of covering family members were not affordable, they would be eligible for APTC. This

change addresses a long-standing problem and will allow more Vermonters to enroll in affordable coverage on Vermont Health Connect.

Thank you for the opportunity to comment. Please feel free to reach out should you have any questions.

Sincerely,

/s/ Marjorie Stinchcombe
Marjorie Stinchcombe
Helpline Director
Office of the Health Care Advocate
Vermont Legal Aid

/s/ Rachel Seelig
Rachel Seelig
Director
Disability Law Project
Vermont Legal Aid

/s/ Barb Prine
Barb Prine
Staff Attorney
Disability Law Project
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State of Vermont
Agency of Human Services
280 State Drive
Waterbury, VT 05671-1000
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Jenney Samuelson, *Secretary*
[phone] 802-241-0440
[fax] 802-241-0450

Date: October 18, 2022

Re: Response to comments received from the public for the Health Benefits Eligibility & Enrollment (HBEE) Rule Update (Proposed GCR 22-029 to 22-033)

A summary of the comments received on the proposed HBEE rule and the Agency of Human Services' responses to those comments is as follows:

General Comment

Comment: On behalf of stakeholders, my family member included, I'd like the committee to allow a comprehensive service system that allows contracted supports which are not available at any designated agencies to follow this law. Currently, ABA providers must operate at a fiscal loss when providing a contracted service under HCAR rule of $30.11 cap. This is discriminatory in use of federal funding. I'd appreciate a chance to discuss this issue further.

Response: The agency appreciates this comment and the concern raised by the commenter. While the commenter's concern speaks to an issue that is outside the scope of this rulemaking effort, the agency will take the concern into consideration.

Comments by Rule Sections

PART TWO

8.05(k)(6) Disabled child in home care (DCHC, Katie Beckett)

Comment 1 from Vermont Legal Aid:

Vermont Legal Aid (VLA) states, "We urge DVHA to delete 8.05 (6)(1)(A and B)." VLA's full comments are part of the final proposed rulemaking filing. VLA opposes proposed 8.05(k)(6)(i)(A)-(B), including for the following reasons:

- *"Requiring eligibility tied to modern standards of admissions for institutions that do not exist in Vermont will make it almost impossible to [sic] for children to be found eligible for Katie Beckett Medicaid."*

- *"... to require proof that 'without the receipt of institutional level of care in the home, the individual would be required to continue to reside in an institution,' as described in (6)(i)(B)(II), is another standard that is impossible to meet."*
- *"DVHA needs to use the institutional standard of 1965."*

Response:

The proposed amendments to the rule at 8.05(k)(6) are not intended to change the current legal standard for eligibility for the optional Medicaid category, Disabled Child in Home Care (DCHC or the "Katie Beckett provision"), including the federal requirement that the individual require an institutional level of care.[1] The intent of the proposed changes is to (1) improve clarity of the institutional level of care eligibility requirement, (2) indicate that Vermont Medicaid may use a standardized medical assessment tool to determine level of care in the future, (3) align the rule with current operations and federal law regarding the frequency of reviews of clinical eligibility, and (4) make technical changes to align the rule with federal law.

While the agency's proposed changes were not intended to change the legal standard for meeting institutional level of care, the agency is revising 8.05(k)(6)(i), including due to the commenter's feedback. Specifically, the agency has revised 8.05(k)(6)(i)(A)-(B) in two ways:

- Removed the references to federal regulations at 8.05(k)(6)(i)(A). This change aligns the rule more closely with the corresponding federal regulation, 42 CFR 435.225; and
- Removed 8.05(k)(6)(i)(B)(II) as recommended by the commenter.

The only remaining changes from those proposed to 8.05(k)(6)(i)(A)-(B) are (1) final proposed 8.05(k)(6)(i)(A)(I) newly defines "medical institution" by aligning the definition with federal law, 42 CFR 435.225(b)(1), which states that to qualify for this Medicaid category, a disabled child must require care in a hospital, SNF [skilled nursing facility], or an ICF [intermediate care facility], and (2) final proposed 8.05(k)(6)(i)(A)(II) aligns with 42 CFR 435.225(a) and clarifies that a disabled child must be living in the home to qualify for DCHC.

---

[1] Explanation of why this Medicaid category is referred to as the "Katie Beckett provision:" At five months old Katie Beckett contracted a devastating brain infection. She suffered paralysis that left her hospitalized on a ventilator for three years. Katie's middle-class family had a million dollars of health insurance, but that was soon exhausted. While she was institutionalized, Medicaid paid for her medical care but when she improved enough to live with her family, her Medicaid was terminated. Katie required professional nurses to meet her needs at home, but Medicaid would not cover it because her family's income was too high. Under the law, Medicaid would only pay for Katie's care if she remained in an institutional setting. Katie's family faced a dilemma, whether to leave her in the hospital or bring her home where there was a lack of certainty about the care that would be provided to her.

In 1981, President Ronald Reagan heard about Katie's dilemma and personally intervened. President Reagan created the Katie Beckett Waiver. The waiver allowed Katie, and children like her who required an institutional level of care, but could safely receive this care at home, to receive their care at home while retaining their Medicaid coverage, regardless of their parents' income. Katie grew up to be an accomplished motivational speaker and was a champion for people with disabilities until her death in her 30s. In 1982, Congress expanded what had been accomplished by the Katie Beckett Waiver by creating a new state plan option in Medicaid pursuant to Section 134 of the Tax Equity and Fiscal Responsibility Act (TEFRA), sometimes referred to as "the Katie Beckett provision."

The commenter's interpretation that level of care for DCHC should be determined by standards that existed in 1965 is contrary to federal law. The level of care standard for DCHC Medicaid has never been tied to the institutional level of care standard of 1965. The Medicaid program was first implemented in 1965, but it was not until 1981 that President Reagan created the Katie Beckett Waiver, and it was not until 1982 that Congress made a related state plan option available to states. There is nothing in federal law or CMS guidance that supports that the Medicaid agency should use the institutional level of care standard from 1965 in determining eligibility for DCHC. 42 CFR 435.225 states in full:

§ 435.225 Individuals under age 19 who would be eligible for Medicaid if they were in a medical institution.

(a) The agency may provide Medicaid to children 18 years of age or younger who qualify under section 1614(a) of the Act, who would be eligible for Medicaid if they were in a medical institution, and who are receiving, while living at home, medical care that would be provided in a medical institution.

(b) If the agency elects the option provided by paragraph (a) of this section, it must determine, in each case, that the following conditions are met:

(1) The child requires the level of care provided in a hospital, SNF, or ICF.

(2) It is appropriate to provide that level of care outside such an institution.

(3) The estimated Medicaid cost of care outside an institution is no higher than the estimated Medicaid cost of appropriate institutional care.

(c) The agency must specify in its State plan the method by which it determines the cost-effectiveness of caring for disabled children at home.

(55 Federal Register 48608, 11/21/90)

Finally, the commenter mentions the lack of certain medical institutions within Vermont; however, the existence of such institutions within Vermont's borders is not relevant to the legal requirements for DCHC Medicaid eligibility and is outside the scope of this rulemaking. The level of care analysis in DCHC is not a placement decision; it is solely to determine eligibility for this Medicaid category.

The agency agrees with the commenter that the DCHC Medicaid category is a critical category for some Vermont families. It is the only means for some disabled children who require an institutional level of care, but whose household income is too high to qualify for Dr. Dynasaur, to avoid institutionalization by the Medicaid agency paying for them to receive that level of care in their home.

Comment 2 from Vermont Legal Aid:

Vermont Legal Aid (VLA) states, "We urge DVHA to cut sections (A- C)." VLA's full comments are part of the final proposed rulemaking filing. VLA opposes proposed 8.05(k)(6)(i)(A)-(C), including for the following reasons:

- *"No information exists that supports the proposition that a standardized level of care tool is necessary or helpful for these eligibility determinations. It is unclear what problem DVHA is trying to solve by use of a standardized tool."*
- *"We have not seen a pattern or 'type' of case that would be amenable to fitting into the standards of a tool. We have not seen a draft of any tool, so it is hard to envision how the diverse experiences of a small number of medically needy children can be standardized."*
- *"There has been no community conversation or consensus on the value of a standardized tool, or the contents of a standardized tool."*

Response:

Vermont Medicaid plans to move to the use of a standardized tool to determine level of care for DCHC eligibility to ensure objective, accurate, and reliable decision making. Much of the care that Vermont Medicaid covers program wide is approved using standardized tools. Such tools are designed to be as objective as possible to achieve the highest "interrater reliability," i.e., that two screeners would answer the same way for the same individual. This promotes best practices by ensuring proper and fair eligibility determinations and will provide greater consistency across Vermont Medicaid.

Presently, Vermont Medicaid is seeking to amend 8.06(k)(6) to indicate that it may designate a standardized assessment tool to determine whether an individual qualifies for an institutional level of care for DCHC. The proposed amendment does not require Vermont Medicaid to designate a tool, but does provide that if the agency designates one, that it must be used in all DCHC level of care decisions. Vermont Medicaid has not selected a standardized tool for deciding level of care in DCHC. The agency informed the commenter, prior to its submission of comments, that it would be seeking its and other stakeholder's input on the standardized level of care tool prior to one being implemented.

Federal law gives Medicaid agencies flexibility in deciding whether to use a standardized tool and if so, which tool. As of 2015, standardized assessment tools were used by the District of Columbia and all 50 state Medicaid agencies in their Medicaid long term support and services (LTSS) programs, including to determine level of care.[2]

Vermont Medicaid has used standardized tools for many years, to determine service needs and eligibility for programs, including level of care. Historically, Vermont Medicaid used a "homegrown" tool to determine if level of care was met in DCHC cases, and, more recently, it has used criteria that functions as a tool and includes a multipage narrative that explains when level of care is met. The Department of Disabilities, Aging, and Independent Living (DAIL) uses a standardized tool to determine eligibility, including level of care, in the Choices for Care program, which allows individuals who require an institutional level of care to receive care in their home to avoid institutionalization. DAIL also uses standardized tools to determine eligibility and/or service needs for individuals applying for or enrolled in

[2] Medicaid and CHIP Payment and Access Commission (MACPAC) – Functional Assessments for Long-Term Services and Supports. https://www.macpac.gov/wp-content/uploads/2016/06/Functional-Assessments-for-Long-Term-Services-and-Supports.pdf. Accessed September 7, 2022.

the Traumatic Brain Injury Program, the Adult High Technology Program, and the Attendant Services Program.

Additionally, Vermont Medicaid uses a standardized tool to determine eligibility for services for children who are medically fragile, including those who need medically complex nursing services in the home. The Department of Vermont Health Access (DVHA) and the Department of Mental Health use InterQual standardized tools to determine both whether level of care is met in certain settings and whether a service authorization request for mental health, substance use disorder, behavioral health services, and medical services should be approved (e.g., inpatient hospitalization, inpatient psychiatric hospitalization; eating disorder treatment in inpatient, residential, PHP and IOP settings; Applied Behavioral Analysis; and psychiatry, across all ages). InterQual is a nationally recognized evidence-based platform that is used by health insurers, Medicaid agencies, and facilities nationwide.

In summary, the use of "tools" to make certain eligibility decision, including level of care, and service authorization decisions is widespread at Vermont Medicaid and at Medicaid agencies across the country. Such tools promote objective and fair decisions through the use of the proper administration of an appropriate assessment tool implemented by a trained person.

The agency is not amending proposed 8.05(k)(6)(i)(C) except to remove the proposed name of the standardized tool from the rule.

9.03(e) Former foster child

Comment: The HCA (Office of the Health Care Advocate at Vermont Legal Aid) and the DLP (Disability Law Project at Vermont Legal Aid) support the proposed changes in Rule 9.03(e) to expand categorical eligibility for foster children. The proposed rule expands eligibility for former foster children to include former foster children from other states. Under the current rule, this category had been limited to former foster children from Vermont. We strongly support this expansion.

We suggest some clarification to Rule 9.03 (e)(iii) that defines eligible former foster children. The rule currently reads,

"If the individual attained 18 years of age on or after January 1, 2023, . . ."

Response: The agency appreciates the commenters' support of this expansion. The agency agrees with the commenters that clarification defining eligible former foster children would be helpful in light of the expansion of eligibility to include foster children from other states that have foster care extended beyond 18. The agency is adding text to the rule to make this clarification.

PART THREE

23.02 Affordable coverage for employer-sponsored MEC

Comment: The HCA (Office of the Health Care Advocate at Vermont Legal Aid) suggests that HBEE Rule 23.02 be amended to mirror the proposed federal rules that address the "family glitch." The Department of Treasury and the IRS have released proposed rules on this issue, and the HBEE rules should mirror the proposed federal rules. The proposed rules will change how affordability is calculated for family members when one member of the household has an offer of employer insurance.

Under current regulations employer-based health insurance is defined as "affordable" if the coverage solely for the employee, and not for family members, meets the affordability requirements. That means that affordability is calculated based on what it would cost for the employee to purchase a self-only plan. If the cost of the employee only plan meets the current affordability test, the employee and their family members are not eligible for Advance Premium Tax Credit (APTC). This is called the "family glitch" because it makes family members ineligible for APTC, even though the cost of a family plan with the employer is not "affordable." The proposed rule change would allow for two separate calculations: one for the employee and the other for family members. Under the proposed federal rules, if the cost of covering family members were not affordable, they would be eligible for APTC. This change addresses a long-standing problem and will allow more Vermonters to enroll in affordable coverage on Vermont Health Connect.

Response: The agency agrees with this comment. The agency is adding text to the rule at 23.02 to address the "family glitch" consistent with the rule proposed by the Internal Revenue Service (IRS) on April 7, 2022. The IRS has indicated that it will finalize this policy change prior to 2023. In revising this section of the rule, the agency is also simplifying the rule text by eliminating examples at (d), some of which are outdated under the family glitch change, and instead referring to the current illustrative examples provided by the IRS.

Annotated Text

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Part Two
Eligibility Standards

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

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

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

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

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

(2) Vermont residency (§ 21.00);

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

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

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

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

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

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

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

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

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

7.00 Medicaid for children and adults (MCA) (01/01/2023~~01/01/2018~~, GCR 22-030~~17-044~~)

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

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

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

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

(a) Social Security number (§ 16.00);

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

(c) Residency (§ 21.00)[2;]

(d) Living arrangements (§ 20.00);

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

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

7.03 Categorical and financial criteria (01/01/2023~~01/01/2018~~, GCR 22-030~~17-044~~)

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

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

(2) Pregnant woman[5]

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

(ii) *Retroactive eligibility:*

---

[1] 42 CFR § 435.406.

[2] 42 CFR § 435.403.

[3] 42 CFR § 435.610.

[4] 42 CFR § 435.110.

[5] 42 CFR § 435.116.

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(A) When the 60-day post partum period applies

When the 60-day post partum period applies, aA woman may be retroactively granted Medicaid eligibility under this coverage group if she was pregnant during the retroactive period defined in § 70.01(b) and met all eligibility criteria. However, she would not be eligible for Medicaid under this coverage group for the 60-day post partum period if she appliesd for Medicaid after her pregnancy ended.

(B) When the 12-month post partum period applies

When the 12-month post partum period applies, a woman may be retroactively granted Medicaid eligibility under this coverage group if she was pregnant during the retroactive period defined in § 70.01(b) and met all eligibility criteria. If she applies for Medicaid after her pregnancy ends, but was pregnant on or after April 1, 2023, and met all eligibility criteria at § 70.01(b), she may also be granted eligibility through the end of the month in which the post partum period ends.

(iii) *Continuous eligibility:*

(A) When the 60-day post partum period applies

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

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

(B) When the 12-month post partum period applies

When the 12-month post partum period applies, an eligible pregnant woman who would lose eligibility because of a change in circumstances, including a change in household income, household composition or categorical eligibility, is deemed to continue to be eligible throughout the pregnancy and the post partum period without regard to a change in circumstances unless:

(I) The woman requests voluntary termination;

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

(III) The woman dies; or

(IV) AHS determines that eligibility was determined incorrectly at the most recent determination or redetermination of eligibility because of agency error or fraud, abuse, or perjury attributed to the woman.[7]

This provision applies to a medically-needy pregnant woman as follows: If the woman meets her

[6] 42 CFR § 435.170(c).

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

Final Proposed

spenddown while pregnant, her eligibility continues during the remainder of her pregnancy and post partum period. The woman does not have to meet a spenddown again until the end of her post partum period.

(3) Child[8]

(i) An individual, who is under the age of 19[9], with a MAGI-based household income, as defined in § 28.03, that is at or below 312 percent of the FPL for the applicable family size.

(ii) *Continuous eligibility for a hospitalized child*[10]*:*

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

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

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

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

(4) [Reserved]

(5) Adult[11]

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

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

(B) Is not pregnant;

(C) Is not entitled to or enrolled in Medicare under parts A or B of Title XVIII of the Act;[12]

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

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

Final Proposed

[8] 42 CFR § 435.118.

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

[10] 42 CFR § 435.172.

[11] 42 CFR § 435.119.

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

(ii) *Coverage for children under 21:*[13]

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

(6) Families with Medicaid eligibility extended because of increased earnings; Transitional Medical Assistance under § 1925 of the Social Security Act[14]

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

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

(iii) Additional six-month extension

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

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

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

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

(B) If TMA for a parent, caretaker relative or child is terminated due to failure to meet the criteria

[13] 42 CFR § 435.119(c).

[14] §§ 408(a)(11)(A), 1902(e)(1)(A), 1925, and 1931(c)(2) of the Social Security Act.

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described in (A) above, Medicaid coverage will continue under another Medicaid category if the parent, caretaker relative, or child is eligible under that category.

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

(7) Families with Medicaid eligibility extended because of increased collection of spousal support[15]

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

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

(8) Medically Needy

(i) In general.[16] An individual under age 21, a pregnant woman, or a parent or other caretaker relative, as described above, may qualify for MCA as medically needy even if their income exceeds coverage group limits.

(ii) Income eligibility.[17] For purposes of determining medically-needy eligibility under this sub clause, AHS applies the MAGI-based methodologies defined in § 28.03 subject to the requirements of § 28.04.

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

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

(9) Coverage of long-term care services and supports.[18] For an individual eligible for MCA who seeks Medicaid coverage of long-term care services and supports under MCA, AHS will apply the following rules

[15] 42 CFR § 435.115, §§ 408(a)(11)(B) and 1931(c)(1) of the Social Security Act.

[16] Former Medicaid Rule 4203.

[17] 42 CFR § 435.831.

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

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in determining the individual's eligibility for such coverage:

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

(ii) Income and resource transfers under § 25.00.

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

8.00 Medicaid for the aged, blind, and disabled (MABD)[19] (01/01/2023~~01/15/2019~~, GCR 22-030~~18-061~~)

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

An individual is eligible for MABD if they meet the nonfinancial, categorical, and financial criteria outlined in this section.[20]

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

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

(a) Social Security number (§ 16.00);

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

(c) Residency (§ 21.00);

(d) Living arrangements (§ 20.00);

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

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

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

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

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

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

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

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[19] Former Medicaid Rules 4200 et seq.

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

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

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

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

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

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

(1) Under age 18, or

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

See, also, § 29.02(a)(1).

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

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

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

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

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

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

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

(5) An individual who claims that:

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

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

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

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

(6) An individual who claims that:

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

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

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

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

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

8.05 The categorically-needy coverage groups (01/01/2023~~01/15/2019~~, GCR 22-030~~18-061~~)

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

(a) Individual enrolled in SSI/AABD[21]

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

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

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

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

(b) Individual who is SSI-eligible[22]

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

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

(ii) Do not meet SSI/AABD requirements not applicable to Medicaid (e.g., participation in vocational

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[21] 42 CFR § 435.120; former Medicaid Rule 4202.1.

[22] 42 CFR § 435.122; former Medicaid Rule 4202.2A.

rehabilitation or a substance abuse treatment program).

(2) An individual in this group must:

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

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

(iii) Meet the MABD nonfinancial criteria.

(c) Individual eligible for SSI but for earnings[23] (Section 1619(b) of the Social Security Act)

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

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

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

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

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

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

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

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

(B) After disregarding the working disabled person's earnings, Social Security Disability Insurance benefits (SSDI) including, if applicable, Social Security retirement benefits automatically converted from SSDI[24], and any veterans' disability benefits, and, if married, all income of the working disabled person's spouse[25], has MABD income that is:

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

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[23] 42 CFR § 435.120(c); former Medicaid Rule 4202.2B.

[24] 33 VSA § 1902(b)~~See, 2015 Acts and Resolves No. 51, Sec. C.9~~.

[25] 33 VSA § 1902(b)~~See, 2015 Acts and Resolves No. 51, Sec. C.9~~.

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

(ii) Has resources at the time of enrollment in the group that do not exceed $10,000.00[26] for a single individual and $15,000.00[27] for a couple (see § 29.08(i)(8) for resource exclusion after enrollment).

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

(i) Federal Insurance Contributions Act tax payments;

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

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

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

(e) Child under 18 who lost SSI because of August 1996 change in definition of disability. An individual under the age of 18 who lost their SSI or SSI/AABD eligibility because of the more restrictive definition of disability enacted in August 1996 but who continues to meet all other MABD criteria until their 18th birthday.[28] The definition of disability for this group is the definition of childhood disability in effect prior to the 1996 revised definition.

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

(1) The individual is:

(i) A surviving spouse; or

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

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

(B) Remains single.

(2) The individual meets one of the following groups of criteria under the Act:[29]

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[26] 33 VSA § 1902(b)~~See, 2015 Acts and Resolves No. 51, Sec. C.9~~.

[27] 33 VSA § 1902(b)~~See, 2015 Acts and Resolves No. 51, Sec. C.9~~.

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

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

(i) The individual:

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

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

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

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

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

(ii) The individual:

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

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

(C) Is at least age 50[30], but has not yet attained age 65; and

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

(3) An individual in this group must:

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

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

(iii) Meet the MABD nonfinancial criteria.

(g) Disabled adult child (DAC)[31]

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

(i) Is at least 18 years of age;

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

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

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

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

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

(2) An individual in this group must:

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

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

(iii) Meet the MABD nonfinancial criteria.

(h) Individual eligible under the Pickle Amendment[32]

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

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

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

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

(2) An individual in this group must:

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

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

(iii) Meet the MABD nonfinancial criteria.

(i) Individual eligible for Medicaid in December 1973.[33] An individual who was eligible for Medicaid in December

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

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

1973 and meets at least one of the following criteria:

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

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

(ii) Continues to reside in the institution; and

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

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

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

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

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

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

(v) Meets the MABD nonfinancial criteria.

(3) An individual who was eligible for Medicaid in December 1973 as an essential spouse of an aged, blind, or disabled individual who was receiving cash assistance, if the following conditions are met:[34]

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

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

(j) Individual eligible for AABD in August 1972[35]

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[34] An "essential spouse" is defined as one who is living with the individual, whose needs were included in determining the amount of SSI or SSI/AABD payment to an aged, blind, or disabled individual living with the essential spouse, and who is determined essential to the individual's well-being.

[35] See 42 CFR § 435.134.

(1) An individual who meets the following conditions:

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

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

(2) An individual in this group must:

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

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

(iii) Meet the MABD nonfinancial criteria.

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

(1) [Reserved]

(2) Individual who would be eligible for cash assistance if they were not in a medical institution[36]

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

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

(A) Is ineligible for SSI/AABD because of lower income standards used under the program to determine eligibility for institutionalized individuals; but

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

(3) Individual living in a medical institution eligible under a special income level.[37] An aged, blind or disabled individual who is living in a medical institution and who:

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

(ii) Has MABD income for the individual's financial responsibility group (as defined in § 29.03) that does not exceed 300 percent of the maximum SSI federal payment to an individual living

[36] 42 CFR § 435.211.

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

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independently in the community (institutional income standard (IIS));[38]

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

(iv) Meets the MABD non-financial criteria.

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

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

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

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

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

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

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

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

(6) Disabled child in home care (DCHC, Katie Beckett).[39] A disabled individual who:

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

(A) For purposes of this part:

(I) A~~a~~ "medical institution" means a hospital ~~(described at 42 CFR § 440.10)~~, skilled nursing facility ~~(described at 42 CFR § 440.40)~~, or intermediate care facility ~~(described at 42 CFR § 440.150).~~; and

(II) ~~For purposes of this part,~~ "R~~r~~equires the level of care provided in a medical institution" means the individual is living at home but requires the level of care provided in a

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

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

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medical institution.;

Is not living in a medical institution but requires the level of care provided in an institution; or

Is living in a medical institution, is being discharged, and continues to require the level of care provided in the medical institution and without the receipt of institutional level of care in the home, the individual would be required to continue to reside in the institution.

(B) AHS determines whether the individual requires the level of care provided in a medical institution. AHS may designate a standardized assessment tool, called an Institutional Level of Care Assessment Tool for DCHC, which AHS will use whenever it determines whether an individual requires an institutional level of care.

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

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

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

(vi)(iv) Is age 18 or younger;

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

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

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

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

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

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

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

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

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(a) In general.[40] An individual who would be a member of a categorically-needy coverage group, as described in § 8.05, may qualify for MABD as medically needy even if their income or resources exceed coverage group limits.

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

(c) Resource standard. To qualify for this coverage group, an individual must have MABD resources for the individual's financial responsibility group that are at or below the SSI/AABD maximum for the individual's Medicaid group, or, as described in paragraph (d) of this subsection, they incur enough expenses to reduce their resources to that level.

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

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

(a) In general

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

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

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

(b) Coverage groups

(1) Qualified Medicare Beneficiaries (QMB)[41]

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

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

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

[40] Former Medicaid Rule 4203.

[41] SSA § 1905(p)(1).

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individuals may enroll for premium part A).

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

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

(iv) Retroactive eligibility is not available.[42]

(v) *Special income disregard for an individual who is receiving a monthly insurance benefit under Title II of the Social Security Act.* If an individual receives a Title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit payable as a result of a Title II cost-of-living adjustment (COLA) is not counted as income until the beginning of the second month following the month of publication of the revised annual FPL. For individuals who have Title II income, the new poverty levels are effective beginning with the month after the last month for which COLAs are disregarded. For individuals without Title II income, the new poverty levels are effective no later than the date of publication in the Federal Register.[43]

(2) Specified Low-Income Medicare Beneficiaries (SLMB)[44]

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

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

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

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

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

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

(v) *Special income disregard for an individual who is receiving a monthly insurance benefit under Title II of the Social Security Act.* If an individual receives a Title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit payable as a result of a Title II cost-of-living adjustment (COLA) is not counted as income until the beginning of the second month following the month of publication of the revised annual FPL. For individuals who have Title II

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

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

[44] SSA § 1902(a)(10)(E)(iii).

income, the new poverty levels are effective beginning with the month after the last month for which COLAs are disregarded. For individuals without Title II income, the new poverty levels are effective no later than the date of publication in the Federal Register.[45]

(3) <u>Qualified Individuals (QI-1)</u>[46]

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

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

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

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

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

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

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

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

(B) The retroactive period is no earlier than January 1 of that calendar year.[47]

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

(4) <u>Qualified Disabled and Working Individuals (QDWI)</u>

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

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

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

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

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

[46] SSA § 1902(a)(10)(E)(iv).

[47] CMS State Medicaid Manual, § 3492.

percent of the FPL;

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

(E) Is not otherwise eligible for Medicaid.

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

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

9.00 Special Medicaid groups (01/01/2023~~01/01/2018~~, GCR 22-030~~17-044~~)

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

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

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

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

(a) Social Security number (§ 16.00);

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

(c) Residency (§ 21.00);

(d) Living arrangements (§ 20.00);

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

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

9.03 Categorical and financial criteria (01/01/2023~~01/01/2018~~, GCR 22-030~~17-044~~)

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

(b) Deemed newborn[48]

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

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[48] 42 CFR § 435.117.

(2) Eligibility

(i) Medicaid coverage will be provided to a child from birth until the child's first birthday without application if, on the date of the child's birth, the child's mother was eligible for and received covered services under Medicaid or CHIP (including during a retroactive period of eligibility under § 70.01(b)) regardless of whether payment for services for the mother is limited to services necessary to treat an emergency medical condition, as defined in § 17.02(d);[49]

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

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

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

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

(vi) There are no Medicaid income or resource standards that apply.

(3) Medicaid identification number

(i) The Medicaid identification number of the child's mother serves as the child's identification number, and all claims for covered services provided to the child may be submitted and paid under such number, unless and until AHS issues the child a separate identification number in accordance with (3)(ii) of this paragraph.

(ii) AHS will issue a separate Medicaid identification number for the child prior to the effective date of any termination of the mother's eligibility or prior to the date of the child's first birthday, whichever is sooner, unless the child is determined to be ineligible (such as, because the child is not a state resident), except that AHS will issue a separate Medicaid identification number for the child promptly after it is notified of a child under 1 year of age residing in the state and born to a mother whose coverage is limited to services necessary for the treatment of an emergency medical condition, consistent with § 17.02(c).

(c) Children with adoption assistance, foster care, or guardianship care under title IV-E[50]

(1) Basis. This sub clause implements §§ 1902(a)(10)(A)(i)(I) and 473(b)(3) of the Act.

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

[50] 42 CFR § 435.145.

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(2) Eligibility. Medicaid coverage will be provided to an individual under age 21, living in Vermont for whom:

(i) An adoption assistance agreement is in effect with a state or tribe under Title IV-E of the Act, regardless of whether adoption assistance is being provided or an interlocutory or other judicial decree of adoption has been issued; or

(ii) Foster care or kinship guardianship assistance maintenance payments are being made by a state or tribe under Title IV-E of the Act.

(3) Income standard. There is no Medicaid income standard that applies. Committed children in the custody of the state who are not IV-E eligible must pass the applicable eligibility tests before their eligibility for Medicaid can be established.

(d) Special needs adoption[51]

(1) Basis. This sub clause implements § 1902(a)(10)(A)(ii)(VIII) of the Act.

(2) Eligibility. Medicaid coverage will be provided to an individual under age 21:

(i) For whom an adoption assistance agreement (other than an agreement under Title IV-E of the Act) between a state and the adoptive parent or parents is in effect;

(ii) Whom the state agency which entered into the adoption agreement determined could not be placed for adoption without Medicaid coverage because the child has special needs for medical or rehabilitative care; and

(iii) Who, prior to the adoption agreement being entered into, was eligible for Medicaid.

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

(e) Former foster child[52]

(1) Basis. This sub clause implements § 1902(a)(10)(A)(i)(IX) of the Act.

(2) Eligibility. Medicaid coverage will be provided to an individual who:

(i) Is under age 26; and

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

(A) Is not eligible and enrolled for mandatory coverage under §§ 7.03(a)(1), (2), (3), (6), (7); 8.05(a), (b), (c), (f), (h), (i), (j); or 9.03(c); and

(B) Was in foster care under the responsibility of Vermont~~the state~~ and enrolled in Medicaid under

[51] 42 CFR § 435.227.

[52] 42 CFR § 435.150; SSA § 1902(a)(10)(A)(i)(IX).

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the state's Medicaid State plan or 1115 demonstration upon attaining age 18; or.

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

(A) Is not eligible and enrolled for mandatory coverage under §§ 7.03(a)(1), (2), (3), (6), (7); 8.05(a), (b), (c), (f), (h), (i), (j); or 9.03(c); and

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

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

(f) Individual with breast or cervical cancer[53]

(1) Basis. This sub clause implements §§ 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.

(2) Eligibility

(i) Medicaid coverage will be provided to an individual who:

(A) Is under age 65;

(B) Is not eligible and enrolled for mandatory coverage under the state's Medicaid State plan;

(C) Has been determined to need treatment for breast or cervical cancer through a screening under the Centers for Disease Control and Prevention (CDC) breast and cervical cancer early detection program (BCCEDP);[54] and

(D) Does not otherwise have creditable coverage, as defined in § 2704(c) of the PHS Act, for treatment of their breast or cervical cancer. Creditable coverage is not considered to be available just because the individual may:

(I) Receive medical services provided by the Indian Health Service, a tribal organization, or an Urban Indian organization; or

(II) Obtain health insurance coverage only after a waiting period of uninsurance.

(ii) An individual whose eligibility is based on this group is entitled to full Medicaid coverage; coverage is not limited to coverage for treatment of breast and cervical cancer.

(iii) Medicaid eligibility for an individual in this group begins following the screening and diagnosis and

[53] 42 CFR § 435.213; CMS State Health Official Letter, dated January 4, 2001, available at http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/sho010401.pdf.

[54] A woman is considered to have been screened and eligible for this group if she has received a screening mammogram, clinical breast exam, or Pap test; or diagnostic services following an abnormal clinical breast exam, mammogram, or Pap test; and a diagnosis of breast or cervical cancer or of a pre-cancerous condition of the breast or cervix as the result of the screening or diagnostic service.

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continues as long as a treating health professional verifies the individual is in need of cancer treatment services.

(iv) There is no waiting period of prior uninsurance before an individual who has been screened can become eligible for Medicaid under this group.

(3) Treatment need. An individual is considered to need treatment for breast or cervical cancer if, in the opinion of the individual's treating health professional (i.e., the individual who conducts the screen or any other health professional with whom the individual consults), the screen (and diagnostic evaluation following the clinical screening) determines that:

(i) Definitive treatment for breast or cervical cancer is needed, including a precancerous condition or early stage cancer, and which may include diagnostic services as necessary to determine the extent and proper course of treatment; and

(ii) More than routine diagnostic services or monitoring services for a precancerous breast or cervical condition are needed.

(4) Income standard. In order to qualify for screening under (f)(2)(i)(C) above, an individual must be determined by BCCEDP to have limited income. In addition to meeting the criteria described in this sub clause, the individual must meet all other Medicaid nonfinancial criteria.

(g) Family planning services[55]

(1) Basis. This sub clause implements §§ 1902(a)(10)(A)(ii)(XXI) and 1902(ii) and clause (XVI) in the matter following 1902(a)(10)(G) of the Act.

(2) Eligibility. Medicaid coverage of the services described in (g)(4) of this sub clause will be provided to an individual (male and female) who meets all of the following requirements:

(i) Is not pregnant; and

(ii) Meets the income eligibility requirements under (g)(3) of this sub clause.

(3) Income standard. The individual has MAGI-based household income (as defined in § 28.03) that is at or below the income standard for a pregnant woman as described in § 7.03(a)(2). The individual's household income is determined in accordance with § 28.03(j).

(4) Covered services. An individual eligible under this sub clause is covered for family planning and family planning-related benefits.

(h) HIV/AIDS. See, HIV/AIDS Rule 5800 *et seq*.

(i) Refugee Medical Assistance. See, Refugee Medical Assistance Rule 5100 *et seq*.

[55] 42 CFR § 435.214.

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10.00 Pharmacy benefits (01/15/2017, GCR 16-095)

10.01 VPharm program (01/15/2017, GCR 16-095)

The VPharm program rules located in Rule 5400 *et seq.* will remain in effect.

10.02 Healthy Vermonter Program (HVP) (01/15/2017, GCR 16-095)

The Healthy Vermonter Program (HVP) rules located in Rule 5700 *et seq.* will remain in effect.

11.00 Enrollment in a QHP (01/15/2017, GCR 16-095)

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

Eligibility for enrollment in a QHP.[56] An individual is eligible for enrollment in a QHP if the individual meets the nonfinancial criteria outlined in this section.

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

The individual must meet all of the following nonfinancial criteria:

(a) Citizenship, status as a national, or lawful presence (§ 17.00). The individual must be reasonably expected to be a citizen, national, or a non-citizen who is lawfully present for the entire period for which enrollment is sought;

(b) Incarceration (§ 19.00); and

(c) Residency (§ 21.00).

11.03 Eligibility for QHP enrollment periods[57] (01/15/2017, GCR 16-095)

An individual is eligible for a QHP enrollment period if they meet the criteria for an enrollment period, as specified in § 71.00.

12.00 Advance payments of the premium tax credit (APTC) (01/01/2018, GCR 17-044)

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

A tax filer is eligible for APTC on behalf of an individual if the tax filer meets the criteria outlined in this section. A tax filer must be eligible for APTC on behalf of an individual in order for the individual to receive the Vermont Premium Reduction. APTC and the Vermont Premium Reduction are paid directly to the QHP issuer on behalf of the tax filer.

[56] 45 CFR § 155.305(a).

[57] 45 CFR § 155.305(b).

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12.02 Nonfinancial criteria[58] (01/15/2017, GCR 16-095)

An applicable tax filer (within the meaning of § 12.03) is eligible for APTC for any month in which one or more individuals for whom the tax filer expects to claim a personal exemption deduction on their tax return for the benefit year, including the tax filer and their spouse:

(a) Meets the requirements for eligibility for enrollment in a QHP, as specified in § 11.00; and

(b) Is not eligible for MEC (within the meaning of § 23.00) other than coverage in the individual market.

12.03 Applicable tax filer[59] (01/01/2018, GCR 17-044)

(a) In general. Except as otherwise provided in this subsection, an applicable tax filer is a tax filer who expects to have household income of at least 100 percent but not more than 400 percent of the FPL for the tax filer's family size for the benefit year.

For purposes of calculating the household income of an applicable tax filer and determining their financial eligibility for APTC, see § 28.05.

(b) Married tax filers must file joint return

(1) Except as provided in (2) below, a tax filer who is married (within the meaning of 26 CFR § 1.7703-1) at the close of the benefit year is an applicable tax filer only if the tax filer and the tax filer's spouse file a joint return for the benefit year.

(2) *Victims of domestic abuse and spousal abandonment:* Except as provided in (5) below, a married tax filer will satisfy the joint filing requirement if the tax filer files a tax return using a filing status of married filing separately and:

(i) Is living apart from their spouse at the time they file their tax return;

(ii) Is unable to file a joint return because they are a victim of domestic abuse as defined in (3) below or spousal abandonment as defined in (4) below; and

(iii) Certifies on their tax return, in accordance with the relevant instructions, that they meet the criteria under (i) and (ii) above.

(3) *Domestic abuse.* Domestic abuse includes physical, psychological, sexual, or emotional abuse, including efforts to control, isolate, humiliate and intimidate, or to undermine the victim's ability to reason independently. All the facts and circumstances are considered in determining whether an individual is abused, including the effects of alcohol or drug abuse by the victim's spouse. Depending on the facts and circumstances, abuse of the victim's child or another family member living in the household may

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

[59] 26 CFR § 1.36B-2(b); 45 CFR § 155.305.

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constitute abuse of the victim.

(4) *Abandonment.* The tax filer is a victim of spousal abandonment for the taxable year if, taking into account all facts and circumstances, the tax filer is unable to locate their spouse after reasonable diligence.

(5) *Three-year rule.* Paragraph (2) above does not apply if the tax filer met the requirements of the paragraph for each of the three preceding taxable years.

(c) Tax dependent. An individual is not an applicable tax filer if another tax filer may claim a deduction under 26 USC § 151 for the individual for a benefit year beginning in the calendar year in which the individual's benefit year begins.

(d) Individual not lawfully present or incarcerated.[60] An individual who is not lawfully present in the United States or is incarcerated (other than incarceration pending disposition of charges) is not eligible to enroll in a QHP through VHC. However, the individual may be an applicable tax filer for purposes of claiming the premium tax credit if a family member is eligible to enroll in a QHP.

(e) Individual lawfully present. An individual is also an applicable tax filer if:

(1) The tax filer would be an applicable tax filer but for income;

(2) The tax filer expects to have household income of less than 100 percent of the FPL for the tax filer's family size for the benefit year for which coverage is requested;

(3) One or more applicants for whom the tax filer expects to claim a personal exemption deduction on their tax return for the benefit year, including the tax filer and spouse, is a non-citizen who is lawfully present and ineligible for Medicaid by reason of immigration status.

(f) Special rule for tax filers with household income below 100 percent of the FPL for the benefit year.[61] A tax filer (other than a tax filer described in paragraph (e) of this subsection) whose household income for a benefit year is less than 100 percent of the FPL for the tax filer's family size is treated as an applicable tax filer for purposes of claiming the premium tax credit if:

(1) The tax filer or a family member enrolls in a QHP through VHC for one or more months during the taxable year;

(2) AHS estimates at the time of enrollment that the tax filer's household income will be at least 100 but not more than 400 percent of the FPL for the benefit year;

(3) APTCs are authorized and paid for one or more months during the benefit year; and

(4) The tax filer would be an applicable tax filer if the tax filer's household income for the benefit year was at

[60] See, ACA §§ 1312(f)(1)(B) and 1312(f)(3) (42 USC § 18032(f)(1)(B) and (f)(3)) and 26 CFR § 1.36B-2(b)(4).

[61] 26 CFR § 1.36B-2(b)(6).

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least 100 but not more than 400 percent of the FPL for the tax filer's family size.

(g) Computation of premium-assistance amounts for tax filers with household income below 100 percent of the FPL. If a tax filer is treated as an applicable tax filer under paragraph (e) or (f) of this subsection, the tax filer's actual household income for the benefit year is used to compute the premium-assistance amounts under § 60.00.

12.04 Enrollment required[62] (01/15/2017, GCR 16-095)

APTC will only be provided on behalf of a tax filer if one or more individuals for whom the tax filer attests that they expect to claim a personal exemption deduction for the benefit year, including the tax filer and spouse, is enrolled in a QHP.

12.05 Compliance with filing requirement[63] (01/15/2017, GCR 16-095)

AHS may not determine a tax filer eligible for APTC if HHS notifies AHS as part of the process described in § 56.03 that APTCs were made on behalf of the tax filer or either spouse if the tax filer is a married couple for a year for which tax data would be utilized for verification of household income and family size in accordance with § 56.01(a), and the tax filer or their spouse did not comply with the requirement to file an income tax return for that year as required by 26 USC § 6011, 6012, and implementing regulations, and reconcile the APTCs for that period.

12.06 Vermont Premium Reduction eligibility criteria (01/15/2017, GCR 16-095)

An individual is eligible for the Vermont Premium Reduction if the individual:

(a) Meets the requirements for eligibility for enrollment in a QHP, as specified in § 11.00;

(b) Meets the requirements for APTC, as specified in this § 12.00; and

(c) Is expected to have household income, as defined in § 28.05(c), that does not exceed 300 percent of the FPL for the benefit year for which coverage is requested.

13.00 Cost-sharing reductions (CSR) (01/15/2017, GCR 16-095)

13.01 Eligibility criteria[64] (01/15/2017, GCR 16-095)

(a) An individual is eligible for federal and/or state CSR if the individual:

(1) Meets the requirements for eligibility for enrollment in a QHP, as specified in § 11.00;

[62] 45 CFR § 155.305(f)(3).

[63] 45 CFR § 155.305(f)(4).

[64] 45 CFR § 155.305(g).

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(2) Meets the requirements for APTC, as specified § 12.00; and

(3) Is expected to have household income, as defined in § 28.05(c), that does not exceed 300 percent of the FPL for the benefit year for which coverage is requested.

(b) An individual who is not an Indian may receive CSR only if they are enrolled in a silver-level QHP.

13.02 Eligibility categories[65] (01/15/2017, GCR 16-095)

The following eligibility categories for CSR will be used when making eligibility determinations under this section:

(a) An individual who is expected to have household income at least 100 but not more than 150 percent of the FPL for the benefit year for which coverage is requested, or for an individual who is eligible for APTC under § 12.03(e), household income less than 100 percent of the FPL for the benefit year for which coverage is requested;

(b) An individual who is expected to have household income greater than 150 but not more than 200 percent of the FPL for the benefit year for which coverage is requested;

(c) An individual who is expected to have household income greater than 200 but not more than 250 percent of the FPL for the benefit year for which coverage is requested; and

(d) An individual who is expected to have household income greater than 250 but not more than 300 percent of the FPL for the benefit year for which coverage is requested.

Income and benefit levels are as shown in the chart below. The actuarial value of the plan must be within one percentage point of the actuarial value listed below.

Income as a Percent of Federal Poverty Level	Tier	Actuarial Value of Plan with Federal and State CSR
Not more than 150%	I	94%
More than 150% but not more than 200%	II	87%
More than 200% but not more than 250%	III	77%
More than 250% but not more than 300%	IV	73%

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[65] 45 CFR § 155.305(g)(2).

13.03 Special rule for family policies[66] (01/15/2017, GCR 16-095)

To the extent that an enrollment in a QHP under a single policy covers two or more individuals who, if they were to enroll in separate policies would be eligible for different cost sharing, AHS will deem the individuals under such policy to be collectively eligible only for the category of eligibility last listed below for which all the individuals covered by the policy would be eligible.

(a) Individuals not eligible for changes to cost sharing;

(b) § 59.02 (Special cost-sharing rules for Indians, regardless of income);

(c) § 13.02(d);

(d) § 13.02(c);

(e) § 13.02(b);

(f) § 13.02(a);

(g) § 59.01 (Eligibility for CSR for Indians).

Example: Person A is the mother of Person B, her 24-year-old son. Person A and Person B both work and file taxes separately. However, they are covered under the same QHP. Person A's income is equal to 125 percent of the FPL and Person B's income is 225 percent of the FPL. Since Person B's income is at the 225 percent level, the CSR that Person A and Person B will receive will be that available at the 225 percent level, which is in the 200 percent to 250 percent range.

14.00 Eligibility for enrollment in a catastrophic plan[67] (01/01/2018, GCR 17-044)

An individual is eligible for enrollment in a catastrophic plan[68] if they have met the requirements for eligibility for enrollment in a QHP, as specified in § 11.00, and they:

(a) Have not attained the age of 30 before the beginning of the plan year; or

(b) Have a certification in effect for any plan year that they are exempt from the requirement to maintain MEC by reason of hardship, including coverage being unaffordable (see § 23.06(a)).

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[66] 45 CFR § 155.305(g)(3).

[67] 45 CFR § 155.305(h).

[68] 45 CFR § 156.155.

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Part Two
Eligibility Standards

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

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

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

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

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

(2) Vermont residency (§ 21.00);

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

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

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

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

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

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

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

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

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

7.00 Medicaid for children and adults (MCA) (01/01/2023, GCR 22-030)

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

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

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

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

(a) Social Security number (§ 16.00);

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

(c) Residency (§ 21.00)[2];

(d) Living arrangements (§ 20.00);

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

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

7.03 Categorical and financial criteria (01/01/2023, GCR 22-030)

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

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

(2) Pregnant woman[5]

(i) A woman during pregnancy and the post partum period, as defined in the definition of pregnant woman in § 3.00, with a MAGI-based household income, as defined in § 28.03, that is at or below 208 percent of the FPL for the applicable family size.

(ii) *Retroactive eligibility:*

(A) When the 60-day post partum period applies

[1] 42 CFR § 435.406.

[2] 42 CFR § 435.403.

[3] 42 CFR § 435.610.

[4] 42 CFR § 435.110.

[5] 42 CFR § 435.116.

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When the 60-day post partum period applies, a woman may be retroactively granted Medicaid eligibility under this coverage group if she was pregnant during the retroactive period defined in § 70.01(b) and met all eligibility criteria. However, she would not be eligible for Medicaid under this coverage group for the post partum period if she applies for Medicaid after her pregnancy ended.

(B) When the 12-month post partum period applies

When the 12-month post partum period applies, a woman may be retroactively granted Medicaid eligibility under this coverage group if she was pregnant during the retroactive period defined in § 70.01(b) and met all eligibility criteria. If she applies for Medicaid after her pregnancy ends, but was pregnant on or after April 1, 2023, and met all eligibility criteria at § 70.01(b), she may also be granted eligibility through the end of the month in which the post partum period ends.

(iii) *Continuous eligibility:*

(A) When the 60-day post partum period applies

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

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

(B) When the 12-month post partum period applies

When the 12-month post partum period applies, an eligible pregnant woman who would lose eligibility because of a change in circumstances, including a change in household income, household composition or categorical eligibility, is deemed to continue to be eligible throughout the pregnancy and the post partum period without regard to a change in circumstances unless:

(I) The woman requests voluntary termination;

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

(III) The woman dies; or

(IV) AHS determines that eligibility was determined incorrectly at the most recent determination or redetermination of eligibility because of agency error or fraud, abuse, or perjury attributed to the woman.[7]

This provision applies to a medically-needy pregnant woman as follows: If the woman meets her spenddown while pregnant, her eligibility continues during the remainder of her pregnancy and

[6] 42 CFR § 435.170(c).

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

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post partum period. The woman does not have to meet a spenddown again until the end of her post partum period.

(3) Child[8]

(i) An individual, who is under the age of 19[9], with a MAGI-based household income, as defined in § 28.03, that is at or below 312 percent of the FPL for the applicable family size.

(ii) *Continuous eligibility for a hospitalized child[10]:*

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

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

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

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

(4) [Reserved]

(5) Adult[11]

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

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

(B) Is not pregnant;

(C) Is not entitled to or enrolled in Medicare under parts A or B of Title XVIII of the Act;[12]

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

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

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[8] 42 CFR § 435.118.

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

[10] 42 CFR § 435.172.

[11] 42 CFR § 435.119.

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

(ii) *Coverage for children under 21:*[13]

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

(6) Families with Medicaid eligibility extended because of increased earnings; Transitional Medical Assistance under § 1925 of the Social Security Act[14]

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

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

(iii) Additional six-month extension

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

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

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

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

(B) If TMA for a parent, caretaker relative or child is terminated due to failure to meet the criteria

[13] 42 CFR § 435.119(c).

[14] §§ 408(a)(11)(A), 1902(e)(1)(A), 1925, and 1931(c)(2) of the Social Security Act.

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described in (A) above, Medicaid coverage will continue under another Medicaid category if the parent, caretaker relative, or child is eligible under that category.

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

(7) Families with Medicaid eligibility extended because of increased collection of spousal support[15]

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

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

(8) Medically Needy

(i) In general.[16] An individual under age 21, a pregnant woman, or a parent or other caretaker relative, as described above, may qualify for MCA as medically needy even if their income exceeds coverage group limits.

(ii) Income eligibility.[17] For purposes of determining medically-needy eligibility under this sub clause, AHS applies the MAGI-based methodologies defined in § 28.03 subject to the requirements of § 28.04.

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

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

(9) Coverage of long-term care services and supports.[18] For an individual eligible for MCA who seeks Medicaid coverage of long-term care services and supports under MCA, AHS will apply the following rules

[15] 42 CFR § 435.115, §§ 408(a)(11)(B) and 1931(c)(1) of the Social Security Act.

[16] Former Medicaid Rule 4203.

[17] 42 CFR § 435.831.

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

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in determining the individual's eligibility for such coverage:

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

(ii) Income and resource transfers under § 25.00.

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

8.00 Medicaid for the aged, blind, and disabled (MABD)[19] (01/01/2023, GCR 22-030)

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

An individual is eligible for MABD if they meet the nonfinancial, categorical, and financial criteria outlined in this section.[20]

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

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

(a) Social Security number (§ 16.00);

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

(c) Residency (§ 21.00);

(d) Living arrangements (§ 20.00);

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

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

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

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

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

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

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

[19] Former Medicaid Rules 4200 et seq.

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

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

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

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

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

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

(1) Under age 18, or

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

See, also, § 29.02(a)(1).

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

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

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

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

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

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

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

(5) An individual who claims that:

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

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

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

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

(6) An individual who claims that:

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

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

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

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

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

8.05 The categorically-needy coverage groups (01/01/2023, GCR 22-030)

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

(a) Individual enrolled in SSI/AABD[21]

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

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

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

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

(b) Individual who is SSI-eligible[22]

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

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

(ii) Do not meet SSI/AABD requirements not applicable to Medicaid (e.g., participation in vocational

[21] 42 CFR § 435.120; former Medicaid Rule 4202.1.

[22] 42 CFR § 435.122; former Medicaid Rule 4202.2A.

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rehabilitation or a substance abuse treatment program).

(2) An individual in this group must:

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

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

(iii) Meet the MABD nonfinancial criteria.

(c) Individual eligible for SSI but for earnings[23] (Section 1619(b) of the Social Security Act)

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

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

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

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

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

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

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

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

(B) After disregarding the working disabled person's earnings, Social Security Disability Insurance benefits (SSDI) including, if applicable, Social Security retirement benefits automatically converted from SSDI[24], and any veterans' disability benefits, and, if married, all income of the working disabled person's spouse[25], has MABD income that is:

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

[23] 42 CFR § 435.120(c); former Medicaid Rule 4202.2B.

[24] 33 VSA § 1902(b).

[25] 33 VSA § 1902(b).

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

(ii) Has resources at the time of enrollment in the group that do not exceed $10,000.00[26] for a single individual and $15,000.00[27] for a couple (see § 29.08(i)(8) for resource exclusion after enrollment).

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

(i) Federal Insurance Contributions Act tax payments;

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

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

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

(e) <u>Child under 18 who lost SSI because of August 1996 change in definition of disability</u>. An individual under the age of 18 who lost their SSI or SSI/AABD eligibility because of the more restrictive definition of disability enacted in August 1996 but who continues to meet all other MABD criteria until their 18th birthday.[28] The definition of disability for this group is the definition of childhood disability in effect prior to the 1996 revised definition.

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

(1) The individual is:

(i) A surviving spouse; or

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

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

(B) Remains single.

(2) The individual meets one of the following groups of criteria under the Act:[29]

[26] 33 VSA § 1902(b).

[27] 33 VSA § 1902(b).

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

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

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(i) The individual:

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

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

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

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

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

(ii) The individual:

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

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

(C) Is at least age 50[30], but has not yet attained age 65; and

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

(3) An individual in this group must:

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

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

(iii) Meet the MABD nonfinancial criteria.

(g) Disabled adult child (DAC)[31]

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

(i) Is at least 18 years of age;

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

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

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

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

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

(2) An individual in this group must:

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

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

(iii) Meet the MABD nonfinancial criteria.

(h) Individual eligible under the Pickle Amendment[32]

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

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

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

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

(2) An individual in this group must:

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

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

(iii) Meet the MABD nonfinancial criteria.

(i) Individual eligible for Medicaid in December 1973.[33] An individual who was eligible for Medicaid in December

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

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

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1973 and meets at least one of the following criteria:

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

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

(ii) Continues to reside in the institution; and

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

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

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

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

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

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

(v) Meets the MABD nonfinancial criteria.

(3) An individual who was eligible for Medicaid in December 1973 as an essential spouse of an aged, blind, or disabled individual who was receiving cash assistance, if the following conditions are met:[34]

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

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

(j) Individual eligible for AABD in August 1972[35]

[34] An "essential spouse" is defined as one who is living with the individual, whose needs were included in determining the amount of SSI or SSI/AABD payment to an aged, blind, or disabled individual living with the essential spouse, and who is determined essential to the individual's well-being.

[35] See 42 CFR § 435.134.

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(1) An individual who meets the following conditions:

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

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

(2) An individual in this group must:

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

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

(iii) Meet the MABD nonfinancial criteria.

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

(1) [Reserved]

(2) Individual who would be eligible for cash assistance if they were not in a medical institution[36]

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

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

(A) Is ineligible for SSI/AABD because of lower income standards used under the program to determine eligibility for institutionalized individuals; but

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

(3) Individual living in a medical institution eligible under a special income level.[37] An aged, blind or disabled individual who is living in a medical institution and who:

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

(ii) Has MABD income for the individual's financial responsibility group (as defined in § 29.03) that does not exceed 300 percent of the maximum SSI federal payment to an individual living

[36] 42 CFR § 435.211.

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

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independently in the community (institutional income standard (IIS));[38]

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

(iv) Meets the MABD non-financial criteria.

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

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

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

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

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

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

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

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

(6) Disabled child in home care (DCHC, Katie Beckett).[39] A disabled individual who:

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

(A) For purposes of this part:

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

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

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

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

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

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

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

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

(iv) Is age 18 or younger;

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

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

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

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

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

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

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

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

(a) In general.[40] An individual who would be a member of a categorically-needy coverage group, as described in § 8.05, may qualify for MABD as medically needy even if their income or resources exceed coverage group limits.

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

[40] Former Medicaid Rule 4203.

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(c) Resource standard. To qualify for this coverage group, an individual must have MABD resources for the individual's financial responsibility group that are at or below the SSI/AABD maximum for the individual's Medicaid group, or, as described in paragraph (d) of this subsection, they incur enough expenses to reduce their resources to that level.

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

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

(a) In general

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

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

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

(b) Coverage groups

(1) Qualified Medicare Beneficiaries (QMB)[41]

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

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

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

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

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

(iv) Retroactive eligibility is not available.[42]

(v) *Special income disregard for an individual who is receiving a monthly insurance benefit under Title II of the Social Security Act.* If an individual receives a Title II benefit, any amounts attributable to

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[41] SSA § 1905(p)(1).

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

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the most recent increase in the monthly insurance benefit payable as a result of a Title II cost-of-living adjustment (COLA) is not counted as income until the beginning of the second month following the month of publication of the revised annual FPL. For individuals who have Title II income, the new poverty levels are effective beginning with the month after the last month for which COLAs are disregarded. For individuals without Title II income, the new poverty levels are effective no later than the date of publication in the Federal Register.[43]

(2) Specified Low-Income Medicare Beneficiaries (SLMB)[44]

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

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

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

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

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

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

(v) *Special income disregard for an individual who is receiving a monthly insurance benefit under Title II of the Social Security Act.* If an individual receives a Title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit payable as a result of a Title II cost-of-living adjustment (COLA) is not counted as income until the beginning of the second month following the month of publication of the revised annual FPL. For individuals who have Title II income, the new poverty levels are effective beginning with the month after the last month for which COLAs are disregarded. For individuals without Title II income, the new poverty levels are effective no later than the date of publication in the Federal Register.[45]

(3) Qualified Individuals (QI-1)[46]

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

[44] SSA § 1902(a)(10)(E)(iii).

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

[46] SSA § 1902(a)(10)(E)(iv).

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

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

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

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

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

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

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

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

(B) The retroactive period is no earlier than January 1 of that calendar year.[47]

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

(4) <u>Qualified Disabled and Working Individuals (QDWI)</u>

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

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

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

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

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

(E) Is not otherwise eligible for Medicaid.

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

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

[47] CMS State Medicaid Manual, § 3492.

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9.00 Special Medicaid groups (01/01/2023, GCR 22-030)

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

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

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

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

(a) Social Security number (§ 16.00);

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

(c) Residency (§ 21.00);

(d) Living arrangements (§ 20.00);

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

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

9.03 Categorical and financial criteria (01/01/2023, GCR 22-030)

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

(b) Deemed newborn[48]

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

(2) Eligibility

(i) Medicaid coverage will be provided to a child from birth until the child's first birthday without application if, on the date of the child's birth, the child's mother was eligible for and received covered services under Medicaid or CHIP (including during a retroactive period of eligibility under § 70.01(b)) regardless of whether payment for services for the mother is limited to services necessary to treat an emergency medical condition, as defined in § 17.02(d);[49]

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

[48] 42 CFR § 435.117.

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

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termination of the child's eligibility) until the child's first birthday.

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

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

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

(vi) There are no Medicaid income or resource standards that apply.

(3) Medicaid identification number

(i) The Medicaid identification number of the child's mother serves as the child's identification number, and all claims for covered services provided to the child may be submitted and paid under such number, unless and until AHS issues the child a separate identification number in accordance with (3)(ii) of this paragraph.

(ii) AHS will issue a separate Medicaid identification number for the child prior to the effective date of any termination of the mother's eligibility or prior to the date of the child's first birthday, whichever is sooner, unless the child is determined to be ineligible (such as, because the child is not a state resident), except that AHS will issue a separate Medicaid identification number for the child promptly after it is notified of a child under 1 year of age residing in the state and born to a mother whose coverage is limited to services necessary for the treatment of an emergency medical condition, consistent with § 17.02(c).

(c) Children with adoption assistance, foster care, or guardianship care under title IV-E[50]

(1) Basis. This sub clause implements §§ 1902(a)(10)(A)(i)(I) and 473(b)(3) of the Act.

(2) Eligibility. Medicaid coverage will be provided to an individual under age 21, living in Vermont for whom:

(i) An adoption assistance agreement is in effect with a state or tribe under Title IV-E of the Act, regardless of whether adoption assistance is being provided or an interlocutory or other judicial decree of adoption has been issued; or

(ii) Foster care or kinship guardianship assistance maintenance payments are being made by a state or tribe under Title IV-E of the Act.

(3) Income standard. There is no Medicaid income standard that applies. Committed children in the custody of the state who are not IV-E eligible must pass the applicable eligibility tests before their eligibility for Medicaid can be established.

[50] 42 CFR § 435.145.

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(d) Special needs adoption[51]

(1) Basis. This sub clause implements § 1902(a)(10)(A)(ii)(VIII) of the Act.

(2) Eligibility. Medicaid coverage will be provided to an individual under age 21:

(i) For whom an adoption assistance agreement (other than an agreement under Title IV-E of the Act) between a state and the adoptive parent or parents is in effect;

(ii) Whom the state agency which entered into the adoption agreement determined could not be placed for adoption without Medicaid coverage because the child has special needs for medical or rehabilitative care; and

(iii) Who, prior to the adoption agreement being entered into, was eligible for Medicaid.

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

(e) Former foster child[52]

(1) Basis. This sub clause implements § 1902(a)(10)(A)(i)(IX) of the Act.

(2) Eligibility. Medicaid coverage will be provided to an individual who:

(i) Is under age 26; and

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

(A) Is not eligible and enrolled for mandatory coverage under §§ 7.03(a)(1), (2), (3), (6), (7); 8.05(a), (b), (c), (f), (h), (i), (j); or 9.03(c); and

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

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

(A) Is not eligible and enrolled for mandatory coverage under §§ 7.03(a)(1), (2), (3), (6), (7); 8.05(a), (b), (c), (f), (h), (i), (j); or 9.03(c); and

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

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

[51] 42 CFR § 435.227.

[52] 42 CFR § 435.150; SSA § 1902(a)(10)(A)(i)(IX).

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(f) Individual with breast or cervical cancer[53]

(1) Basis. This sub clause implements §§ 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.

(2) Eligibility

(i) Medicaid coverage will be provided to an individual who:

(A) Is under age 65;

(B) Is not eligible and enrolled for mandatory coverage under the state's Medicaid State plan;

(C) Has been determined to need treatment for breast or cervical cancer through a screening under the Centers for Disease Control and Prevention (CDC) breast and cervical cancer early detection program (BCCEDP);[54] and

(D) Does not otherwise have creditable coverage, as defined in § 2704(c) of the PHS Act, for treatment of their breast or cervical cancer. Creditable coverage is not considered to be available just because the individual may:

(I) Receive medical services provided by the Indian Health Service, a tribal organization, or an Urban Indian organization; or

(II) Obtain health insurance coverage only after a waiting period of uninsurance.

(ii) An individual whose eligibility is based on this group is entitled to full Medicaid coverage; coverage is not limited to coverage for treatment of breast and cervical cancer.

(iii) Medicaid eligibility for an individual in this group begins following the screening and diagnosis and continues as long as a treating health professional verifies the individual is in need of cancer treatment services.

(iv) There is no waiting period of prior uninsurance before an individual who has been screened can become eligible for Medicaid under this group.

(3) Treatment need. An individual is considered to need treatment for breast or cervical cancer if, in the opinion of the individual's treating health professional (i.e., the individual who conducts the screen or any other health professional with whom the individual consults), the screen (and diagnostic evaluation following the clinical screening) determines that:

(i) Definitive treatment for breast or cervical cancer is needed, including a precancerous condition or

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[53] 42 CFR § 435.213; CMS State Health Official Letter, dated January 4, 2001, available at http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/sho010401.pdf.

[54] A woman is considered to have been screened and eligible for this group if she has received a screening mammogram, clinical breast exam, or Pap test; or diagnostic services following an abnormal clinical breast exam, mammogram, or Pap test; and a diagnosis of breast or cervical cancer or of a pre-cancerous condition of the breast or cervix as the result of the screening or diagnostic service.

early stage cancer, and which may include diagnostic services as necessary to determine the extent and proper course of treatment; and

(ii) More than routine diagnostic services or monitoring services for a precancerous breast or cervical condition are needed.

(4) Income standard. In order to qualify for screening under (f)(2)(i)(C) above, an individual must be determined by BCCEDP to have limited income. In addition to meeting the criteria described in this sub clause, the individual must meet all other Medicaid nonfinancial criteria.

(g) Family planning services[55]

(1) Basis. This sub clause implements §§ 1902(a)(10)(A)(ii)(XXI) and 1902(ii) and clause (XVI) in the matter following 1902(a)(10)(G) of the Act.

(2) Eligibility. Medicaid coverage of the services described in (g)(4) of this sub clause will be provided to an individual (male and female) who meets all of the following requirements:

(i) Is not pregnant; and

(ii) Meets the income eligibility requirements under (g)(3) of this sub clause.

(3) Income standard. The individual has MAGI-based household income (as defined in § 28.03) that is at or below the income standard for a pregnant woman as described in § 7.03(a)(2). The individual's household income is determined in accordance with § 28.03(j).

(4) Covered services. An individual eligible under this sub clause is covered for family planning and family planning-related benefits.

(h) HIV/AIDS. See, HIV/AIDS Rule 5800 *et seq.*

(i) Refugee Medical Assistance. See, Refugee Medical Assistance Rule 5100 *et seq.*

10.00 Pharmacy benefits (01/15/2017, GCR 16-095)

10.01 VPharm program (01/15/2017, GCR 16-095)

The VPharm program rules located in Rule 5400 *et seq.* will remain in effect.

10.02 Healthy Vermonter Program (HVP) (01/15/2017, GCR 16-095)

The Healthy Vermonter Program (HVP) rules located in Rule 5700 *et seq.* will remain in effect.

11.00 Enrollment in a QHP (01/15/2017, GCR 16-095)

[55] 42 CFR § 435.214.

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

Eligibility for enrollment in a QHP.[56] An individual is eligible for enrollment in a QHP if the individual meets the nonfinancial criteria outlined in this section.

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

The individual must meet all of the following nonfinancial criteria:

(a) Citizenship, status as a national, or lawful presence (§ 17.00). The individual must be reasonably expected to be a citizen, national, or a non-citizen who is lawfully present for the entire period for which enrollment is sought;

(b) Incarceration (§ 19.00); and

(c) Residency (§ 21.00).

11.03 Eligibility for QHP enrollment periods[57] (01/15/2017, GCR 16-095)

An individual is eligible for a QHP enrollment period if they meet the criteria for an enrollment period, as specified in § 71.00.

12.00 Advance payments of the premium tax credit (APTC) (01/01/2018, GCR 17-044)

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

A tax filer is eligible for APTC on behalf of an individual if the tax filer meets the criteria outlined in this section. A tax filer must be eligible for APTC on behalf of an individual in order for the individual to receive the Vermont Premium Reduction. APTC and the Vermont Premium Reduction are paid directly to the QHP issuer on behalf of the tax filer.

12.02 Nonfinancial criteria[58] (01/15/2017, GCR 16-095)

An applicable tax filer (within the meaning of § 12.03) is eligible for APTC for any month in which one or more individuals for whom the tax filer expects to claim a personal exemption deduction on their tax return for the benefit year, including the tax filer and their spouse:

(a) Meets the requirements for eligibility for enrollment in a QHP, as specified in § 11.00; and

(b) Is not eligible for MEC (within the meaning of § 23.00) other than coverage in the individual market.

[56] 45 CFR § 155.305(a).

[57] 45 CFR § 155.305(b).

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

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12.03 Applicable tax filer[59] (01/01/2018, GCR 17-044)

(a) In general. Except as otherwise provided in this subsection, an applicable tax filer is a tax filer who expects to have household income of at least 100 percent but not more than 400 percent of the FPL for the tax filer's family size for the benefit year.

For purposes of calculating the household income of an applicable tax filer and determining their financial eligibility for APTC, see § 28.05.

(b) Married tax filers must file joint return

(1) Except as provided in (2) below, a tax filer who is married (within the meaning of 26 CFR § 1.7703-1) at the close of the benefit year is an applicable tax filer only if the tax filer and the tax filer's spouse file a joint return for the benefit year.

(2) *Victims of domestic abuse and spousal abandonment:* Except as provided in (5) below, a married tax filer will satisfy the joint filing requirement if the tax filer files a tax return using a filing status of married filing separately and:

(i) Is living apart from their spouse at the time they file their tax return;

(ii) Is unable to file a joint return because they are a victim of domestic abuse as defined in (3) below or spousal abandonment as defined in (4) below; and

(iii) Certifies on their tax return, in accordance with the relevant instructions, that they meet the criteria under (i) and (ii) above.

(3) *Domestic abuse*. Domestic abuse includes physical, psychological, sexual, or emotional abuse, including efforts to control, isolate, humiliate and intimidate, or to undermine the victim's ability to reason independently. All the facts and circumstances are considered in determining whether an individual is abused, including the effects of alcohol or drug abuse by the victim's spouse. Depending on the facts and circumstances, abuse of the victim's child or another family member living in the household may constitute abuse of the victim.

(4) *Abandonment*. The tax filer is a victim of spousal abandonment for the taxable year if, taking into account all facts and circumstances, the tax filer is unable to locate their spouse after reasonable diligence.

(5) *Three-year rule*. Paragraph (2) above does not apply if the tax filer met the requirements of the paragraph for each of the three preceding taxable years.

(c) Tax dependent. An individual is not an applicable tax filer if another tax filer may claim a deduction under 26 USC § 151 for the individual for a benefit year beginning in the calendar year in which the individual's benefit year begins.

[59] 26 CFR § 1.36B-2(b); 45 CFR § 155.305.

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(d) Individual not lawfully present or incarcerated.[60] An individual who is not lawfully present in the United States or is incarcerated (other than incarceration pending disposition of charges) is not eligible to enroll in a QHP through VHC. However, the individual may be an applicable tax filer for purposes of claiming the premium tax credit if a family member is eligible to enroll in a QHP.

(e) Individual lawfully present. An individual is also an applicable tax filer if:

(1) The tax filer would be an applicable tax filer but for income;

(2) The tax filer expects to have household income of less than 100 percent of the FPL for the tax filer's family size for the benefit year for which coverage is requested;

(3) One or more applicants for whom the tax filer expects to claim a personal exemption deduction on their tax return for the benefit year, including the tax filer and spouse, is a non-citizen who is lawfully present and ineligible for Medicaid by reason of immigration status.

(f) Special rule for tax filers with household income below 100 percent of the FPL for the benefit year.[61] A tax filer (other than a tax filer described in paragraph (e) of this subsection) whose household income for a benefit year is less than 100 percent of the FPL for the tax filer's family size is treated as an applicable tax filer for purposes of claiming the premium tax credit if:

(1) The tax filer or a family member enrolls in a QHP through VHC for one or more months during the taxable year;

(2) AHS estimates at the time of enrollment that the tax filer's household income will be at least 100 but not more than 400 percent of the FPL for the benefit year;

(3) APTCs are authorized and paid for one or more months during the benefit year; and

(4) The tax filer would be an applicable tax filer if the tax filer's household income for the benefit year was at least 100 but not more than 400 percent of the FPL for the tax filer's family size.

(g) Computation of premium-assistance amounts for tax filers with household income below 100 percent of the FPL. If a tax filer is treated as an applicable tax filer under paragraph (e) or (f) of this subsection, the tax filer's actual household income for the benefit year is used to compute the premium-assistance amounts under § 60.00.

12.04 Enrollment required[62] (01/15/2017, GCR 16-095)

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[60] See, ACA §§ 1312(f)(1)(B) and 1312(f)(3) (42 USC § 18032(f)(1)(B) and (f)(3)) and 26 CFR § 1.36B-2(b)(4).

[61] 26 CFR § 1.36B-2(b)(6).

[62] 45 CFR § 155.305(f)(3).

APTC will only be provided on behalf of a tax filer if one or more individuals for whom the tax filer attests that they expect to claim a personal exemption deduction for the benefit year, including the tax filer and spouse, is enrolled in a QHP.

12.05 Compliance with filing requirement[63] (01/15/2017, GCR 16-095)

AHS may not determine a tax filer eligible for APTC if HHS notifies AHS as part of the process described in § 56.03 that APTCs were made on behalf of the tax filer or either spouse if the tax filer is a married couple for a year for which tax data would be utilized for verification of household income and family size in accordance with § 56.01(a), and the tax filer or their spouse did not comply with the requirement to file an income tax return for that year as required by 26 USC § 6011, 6012, and implementing regulations, and reconcile the APTCs for that period.

12.06 Vermont Premium Reduction eligibility criteria (01/15/2017, GCR 16-095)

An individual is eligible for the Vermont Premium Reduction if the individual:

(a) Meets the requirements for eligibility for enrollment in a QHP, as specified in § 11.00;

(b) Meets the requirements for APTC, as specified in this § 12.00; and

(c) Is expected to have household income, as defined in § 28.05(c), that does not exceed 300 percent of the FPL for the benefit year for which coverage is requested.

13.00 Cost-sharing reductions (CSR) (01/15/2017, GCR 16-095)

13.01 Eligibility criteria[64] (01/15/2017, GCR 16-095)

(a) An individual is eligible for federal and/or state CSR if the individual:

(1) Meets the requirements for eligibility for enrollment in a QHP, as specified in § 11.00;

(2) Meets the requirements for APTC, as specified § 12.00; and

(3) Is expected to have household income, as defined in § 28.05(c), that does not exceed 300 percent of the FPL for the benefit year for which coverage is requested.

(b) An individual who is not an Indian may receive CSR only if they are enrolled in a silver-level QHP.

13.02 Eligibility categories[65] (01/15/2017, GCR 16-095)

[63] 45 CFR § 155.305(f)(4).

[64] 45 CFR § 155.305(g).

[65] 45 CFR § 155.305(g)(2).

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The following eligibility categories for CSR will be used when making eligibility determinations under this section:

(a) An individual who is expected to have household income at least 100 but not more than 150 percent of the FPL for the benefit year for which coverage is requested, or for an individual who is eligible for APTC under § 12.03(e), household income less than 100 percent of the FPL for the benefit year for which coverage is requested;

(b) An individual who is expected to have household income greater than 150 but not more than 200 percent of the FPL for the benefit year for which coverage is requested;

(c) An individual who is expected to have household income greater than 200 but not more than 250 percent of the FPL for the benefit year for which coverage is requested; and

(d) An individual who is expected to have household income greater than 250 but not more than 300 percent of the FPL for the benefit year for which coverage is requested.

Income and benefit levels are as shown in the chart below. The actuarial value of the plan must be within one percentage point of the actuarial value listed below.

Income as a Percent of Federal Poverty Level	Tier	Actuarial Value of Plan with Federal and State CSR
Not more than 150%	I	94%
More than 150% but not more than 200%	II	87%
More than 200% but not more than 250%	III	77%
More than 250% but not more than 300%	IV	73%

13.03 Special rule for family policies[66] (01/15/2017, GCR 16-095)

To the extent that an enrollment in a QHP under a single policy covers two or more individuals who, if they were to enroll in separate policies would be eligible for different cost sharing, AHS will deem the individuals under such policy to be collectively eligible only for the category of eligibility last listed below for which all the individuals covered by the policy would be eligible.

(a) Individuals not eligible for changes to cost sharing;

[66] 45 CFR § 155.305(g)(3).

Final Proposed

(b) § 59.02 (Special cost-sharing rules for Indians, regardless of income);

(c) § 13.02(d);

(d) § 13.02(c);

(e) § 13.02(b);

(f) § 13.02(a);

(g) § 59.01 (Eligibility for CSR for Indians).

Example: Person A is the mother of Person B, her 24-year-old son. Person A and Person B both work and file taxes separately. However, they are covered under the same QHP. Person A's income is equal to 125 percent of the FPL and Person B's income is 225 percent of the FPL. Since Person B's income is at the 225 percent level, the CSR that Person A and Person B will receive will be that available at the 225 percent level, which is in the 200 percent to 250 percent range.

14.00 Eligibility for enrollment in a catastrophic plan[67] (01/01/2018, GCR 17-044)

An individual is eligible for enrollment in a catastrophic plan[68] if they have met the requirements for eligibility for enrollment in a QHP, as specified in § 11.00, and they:

(a) Have not attained the age of 30 before the beginning of the plan year; or

(b) Have a certification in effect for any plan year that they are exempt from the requirement to maintain MEC by reason of hardship, including coverage being unaffordable (see § 23.06(a)).

Final Proposed

[67] 45 CFR § 155.305(h).

[68] 45 CFR § 156.155.

VERMONT **GENERAL ASSEMBLY**

The Vermont Statutes Online

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.)

VERMONT **GENERAL ASSEMBLY**

The Vermont Statutes Online

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.)

VERMONT **GENERAL ASSEMBLY**

The Vermont Statutes Online

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.)

Proposed Rules Postings
A Service of the Office of the Secretary of State

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Deadline For Public Comment

Deadline: Aug 24, 2022

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

Rule Details

Rule Number:	22P015
Title:	Health Benefits Eligibility and Enrollment Rule, Eligibility Standards (Part 2).
Type:	Standard
Status:	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:	This proposed rulemaking amends Parts 1, 2, 3, 5, and 7 of the 8-part Health Benefits Eligibility and Enrollment (HBEE) rule. Parts 1, 5 and 7 were last amended effective October 1, 2021. Parts 2 and 3 were last amended effective January 15, 2019. Substantive revisions include: codifying the annual open enrollment period for qualified health plans from November 1 - January 15; adding a new income-based special enrollment period for qualified health plans that allows ongoing enrollment for those at or below 200 of the Federal Poverty Level (FPL); extending the Medicaid postpartum period for pregnant women from 60 days to 12 months; adding Compacts of Free Association (COFA) migrants as qualified non-citizens eligible for Medicaid and exempt from the 5-year bar; and expanding Medicaid eligibility for former foster care children to include children aging out of foster care in another state.

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 COPIES OF FILINGS MAY BE REQUESTED OR WHO MAY ANSWER QUESTIONS ABOUT FORMS SUBMITTED FOR FILING IF DIFFERENT FROM THE PRIMARY CONTACT PERSON.

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SEND A COMMENT

Keyword Information

Keywords:

- HBEE
- Health Benefits Eligibility and Enrollment
- Vermont Health Connect
- Exchange
- Medicaid
- QHP
- Qualified Health Plan
- Health Benefit
- Pregnant
- Foster Care
- Special Enrollment Period
- SEP
- Annual Open Enrollment Period
- AOEP
- Post Partum

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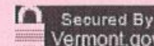

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	Vermont Lawyer (hunter.press.vermont@gmail.com)	Attn: Will Hunter

FROM: APA Coordinator, VSARA **Date of Fax:** July 12, 2022

RE: The "Proposed State Rules " ad copy to run on **July 21, 2022**

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 five 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 rule(s) you are interested in.

- Health Benefits Eligibility and Enrollment Rule, General Provisions and Definitions (Part 1). - 22P014
- Health Benefits Eligibility and Enrollment Rule, Eligibility Standards (Part 2). - 22P015
- Health Benefits Eligibility and Enrollment Rule, Nonfinancial Eligibility Requirements (Part 3). - 22P016
- Health Benefits Eligibility and Enrollment Rule, Financial Methodologies (Part 5). - 22P017
- Health Benefits Eligibility and Enrollment Rule, Eligibility-and-Enrollment Procedures (Part 7). - 22P018

AGENCY: Agency of Human Services

CONCISE SUMMARY: This proposed rulemaking amends Parts 1, 2, 3, 5, and 7 of the 8-part Health Benefits Eligibility and Enrollment (HBEE) rule. Parts 1, 5 and 7 were last amended effective October 1, 2021. Parts 2 and 3 were last amended effective January 15, 2019. Substantive revisions include: codifying the annual open enrollment period for qualified health plans from November 1 - January 15; adding a new income-based special enrollment period for qualified health plans that allows ongoing enrollment for those at or below 200% of the Federal Poverty Level (FPL); extending the Medicaid postpartum period for pregnant women from 60 days to 12 months; adding Compacts of Free Association (COFA) migrants as qualified non-citizens eligible for Medicaid and exempt from the 5-year bar; and expanding Medicaid eligibility for former foster care children to include children aging out of foster care in another state.

FOR FURTHER INFORMATION, CONTACT: Danielle Fuoco, Agency of Human Services, 280 State Drive, Center Building, Waterbury, Vermont 05671-1000 Tel: 802-585-4265 Fax: 802-241-0450 Email: 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, Center Building, Waterbury, Vermont 05671-1000 Tel: 802-585-0454 Fax: 802-241-0450 Email: jessica.ploesser@vermont.gov.