FINAL PROPOSED RULE # 22-P17

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, Financial Methodologies (Part 5)

/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

1. TITLE OF RULE FILING:
   Health Benefits Eligibility and Enrollment Rule, Financial Methodologies (Part 5)
2. PROPOSED NUMBER ASSIGNED BY THE SECRETARY OF STATE
   22P017
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

VERMONT

State of Vermont
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280 State Drive
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[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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OFFICE OF THE SECRETARY
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JENNEY SAMUELSON
SECRETARY

TODD W. DALOZ
DEPUTY SECRETARY

STATE OF VERMONT
AGENCY OF HUMAN SERVICES

MEMORANDUM

TO: Jim Condos, Secretary of State

FROM: Jenney Samuelson, Secretary, Agency of Human Services

DATE: April 1, 2022

SUBJECT: Signatory Authority for Purposes of Authorizing Administrative Rules

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

Cc: Todd W. Daloz

State of Vermont
Agency of Human Services
280 State Drive
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Jenney Samuelson, Secretary
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[fax] 802-241-0450

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.

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, Financial Methodologies (Part 5)
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.

State of Vermont
Agency of Administration
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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.

Proposed Rule: Health Benefits Eligibility and Enrollment Rule, Financial Methodologies (Part 5), 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.'

Economic Impact Analysis

Instructions:

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

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

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

1. TITLE OF RULE FILING:

   Health Benefits Eligibility and Enrollment Rule, Financial Methodologies (Part 5)

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

1. TITLE OF RULE FILING:

   Health Benefits Eligibility and Enrollment Rule, Financial Methodologies (Part 5)

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:

1. TITLE OF RULE FILING:

   Health Benefits Eligibility and Enrollment Rule, Financial Methodologies (Part 5)

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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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.

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[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.

Arimotake Text

Table of Contents

Part Five
Financial Methodologies

Part Five describes the financial standards and methodologies, including income and resource tests, that apply to the various health-benefits programs and categories of assistance.

28.00 Financial eligibility standards – application of modified adjusted gross income (MAGI) (10/01/2021, GCR 20-002)

28.01 Basis, scope, and implementation[1] (01/15/2019, GCR 18-063)

(a) This section implements § 1902(e)(14) of the Act.

(b) The financial methodologies set forth in this section will be applied in determining the financial eligibility of all individuals for health benefits, except for individuals identified in paragraph (i) of § 28.03.

28.02 Definitions (01/15/2017, GCR 16-098)

For purposes of this section:

(a) Family size[2]

(1) The number of persons counted as members of the individual's household. Family size may include individuals who are not subject to or are exempt from penalty for failing to maintain MEC.

(2) Special counting rule for Medicaid: In the case of determining the family size of a pregnant woman, or the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted as herself plus the number of children she is expected to deliver.

(b) Modified Adjusted Gross Income (MAGI).[3] Adjusted gross income (within the meaning of § 62 of the Code) increased by:

(1) Amounts excluded from gross income for citizens or residents of the United States living abroad;

(2) Tax-exempt interest the tax filer receives or accrues during the benefit year; and

(3) Social Security benefits not already included in adjusted gross income.

[1] 42 CFR § 435.603(a).

[2] 26 CFR § 1.36B-1(d); 42 CFR § 435.603(b). Note: The IRS rules do not include unborn children in the determination of family size.

[3] 26 CFR § 1.36B-1(e)(2); 42 CFR 435.4; 45 CFR § 155.300. These sections reference § 36B(d)(2)(B) of the Code. This is the definition found in that provision.

28.03 MAGI-Based Medicaid (10/01/2021, GCR 20-002)

(a) Definition: Tax dependent. For purposes of MAGI-based Medicaid, the term "tax dependent" has the same meaning as the term "dependent" under § 152 of the Code, and also includes an individual for whom another individual claims a deduction for a personal exemption under § 151 of the Code for the benefit year.[4]

(b) Basic rule.[5] Except as specified in paragraphs (h), (i), and (j) of this subsection, financial eligibility for MAGI-based Medicaid is determined based on household income, as defined in paragraph (c) of this subsection. Household composition is determined separately for each individual; see paragraph (e) of this subsection for details on household composition.

(c) Household income[6]

(1) General rule. Except as provided in paragraphs (c)(2) through (c)(4) of this subsection, household income for MAGI-based Medicaid is the sum of the MAGI-based income, as defined in paragraph (d) of this subsection, of every person included in the individual's household, as defined in paragraph (e) of this subsection.

(2) Income of children and tax dependents

(i) The MAGI-based income of a person who is included in the household of their natural, adopted, or step-parent, and is not expected to be required to file a federal tax return[7] for the benefit year in which eligibility for Medicaid is being determined, is not included in household income whether or not such person files a federal tax return.

(ii) The MAGI-based income of a tax dependent described in paragraph (e)(3)(i) of this subsection (individual other than a spouse or child who expects to be claimed as a tax dependent by another tax filer) who is not expected to be required to file a federal tax return[8] for the benefit year in which eligibility for Medicaid is being determined, is not included in the household income of the tax filer whether or not such tax dependent files a federal tax return.

(3) Available cash support not included. In the case of an individual described in paragraph (e)(3)(i) of this subsection (individual other than a spouse or child who expects to be claimed as a tax dependent by another tax filer), household income does not include cash support provided by the person claiming such individual as a tax dependent.

(4) Five-percent disregard. Effective January 1, 2014, in determining the eligibility of an individual for

[4] 42 CFR § 435.4

[5] 42 CFR § 435.603(c).

[6] 42 CFR § 435.603(d).

[7] As required under section 6012(a)(1) of the Code.

[8] *Id*

Medicaid under the eligibility group with the highest income standard under which the individual may be determined eligible using MAGI-based methodologies, an amount equivalent to 5 percentage points of the FPL for the applicable family size is deducted from household income.

(5) Sponsored noncitizens

(i) In determining the financial eligibility of a noncitizen who is admitted to the United States on or after August 22, 1996, based on a sponsorship under § 204 of the INA, the income of the sponsor and the sponsor's spouse, if living with the sponsor, must be counted as available to the noncitizen when all four of the conditions set forth in (A) through (D) below are met. The responsibility of a sponsor continues until the noncitizen is naturalized or credited with 40 qualifying quarters of coverage by the SSA (as described in (ii) below). Children and pregnant women who are exempt from the five-year bar pursuant to § 17.03(c)(6) are not subject to these provisions. The four conditions are as follows:

(A) The sponsor has signed an affidavit of support on a form developed by the United States Attorney General as required by PRWORA to conform to the requirements of § 213A(b) of INA;

(B) The noncitizen is lawfully admitted for permanent residence, and a five-year period of ineligibility for Medicaid following entry to the United States has ended;

(C) The noncitizen is not battered; and

(D) The noncitizen is not indigent, defined as unable to obtain food and shelter without assistance, because his or her sponsor is not providing adequate support.

(ii) *Qualifying quarters of coverage.*

(A) A noncitizen is credited with the following qualifying quarters of coverage (as defined under Title II of the Act);

(I) All of the qualifying quarters of coverage worked by the noncitizen;

(II) All of the qualifying quarters of coverage worked by a parent of such noncitizen while the noncitizen was under age 18; and

(III) All of the qualifying quarters of coverage worked by a spouse of such noncitizen during their marriage as long as the noncitizen remains married to such spouse or such spouse is deceased.

(B) No qualifying quarter of coverage for any period beginning after December 31, 1996 may be credited to a noncitizen under (II) or (III) above if the parent or spouse, as the case may be, of such noncitizen received any federal means-tested public benefit during the period for which the qualifying quarter of coverage is credited. Federal means-tested benefits for this purpose do not include:

(I) Emergency medical assistance;

(II) Short-term, non-cash, in-kind emergency disaster relief;

(III) Assistance under the National School Lunch Act or the Child Nutrition Act of 1966:

(IV) Public health assistance for immunizations or testing and treatment of symptoms of communicable diseases not paid by Medicaid;

(V) Payments for foster care and adoption assistance under parts B and E of Title IV of the Act, under certain conditions;

(VI) Programs, services or assistance specified by the Attorney General;

(VII) Programs of student assistance under Titles IV, V, IX and X of the Higher Education Act of 1965, and Titles III, VII and VIII of the PHS Act;

(VIII) Means-tested programs under the Elementary and Secondary Education Act of 1965;

(IX) Benefits under the Head Start Act; or

(X) Benefits under the Job Training Partnership Act.

(d) MAGI-based income.[9] For the purposes of this subsection, MAGI-based income means income calculated using the same financial methodologies used to determine MAGI, with the following exceptions:

(1) An amount received as a lump sum is counted as income only in the month received unless otherwise required by federal law with respect to qualified lottery and gambling winnings of $80,000 or greater.[10]

(2) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are excluded from income.

(3) *American Indian/Alaska Native exceptions.* The following are excluded from income:

(i) Distributions from Alaska Native Corporations and Settlement Trusts;

(ii) Distributions from any property held in trust, subject to federal restrictions, located within the most recent boundaries of a prior federal reservation, or otherwise under the supervision of the Secretary of the Interior;

(iii) Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from:

(A) Rights of ownership or possession in any lands described in paragraph (d)(3)(ii) of this subsection; or

(B) Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources;

(iv) Distributions resulting from real property ownership interests related to natural resources and improvements:

(A) Located on or near a reservation or within the most recent boundaries of a prior federal reservation; or

[9] 42 CFR § 435.603(e).

[10] Bipartisan Budget Act of 2018, section 53103; CMS SHO Letter No. 19-003 (August 22, 2019).

(B) Resulting from the exercise of federally-protected rights relating to such real property ownership interests;

(v) Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom;

(vi) Student financial assistance provided under the Bureau of Indian Affairs education programs.

(e) Household

(1) In general. For purposes of household composition:

(i) "Child" includes a natural or biological, adopted or step-child.

(ii) "Parent" includes a natural or biological, adopted or step-parent.

(iii) "Sibling" includes a natural or biological, adopted or step-sibling.

(2) Basic rule for tax filers not claimed as a tax dependent. In the case of an individual who expects to file a federal tax return for the benefit year in which an initial determination or renewal of eligibility is being made, and who does not expect to be claimed as a tax dependent by another tax filer, the household consists of the tax filer and, subject to paragraph (e)(6) of this subsection, all persons whom such individual expects to claim as a tax dependent.

(3) Basic rule for individuals claimed as a tax dependent. In the case of an individual who expects to be claimed as a tax dependent by another tax filer for the benefit year in which an initial determination or renewal of eligibility is being made, the household is the household of the tax filer claiming such individual as a tax dependent, except that the household must be determined in accordance with paragraph (e)(4) of this subsection in the case of:

(i) Individuals who expect to be claimed as a tax dependent by a tax filer who is not the individual's spouse or parent;

(ii) Individuals under the age specified under paragraph (e)(4)(iv) of this subsection who expect to be claimed by one parent as a tax dependent and are living with both parents but whose parents do not expect to file a joint federal tax return; and

(iii) Individuals under the age specified under paragraph (e)(4)(iv) of this subsection who expect to be claimed as a tax dependent by a non-custodial parent. For purposes of this paragraph:

(A) The custodial parent is the parent so named in a court order or binding separation, divorce, or custody agreement establishing physical custody; or

(B) If there is no such order or agreement, or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights.

(4) Rules for individuals who neither file a tax return nor are claimed as a tax dependent. In the case of an individual who does not expect to file a federal tax return and does not expect to be claimed as a tax dependent for the benefit year in which an initial determination or renewal of eligibility is being made, or who is described in paragraph (e)(3)(i), (e)(3)(ii), or (e)(3)(iii) of this subsection, the household consists of

the individual and, if living with the individual:

(i) The individual's spouse;

(ii) The individual's children under the age specified in (iv) of this paragraph (e)(4); and

(iii) In the case of an individual under the age specified in (iv) of this paragraph (e)(4), the individual's parents and siblings under the age specified in (iv) of this paragraph (e)(4).

(iv) The age specified in this paragraph (e)(4) is age 19 or, in the case of a full-time student, age 21.

(5) Couples. In the case of a couple living together, each spouse is included in the household of the other spouse, regardless of whether they expect to file a joint federal tax return[11] or whether one spouse expects to be claimed as a tax dependent by the other spouse.

(6) Households of individuals whom tax filer cannot establish as a dependent. For purposes of paragraph (e)(2) of this subsection, if, consistent with the procedures adopted by the state in accordance with § 56.00, a tax filer cannot reasonably establish that another person is a tax dependent of the tax filer for the benefit year in which Medicaid is sought, the inclusion of such person in the household of the tax filer is determined in accordance with paragraph (e)(4) of this subsection.

(f) No resource test or income disregards.[12] In the case of an individual whose financial eligibility for Medicaid is determined in accordance with this subsection, AHS will not:

(1) Apply any resources test; or

(2) Apply any income or expense disregards under §§ 1902(r)(2) or 1931(b)(2)(C), or otherwise under Title XIX of the Act, except as provided in paragraph (c)(4) of this subsection.

(g) Budget period[13]

(1) Applicants and new enrollees. Financial eligibility for Medicaid for applicants, and other individuals not receiving Medicaid benefits at the point at which eligibility for Medicaid is being determined, must be based on current monthly household income and family size.

(2) Current beneficiaries. For an individual who has been determined financially eligible for Medicaid using the MAGI-based methods set forth in this section, AHS will base financial eligibility on projected annual household income and family size for the remainder of the current calendar year.

(h) Alternative methodology to avoid eligibility gap.[14] If an individual who meets the non-financial eligibility

[11] See, § 6013 of the Code.

[12] 42 CFR § 435.603(g).

[13] 42 CFR § 435.603(h).

[14] 42 CFR § 435.603(i).

requirements for Medicaid is determined to be financially ineligible for Medicaid using the MAGI-based Medicaid methodologies set forth in this subsection, but their household income is determined to be less than 100 percent of the FPL using the MAGI methodologies for determining eligibility for APTC and CSR, as set forth in § 28.05, the individual's eligibility for Medicaid will be determined using the MAGI methodologies set forth in § 28.05.

(i) Eligibility groups for which MAGI-based methods do not apply.[15] The financial methodologies described in this subsection are not applied in determining the Medicaid eligibility of individuals described in this paragraph. Except for the individuals described in (1) of this paragraph (i), the financial methods described in § 29.00 (MABD financial eligibility standards) will be used to determine Medicaid eligibility for such individuals.

(1) Individuals whose eligibility for Medicaid does not require a determination of income, including, but not limited to, individuals receiving SSI eligible for Medicaid under § 8.05(a) and individuals deemed to be receiving SSI and eligible for Medicaid under § § 8.05(c), (f) and (h).

(2) Individuals who are age 65 or older when age is a condition of eligibility.

(3) Individuals whose eligibility is being determined on the basis of being blind or disabled, or on the basis of being treated as being blind or disabled, including, but not limited to, individuals under § 8.05(k)(6)(Katie Beckett) and individuals receiving state supplements, but only for the purpose of determining eligibility on such basis.

(4) Individuals who request that the financial methods described in § 29.00 be used to determine their eligibility for Medicaid coverage of long-term care services and supports.

(5) Individuals who are being evaluated for eligibility for Medicare cost-sharing assistance under § 8.07, but only for purposes of determining eligibility for such assistance.

(j) Special rule: family planning services.[16] In the case of an individual whose eligibility is being determined under § 9.03(g) (family planning services), AHS will:

(1) Consider the household to consist of only the individual for purposes of paragraph (e) of this subsection;

(2) Count only the MAGI-based income of the individual for purposes of paragraph (c) of this subsection; and

(3) Increase the family size of the individual, as defined in § 28.02, by one.

28.04 Medically-needy MCA – income eligibility (01/01/2018, GCR 17-047)

(a) In general. Income eligibility of an individual requesting medically-needy MCA is determined by calculating the individual's MAGI-based income as described in § 28.03(d). The individual's MAGI-based income is then adjusted, if applicable, by apportioning the income of financially responsible family members according to the

[15] 42 CFR § 435.603(j).

[16] 42 CFR § 435.603(k).

requirements set forth in paragraph (b) of this subsection.

For the individuals who may qualify for medically-needy MCA, see § 7.03(a)(8).

(b) Financial responsibility of relatives and other individuals[17]

(1) Financial responsibility of relatives and other persons for the individual is limited to the following:

(i) A spouse for their spouse when both are living in the same household; and

(ii) A parent, step-parent, or adoptive parent for their unmarried child under the age of 21 living in the same household unless the child is pregnant or a parent whose own child is living in the household and they make a monthly (or more frequent) room or board payment to their parents.

(2) Except for a spouse of an individual or a parent for a child who is under age 21, no income or resources of any other relative will be considered as available to the individual.

(3) When a couple ceases to live together, only the income of the individual spouse will be counted in determining their eligibility, beginning the first month following the month the couple ceases to live together.

(c) Spenddown. The income spenddown provisions set forth in § 30.00 apply to an individual requesting medically-needy MCA. For purposes of the spenddown provisions at § 30.00, anyone identified in paragraph (b) above as financially responsible for the individual is considered a member of the individual's financial responsibility group as that term is used throughout § 30.00.

28.05 APTC and CSR (01/15/2017, GCR 16-098)

(a) Definition: Tax dependent. For purposes of APTC and CSR, the term "tax dependent" has the same meaning as the term "dependent" under § 152 of the Code.

(b) Basic rule. Financial eligibility for APTC and CSR is determined based on household income as defined in paragraph (c) of this subsection.

(c) Household income.[18] Household income is the sum of:

(1) A tax filer's MAGI; plus

(2) The aggregate MAGI of all other individuals who:

(i) Are included in the tax filer's household (as defined in paragraph (d) of this subsection); and

(ii) Are required to file a federal income tax return for the benefit year.

[17] 42 CFR § 435.602.

[18] 26 CFR § 1.36B-1(e).

(d) Household. The household consists of the tax filer, the tax filer's spouse (if married within the meaning of 26 CFR § 1.7703-1), and all individuals claimed as the tax filer's tax dependents. As described in § 58.02(b)(2), married couples must file joint federal tax returns in order to be considered for APTC and CSR, unless the tax filer meets the exception criteria defined in § 12.03(b) (victim of domestic abuse or spousal abandonment). Parties to a civil union may qualify for APTC and CSR by filing separate tax returns.

29.00 Financial eligibility standards – Medicaid for the aged, blind, and disabled (MABD) (01/01/2023~~10/01/2021~~, GCR 22-032~~20-002~~)

29.01 Introduction (01/15/2017, GCR 16-098)

An individual who meets the nonfinancial and categorical requirements for MABD must also meet the financial requirements specified in this section. AHS determines financial eligibility for MABD, including Medicaid coverage of long-term care services and supports under MABD.

To determine an individual's financial eligibility for MABD, AHS calculates the countable income and countable resources of the individual's financial responsibility group and compares those amounts to standards based on the size of the individual's Medicaid group. The first step in determining financial eligibility is to identify the members of the individual's financial responsibility group and the members of the individual's Medicaid group. An aged, blind, or disabled individual requesting MABD is always a member of both groups.

The rules for forming the financial responsibility group are specified in § 29.03.

The rules for forming the Medicaid group are specified in § 29.04.

The rules on resources are specified in §§ 29.07 through 29.10.

The rules on income are specified in §§ 29.11 through 29.15.

29.02 Definitions (01/15/2017, GCR 16-098)

As used in this § 29.00, the following terms have the following meanings:

(a) Child

(1) An individual who:

(i) Is under age 18 or is a student under age 22;

(ii) Has always been single; and

(iii) Lives with a parent.

(A) A child is not considered living with a parent when:

(I) The parent has relinquished control to a school or vocational facility;

(II) The child is confined to a public institution or is in the custody of a public agency;

(III) The child is a member of the armed forces;

(IV) The child lives in a private nonmedical facility; or

(V) The child has been admitted to long-term care.

(B) A child away at school who returns to a parent's home for vacations, holidays, or some weekends is considered living with that parent.

(2) An individual who qualifies for the Katie Beckett coverage group (see § 8.05(k)(6)) is not considered a child for the purposes of determining their financial eligibility for MABD.

(3) An individual is no longer considered a child on the first day of the month following the calendar month in which they no longer meet the definition of child.

(b) Adult. An individual who is not a child.

(c) Eligible child. For purposes of deeming, as described in § 29.05, a child who is a natural or adopted child under the age of 18, who lives in a household with one or both parents, is not married, and meets the non-financial eligibility requirements for MABD.

(d) Ineligible child. For deeming purposes, a child, as defined in (a) of this subsection, who does not meet the non-financial criteria for MABD, lives in the same household as the individual requesting MABD, and is:

(1) The natural child or adopted child of the individual;

(2) The natural or adopted child of the individual's spouse, or

(3) The natural or adopted child of the individual's parent or of the spouse of the individual's parent.

(e) Ineligible parent. For deeming purposes, a person who does not meet the non-financial criteria for MABD, lives with an eligible child, and is:

(1) A natural or adoptive parent of the child; or

(2) The spouse of a natural or adoptive parent of the child.

(f) Ineligible spouse. For deeming purposes, the spouse who lives with the individual requesting MABD and does not meet the nonfinancial eligibility criteria for MABD.

29.03 Formation of the financial responsibility group (01/15/2017, GCR 16-098)

(a) In general. The financial responsibility group for MABD consists of the individuals whose income and resources are considered available to the Medicaid group in the eligibility determination. With some exceptions, spouses are considered financially responsible for each other, and parents are considered financially responsible for their children. The following paragraphs set forth the rules for determining membership in the financial responsibility group and the portion of the group's income considered available to the Medicaid group.

(b) Financial responsibility group for an adult. The financial responsibility group for an adult requesting MABD, including Medicaid coverage of long-term care services and supports under MABD, is the same as the adult's

Medicaid group.

(c) Financial responsibility group for a child. The financial responsibility group for a child requesting MABD includes the child and any parents living with the child until the child reaches the age of 18.

(d) Financial responsibility group for a sponsored noncitizen

(1) The financial responsibility group for a noncitizen admitted to the United States on or after August 22, 1996, based on a sponsorship under §204 of the INA, includes the income and resources of the sponsor and the sponsor's spouse, if living with the sponsor, when all four of the conditions set forth in (i) through (iv) below are met. Children and pregnant women who are exempt from the five-year bar pursuant to § 17.03(c)(6) are not subject to these provisions. The four conditions are as follows:

(i) The sponsor has signed an affidavit of support on a form developed by the United States Attorney General as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) to conform to the requirements of §213A(b) of the INA;

(ii) The noncitizen is lawfully admitted for permanent residence, and a five-year period of ineligibility for MABD following entry to the United States has ended;

(iii) The noncitizen is not battered; and

(iv) The noncitizen is not indigent, defined as unable to obtain food and shelter without assistance, because their sponsor is not providing adequate support.

(2) The financial responsibility of a sponsor continues until the noncitizen is naturalized or credited with 40 qualifying quarters of coverage by the SSA (see (3) below for crediting of qualifying quarters).

(3) A non-citizen is credited with the following qualifying quarters of coverage as defined under Title II of the Act:

(i) Those worked by the non-citizen;

(ii) Those worked by a parent of such non-citizen while the non-citizen was under age 18 unless the parent received any federal means-tested public benefit during the period for which the qualifying quarter of coverage is credited after December 31, 1996;

(iii) Those worked by a spouse of the non-citizen while they were spouses, as long as the non-citizen remains the spouse or the spouse is deceased and the spouse did not receive any federal means-tested public benefit during the period for which the qualifying quarter of cover is credited after December 31, 1996;

(iv) For this purpose, federal means-tested benefits do not include:

(A) Emergency medical assistance;

(B) Short-term, non-cash, in-kind emergency disaster relief;

(C) Assistance under the National School Lunch Act or the Child Nutrition Act of 1966;

(D) Public health assistance for immunizations or testing and treatment of symptoms of communicable diseases not paid by Medicaid;

(E) Payments for foster care and adoption assistance under parts B and E of Title IV of the Act, under certain conditions;

(F) Programs, services or assistance specified by the Attorney General;

(G) Programs for student assistance under Titles IV, V, IX, and X of the Higher Education Act of 1965, and Titles III, VII, and VIII of the Public Health Service Act;

(H) Means-tested programs under the Elementary and Secondary Education Act of 1965;

(I) Benefits under the Head Start Act; or

(J) Benefits under the WIA.

29.04 Formation of the Medicaid group (01/15/2017, GCR 16-098)

(a) In general. The Medicaid group consists of individuals whose needs are included in the financial eligibility determination for MABD. The following paragraphs set forth the rules for determining membership in the Medicaid group. AHS compares countable income and resources of the financial responsibility group to maximums based on the size of the Medicaid group.

(b) Medicaid group for a single adult. A single adult requesting MABD, including Medicaid coverage of long-term care services and supports under MABD, is treated as a Medicaid group of one.

(c) Medicaid group for an adult with a spouse

(1) When spouses are living together, both the individual requesting MABD and the individual's spouse are considered members of the individual's Medicaid group, a Medicaid group of two, unless one of the exceptions specified in paragraph (d) of this subsection applies. This is true whether or not the individual's spouse is also requesting MABD.

(2) Spouses are considered living together in any of the following circumstances:

(i) Until the first day of the month following the calendar month of death or separation, when one spouse dies or the couple separates.

(ii) When one spouse is likely to need long-term care for fewer than 30 consecutive days.

(iii) When the resources of the couple are assessed and allocated as of the date of initial application for Medicaid coverage of long-term care services and supports under MABD.

(d) Exceptions for an adult with a spouse. An adult requesting MABD with a spouse is treated as a Medicaid group of one in the following circumstances:

(1) When one spouse is applying for Medicaid coverage of long-term care services and supports under MABD, they are considered a Medicaid group of one for:

(i) The determination of their initial and ongoing income eligibility; and

(ii) Resource reviews of their eligibility.

(iii) AHS considers the spouses to be no longer living together as of the first day of the calendar month one spouse begins receiving Medicaid coverage of long-term care services and supports under MABD. This remains true even if the other spouse begins receiving Medicaid coverage of long-term care services and supports in a subsequent month.

(2) When AHS determines the eligibility of one spouse for MABD when the other spouse already receives Medicaid coverage of long-term care services and supports in a home and community-based setting.

(3) When both spouses are admitted to the same residential care home, each spouse is considered a Medicaid group of one if the residential care home is designed for four or more residents.

(4) When both spouses have been admitted to the same institution for long-term care in the same month and have lived there at least six months beginning with the first month following the month of their admission, for purposes of determining each spouse's eligibility for Medicaid coverage of long-term care services and supports under MABD, each spouse is considered a Medicaid group of one for the determination of their initial and ongoing income eligibility and resource reviews of their eligibility. However, if it works to their advantage, they may be considered a Medicaid group of two.

(5) When one spouse is receiving custodial care in their home, as defined in AABD Rule 2766, they are considered a Medicaid group of one.

(e) Medicaid group for a child

(1) A child requesting MABD is treated as a Medicaid group of one.

(2) When a parent and child living together are both requesting MABD, they are treated as two Medicaid groups of one, if the parent is not living with a spouse. If the parent is living with a spouse, the parent and their spouse are treated as a Medicaid group of two and the child as a Medicaid group of one.

29.05 Deeming (01/15/2017, GCR 16-098)

(a) In general. MABD financial eligibility is based on the financial eligibility rules for the SSA's SSI program. Like SSI, the term "deeming" is used to identify countable resources and income from other people as belonging to the individual requesting MABD. When the deeming rules apply, it does not matter whether the resources or income of the other person are actually available to the individual.

(b) Categories of people whose income and resources are counted

(1) Resources and income from two categories of people may be counted as belonging to the individual. These people are members of the individual's financial responsibility group. AHS considers:

(i) Spousal resources and income to decide whether it must deem some of it to the Medicaid group; and

(ii) Parental resources and income for an eligible child to decide whether it must deem some of it to the Medicaid group.

(2) § 29.10 specifies the resources counted when determining MABD financial eligibility.

(3) § 29.14 specifies the income counted when determining MABD financial eligibility.

29.06 Temporary absences and deeming rules (01/15/2017, GCR 16-098)

(a) Effect of temporary absence. For purposes of deeming, during a temporary absence, the absent person continues to be considered a member of the individual's household.

(b) Definition of temporary absence. A temporary absence occurs when the individual or their ineligible spouse, parent, or an ineligible child leaves the household but intends to and does return in the same month or the next month.

(c) Treatment of absences due to schooling. An eligible child is considered temporarily absent from their parent's (or parents') household if they are away at school but come home on some weekends or lengthy holidays and are subject to the control of their parent(s).

(d) Absences related to active duty assignment. If the individual's ineligible spouse or parent is absent from the household due solely to a duty assignment as a member of the armed forces on active duty, that person is considered to be living in the same household as the individual, unless evidence indicates that the individual's spouse or parent should no longer be considered to be living in the same household. When such evidence exists, AHS stops deeming their resources and income beginning with the month after the spouse or parent no longer lived in the same household.

29.07 Resources (01/15/2017, GCR 16-098)

(a) In general

(1) Resources are cash and other property, real or personal, that an individual (or their spouse, if any):

(i) Owns;

(ii) Has the right, authority or power to convert to cash (if not already cash); and

(iii) Is available for their support and maintenance.

(2) Resources are treated in different ways depending on the rules of the coverage group involved and the type and liquidity of the resource.

(3) Resources are counted based upon their availability and the ease with which they can be converted into cash. Availability is often affected when more than one person has an ownership interest in the same resource.

(4) Resource limits vary depending on the type of category and services, and the size of the Medicaid group. Resource eligibility for each coverage group is determined by comparing the resources of the financial responsibility group to the resource limit based on the size of the Medicaid group. Resource maximums are specified in Vermont's Medicaid Procedures Manual.

(5) All resources of the members of the financial responsibility group must be counted except those

specifically excluded. See § 29.08 for the resource exclusion rules.

(6) Equity value as well as availability is considered when determining the amount of a resource that counts. In general, equity value means the price an item can be reasonably expected to sell for on the local open market minus any encumbrances. See § 29.09 for the general rules on valuing countable resources.

(b) Types of resources. This paragraph describes some of the kinds of resources the availability of which are considered in determining MABD eligibility. The descriptions are divided into two categories – nonliquid resources and liquid resources. Except for cash, any kind of property may be either liquid or nonliquid. The liquidity (or nonliquidity) of a resource has no effect on the resource's countability for MABD eligibility purposes.

(1) Definition: Nonliquid resources. A nonliquid resource means property that is not cash, including real and personal property that cannot be converted to cash within 20 work days. Real property, life estates, life insurance and burial funds, described below, are some of the more common kinds of nonliquid resources. Certain other noncash resources, though they may occasionally be liquid, are nearly always nonliquid. These include, but are not limited to, household goods and personal effects, vehicles, livestock, and machinery.

(i) Real property. Land and generally whatever is erected, growing on, or affixed to land. See § 29.08(a) for information on the resource exclusion of real property.

(ii) Life estates. Life estate means a legal arrangement entitling the owner of the life estate (sometimes referred to as the "life tenant") to possess, rent, and otherwise profit from real or personal property during their lifetime. The owner of a life estate sometimes may have the right to sell the life estate, but does not normally have future rights to the property. Ownership of a life estate may be conditioned upon other circumstances, such as a new spouse. The document granting the life estate includes the conditions for the life estate and the right of the owner of the life estate to sell or bequeath it, if these property rights were retained. See § 29.08(a)(6) for information on the resource exclusion of life estates.

(iii) Life insurance. A contract that provides for its purchaser to pay premiums to the insurer, who agrees to pay a specific sum to a designated beneficiary upon the death of the insured. Life insurance is usually sold by an insurance company but may also be sold by other financial institutions, such as brokerage firms. See § 29.08(b) for information on the resource exclusion of life insurance.

The following are terms related to life insurance:

(A) Face value. The amount the life insurance policy pays the designated beneficiary upon the death of the insured.

(B) Term life insurance. A life insurance policy that does not accumulate any cash value as premiums are paid.

(C) Whole life insurance (sometimes called ordinary life, limited payment or endowment insurance). A life insurance policy that accumulates cash value as premiums are paid. It may also pay periodic dividends on this value when all premiums have been paid. These dividends may be paid to the owner, or they may be added to the cash surrender value (defined below) of the policy.

(D) Cash surrender value (CSV) of whole life insurance. The amount the owner would receive if the life insurance policy were terminated before the insured dies. It is a form of equity that accumulates over time as life insurance premiums are paid. The owner may borrow against the CSV according to the terms of the policy. A loan against a policy reduces its CSV.

(E) Group policy. A life insurance policy that is usually issued through a company or organization insuring the participating employees or members and, perhaps, their families. The group policy may be paid partially by the employer. A group insurance policy generally has no CSV.

(iv) Burial Funds

(A) Any separately-identifiable fund clearly designated for burial expenses (which includes expenses for burial spaces, items related to burial spaces and services related to burial spaces) through the title to the fund or by a sworn statement provided. Burial funds include contracts, trusts, or other agreements, accounts, or instruments with a cash value. Some burial funds include accumulated interest, and the value of some burial funds may change through time (e.g., when the fund consists of bonds). See § 29.08(c) for information on the resource exclusion of burial funds.

(B) The cash value of life insurance policies may also be treated as a burial fund if owned by a person whose income and resources are considered in determining an individual's MABD eligibility and if designated as specified above.

(C) For the purposes of determining MABD eligibility, burial spaces, if not fully paid, are considered burial funds and include burial plots, gravesites, crypts, mausoleums, caskets, urns, and other repositories customarily and traditionally used for the deceased's bodily remains. Items related to burial spaces include, but are not limited to, vaults, headstones, markers, plaques, and burial containers for caskets. Services related to burial include, but are not limited to, embalming, opening and closing of the gravesite, and care and maintenance of the gravesite, sometimes called an endowment or perpetual care.

(2) Definition: Liquid resources. A liquid resource means cash or other property that can be converted to cash within 20 working days. Accounts in financial institutions; retirement funds; stocks, bonds, mutual funds, and money market funds; annuities; mortgages and promissory notes; and home equity conversion plans, described below, are some of the more common kinds of liquid resources.

(i) Accounts in financial institutions

(A) Accounts in depository financial institutions such as banks and credit unions include, but are not limited to, savings accounts, checking accounts, joint fiduciary accounts, and certificates of deposit. Depository institutions may also manage mutual fund and money market fund accounts for depositors.

(B) Nondepository financial institutions, such as brokerage firms, investment firms, and finance companies, also offer certificates of deposits as well as accounts and services related to the purchase and sale of stocks, bonds, mutual funds, money market funds, and other investments.

(ii) Stocks, bonds, and funds

(A) Legal instruments authenticating an investment, such as stocks, bonds, mutual funds, and money market funds pay interest at specified intervals, sometimes pay dividends, and are convertible into cash either on demand or at maturity.

(B) U. S. savings bonds are obligations of the federal government. Unlike other government bonds,

they are not tradable in the usual sense through brokers and security traders and, as described below, the value of the bond depends on its type. See § 29.08(i)(11) for information on the resource exclusion of U.S. savings bonds.

(I) Series E and EE bonds are sold at one half of their face value and increase in redemption value as interest accrues.

(II) Series I bonds are sold at their full face value and increase in redemption value as interest accrues.

(III) Series H and HH bonds are sold at their full face value and do not increase in value. Instead, they pay interest to the owner each six months.

(iii) Annuities. A contract reflecting payment to an insurance company, bank, charitable organization, or other registered or licensed entity; it may also be a private contract between two parties. There are two phases to an annuity: An accumulation phase and a pay-out phase, and their countability as a resource for MABD eligibility purposes is impacted by the phase the annuity is in (see below). Annuities vary in how they accumulate and pay out money. Annuities may accumulate money by payment of a single lump sum or by payments on a schedule, which accumulate interest over time. Once an annuity has reached its pay-out phase (often referred to as "matured"), money is paid to the beneficiary according to the terms of the annuity contract.

(A) Parties to an annuity

(I) There are always two parties to an annuity: The writer of the annuity, usually an insurance carrier or charitable organization, and the purchaser who owns the annuity (sometimes referred to as the annuitant). There may also be a third party to the annuity if someone other than the owner is the annuitant.

(II) In addition, annuities also name a beneficiary. The beneficiary is the person who will be paid a regular stream of income from the annuity in equal payments. Anyone can be a beneficiary, including but not limited to, the owner of the annuity, a spouse, dependent, trust, estate, commercial entity, proprietorship, or charitable organization.

(III) Beneficiaries may be revocable or irrevocable. A revocable beneficiary can be changed by the owner of the annuity at any time. An irrevocable beneficiary can be changed only by the written permission of that beneficiary.

(IV) In addition to the beneficiary described in (II) above, annuities can also provide for a contingent beneficiary or residual beneficiary. A contingent or residual beneficiary will receive annuity payments upon the occurrence of a specified condition.

(B) Types of annuities. There are many types of annuities. For MABD purposes, AHS considers whether annuities of any type are available as a liquid resource. Since annuities are trust-like instruments, terminology similar to trusts is used when it describes the availability of cash from annuities.

(I) Annuity naming revocable beneficiaries. An annuity that names revocable beneficiaries is available to the owner because the owner can change the beneficiary. This type of an annuity is considered a countable resource for purposes of the owner's MABD eligibility. See subsection 29.09(d)(1) for information on how to value an annuity when it is a countable resource.

(II) Annuity that can be surrendered, cashed in or assigned. An annuity that can be surrendered, cashed in or assigned by the owner is presumed to be a revocable annuity. A revocable annuity is considered a countable resource for purposes of the owner's MABD eligibility. An annuity is presumed to be revocable when the annuity contract is silent on revocability. See § 29.09(d)(1) for information on how to value an annuity when it is a countable resource.

(III) Annuity owned by someone other than the applicant or spouse. An annuity is an unavailable resource for purposes of MABD eligibility when the owner of the annuity is not the individual requesting MABD or the individual's spouse, or the individual or their spouse has abandoned all rights of ownership. However, if payments from the annuity are being made to the individual (or spouse), those payments may be counted as income to the individual (or spouse).

(C) Standard of review

(I) For the purposes of MABD eligibility:

(i) An annuity in its accumulation phase is considered a countable resource of the owner because it can be liquidated or sold by the owner. See § 29.09(d)(1) for information on how to value an annuity when it is a countable resource.

(ii) An annuity in its pay-out phase may be excluded as a resource of the owner if certain criteria are met. See § 29.08(d)(1) for information on the resource exclusion of an annuity.

(II) For purposes of MABD for long-term care, an annuity purchased, or subjected to certain transactions, by an individual or their spouse on or after February 6, 2006, is subject to transfer review. See § 25.03(h) for information on transfer analysis of annuities.

(iv) Mortgages

(A) The pledging of real estate or conveyance of an interest in land to a creditor as security for repayment of a debt.

(B) A mortgage owned by an individual, as the creditor, may be excluded as a resource if certain criteria are met. See § 29.08(d)(2) for information on the resource exclusion of a mortgage. If a mortgage is a countable resource of the individual, see § 29.09(d)(5) for information about the valuation of the mortgage.

(v) Promissory notes

(A) Written promises to pay a certain sum of money to a certain person, the bearer, upon demand or on a specified date.

(B) A promissory note owned by an individual, as the bearer, may be excluded as a resource if certain criteria are met. See § 29.08(d)(2) for information on the resource exclusion of a promissory note. If a promissory note is a countable resource of the individual, see § 29.09(d)(5) for information about the valuation of the promissory note.

(vi) Retirement funds. Any resource set aside by a member of the individual's financial responsibility group to be used for self-support upon their withdrawal from active life, service, or business.

Retirement funds include but are not limited to IRAs, Keogh plans, 401K plans, pensions, mutual funds, stocks, bonds, securities, money market accounts, whole life insurance, and annuities. The value of a retirement fund is the amount of money that can currently be withdrawn from the fund.

See § 29.08(i)(5) for information on the resource exclusion of retirement funds. See § 29.08(f) for information on the exclusion of early withdrawal and surrender penalties.

(vii) Health savings accounts (HSAs). Accounts used to set aside funds to meet medical expenses. Unless the individual can demonstrate that the funds in their HSA are not available to them, the HSA is a countable resource.

(c) Resources managed by a third party. Resources, liquid and nonliquid, managed by a third party include, but are not limited to, trusts, guardianship accounts, and retirement funds. Resources of a member of the financial responsibility group managed by a third party (e.g., trustee, guardian, conservator, or agent under a power of attorney) are considered available to the member as long as the member can direct the third party to dispose of the resource or the third party has the legal authority to dispose of the resource on the member's behalf without the member's direction.

(1) Definitions

(i) Guardian. A person or institution appointed by a court in any state to act as a legal representative for another person, such as a minor or a person with disabilities. Guardianship funds are presumed to be available for the support and maintenance of the protected person. That person may rebut the presumption of the availability of guardianship funds by presenting evidence to the contrary, including, but not limited to, restrictive language in the court order establishing the account or in a subsequent court order regarding withdrawal of funds.

(ii) Power of attorney. A written document signed by a person giving another person authority to make decisions on behalf of the person signing it, according to the terms of the document. Vermont law requires a power of attorney to be executed according to certain formalities, such as being signed, witnessed, and acknowledged. Funds managed by an agent under a power of attorney are not property of the agent and cannot be counted as resources of the agent.

(iii) Representative payee. An individual, agency, or institution selected by a court or the SSA to receive and manage benefits on behalf of another person. A representative payee has responsibilities to use these payments only for the use and benefit of that person, to notify the payer of any event that will affect the amount of benefits the person receives or circumstances that would affect the performance of the representative payee's responsibilities, and account periodically for the benefits received. Funds managed by a representative payee are not property of the representative payee and cannot be counted as resources of the representative payee.

(iv) Trust. A trust is a property interest where property is held by an individual or an entity (called a "trustee") subject to a fiduciary duty to use the property for the benefit of another person (the "trust beneficiary"). A trust includes a legal instrument or device that is similar to a trust but may not be called a trust. See § 29.08(e) for information on resource exclusion of trusts. The following are terms related to trusts:

(A) Grantor (also known as settler or trustor)

(I) The person who transfers liquid or nonliquid property to another person or entity (the "trustee"), with the intention that it be held, managed, or administered by the trustee for the benefit of one or more persons (the "grantees") In some cases, the grantor is named as a grantee.

(II) A person is considered the grantor of a trust if:

(i) The assets of the person were used to form all or part of the principal of the trust; and

(ii) One of the following established the trust:

(A) The person;

(B) Another person, court, or administrative body, with legal authority to act in place of or on behalf of the person; or

(C) Another person, court, or administrative body, acting at the direction of or upon the request of the person.

(B) Trustee. The person or entity (such as a bank or insurance company) that holds, manages, or administers trust property for the benefit of the trust's grantee(s). In most cases, a trustee does not have the legal right to use the trust property for their own benefit. Some, but not all, trusts grant discretion to the trustee to use judgment as to when or how to handle trust principal or trust income. A trust may provide reasonable compensation to the trustee for managing the trust as well as reimbursement for reasonable costs associated with managing the trust property.

(C) Grantee (also known as beneficiary). The person or entity that receives the benefit of a trust. A trust can have more than one grantee at the same time; it can also have different grantees under different circumstances.

(D) Trust income (also known as trust earnings). Monies earned by the trust property. It may take various forms, such as interest, dividends, or rental payments. These amounts may be countable unearned income to any person legally able to use them for their support and maintenance.

(E) Trust principal (also known as trust corpus). The property that the grantor transfers to the trustee for the benefit of the grantee(s).

(F) Trust property. The sum of the trust principal and the trust income.

(G) Residual beneficiary. The person or entity named in the trust to receive the trust property upon termination of the trust.

29.08 Excluded resources (01/01/2023~~10/01/2021~~, GCR 22-032~~20-002~~)

This subsection specifies the resources whose value is excluded in determining MABD eligibility.

(a) Real property

(1) Home and contiguous land

(i) Definition. Home means the property in which an individual resides and has an ownership interest and which serves as the individual's principal place of residence. This property includes the shelter

in which the individual resides, the land on which the shelter is located, related outbuildings, and surrounding property not separated from the home by intervening property owned by others. Public rights of way, such as roads that run through the surrounding property and separate it from the home, will not affect the exemption of the property. The home includes contiguous land and any other nonresidential buildings located on the contiguous land that are related to the home.

(ii) Exclusion

(A) Except when determining an individual's eligibility for Medicaid coverage of long-term care services and supports, a home is excluded as a resource, regardless of its value.

(B) For Medicaid coverage of long-term care services and supports, the home is considered a resource when the equity in the home is substantial. See Vermont's Medicaid Procedures Manual for the current substantial home equity limit; see § 29.09(d)(6) for information on exceptions to the application of the substantial home equity limit. The home may also be considered as a resource when determining whether the home has been transferred and should be subject to a penalty period (see § 25.00)

(C) The home exclusion applies even if the owner is making an effort to sell the home.

(D) The home exclusion also applies if the owner is absent from the home due to institutionalization, provided they have not placed the home in a revocable trust, and any one of the following three conditions is satisfied:

(I) The owner intends to return to the home even if the likelihood of return is apparently nil.

(II) The owner has a spouse or dependent relative residing in the home. Dependent relative in this context applies to:

(i) Any kind of dependency (medical, financial, etc.); and

(ii) A relationship to the owner that is one of the following: child, step-child, or grandchild; parent, step-parent, or grandparent; aunt, uncle, niece, or nephew; brother or sister, step-brother or step-sister, half brother or half sister; cousin; or in-law.

(III) The owner has a medical condition that prevented them from residing in the home before institutionalization.

(E) Unless one of the exceptions listed in (D) applies, the home becomes a countable resource when the owner moves out of the home without the intent to return, because it is no longer their principal place of residence.

(F) Temporary absences, such as for hospitalization or convalescence with a relative, do not affect the determination of the owner's principal place of residence.

(2) Proceeds from the sale of an excluded home

(i) Proceeds from the sale of a home is excluded to the extent that the owner intends to use the proceeds and, in fact, uses or obligates them to purchase or construct another home within three months of the date the proceeds are received.

(ii) Use of proceeds from the sale of a home to pay costs of another home will be excluded only if the

other costs are paid within three months of the sale of the home. Such costs are limited to the down payment, settlement costs, loan processing fees and points, moving expenses, necessary repairs to or replacements of the new home's structure or fixtures (e.g., roof, furnace, plumbing, built-in appliances) identified and documented prior to occupancy, and mortgage payments for the new home.

(iii) The value of a promissory note or similar installment sales contract constitutes a "proceed." Other proceeds consist of the down payment and the portion of any installment amount constituting payment against the principal. These are also excluded if used within 3 months to make payment on the replacement home.

(iv) When all of the proceeds are not timely reinvested as specified above, the portion of the proceeds retained by the owner are combined with the value of the promissory note or installment sales contract and counted as a resource beginning with the month following the month the note or contract is executed. If the entire proceeds are fully reinvested in a replacement home at a later date, the value of the note or contract and reinvested proceeds are excluded beginning with the month after the month in which they are reinvested, but any proceeds not reinvested as specified above remain a countable resource until fully reinvested.

(3) Real property up-for-sale

(i) Real property is excluded from being a countable resource as long as the owner verifies that they are making reasonable efforts to sell it. Reasonable efforts to sell property means taking all necessary steps to sell it for fair market value in the geographic area covered by the media serving the area in which property is located, unless the owner is prevented by circumstances beyond their control from taking these steps.

(ii) The steps considered necessary to sell the property depend on the method of sale. An owner may choose to list the real property with a real estate agent or undertake to sell it themselves.

(iii) If the owner chooses to list the property with a real estate agency, they must take the necessary step of listing it and cooperating with the real estate agent's efforts to sell it.

(iv) If the owner chooses to sell the property without an agent, they must take all of the following necessary steps:

(A) Advertise the property in at least one of the appropriate local media continuously;

(B) Place a "For Sale" sign on the property continuously, unless prohibited by zoning regulations;

(C) Conduct open houses or otherwise show the property to prospective buyers; and

(D) Attempt any other appropriate methods of sale.

(v) If any prospective buyer makes a reasonable offer for the property, the owner must accept it or demonstrate why it was not a reasonable offer. Any offer of at least two-thirds of the most recent estimate of the property's fair market value is considered a reasonable offer.

(vi) Fair market value means:

(A) A certified appraisal; or

(B) An amount equal to the price of the property on the open market in its locality at the time of the transfer or contract for sale, if earlier.

(4) Home equity conversion plans

(i) Definition. Home equity conversion plans are financial instruments used to secure loans with real property as collateral. Home equity conversion plans include reverse mortgages, reverse annuity mortgages, sale-leaseback arrangements, time-sale agreements, and deferred payment loans.

(ii) Exclusion as a resource in month received. In the month of receipt, funds an owner of the real property receives from any home equity conversion arrangements on their real property are excluded as a resource. Any funds received from a home equity conversion plan that are retained after the month of receipt are counted as a resource beginning the month after receipt.

For information on the treatment of the funds for purposes of income eligibility, see § 29.13(b)(30).

(5) Jointly-owned real property

(i) Exclusion due to joint owner's refusal to sell

(A) An owner's interest in jointly-owned real property is excluded as a resource as long as:

(I) At least one of the other joint owners refuses to sell the property; and

(II) The joint ownership was created more than 60 months before the date of the MABD application.

(B) The addition of a new joint owner (or joint owners) to a property is considered as the creation of a new joint ownership. The new joint ownership will be evaluated as a countable resource under § 29.09(d)(3) if the addition of the new joint owner was made within 60 months of the date of the MABD application.

(ii) Exclusion due to undue hardship. An owner's interest in jointly-owned real property is excluded as a resource if the sale of the property would cause the other joint owner (or owners) undue hardship due to loss of housing. Undue hardship would result when:

(A) The property serves as the principal place of residence for one or more of the other joint owners;

(B) Sale of the property would result in loss of that residence; and

(C) No other housing would be readily available for the displaced other owner.

(6) Life estates

(i) Treatment of life estate interest created on or after July 1, 2002. For a life estate ownership in real property created on or after July 1, 2002:

(A) The value of the life estate is excluded as a resource when the life estate owner does not retain the power to sell or mortgage the real property. For purposes of eligibility for Medicaid coverage of long term care services and supports, however, the life estate may be considered as a resource when determining whether it has been transferred and should be subject to a penalty period (see § 25.00).

(B) When the life estate owner retains the power to sell or mortgage the real property, including any remainder interest, the value of the life estate is excluded only if the life estate is an interest in the life estate owner's home (§ 29.08(a)(1)). Otherwise, the value of the life estate is counted. For this purpose, the value of the life estate includes the value of the remainder interest.

(C) When an individual transfers their home and retains a life estate with the power to sell or mortgage the property, the transfer is not subject to a transfer penalty analysis under § 25.00. In this situation, no transfer has occurred because the individual's ownership interest in the home has not been reduced or eliminated.

(ii) Treatment of life estate interest created before July 1, 2002. For a life estate ownership created before July 1, 2002:

(A) When the life estate owner retains the power to sell the real property, including any remainder interest, the value of the life estate is excluded only if the life estate is excludable on another basis, such as because it is real property producing significant income. Otherwise, the value of the life estate is counted. For this purpose, the value of the life estate includes the value of the remainder interest.

(B) The life estate ownership is excluded as a resource when the life estate owner does not retain the power to sell the real property.

(7) Income-producing real property

(i) *Non-business real property.* Non-business real property is excluded as a resource if the property produces significant income to the owner. Real property is considered to produce significant income if it generates at least 6 percent of its fair market value in net annual income after allowable expenses related to producing the income are deducted.

(ii) *Real property used in a trade or business.* Real property is excluded as a resource if the real property is essential to the owner's self-support and used by the owner in a trade or business. For purposes of this exclusion, the property must be in current use in the type of activity that qualifies it as essential.

(8) Goods for home consumption. Non-business real property is excluded as a resource of the owner when used by the owner to produce goods for only home consumption (e.g., a garden plot used to raise vegetables to be eaten at home or a wood lot used to provide fuel to heat the home). When real property is used to produce goods for both home consumption and income production, only the part used to produce goods for home consumption is excluded. The part of the property used for income production is evaluated for exclusion under (7) above.

(b) Insurance

(1) Exclusion of life insurance

(i) Whole life insurance

(A) If the combined face values of the whole life insurance policies owned by any one member of the financial responsibility group do not exceed $1500, the cash surrender values of the policies are excluded.

(B) If the combined face values exceed $1500, the cash surrender values, excluding any amounts

up to $1500, and all dividend additions are a countable resource.

(ii) Term life insurance. Regardless of its face value, a term life insurance policy is not a countable resource.

(2) Long-term care insurance partnership

(i) Definition: Qualified State Long-Term Care Insurance Partnership. A state plan amendment that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made under a long-term care insurance policy (including a certificate issued under a group insurance contract), but only if:

(A) The policy covers an insured who, at the time coverage under the policy first becomes effective, is a resident of such State or of a State that maintains a Qualified Long-Term Care Insurance Partnership;

(B) The policy is a qualified long-term care insurance contract within the meaning of § 7702B(b) of the Code;

(C) The policy provides some level of inflation protection as set forth in regulations promulgated by the Department of Financial Regulations (DFR);

(D) The policy satisfies any requirements of State or other applicable law that apply to a long-term care insurance policy as certified by the DFR; and

(E) The issuer of the policy reports:

(I) To the Secretary of HHS such information or data as the Secretary may require; and

(II) To the State, the information or data reported to the Secretary of HHS (if any), the information or data required under the minimum reporting requirements developed under § 2(c)(1) of the State Long-Term Care Partnership Act of 2005, and such additional information or data as the State may require.

(ii) Exclusion

(A) Subject to approval by CMS, assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a qualified State long-term care insurance partnership policy are excluded.

(B) This section is further contingent on the passage of changes to 33 VSA § 1908a necessary to bring the Vermont statute on Long-Term Care Partnership Insurance into conformance with the requirements of § 6021 of the federal Deficit Reduction Act of 2005.

(c) Burial Funds Exclusion

(1) For any person whose income and resources are considered in determining MABD eligibility, up to $10,000 of burial funds are excluded, as long as the person shows that the funds are designated for burial expenses through the title to the funds or by a sworn statement provided. The funds must be separately identifiable and not commingled with other funds.

(2) Burial funds may be excluded as of the first day of the month in which the person whose income and resources are considered in determining MABD eligibility established it. Interest and appreciation accrued

on burial funds are excluded if the funds have been left to accumulate.

(3) The value of certain burial spaces, if not fully paid, may also be excluded under the allowable limit of $10,000 for each person whose income and resources are considered in determining MABD eligibility. Such spaces must be held for the burial of a member of the individual's immediate family. For this purpose, the immediate family includes the individual's spouse, children, brothers, sisters, and parents.

(4) Irrevocable burial trusts established prior to July 1, 2002 and funded in excess of $10,000 are excluded up to the value of the trust as of June 30, 2002.

(d) Other income-producing resources

(1) Annuities

(i) An annuity is excluded as a resource of an individual requesting MABD or of their spouse if the annuity is in its pay-out phase and meets all of the following conditions:

(A) Has no beneficiary (or payee) other than the individual requesting MABD or their spouse;

(B) Provides for payments to the beneficiary in equal intervals and equal amounts;

(C) Does not exceed the life expectancy of the beneficiary as determined by using the actuarial life table published by the Office of the Chief Actuary of the SSA (http://socialsecurity.gov/OACT/STATS/table4c6.html) and set forth in Vermont's Medicaid Procedures Manual;

(D) Returns to the beneficiary at least the amount used to establish the annuity contract and any additional payments plus any earnings, as specified in the contract; and

(E) Except as provided in (ii) below, does not pay anyone else, as residual beneficiary, in the event the beneficiary dies before the payment period ends.

(ii) An annuity will also be considered to meet the requirements of (A) throughand (E) of (i) above if the individual or their spouse, as the owner of the annuity, elects to designate Vermont Medicaid as the primary residual beneficiary up to the amount of Medicaid payments made on behalf of the individual (or their spouse), and names a contingent residual beneficiary other than the individual or their spouse to receive any surplus after Vermont Medicaid is paid.

(2) Promissory notes and other income-producing resources

(i) A promissory note or similar resource that produces income is excluded as a resource of an individual requesting MABD eligibility or of their spouse if:

(A) It meets the requirements in paragraph (1)(i)(A) through (E) above; or

(B) The owner owned a nonnegotiable or nonassignable promissory note executed before September 1, 2005 and they can expect to receive the full fair market value of the resource within their expected lifetime, as determined by using the actuarial life table published by the Office of the Chief Actuary of the SSA (http://socialsecurity.gov/OACT/STATS/table4c6.html) and set forth in Vermont's Medicaid Procedures Manual.

(ii) All other promissory notes and similar resources that produce income are evaluated for whether they

are a countable resource as specified in § 29.09(d)(5) or, for purposes of Medicaid coverage of long-term care services and supports, subject to a transfer penalty as specified in § 25.00.

(e) Excluded trusts

(1) In general

(i) A trust is excluded as a resource if the member of the financial responsibility group is the grantor or grantee of the trust and cannot revoke the trust or receive trust property, whether or not the trustee exercises their full discretion. Trust property is also excluded as a resource when the grantor is a member of the financial responsibility group and establishes a trust by will (often referred to as a "testamentary trust").

(ii) The following trust property is excluded as a resource when either the grantor or the grantee is a member of the financial responsibility group:

(A) Trust property in a trust established prior to April 7, 1986, for the sole benefit of a person who is developmentally disabled residing in an ICF-DD.

(B) Trust property in a trust for which the grantee is a disabled child under the decision in Sullivan v. Zebley, 493 U. S. 521 (1990).

(C) Trust property or any portion of trust property that cannot be made available to the member of the financial responsibility group, either through full exercise of the trustee's discretion under the terms of the trust or through revocation of the trust by a member of the financial responsibility group.

(D) Trust property in a trust established by persons other than the individual or the individual's spouse (known as a third-party trust) unless the terms of the trust permit the individual (or their spouse) to revoke the trust or to have access to it without trustee intervention.

(E) Trust property in an irrevocable trust, including a home placed in an irrevocable trust by an institutionalized individual who intends to return to it, from which no payment under any circumstances could be made to the individual.

(F) A special needs trust that contains the assets of a disabled individual under the age of 65, and meets all of the criteria below:

(I)

(i) For a trust established on or after December 13, 2016, was established through the actions of the disabled individual, a parent, grandparent or legal guardian of the disabled individual, or by a court; or

(ii) For a trust established before December 13, 2016, was established through the actions of a parent, grandparent, or legal guardian of the disabled individual, or by a court;

(II) Was established for the sole benefit of the disabled individual which means that no person or entity except the disabled individual can benefit from the trust in any way, until after the death of the disabled individual and then not before Vermont Medicaid receives sums owed under the payback provision under (III) below; and

(III) Includes a payback provision which requires that, upon the death of the disabled individual, any amounts remaining in the trust will first be paid to Vermont Medicaid in an amount equal to the total Medicaid payments made on behalf of the disabled individual.

(G) A pooled trust that contains the assets of a disabled individual, and meets all of the criteria below:

(I) Was established and administered by a non-profit association;

(II) Maintains a separate account for the disabled individual, but assets are pooled for investing and management purposes;

(III) The separate account was established for the sole benefit of the disabled individual;

(IV) The account was established through the actions of the disabled individual, their parent, grandparent or legal guardian, or by a court; and

(V) The trust contains a pay-back provision which requires that to the extent any amounts in the separate account for the disabled individual upon their death are not retained by the trust, such amounts will first be paid to Vermont Medicaid in an amount equal to the total Medicaid payments made on behalf of the disabled individual.

(VI) Any asset of the disabled individual that is added to the trust after the disabled individual reaches the age of 65 may be subject to transfer penalty (see § 25.00) for purposes of the disabled individual's eligibility for Medicaid coverage of long-term care services and supports.

(iii) In the case of a trust with more than one grantor, these exclusions apply only to that portion of the trust attributable to the income or resources of a member of the financial responsibility group. In the case of a trust with more than one grantee, the exclusions apply only to that portion of the trust available for the benefit of a member of the financial responsibility group.

(2) Trusts excluded due to hardship

(i) Trust property that has not been distributed may be excluded if counting it as a resource would cause undue hardship to a grantor or grantee who is a member of the financial responsibility group.

(ii) Undue hardship includes situations in which a member of the financial responsibility group or someone in the member's immediate family would be forced to go without life-sustaining services because the trust property could not be made available to pay for the services. For this purpose, the immediate family includes the member's spouse, children, brothers, sisters, and parents.

(iii) The following situations also would cause undue hardship:

(A) Funds can be made available for medical care only if trust property is sold, and this property is the sole source of income for the member or someone in the member's immediate family; and

(B) Funds can be made available for medical care only if income-producing trust property is sold and, as a result of this sale, the member or someone in the member's immediate family would qualify for SSI, Reach Up, AABD, General Assistance, 3SquaresVT, or another public assistance program requiring a comparable showing of financial need.

(iv) Undue hardship does not exist when application of the trust regulations does not cause risk of serious deprivation to the member of someone in the member's immediate family.

(v) An individual claiming undue hardship must submit a written request and any supporting documentation. Required documentation from the individual can include, but is not limited to, the following:

(A) A statement from the individual's attorney, if one was involved;

(B) Verification of medical insurance coverage and statements from medical providers relative to usage not covered by the insurance; or

(C) A statement from the trustee of the trust.

(vi) When application of trust provisions are waived because they would cause the individual undue hardship, only amounts actually distributed from the trust and held for more than a month are counted as a resource.

(vii) Request for consideration of undue hardship does not limit an individual's right to appeal denial of eligibility for any reason, including the determination of undue hardship.

(f) Early withdrawal and surrender penalties

(1) Early withdrawal penalties and surrender fees assessed by a financial institution are excluded to the extent that they reduce the value of a countable resource that has been liquidated. Examples of resources to which this exclusion applies are retirement funds, annuities, bonds, and certificates of deposit.

(2) Income tax withholding and tax penalties for early withdrawal are not excluded.

(g) Jointly-owned accounts. A jointly-owned account in a financial institution is excluded as a resource only if the owner rebuts the presumption of availability by:

(1) Submitting a statement, along with a corroborating statement (or statements) from the other joint owner (or owners) of the account, regarding who owns the funds in the joint account, why there is a joint account, who has made deposits to and withdrawals from the account, and how withdrawals have been spent;

(2) Submitting account records showing deposits, withdrawals, and interest, if any, in the months for which ownership of funds is at issue; and

(3) Taking one of the following two actions:

(i) If the member of the financial responsibility group owns none of the funds in the account, correcting the account title to show that the member is no longer a co-owner of the account; or

(ii) If the member owns only a portion of the funds in the account, separating the funds owned by other account owners from the member's funds and correcting the account title on the member's funds to show they are solely owned by the member.

(h) Fiduciary for a joint fiduciary account[19]

(1) Definition: Joint fiduciary account. A deposit in a financial institution in the name of an owner naming one or more fiduciaries. The owner makes a clear statement about how the money can be used, and the fiduciary is required to follow those instructions and keep track of how the money is spent.

(2) Exclusion. When an individual owns a joint fiduciary account, it is counted as a resource. When an individual is designated a fiduciary of a joint fiduciary account, the joint fiduciary account is an excluded resource for the fiduciary.

(i) Other excluded resources

(1) Household goods, personal effects and other personal property

(i) Except as provided in (ii), home furnishings, apparel, personal effects, and household goods are excluded as resources. Tools, equipment, uniforms and other nonliquid property required by the owner's employer or essential to the owner's self-support are also excluded as resources.

(ii) Items an owner acquires or holds because of their value or as an investment are not excluded.

(2) Vehicles

(i) Except as provided in (ii), all automobiles are excluded as resources. Other vehicles, such as trucks, boats, and snowmobiles, are excluded only if they are used to provide necessary transportation (i.e., an automobile is unavailable or cannot be used to transport the aged, blind or disabled individual).

(ii) Automobiles or other vehicles an owner acquires or holds because of their value or as an investment are not excluded.

(3) Independent living contracts

(i) Definitions

(A) Contracts for medical care, assistive technology devices, and home modifications. Any written agreement, contract, or accord (including modifications) for reasonable and necessary medical care, assistive technology devices, or home modifications not covered by Medicare, private insurance, or Medicaid and determined by AHS to be needed to keep an individual at home and out of a skilled nursing facility.

(B) Medical care. Care not covered under AHS's Choices for Care program, including but not limited to, general supervision when required by the cognitive impairment of the individual and/or unstable medical condition that requires monitoring of the individual.

(C) Assistive technology devices. Any item, piece of equipment or product system whether acquired commercially off the shelf, modified, or customized, to increase, maintain, or improve the individual's functional capabilities.

(D) Home modifications. Physical adaptations to the individual's home that ensure the health and

[19] 8 VSA § 14212

welfare of the individual, or that improve the individual's ability to perform activities of daily living or instrumental activities of daily living.

(ii) Exclusion. Resources set aside under a contract or contracts for medical care, assistive technology devices, or home modifications are considered to be available resources unless all of the following criteria are met:

(A) The contract is in writing and signed before any services are provided;

(B) The funds, not to exceed a total of $30,000, are held in a separate bank account from other resources in the sole name of the individual applying for MABD;

(C) Any amounts due are paid after the services are rendered;

(D) The payments for:

(I) Medical care or assistive technology services do not exceed $500 per month; and

(II) Home modifications do not exceed a one-time expenditure of $7,500;

(E) The payments to nonlicensed individuals or providers do not exceed the fair market value of such services being provided by similarly situated and trained nonlicensed individuals, not to exceed the amount paid under AHS's Choices for Care program.

(F) Periodic accountings, as requested by AHS, must be provided specifying the amount of each expenditure, who was paid, the service given, and the number of hours and dates of service covered;

(G) The individual has the power to modify, revoke or terminate the contract for care;

(H) The contract ceases upon the death of the individual. It also ceases upon the individual's admission to an institution for long term care for more than 45 days if not eligible for the home upkeep deduction under § 24.04(d), or 6 months if eligible for the deduction. In addition, revocation or termination of the contract ceases the agreement.

(I) Upon cessation of the contract as specified above, any remaining balance of funds shall be treated as:

(I) An asset of the individual's estate, if the individual is deceased;

(II) An available resource that may not be converted to an excluded resource and must be applied at the Medicaid pay rate toward long term care services and supports if the individual is admitted to an institution for long-term care for more than 6 months. In cases where the individual dies before the resource is fully expended, the remainder shall become an asset of the individual's estate; or

(III) An excluded resource, if the individual revokes or terminates the contract and continues to receive services under AHS's Choices for Care program.

(4) Cash/liquid resources

(i) Income is excluded as a resource in the month of receipt, such as an automatic deposit of a social security check into a checking account.

(ii) Liquid resources used in the operation of the owner's trade or business as property essential to self-support are excluded.

(5) Exclusion of retirement funds

(i) Any retirement fund owned by a member of the financial responsibility group is excluded when:

(A) The member must terminate employment in order to obtain any payment from the fund;

(B) The member is not eligible for periodic payments from the fund and does not have the option of withdrawing a lump sum from the fund; or

(C) The member is drawing on the retirement fund at a rate consistent with their life expectancy, as specified in § 25.03(b).

(ii) If the member is eligible for periodic payments or a lump sum, the member must choose the periodic payments. If the member receives a denial on a claim for periodic retirement benefits, but can withdraw the funds in a lump sum, the lump sum value is counted in the resources determination for the month following that in which the member receives the denial notice.

(iii) When a member of the financial responsibility group is seeking Medicaid coverage of long-term care services and supports under MABD and has a spouse, any retirement fund held by the member in an individual retirement account (IRA) or in a work-related pension plan (including Keogh plans) as defined by the Code, does not require a change in the title of ownership in order for the fund to be treated as an excluded resource for the benefit of the spouse.

(6) Tax refunds. Tax refunds on real property, income, and food are excluded as resources.

(7) Student benefits. Any portion of any grant, scholarship, or fellowship used to pay fees, tuition, or other expenses necessary to securing an education is excluded. Portions used to defray costs of food or shelter must be counted.

(8) Savings from excluded income. Savings from excluded income and resources are excluded as resources. This includes, but is not limited to, the following:

(i) Liquid resources, including interest earned by the resources accumulated from earnings by a person working with disabilities (see § 8.05(d)) on or after January 1, 2000, and kept in a separate bank account from other liquid resources, unless no bank within a reasonable distance from the person's residence or place of work permits the person working with disabilities to establish a separate account without charging fees; and

(ii) Nonliquid resources purchased by a person working with disabilities on or after January 1, 2000, with savings from earnings or with a combination of savings from earnings and other excluded income or resources.

(9) Resources excluded by federal law. The following are excluded by federal law from both income and resources:

(i) The value of meals and food commodities distributed under the National School Lunch Act and the Child Nutrition Act.

(ii) The value of 3SquaresVT or 3SquaresVT cash-out checks.

(iii) The value of food or vouchers received through the WIC Program.

(iv) The value of food or meals received under the Older Americans Act.

(v) Compensation or remuneration received for volunteer work in ACTION programs including foster grandparents, RSVP, SCORE, ACV, ACE, VISTA, Senior Companion Program and UYA.

(vi) The value of assistance received under the U. S. Housing Act, U. S. Housing Authorization Act and the Housing and Urban Development Act.

(vii) The value of relocation assistance to displaced persons under the Uniform Relocation and Real Property Acquisition Policies Act.

(viii) Per capita distributions to certain Indian Tribes and receipts from lands held in trust for certain Indian Tribes.

(ix) Payments received under the Alaskan Native Claims Settlement Act.

(x) Grants or loans received for educational purposes under any U. S. Department of Education program.

(xi) Any assistance received under the Emergency Energy Conservation or Energy Crisis Program.

(xii) Any assistance received under the Low-Income Home Energy Assistance Act, either in cash or through vendor payments.

(xiii) Compensation paid to Americans of Japanese or Aleut ancestry as restitution for their incarceration during World War II.

(xiv) Agent Orange Settlement payments.

(xv) German reparations to concentration camp survivors, slave laborers, partisans, and other victims of the Holocaust. Settlement payments to victims of Nazi persecution or their legal heirs resulting from the confiscation of assets during World War II.

(xvi) War reparations paid under the Austrian government's pension system.

(xvii) Radiation Exposure Compensation Trust Fund payments.

(xviii) Assistance received under the Disaster Relief and Emergency Assistance Act or other assistance provided under a Federal statute because of a catastrophe which is declared to be a major disaster by the President of the United States. Comparable assistance received from a State or local government, or from a disaster assistance organization is also excluded. Interest earned on the assistance is also excluded.

(xix) Netherlands' Act on Benefits for Victims of Persecution 1940-1945 payments.

(xx) Any account, including interest or other earnings on the account, established and maintained in accordance with § 1631(a)(2)(F) of the Act. These accounts are established with retroactive SSI

payments made to a child under age 18 and used in ways specified in the Act. The exclusion continues after the child has reached age 18.

(xxi) Earnings deposited in a special savings account under the Tangible Assets project managed by the Central Vermont Community Action Council and authorized by PRWORA.

(xxii) Payments as the result of a settlement in the case of Susan Walker v. Bayer Corporation, et al. made to hemophiliacs who contracted the HIV virus from contaminated blood products.

(xxiii) Any resource of a blind or disabled individual that is necessary for them to carry out their approved Plan for Achieving Self-Support (PASS). The plan must be approved by the SSA.

~~(xxiii)~~(xxiv) An account established under the Achieving a Better Life Experience Act (ABLE Act), as permitted by that Act.[20]

(10) Exclusions for limited periods. The following resources are excluded for specific periods:

(i) Retroactive Social Security and SSI/AABD. Retroactive payments of SSI, the AABD supplement to SSI, or Social Security benefits for nine months beginning with the month after the month of receipt. These payments are also excluded as resources during the month of receipt.

(ii) Funds for replacing excluded resources. Cash and interest earned on that cash received from any source, including casualty insurance, for the purpose of repairing or replacing an excluded resource that is lost, stolen, or damaged, if used to replace or repair that resource. The exclusion is allowed for nine months from the month of receipt. An extension of an additional nine months can be granted for good cause.

(iii) Earned income tax credit. State and federal earned income tax credit refunds and advance payments for nine months beginning with the month after the month of receipt.

(iv) Medical or Social Services payments. Cash received for medical or social services for the calendar month following the month of receipt. In the second month following the month of receipt, it is counted as a resource if it has been retained.

(v) Victim's compensation payments. State-administered victims' compensation payments for nine months after the month of receipt.

(vi) Relocation payments. State and local government relocation payments for nine months after the month of receipt.

(vii) Expenses from last illness and burial. Payments, gifts, and inheritances occasioned by the death of another person provided that they are spent on costs resulting from the last illness and burial of the deceased by the end of the calendar month following the month of receipt.

(11) Exclusion of U. S. savings bonds

(i) A U. S. savings bond is excluded as a resource during its minimum retention period if the owner of

[20] Stephen Beck, Jr., ABLE Act of 2014.

the savings bond requested a hardship waiver based on financial need due to medical expenses and received a denial from the United States Department of the Treasury, Bureau of Public Debt, Accrual Services Division in Parkersburg, P. O. Box 1328, Parkersburg, West Virginia 26106-1328.

(ii) Upon verification of a denial of a hardship waiver, as described above, a U. S. savings bond is considered an available resource of the owner following the expiration of the minimum retention period. Once the minimum retention period expires, the denial of a hardship waiver is not a basis for exclusion of new bond purchases or other excluded assets purchased with the proceeds.

(iii) A U. S. savings bond purchased before June 15, 2004, that has its minimum retention period expire after that date, continues to be an excluded resource if it is not redeemed or exchanged, surrendered, reissued, used to purchase or fund other excluded assets, or otherwise becomes available.

(12) Home-based long-term care disregard. An additional resource disregard of $3,000 to the standard $2,000 resource disregard is allowed for an aged or disabled individual without a spouse who resides in and has an ownership interest in their principal place of residence and chooses Medicaid coverage of long-term care services and supports under MABD to be provided in their residence provided all other eligibility criteria are met. This additional resource disregard remains available until the individual begins receiving Medicaid coverage of long term care services and supports under MABD in an institution or in a residential care home that provides enhanced residential care services. Thereafter, if the individual meets the requirements for a home upkeep deduction (see § 24.04(d)), they are eligible to continue this resource disregard for up to 6 months.

~~(12)~~(13) Burial spaces. The value of fully paid burial spaces for the individual, the individual's spouse or any member of the individual's immediate family is excluded as a resource. For this purpose, the immediate family means the individual's children, brothers, sisters, parents and the spouses of those individuals.

29.09 Value of resources counted toward the Medicaid resource limit (01/01/2018, GCR 17-047)

(a) In general. Unless an exception under paragraph (d) below applies, the ownership interests of resources of the members of the financial responsibility group are valued according to these general rules.

(1) Resources not excluded under § 29.08 are valued at their equity value (see (b) below for definition of equity value).

(2) The portion of jointly-owned resources not excluded and countable toward the MABD resource limit is determined according to the rules in paragraph (c) below.

(3) The equity value of any resource owned entirely by members of the financial responsibility group and not excluded under § 29.08 is counted toward the MABD resource limit.

(b) Definition: Equity value

(1) The fair market value of the resource minus the total amount owed on it in mortgages, liens, or other encumbrances.

(2) The original estimate of the equity value of a resource is used unless the owner submits evidence from a

disinterested, knowledgeable source that, in AHS's judgment, establishes a reasonable lower value.

(c) Counting jointly-owned resources

(1) In general

(i) This paragraph defines each type of joint ownership and the amount of the resource that is counted when ownership is shared.

(ii) When two or more parties share rights to sell, transfer, or dispose of part or all of personal or real property, the ownership share held by members of the financial responsibility group is counted as prescribed by state law. Shared ownership or control occurs in different forms, including tenancy-in-common, joint tenancy, and tenancy-by-the-entirety. The type of shared ownership involved is determined and used to compute the countable value of the resource. If an individual submits evidence supporting another type of shared ownership, AHS will make a decision about which type applies. If AHS decides not to use the type submitted by the individual, it will provide the individual with a written notice stating the basis for its decision.

(iii) Under Vermont law, a co-owner may demand partition, the dividing of lands held by more than one person. For this reason, AHS counts the individual's proportionate share of the lands as an available resource, unless excluded as a home or property up for sale.

(2) Definition: Tenancy-in-common

(i) In tenancy-in-common, two or more parties each have an undivided fractional interest in the whole property. These interests are not necessarily equal. One owner may sell, transfer or otherwise dispose of their share of the property without permission of the other owner(s) but cannot take these actions with respect to the entire property.

(ii) When a tenant-in-common dies, the surviving tenant(s) has no automatic survivorship rights to the deceased's ownership interest in the property. Upon a tenant's death, their interest passes to their estate or heirs.

(iii) Tenancy-in-common applies to all jointly-owned resources when title to the resource does not specify joint tenancy or tenancy-by-the-entirety.

(iv) See (c)(5) below for how a resource owned by a member of the financial responsibility group as a tenant-in-common is counted.

(3) Definition: Joint tenancy

(i) In joint tenancy, each of two or more parties has an undivided ownership interest in the whole property. In effect, each joint tenant owns all of the property. When the property is personal property, the interests of the joint tenants are equal. When the property is real property, the interests of the joint tenants can be equal or unequal (unless the instrument creating the joint tenancy contains

language indicating a contrary intent, the joint tenants' interests are presumed to be equal).[21]

(ii) Upon the death of only one of two joint tenants, the survivor becomes the sole owner. Upon the death of one of three or more joint tenants, the survivors become joint tenants of the entire interest. For real property, the deceased joint tenant's interest is allocated among the surviving joint tenants in proportion to their respective interests at the time of the deceased joint tenant's death unless the instrument creating the joint tenancy contains language indicating a contrary intent.[22]

(iii) See (c)(5) below for how a resource owned by a member of the financial responsibility group as a joint tenant is counted.

(4) Definition: Tenancy-by-the-entirety

(i) Tenancy-by-the-entirety can only exist between members of a married couple, including parties to a civil union.

(ii) The couple, as a unit, owns the entire property which can be sold only with the consent of both parties.

(iii) Upon the death of one tenant-by-the-entirety, the survivor takes the whole. Upon legal dissolution, the former couple become tenants-in-common (see (c)(2) above), and one can sell their share without the consent of the other.

(iv) When a member of the financial responsibility group owns a resource as a tenant-by-the-entirety, the entire equity value of the resource is counted as available to the member.

(5) Countability

(i) General rule for tenancy-in-common and joint tenancy. With the exception noted in (ii) below and subject to the presumption under § 29.09(d)(3) regarding real property joint ownerships created within 60 months prior to the date of the MABD application, AHS assumes, absent evidence to the contrary, that each owner of shared property owns only their fractional interest in the property. The total value of the property is divided among all of the owners in direct proportion to the ownership share held by each.

(ii) Exception: Accounts in financial institutions. For an account in a financial institution, AHS assumes that all of the funds in the account belong to the individual. If another member (or members) of the individual's financial responsibility group is on the account, AHS assumes the funds in the account belong to those account owners in equal shares.

(d) Exceptions to general valuation rule. The following paragraphs describe exceptions to the general valuation rules described in paragraph (a) above.

(1) Annuities. Unless an annuity is excluded as a resource under § 29.08(d)(1) or, for purposes of Medicaid

[21] 27 VSA § 2(b)

[22] Id.

coverage of long term care services and supports, treated as a transfer under § 25.03(h), the fair market value of an annuity is counted. The fair market value is equal to the amount of money used to establish the annuity and any additional payments used to fund the annuity, plus any earnings and minus any early withdrawals and surrender fees. If evidence is furnished from a reliable source showing that the annuity is worth a lesser amount, AHS will consider a lower value. Reliable sources include banks, other financial institutions, insurance companies, and brokers, as well as any other source AHS considers, in its discretion, to be reliable.

(2) Life estates. Unless a life estate interest in property is excluded under § 29.08(a)(6), or the fair market value of the entire property (the life estate and the remainder) is counted as a resource, the fair market value of a life estate interest in property is established by multiplying the fair market value of the property at the time the life estate interest was created by the number in the life expectancy table that corresponds with the individual's age at that time. The life estate table is found in the SSA's POMS at SI 01140.120 (https://secure.ssa.gov/apps10/poms.nsf/lnx/0501140120). If an individual submits evidence supporting another method of establishing the fair market value of a life estate, AHS will make a decision about what method to use. If AHS decides not to use the method submitted, it will provide the individual with a written notice stating the basis for its decision.

(3) Jointly-owned real property. Regardless of a co-owner's refusal to sell jointly-owned real property pursuant to the resource exclusion under § 29.08(a)(5)(ii), AHS presumes that a member of the financial responsibility group that owns real property jointly with another person (or persons) owns the entire equity value of the real property if the joint ownership was created less than 60 months prior to the date of the MABD application. This presumption may be rebutted by a showing, through reliable sources, that the other joint owner (or owners) purchased shares of the property at fair market value. Reliable sources include cancelled checks or property transfer tax returns. When it has been established that one or more other co-owners purchased their shares of the property, the proportional interest owned by the member is counted.

(4) U. S. savings bonds. Unless a U. S. savings bond is excluded under § 29.08(i)(11), it is counted as a resource beginning on the date of purchase. To establish the value of the bond, the Savings Bond Calculator or the Comprehensive Savings Bond Value Table on the U. S. Bureau of Public Debt's internet website is used. Alternately, AHS obtains the value by telephone from a local bank. The following general rules apply to valuation:

(i) Series E and EE bonds are valued at their purchase price.

(ii) Series I bonds are valued at their face value.

(iii) Service HH bonds are valued at their face value.

(5) Income-producing promissory notes and contracts

(i) Unless the promissory note or other income-producing resource (contract) is excluded under § 29.08(d)(2) or, for purposes of Medicaid coverage of long-term care services and supports, treated as a transfer under § 25.03(i), the fair market value of a promissory note or contract is counted. Regardless of negotiability, fair market value equals the amount of money used to establish the note or contract and any additional payments used to fund it, plus any earnings and minus any payments already received. If evidence is furnished to AHS of a good faith effort to sell the note or contract by

obtaining three independent appraisals by reliable sources which reflect that the value of the note or contract is less than fair market value, AHS will consider the note or contract available to its owner only in the amount of this discounted value. Reliable sources include banks, other financial institutions, insurance companies, and brokers, as well as any other source AHS considers, in its discretion, to be reliable.

(ii) For an individual requesting Medicaid coverage of long-term care services and supports under MABD, a note or contract valued at a discount will be treated as an available resource at the discounted amount and may also be subject to a transfer penalty to the extent of the amount discounted from the fair market value, in the discretion of AHS. Where the note or contract is determined to have no value on the open market, a transfer penalty will be applied for the full value used to establish the note or contract and any additional payments used to fund it, plus any earnings and minus any payments already received.

(6) Substantial home equity

(i) Definition: Home equity. The value of a home based on the town's assessment adjusted by the common level of appraisal (CLA), minus the total amount owed on it in mortgages, liens, or other encumbrances. When an individual requesting Medicaid owns their home in a joint ownership with someone other than their spouse, absent evidence to the contrary, the individual's equity interest in the home is reduced by the amount of the other joint owner's equity interest when the other joint owner resides in the home.

(ii) Counting rule

(A) A home is considered a resource, for purposes of eligibility for Medicaid coverage of long term care services and supports, when the owner's equity in the home is substantial. See Vermont's Medicaid Procedures Manual for the current substantial home equity limit. The substantial home equity limit increases from calendar year to year based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average) rounded to the nearest $1,000.

(B) Substantial home equity precludes payment for Medicaid coverage of long-term care services and supports unless one of the following individuals lawfully resides in the home:

(I) The owner's spouse;

(II) The owner's child who is under age 21; or

(III) The owner's child who is blind or permanently and totally disabled, regardless of age.

(C) A individual with excess equity in their home who is found ineligible for Medicaid coverage of long-term care services and supports may receive other Medicaid services besides long-term care services and supports if they meet the eligibility criteria for a coverage group that covers services other than long-term care services and supports.

(iii) Hardship waivers. An individual who is ineligible for Medicaid coverage of long-term care services and supports due to excess equity in their home may request an undue hardship waiver based on the criteria specified at § 25.05.

(iv) Home equity conversion plans (reverse mortgages) and home equity loans. An individual is

permitted to use a home equity conversion plan (reverse mortgage) or a home equity loan to reduce their equity interest in their home. In such circumstances, the funds are valued as follows:

(A) The existence of a line of credit is not considered to diminish the equity value except in amounts from the line of credit actually paid to the borrower.

(B) In the month of receipt, lump-sum payments from a home equity conversion plan or from a home equity loan are excluded as a resource and proceeds paid in a stream of income are excludable income.

(C) Lump sum payments from home equity loans retained for more than a month continue to be an excluded resource.

Lump sum payments and streams of income are subject to transfer penalties if given away in the month of receipt or thereafter.

29.10 Determination of countable resources (01/01/2018, GCR 17-047)

(a) In general. Countable resources are determined by combining the resources of the members of the financial responsibility group, as described in § 29.03, and comparing them to the resource standard of the Medicaid group, as described in § 29.04. Countable resources are determined for different types of Medicaid groups: adults without spouses, adults with spouses, children, and individuals requesting Medicaid coverage of long-term care services and supports. If the resources of the Medicaid group fall below or are equal to the applicable resource standard, the resource test is passed. If an excess resource amount remains after all exclusions have been applied (see § 29.08), the individual has not passed the resource test. An individual may become eligible for MABD by spending down or giving away excess resources as provided in § 30.00 subject to transfer of resource rules (see § 25.00) for those seeking Medicaid coverage of long-term care services and supports.

(b) Determining countable resources for individuals other than children. The general rule in paragraph (a) above is followed to determine whether total resources, after exclusions, of an individual other than a child falls below the resource maximum for one.

(c) Determining countable resources for individuals with spouses and not in long-term care. The general rule in paragraph (a) above is followed to determine whether the total resources, after exclusions, of an individual living with their spouse and requesting MABD, other than Medicaid coverage of long-term care services and supports under MABD, falls below the resource maximum for two.

(d) Determining countable resources for children

(1) Unless otherwise specified in the coverage group rules at §§ 8.05 and 8.06, the countable resources of an eligible child are determined by:

(i) Combining the resources of the parents living with the child with the child's resources, until the child reaches the age of 18;

(ii) Subtracting the resource maximum for one, if one parent, or two, if two parents, from the parent's countable resources; and

(iii) Deeming and adding the remainder to the child's own countable resources.

(2) If the child's total countable resources fall below the resource maximum for one, the resource test is passed.

(e) Determining countable resources for individuals requesting Medicaid coverage of long term care services and supports under MABD who have spouses. For an individual requesting Medicaid coverage of long-term care services and supports under MABD who has a spouse, the resource evaluation process of assessment and allocation is performed as set forth in this paragraph at the beginning of the first continuous period of long-term care. An individual discharged from long-term care and readmitted later does not undergo these steps again; only the resources of, and any new transfers by, the readmitted individual are counted. An institutionalized spouse (sometimes referred to in this rule as the "IS") who receives additional resources after allocating less than the community spouse resource allocation (CSRA) maximum to their community spouse (sometimes referred to in this rule as the "CS") and being found eligible for Medicaid coverage of long-term care services and supports under MABD, may, until the first annual review of their eligibility, continue to transfer resources to the CS up to a combined total transfer of no more than the CSRA maximum. After the IS's first regularly-scheduled annual redetermination of eligibility, no further transfers are allowed even if the CSRA maximum has not been allocated to the CS; the rules regarding transfers apply after the IS's first regularly-scheduled annual redetermination (see § 25.00).

See Vermont's Medicaid Procedures Manual for the current CSRA maximum.

(1) Assessment of resources for individuals with community spouses. At the time of admission to long-term care and application for Medicaid coverage of long-term care services and supports under MABD, including long-term care services and supports in a home and community-based setting, AHS completes an assessment of resources. An individual or their spouse may also request a resource assessment prior to admission to long-term care. AHS provides a copy of the assessment to each spouse and retains a copy. The assessment must include at least:

(i) The total value of countable resources in which either spouse has an ownership interest;

(ii) The basis for determining total value;

(iii) The spousal share or one-half the total;

(iv) Conclusion as to whether the IS would be eligible for MABD based on resources;

(v) The highest amount of resources the IS and CS may retain and still permit the IS to be eligible;

(vi) Information regarding the transfer of assets policy; and

(vii) The right of the IS or the CS to a fair hearing at the time of application for MABD.

(2) Allocation of resources for individuals with community spouses

(i) An allocation of resources is completed at the time of the IS's application for Medicaid coverage of long-term care services and supports under MABD, as follows:

(A) The total countable resources of the couple are determined at the time of the application for Medicaid coverage of long-term care services and supports under MABD, regardless of which spouse has an ownership interest in the resource;

(B) The greatest of the following is deducted:

(I) CSRA maximum;

(II) Amount set by a fair hearing, or

(III) Amount transferred from the IS to the CS under a court order.

(ii) The remaining resources allocated to the IS are compared to the resource maximum for one to determine whether or not the IS passes the MABD resource test. If the IS does not pass the resource test, see the spenddown provisions at § 30.00.

(iii) The resources of the CS are considered available to the IS until the month after the month in which the IS becomes eligible for Medicaid coverage of long-term care services and supports under MABD. If the CS fails to make the resources accessible to the IS, after AHS has determined that they are available, AHS may still grant the IS Medicaid coverage of long-term care services and supports under MABD if:

(A) The IS assigns any rights to support from the CS to AHS; or

(B) Denial of Medicaid coverage of long-term care services and supports would work an undue hardship, as specified in § 25.05.

(iv) The CS is provided with the amount determined to be the share of the CS (or to someone else for the sole benefit of the CS). Any transfer of resources from the IS to the CS must be completed by the next review of eligibility of the IS. The transfer will be verified at the next regularly scheduled redetermination of the IS's eligibility.

(v) For purposes of allocation, an "assisted living" facility is considered a community setting and not an institution for long term care provided that the assisted living facility does not include 24-hour care, has privacy, a lockable door, and is a homelike setting. An IS is permitted to allocate income and resources to a CS when the CS resides in an assisted living facility.

29.11 Overview of income requirements (01/15/2017, GCR 16-098)

(a) Definition: Income. Any form of cash payment from any source received by an individual or by a member of the individual's financial responsibility group. Income is considered available and counted in the month it is received or credited to the individual with the exception of a lump sum receipt of earnings such as sale of crops or livestock. These receipts are only counted if received during the six-month accounting period and are averaged over the six-month period.

(b) Counting rules

(1) All earned and unearned income of an individual who is aged, blind or disabled and of the members of the individual's financial responsibility group is counted except income that is specifically excluded (see § 29.13) or deducted (see § 29.15). All countable income is verified.

(2) Countable income depends on the coverage group for which an individual is eligible. It is determined according to the rules at § 29.14 and compared to the highest applicable income standard. If total countable income for the Medicaid group exceeds the income standard for every coverage group in §§

8.05 and 8.06, the individual is denied eligibility and given a spenddown (see § 30.00).

29.12 Types of income (01/15/2017, GCR 16-098)

(a) In general. This subsection describes the kinds of income considered when determining MABD eligibility.

(b) Earned income. Earned income includes the following:

(1) Gross salary, wages, commissions, bonuses, severance pay received as a result of employment.

(2) Income from self-employment (see (c) below for more information about self-employment income).

(3) Payments from Economic Opportunity Act of 1964 programs as recipients or employees, such as:

(i) Youth Employment Demonstration Act Programs;

(ii) Job Corps Program (Title I, Part A);

(iii) Work Training Programs (Title I, Part B);

(iv) Work Study Programs (Title I, Part C);

(v) Community Action Programs (Title II); and

(vi) Voluntary Assistance Program for Needy Children (Title II); and

(4) Income from:

(i) Employment under Title I of the Elementary and Secondary Education Act (e.g., as a teacher's aide, lunch room worker, etc.);

(ii) Wages from participation in the Limited Work Experience Program under the Workforce Investment Act of 1998 (29 U. S. C. §794d); and

(iii) Earnings from the Senior Community Service Employment (SCSE) program.

(c) Self-employment income

(1) Net earnings from self-employment are counted. Net earnings means gross income from any trade or business less the allowable deductions specified in § 29.15(a)(1).

(2) Tax forms are used to determine countable income from self-employment. An individual who states that the income on their tax forms is no longer reflective of their situation may submit alternate documentation.

(3) When the individual's business has been the same for several years, income reported on tax forms from the last year is used.

(4) When the individual's business was new in the previous or current year and the individual has business records, income reported on tax forms and other available business records is divided by the number of months the individual has had the business.

(5) When the individual's business has no records, is seasonal or has unusual income peaks, income reported on the individual's signed statement estimating annual income is included.

(d) Unearned income

(1) Any payment other than earned income from any source received by an individual or by a member of the individual's financial responsibility group. It is the gross payment, less allowable deductions at § 29.15(b). Periodic benefits received by an individual as unearned income are counted.

(2) Unearned income includes income from capital investments in which the individual is not actively engaged in managerial effort. This includes rent received for the use of real or personal property. Ordinary and necessary expenses of rental property such as interest on debts, state and local taxes, the expenses of managing or maintaining the property, etc. are deducted in determining the countable unearned income from this source. The deduction is permitted as of the date the expense is paid. Depreciation or depletion of property is not a deductible expense.

(3) Unearned income also includes, but is not limited to, the following:

(i) Social Security retirement, disability, SSI, survivor benefits for surviving spouses, children of a decedent, and dependent parents;

(ii) Railroad Retirement;

(iii) Unemployment compensation;

(iv) Private pension plans;

(v) Annuities;

(vi) Interest earned on life insurance dividends;

(vii) Regular and predictable voluntary cash contributions received from friends or relatives;

(viii) Cash prizes or awards;

(ix) Withheld overpayments of unearned income, unless the overpayment was counted as income in determining Medicaid eligibility in the month received;

(x) Royalty payments to holders of patents or copyrights for which no past or present work was or is involved;

(xi) Retroactive Retirement, Survivors and Disability Insurance (RSDI) benefits for an individual with drug addiction or alcoholism (such benefits are treated as if they had all been received in a lump sum payment, even if paid in installments);

(xii) Veteran's Administration (VA) pension, compensation and educational payments that are not part of a VA program of vocational rehabilitation and do not include any funds which the veteran contributed;

(xiii) Interest payments received by the individual on an income-producing promissory note or contract

(such as a property agreement or loan agreement) when the individual is the lender and the note or contract is excluded as a resource under § 29.08(d)(2).

(xiv) Alimony and support payments received; and

(xv) Death benefits received by an individual to the extent the benefits exceed what was paid by the individual for the expenses of the deceased person's last illness and burial.

29.13 Income exclusions[23] (01/15/2019, GCR 18-063)

(a) Earned income exclusions. The following are excluded from earned income:

(1) Support service payments made directly to the providers of services in the Limited Work Experience Program under the Workforce Investment Act of 1998 (29 USC § 794d) or needs-based payments of $10 per day made to participants in the program.

(2) The earned income of an individual under the age of 22 who is a student regularly attending school. This applies to wages received from regular employment, self-employment, or payments from the Neighborhood Youth Corps, Work Study and similar programs.

(3) Infrequent or irregular earned income received, not to exceed $30 per calendar quarter.

(4) Any in-kind assistance received from others.

(5) Earned Income Tax Credit payments (both refunds and advance payments).

(6) Earned income of a working disabled individual when performing the second step of the categorically-needy eligibility test redetermining net income, set forth in § 8.05(d).

(7) Earned income of a child under the age of 18.

(8) Wages paid by the Census Bureau for temporary employment.

(b) Unearned income exclusions. Unearned income exclusions are limited to the following:

(1) Expenses incurred as a condition of receiving the unearned income. For example, guardianship fees may be deducted from unearned income if having a guardian is a requirement for receiving the income, or attorney fees and court costs may be deducted from unearned income if they were incurred in order to establish a right to the income.

(2) The following VA payments:

(i) Portion of pension or compensation payment for aid and attendance and housebound allowances, even when the provider is a spouse or a parent of the veteran;

(ii) Augmented portion of pensions, compensation or other benefits for a dependent of a veteran or a

[23] See, also, § 29.08(i)(9) for income excluded by federal law.

veteran's spouse;

(iii) $20 from educational benefits to the veteran funded by the government;

(iv) Educational benefits paid as either part of a plan of vocational rehabilitation or by withdrawals from the veteran's own educational fund;

(v) Clothing allowance; and

(vi) Payment adjustments for unusual medical expenses.

(3) Ordinary and necessary expenses of rental property and other capital investments except depreciation or depletion of property. This includes, but is not limited to, interest on debts, state and local taxes. The expenses of managing or maintaining the property, as of the date the expense is paid, are deductible.

(4) The first $20 per month of any unearned income unless all of the unearned income is from a source that gives assistance based on financial need.

(5) Any public agency's refund of taxes on food or real property.

(6) Infrequent or irregular unearned income received, not to exceed $60 per calendar quarter.

(7) Bills paid directly to vendors by a third party.

(8) Replacement of lost, stolen or destroyed income.

(9) Weatherization assistance.

(10) Receipts from the sale, exchange or replacement of a resource.

(11) Any assistance based on need which is funded wholly by the state, such as General Assistance.

(12) Public assistance benefits of any person who is living with the individual, as well as any income that was used to determine the amount of those benefits.

(13) Any portion of a grant, scholarship or fellowship used to pay tuition, fees or other necessary educational expenses.

(14) Home produce used for personal consumption.

(15) Assistance and interest earned on assistance for a catastrophe from the Disaster Relief and Emergency Assistance Act or other comparable assistance provided by the federal, state or local government.

(16) Irregular and unpredictable voluntary cash contributions or gifts received from friends or relatives.

(17) Payments for providing foster care for children or adults placed in the individual's home by a public or private non-profit placement agency.

(18) One-third of child support payments received for a child in the household of the individual. The remaining

two-thirds of the support payments are considered the unearned income of the child received from the absent parent.

(19) Income paid for chore, attendant or homemaker services under a government program, such as Title XX personal services payments or the $90 VA Aid and Attendance payments to veterans in nursing homes.

(20) Any "in-kind" assistance received from others.

(21) Assistance provided in cash or in kind (including food, clothing, or shelter) under a government program that provides medical care or services (including vocational rehabilitation).

(22) That portion of a benefit intended to cover the financial need of other individuals, such as AABD-EP grants.

(23) Retroactive payments of SSI, AABD or OASDI benefits if the payments were included in determining financial eligibility for Medicaid in the month it was actually owed to the individual.

(24) Home energy assistance provided by a private nonprofit organization or a regulated supplier of home energy.

(25) State-administered victims' compensation payments.

(26) State or local government relocation payments.

(27) Payments occasioned by the death of another person to the extent that they are used to pay for the deceased person's last illness and burial, including gifts and inheritances.

(28) Earned Income Tax Credit payments (both refunds and advance payments).

(29) Social security disability insurance benefits (SSDI) and veterans disability benefits provided to working disabled persons when determining categorically-needy eligibility, specified in § 8.05(d).

(30) Income from a home equity conversion plan in the month received.

(31) Dividends paid on life insurance policies.

(32) Payments made by someone other than the individual to a third-party trust for the benefit of the individual.

(33) Interest and dividend income from a countable resource or from a resource excluded under a federal statute other than § 1613 of the SSA.

(34) Any interest on an excluded burial space purchase agreement if left to accumulate as part of the value of the agreement.

(35) Any amount refunded on income taxes that the individual has already paid.

(36) Proceeds of a loan in the month received when the individual is the borrower because of the borrower's obligation to repay.

(37) Exclusions based on federal law as set forth in § 29.08(i)(9).

29.14 Determination of countable income (01/01/2018, GCR 17-047)

(a) In general

(1) The earned and unearned income of the members of the financial responsibility group is counted. Income is considered available and counted in the month it is received or credited to the member.

(2) The general approach AHS follows when it determines countable income for MABD is set forth below. These general rules apply to all individuals.

(i) Determine income of the financial responsibility group.

(ii) The income of all members of the financial responsibility group is combined, and the appropriate exclusions (see § 29.13) and standard deductions applied (see § 29.14).

(iii) Compare countable income to the applicable income standard.

(iv) An individual passes the income test when their Medicaid group's income does not exceed the appropriate PIL, or the applicable income maximum, whichever is higher. An individual with income greater than the applicable income standard may establish financial eligibility by incurring eligible medical expenses that at least equal the difference between their countable income and the applicable PIL.

(3) The following subsections specify how income is allocated and deemed based on the type of coverage sought and the size of the financial responsibility group.

(b) Financial responsibility group of one individual seeking MABD other than Medicaid coverage of long-term care services and supports under MABD. Common financial responsibility groups of one include a single adult, an individual residing in a residential care home, and a child seeking Katie Beckett coverage. AHS determines countable income for an individual seeking MABD, other than Medicaid coverage of long-term care services and supports under MABD, with a financial responsibility group of one as follows:

(1) Determine and combine the total countable unearned income of the individual.

(2) Subtract a $20 disregard (pursuant to § 29.13(b)(4)), if applicable.

(3) Deduct an allocation for each ineligible child in the household for whom the individual is financially responsible. The amount of each allocation is equal to the maximum allocation amount minus any countable income of the child. If the unearned income is not at least equal to the applicable allocation amount, any remaining allocation may be deducted from earned income.

(4) Deduct from unearned income amounts used to comply with the terms of court-ordered support or Title IV-D support payments (pursuant to § 29.15(b)), if applicable. If unearned income is insufficient, any remaining amounts may be deducted from earned income.

(5) Determine and combine the individual's countable earned income.

(6) Deduct any remaining amount of the $20 disregard, allocations for children and child support payments from the earned income.

(7) Deduct $65 from the remaining earned income.

(8) Deduct allowable work expenses for the disabled (§ 29.15(a)(3)).

(9) Deduct one-half of the remaining earned income.

(10) Deduct any allowable work expenses for the blind (§ 29.15(a)(2)).

(11) Combine the remaining earned income with any remaining unearned income.

(12) Deduct the amount of any income of a blind or disabled individual that is necessary for them to carry out a Plan to Achieve Self-Support (PASS), if applicable.

(13) The result is the individual's countable income for the month. For a child seeking Katie Beckett coverage, compare it to the institutional income standard (IIS). For all others, compare it to the protected income level (PIL) or the SSI/AABD payment standard for one, whichever is higher.

(c) Financial responsibility group of two seeking MABD other than Medicaid coverage of long-term care services and supports under MABD. Countable income for MABD for any individual with a financial responsibility group of two is determined according to the rules under paragraph (b) above, as well as the following additional rules:

(1) *Deem income at step (1).* Earned and unearned income is deemed to the individual at step (1) from their ineligible spouse or ineligible parent, except no income is deemed to an individual from their ineligible children.

(2) *Allocate income at step (3).* Income is allocated from the financial responsibility group to each member of the financial responsibility group who is not applying for MABD at step (3) in the following amounts:

(i) For a child, the difference between the SSI federal payment rate for one and the SSI federal payment rate for a couple is allocated. The allocation is reduced for ineligible children if they have income, unless the ineligible children are students with earned income. No allocation is made to children receiving public assistance.

(ii) For a parent in a one-parent financial responsibility group, the SSI federal payment for one is allocated.

(iii) For parents in two-parent financial responsibility groups, the SSI federal payment for two is allocated.

(3) *Count income at step (13) for an individual requesting MABD who has a spouse.* Countable income for an individual whose spouse is not requesting MABD is determined, according to the rules under paragraph (b) above, except at step (13) the countable income of the Medicaid group is compared to the PIL or the SSI/AABD payment standard for two, whichever is higher.

(d) Parent and child living together seeking MABD, other than Medicaid coverage of long-term care services and

supports under MABD. These groups include a parent who is aged, blind, or disabled and a child who is blind or disabled. When a parent and a child in the same household both request MABD, countable income is determined as a financial responsibility group of two as follows:

(1) Determine the net income available to the parent following the steps under paragraph (b) if the parent is single, or under paragraph (c) if the parent has a spouse, except do not allocate any income to the eligible child. Compare the parent's income to the PIL for one or, if married, the SSI/AABD payment standard for two. If the parent's countable income is below the highest applicable income standard, the parent has passed the income test for eligibility. If the parent's income exceeds the highest applicable income standard, deem the amount of income in excess of the highest applicable income standard to the eligible child as unearned income.

(2) Determine the child's countable income by deeming any income from (1) above and then following the steps in paragraphs (e)(3)(iv) through (xiv). If the child's income is less than the PIL, both the parent and the child pass the income test for MABD eligibility.

(3) When both a parent and child have a spenddown requirement, the parent and child will pass the income test once the child's spenddown requirement has been met because the parent's excess income was deemed to the child. If the parent's spenddown requirement is less than the child's and the parent meets their spenddown requirement, the parent will become eligible. The child, however, will remain ineligible until the remainder of the child's spenddown is met. The parent's incurred eligible medical expenses are deducted from the spenddown requirements of both the parent and child because the parent's income was included in both income computations.

(e) Children seeking MABD, other than Medicaid coverage of long-term care services and supports under MABD (excluding Katie Beckett)

(1) The provisions of this paragraph generally apply when countable income for an eligible child is determined as a financial responsibility group of one. They do not apply in the following contexts:

(i) Katie Beckett (see paragraph (b) above);

(ii) A child whose parent also requests Medicaid (see paragraph (d) above); or

(iii) Medicaid coverage of long-term care services and supports under MABD (see paragraph (f) below).

(2) Since parents are financially responsible for their children, their income must be considered available to their child requesting MABD, until the child reaches the age of 18.

(3) AHS determines countable income in applicable cases as follows:

(i) Determine the total countable income, both earned and unearned, of the parents living with the child.

(ii) Deduct an allocation specified in paragraph (c)(2)(ii)(B) of (C) for the needs of the parents living in the household from the total countable income of the parents.

(iii) Deem the remaining amount to the child. If there is more than one blind or disabled child in the household, divide the remainder by the number of blind or disabled children and deem an equal portion to each. Do not deem more income to a child than the amount which, when combined with

the child's own income, would bring their countable income to the PIL. If the share of parental income that would be deemed to a child makes that child ineligible because that child has other countable income, deem parental income to other blind and disabled children under age 18 in the household and no portion to the child.

(iv) Add the child's own unearned income. This is the total unearned income.

(v) Deduct the $20 disregard. This is the total countable unearned income.

(vi) Determine the earned income of the child.

(vii) Deduct the balance of the $20 disregard.

(viii) Deduct the $65 earned income exclusion from any earned income.

(ix) Deduct any allowable work expenses of a disabled child (§ 29.15(a)(3).

(x) Deduct one-half of the remaining earned income.

(xi) Deduct any allowable work expenses of a blind child (§ 29.15(a)(2).

(xii) Combine the remaining earned and unearned income.

(xiii) Deduct the amount of any income that is necessary to carry out a Plan to Achieve Self-Support (PASS), if applicable.

(xiv) The result is the child's countable income. Compare it to the PIL for one. A child with income below the PIL passes the income test.

(f) Individuals seeking Medicaid coverage of long-term care services and supports under MABD. Countable income for an individual requesting Medicaid coverage of long-term care services and supports under MABD is determined as follows:

(1) The countable income of the individual is compared to the applicable income standard for their coverage group beginning with the date of admission to long-term care.

(2) The institutional income standard (IIS) for an individual equals 300 percent of the maximum SSI federal payment to an individual living independently in the community. The IIS for a couple equals twice the IIS for an individual.

(3) When an individual is in a nursing facility and AHS has an indication that they will need long-term care for fewer than 30 days, AHS uses the PIL for the month of admission, and applies the rules for MABD other than the rules for Medicaid coverage of long-term care services and supports under MABD.

(g) Long-term care individuals in an institution

(1) Countable income for an individual seeking Medicaid coverage of long-term care services and supports under MABD in an institution is determined according to the rules under paragraph (b) above, except AHS:

(i) Allocates income to the individual's community spouse, other family members and for home upkeep, according to the rules in § 24.04;

(ii) Allocates a personal needs allowance to the individual; and

(iii) Compares the countable income of the Medicaid group to the IIS beginning with the date of admission to long-term care.

(2) For an individual whose gross income exceeds the IIS, AHS determines whether they may spend down their excess income to the PIL to establish their financial eligibility as medically needy, according to the rules at § 30.00. AHS determines whether the individual has incurred eligible medical expenses that equal the difference between their countable income and the PIL.

(h) Long-term care individuals seeking services in a home and community-based setting

(1) Countable income for an individual seeking Medicaid coverage of long-term care services and supports under MABD in a home and community-based setting is determined according to the rules under paragraph (b) above, except AHS:

(i) Allocates income to the individual's community spouse and other family members according to the rules in § 24.04; and

(ii) Allocates a community maintenance allowance to the individual; and

(iii) Approves income eligibility if the individual:

(A) Has gross income that does not exceed the IIS; or

(B) Passes the net income test for an individual working with disabilities (see § 8.05(d)).

(2) For an individual whose gross income exceeds the IIS, AHS determines whether they may spend down their excess income to the PIL to establish their income eligibility as medically needy using the rules at § 30.00. AHS determines whether the individual has incurred eligible medical expenses that equal the difference between their countable income and the PIL.

29.15 Income deductions (01/15/2017, GCR 16-098)

Deductions from earned income, including self employment, and from unearned income are allowed.

(a) Earned income deductions. A deduction of $65.00 and one-half of the remainder applies to all determinations of earned income.

(1) Business expenses. Deductions of business expenses from self-employment income are limited to the following:

(i) Operating costs necessary to produce cash receipts, such as office or shop rental; taxes on farm or business property; hired help; interest on business loans; cost of materials, livestock and equipment required for the production of income; and any business depreciation.

(ii) The cost of any meals provided to children for whom an individual provides day care in their own

home, at the currently allowed rate per meal.

(iii) The actual operating expenses necessary to produce cash receipts for commercial boarding houses: an establishment licensed as a commercial enterprise that offers meals and lodging for compensation, or, in areas without licensing requirements, a commercial establishment that offers meals and lodging with the intention of making a profit.

(iv) Room and board, alone or as part of custodial care, provided that the amount shall not exceed the payment the household receives for room and board.

(v) Foster care payments made by AHS to licensed foster homes, including room and board of children in the custody of and placed by AHS when the Medicaid group includes a foster parent.

(vi) Ordinary and necessary expenses for active management of capital investments, like rental property. These may include fire insurance, water and sewer charges, property taxes, minor repairs which do not increase the value of the property, lawn care, snow removal, advertising for tenants and the interest portion of a mortgage payment.

(2) Work expenses of blind individuals. In addition to other allowable deductions, work expenses from income of a blind individual include the following[24]:

(i) Cost of purchasing and caring for a guide dog;

(ii) Work-related fees such as licenses, professional association dues or union fees;

(iii) Transportation to and from work including vehicle modifications;

(iv) Training to use an impairment-related item such as Braille or a work-related item such as a computer;

(v) Federal, state and local income taxes;

(vi) Social Security taxes and mandatory pension contributions;

(vii) Meals consumed during work hours;

(viii) Attendant care services;

(ix) Structural modifications to the home; and

(x) Medical devices such as wheelchairs.

(3) Work expenses of disabled individuals. In addition to other allowable deductions, work expenses from income of a disabled individual include the following[25]:

[24] Rates for mileage reimbursement are the rates established by the U.S. General Services Administration. The rates fluctuate periodically. For the current rate, refer to the U.S. General Services Administration's website at www.gsa.gov/mileage.

[25] Rates for mileage reimbursement are the rates established by the U.S. General Services Administration. The rates

(i) Transportation to and from work, including vehicle modifications;

(ii) Impairment-related training;

(iii) Attendant care;

(iv) Structural modifications to the home; and

(v) Medical devices such as wheelchairs.

(b) Unearned income deduction

Amounts used to comply with the terms of court-ordered support or Title IV-D support payments are deducted from unearned income.

30.00 Spenddowns (10/01/2021, GCR 20-002)

(a) When the total countable income or, if applicable, resources of an individual exceeds the applicable income or resource standard for eligibility after allocations are made, and exclusions and disregards, if applicable, are applied, an individual requesting Medicaid, including Medicaid coverage of long-term care services and supports, may use the spenddown provisions set forth in this section to attain financial eligibility.

As stated in § 28.04(c), the income spenddown provisions under this section apply to an individual requesting MCA, including Medicaid coverage of long-term care services and supports under MCA, whose income exceeds the applicable income standard for eligibility for MCA and who is seeking MCA eligibility as medically needy and is subject to an income spenddown in order to be eligible. For this purpose, all references to "countable income" in this section shall mean the individual's MAGI-based income as described in § 28.03(d) adjusted, if applicable, by apportioning the income of financially responsible family members according to the requirements set forth in § 28.04(b). Since there is no resource test for MCA eligibility, none of the resource spenddown provisions under this section apply.

See § 7.03(a)(8)(i) for the individuals who may qualify for MCA as medically needy.

(b) Spending down is the process by which an individual incurs allowable expenses to be deducted from their income or spends resources to meet financial eligibility requirements.

(c) Spenddown is calculated using an accounting period of either one or six months, depending on the type of Medicaid services requested (see § 30.02). For purposes of calculating the spenddown for an individual requesting MCA eligibility as medically needy, other than Medicaid coverage of long-term care services and supports under MCA, a six month accounting period is used.

30.01 Definitions (01/15/2019, GCR 18-063)

(a) Accounting period. The one-month or six-month span of time used to budget the income of an individual

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fluctuate periodically. For the current rate, refer to the U.S. General Services Administration's website at www.gsa.gov/mileage.

requesting Medicaid.

(b) Community living arrangement

(1) A community living arrangement includes any residence, such as a house, apartment, residential care home, assisted living facility, boarding house, or rooming house. In a community living arrangement, the individual requesting Medicaid obtains and pays for basic maintenance items, such as food, shelter, clothing, personal needs, separately from medical care. The individual requesting Medicaid may live alone, as a member of a family, or with non-relatives.

(2) An individual requesting Medicaid coverage of long-term care services and supports is not considered to be in a community living arrangement.

(c) [Reserved]

(d) Long-term care living arrangement. An individual requesting Medicaid coverage of long-term care services and supports, including services and supports in a home and community-based setting, is considered to be in a long-term care living arrangement. Medicaid eligibility is determined according to the applicable long-term care Medicaid eligibility rules.

An individual receiving hospice services is considered to be in a long-term care living arrangement.[26] An individual receiving hospice services is:

(1) Terminally ill;

(2) Would be eligible for Medicaid coverage of long-term care services and supports if they lived in a medical institution; and

(3) Needs additional interdisciplinary medical care and support services to enable them and their families to maintain personal involvement and quality of life in their choice of care setting and site of death.

(e) Income spenddown. The amount of qualifying medical expenses an individual must incur to reduce their excess income to the maximum applicable to their Medicaid coverage category.

(f) Resource spenddown. The amount an individual must spend to reduce their excess resources to the resource standard applicable to the appropriate Medicaid coverage category.

30.02 Accounting periods (01/15/2017, GCR 16-098)

(a) Accounting periods are based on living arrangements. The length of the accounting period used to compute spenddown requirements depends on the living arrangement of the individual requesting Medicaid. For the purposes of Medicaid eligibility, an individual may be in a community living arrangement or a long-term care living arrangement.

[26] For information about hospice services, see Health Care Administrative Rules (HCAR) at § 4.227.

(b) Six-month accounting period for community living arrangement

(1) A six-month accounting period is used to determine spenddown requirements for an individual in a community living arrangement.

(2) The six-month period begins with the first month for which Medicaid is requested, usually the month of application. If Medicaid is requested for expenses incurred during any one or more of the three months preceding the month of application, the six-month period begins with the earliest of these three months in which expenses were incurred and the individual met all other eligibility requirements.

(3) To determine the amount of income an individual must spend down, AHS makes reasonable estimates of future income, subject to review and adjustment if the individual's circumstances change during the remainder of the six-month accounting period.

(c) One-month accounting period for long-term care living arrangement

(1) A one-month accounting period is used to determine spenddown requirements for an individual in a long-term care living arrangement.

(2) The one-month accounting period begins with the first calendar month during which the individual is in a long-term care living arrangement for any part of the month, applies for Medicaid coverage of long-term care services and supports for that month, and meets the general and categorical requirements for eligibility for Medicaid coverage of long-term care services and supports.

(3) The one-month accounting period ends with the last calendar month during which the individual is in a long-term care living arrangement for any part of the month and passes all other eligibility tests for Medicaid coverage of long-term care services and supports.

30.03 Spend down of excess resources and income – in general (01/15/2017, GCR 16-098)

An individual who passes all nonfinancial eligibility tests may qualify for Medicaid by spending down the income or resources, if applicable, that are in excess of the maximums applicable to them. The income and resource maximums for each MABD eligibility category are specified in the descriptions found in §§ 8.05 and 8.06. Income and resource maximums can also be found in Vermont's Medicaid Procedures Manual. The income maximums for the MCA categories are specified in the descriptions found in § 7.03(a).

30.04 Resource spenddowns (01/15/2017, GCR 16-098)

(a) Spending down excess resources

(1) An individual requesting MABD with excess resources is determined to have passed the resource test upon proof that the excess resources are no longer held as a resource and have actually been spent or given away. However, an individual with excess resources seeking Medicaid coverage of long-term care services and supports under MABD is subject to the transfer-of-resource provisions at § 25.00 if they spend or give away excess resources within the penalty period specified in § 25.04.

(2) MABD may be granted for the month of application if the resource test is passed at any point in the month and all other eligibility criteria are met. Resources may rise above the resource maximum, for example,

due to interest added to bank accounts or failure to use the full monthly income amount protected for maintenance expenses during the month it is received. An individual enrolled in MABD may maintain MABD eligibility for any month in which resources exceed the resource maximum by taking any action that reduces the excess amount, including giving the excess to AHS to repay expenditures on the individual's care. As long as resources are reduced to the resource maximum before the end of the month during which resources exceed the limit, MABD continues without interruption.

(3) When a third party who handles any resources of an individual receiving MABD or of a member of the individual's financial responsibility group is unaware of a resource or its value, AHS provides uninterrupted MABD to the individual as long as the excess amount is paid to AHS as a recovery of Medicaid payments. Excess resources reimbursed to AHS in these situations will not result in ineligibility.

(b) Retroactive coverage. One or more of the following actions may be taken to reduce excess resources in order to qualify for MABD up to three months prior to the month of application, as long as all other eligibility tests are passed:

(1) Set up a burial fund that meets the requirements specified in § 29.08 for an excluded resource.

(2) If countable income is less than the applicable PIL, spend resources on maintenance expenses, such as housing, food, clothing and fuel, up to a maximum per month of the difference between the countable income and the applicable PIL.

(3) Spend excess resources on covered or noncovered medical expenses.

30.05 Income spenddowns (10/01/2021, GCR 20-002)

(a) Spending down excess income on medical expenses. AHS determines that an individual requesting Medicaid with excess income has passed the income test upon proof that medical expenses have been paid or incurred at least equal to the difference between the countable income and the applicable income maximum for the accounting period.

(b) Allowable uses of excess income. Medical expenses of any member of the individual's financial responsibility group, whether they are paid or incurred but not paid, may be used to meet the individual's income spenddown requirement; references in § 30.06 to the medical expenses of the "individual" include the medical expenses of any member of the individual's financial responsibility group.

(c) Income spenddown methodology

(1) An individual requesting Medicaid may spend their excess income down to the PIL on medical expenses following the methodology specified below to receive Medicaid as part of the medically-needy coverage group.

(2) The spenddown methodology is the same for all living arrangements, except that a one-month accounting period applies to an individual in a long-term care living arrangement and a six-month accounting period applies to an individual in a community living arrangement.

(d) Eligibility date

(1) An individual with excess income passes their income test on the first day within their accounting period that deductible medical expenses meet or exceed their spenddown requirement. Sometimes this allows for retroactive coverage.

(2) Eligibility becomes effective:

(i) On the first day of the month when a spenddown requirement is met using health insurance expenses and noncovered medical expenses.

(ii) Later than the first day of the month when a spenddown requirement is met using covered medical expenses.

(3) Special eligibility dates apply, as set forth in § 30.06, for an individual who meets their spenddown requirement using noncovered assistive community care services (ACCS).

(4) Medicaid pays for covered services on the first day that the individual's medical expenses exceed the amount of their spenddown requirement. Medicaid continues until the end of the accounting period unless the individual's situation or PIL changes.

(e) Continuing responsibility for medical expenses incurred before the eligibility date

(1) An individual remains responsible for medical expenses they incurred before the date of eligibility.

(2) When services are received from more than one provider on the day that Medicaid begins, the individual must decide which services they will be responsible for paying and which ones Medicaid will cover.

(f) Deduction sequence. Medical expenses are deducted from income in the following order:

(1) Health insurance expenses (see § 30.06(b)).

(2) Noncovered medical expenses (see § 30.06(c)).

(3) Covered medical expenses (see § 30.06(d)) that exceed limitations on amount, duration, or scope of services covered (see DVHA Rules 7201-7606).

(4) Covered medical expenses (see § 30.06(d)) that do not exceed limitations on amount, duration or scope of services covered. These must be deducted in chronological order of the date the service was received beginning with the oldest expense.

(g) Time frames for deductions

(1) Deductible medical expenses include medical expenses incurred:

(i) During the current accounting period, whether paid or unpaid;

(ii) Before the current accounting period and paid in the current accounting period, or

(iii) Before the current accounting period, remaining unpaid, and for which continuing liability can be established (see paragraph (i) of this § 30.05 for details on how to establish continuing liability).

(2) Deductible medical expenses also include medical expenses paid during the current accounting period by a state or local program other than a program that receives Medicaid funding.

(3) Medical expenses incurred before or during the accounting period and paid for by a bona fide loan, as described in (4) below, may be deducted if the expense has not been previously used to meet a spenddown requirement and the individual establishes continuing liability for the loan (see paragraph (i) of this § 30.05 for details on how to establish continuing liability) and documents that all or part of the principal amount of the loan remains outstanding at any time during the accounting period. Only the amount of the principal outstanding during the accounting period, including payments made on the principal during the accounting period, may be deducted.

(4) For purposes of this subsection, a "bona fide loan" is an obligation documented from its outset by a written contract and a specified repayment schedule.

(h) Predictable expenses. In general, an expense is incurred on the date liability for the expense begins. However, there are four types of predictable medical expenses that may be deducted before they are incurred, if it can be reasonably assumed that the expense will continue during the accounting period:

(1) Premiums on health insurance (see § 30.06(b));

(2) Medically necessary over-the-counter drugs and supplies (see § 30.06(c)(1));

(3) Ongoing, noncovered personal care services (see § 30.06(c)(3)); and

(4) ACCS provided to an individual residing in a level III residential care home which is either:

(i) Not enrolled as a Medicaid provider; or

(ii) With an admission agreement specifying the resident's financial status as a privately-paying resident (see § 30.06(c)(4)).

(i) Establishing continuing liability for prior medical expenses. Continuing liability for unpaid medical expenses, including liability on a bona fide loan used to pay medical expenses, incurred before the current accounting period is established when any of the following conditions is met. The liability was incurred:

(1) Within six months of the date of application or the first day of the accounting period, whichever is later.

(2) More than six months before the date of application or the first day of the accounting period, whichever is later, and there is a bill for the liability dated within 90 days of that date.

(3) More than six months before the date of application or the first day of the accounting period, whichever is later, and the service provider or lender has confirmed that the unpaid liability has not been forgiven and is not expected to be forgiven at any time within the current accounting period.

30.06 Allowable medical expenses (01/15/2017, GCR 16-098)

(a) In general

(1) Medical expenses that are the current liability of the individual and for which no third party is legally liable

may be deducted from total excess income or resources for the accounting period.

(2) No medical expense may be used more than once to meet a spenddown requirement.

(3) A medical expense may be used to spend down either income or resources.

(4) If only a portion of a medical expense is used to meet the spenddown requirement for a given accounting period, that portion of the medical expense that was not used and remains a current liability may be applied toward a spenddown requirement in a future accounting period.

(5) Upon receiving coverage, the individual remains directly responsible to providers for expenses incurred before the spenddown was met.

(b) Health insurance expenses

(1) Health insurance is insurance that covers medical care and services, such as Medicare part B, and similar group or individual policies. A deduction is allowed for health insurance premiums paid by the individual if it can be reasonably assumed that health insurance coverage will continue during the accounting period. Deductions may also be allowed for other health insurance expenses, including enrollment fees and deductibles or coinsurance imposed by Medicare or other health insurance not subject to payment by a third party (such as another insurance policy). Health insurance coverage, the amount of the premium for the coverage, and any other deductible expense amounts must be verified.

(2) Premiums, or other expenses, for the following types of insurance are not deductible:

(i) Income protection or similar insurance plans designed to replace or supplement income lost due to sickness or accident; or

(ii) Automobile or other liability insurance, although these may include medical benefits for the insured or their family.

(c) Expenses not covered by Medicaid. A deduction is allowed for necessary medical and remedial expenses recognized by state law but not covered by Medicaid in the absence of an exception for Medicaid coverage under OVHA Rule 7.104. In determining whether a medical expense meets these criteria, AHS may require medical or other related information to verify that the service or item for which the expense was incurred was medically necessary and was a medical or remedial expense. The patient's physician shall verify medical necessity with a written statement or prescription specifying the need, quantity, and time period covered. Examples of medical expenses not covered by Medicaid include, but are not limited to, expenses for the services and items listed in (1) through (6) below. Any medical bills, including those incurred during a period of Medicaid eligibility, that are the current liability of the individual and have not been used to meet a previous spenddown requirement may be deducted from excess income. Generally, the individual is required to present a bill or receipt to verify that medical expenses have been incurred or paid.

(1) Over-the-counter drugs

(i) In general. Either standard deductions or actual costs, if greater, may be used to deduct noncovered over-the-counter drugs and supplies.

(ii) Documentation

(A) Documentation verifying medical necessity is not required when AHS determines that an over-the-counter drug or supply is a common remedy for the medical condition of the individual or of the member of the individual's financial responsibility group and the usage is within the maximum amount for common over-the-counter drugs and supplies.

(B) Documentation verifying medical necessity may be required whenever one or both of the following two situations apply:

(I) When the drug or supply is not a common remedy for the medical condition, or

(II) When the reported usage exceeds the maximum amount.

(iii) Amount deductible

(A) Instead of actual expenses, a reasonable estimate of ongoing expenses for over-the-counter drugs and supplies may be applied prospectively to the accounting period. Reasonable estimates of unit sizes, costs and maximums for common over-the-counter drugs and supplies used to meet the spenddown requirement are found in Vermont's Medicaid Procedures Manual.

(B) If an individual uses an ongoing expense to meet their spenddown requirement, they are not eligible to receive Medicaid coverage during that accounting period for the same expense.

(2) Transportation. Noncovered commercial and private transportation costs may be deducted.

(i) For commercial transportation, the actual cost of the transportation, verified by receipt, may be deducted.

(ii) For private transportation, either a standard deduction or the actual cost, if greater, may be used. The process set forth in Vermont's Medicaid Procedures Manual determines the deductible expense for private transportation.

(iii) The cost of transportation may be deducted without verification of medical necessity provided that:

(A) The transportation was essential to secure the medical service; and

(B) The individual was responsible for the cost and was charged an agreed-upon fee or purchased fuel to use a family-owned vehicle or other non-commercial vehicle.

(iv) Mileage reimbursement rates are the rates established by the U.S. General Services Administration. The rates fluctuate periodically. It is important to refer to the federal website in order to determine the current rate. The website is www.gsa.gov/mileage.

(3) Personal care services

(i) In general. A deduction for noncovered personal care services provided in an individual's own home or in a level IV residential care home is allowed when they are medically necessary in relation to an individual's medical condition.

(ii) Deductible personal care services. Deductible personal care services include the personal care services described in DVHA Rule 7406.2 and assistance with managing money. They also include general supervision of physical and mental well-being where a physician states such care is required

due to a specific diagnosis, such as Alzheimer's disease or dementia or like debilitating diseases or injuries. Room and board is not a personal care service.

(iii) Qualified personal-care service providers

(A) Except as stated in (B) below, services may be deducted when performed by a home-health agency or other provider identified by the individual's physician as qualified to provide the service.

(B) When the service provider is living in the home, deductions may not be based on payments for personal care services provided to an individual:

(I) Under age 21 by the individual's parent, stepparent, or legal guardian, unless the individual is 18, 19, or 20 years old and payment for personal care services is made from and does not exceed the individual's own income or assets;

(II) By the individual's spouse;

(III) By the individual's sibling, child, or grandchild when the person providing the services is under age 18; or

(IV) By a parent of the individual's minor child.

(iv) Documentation

(A) To document the need for personal care services, the provider must submit:

(I) A plan of care;

(II) A list of the personal care services required;

(III) A statement that the services are necessary in relation to a particular medical condition; and

(IV) A statement that the level of care provided by the particular level IV residential care home is appropriate or, if the individual is not living in a level IV residential care home and the services are not provided by a home health agency, that the provider is qualified to provide the service.

(B) Upon the initial submission of a plan of care, it is assumed that the individual will continue to need the personal care services for the entire accounting period, unless the plan of care has specified a date by which the individual's need for services is expected to change.

A plan of care can be submitted to AHS using a form provided by AHS or using a statement, signed by the physician, that contains information sufficient, as determined by AHS, to document the individual's need for personal care services.

(C) A new plan must be submitted:

(I) Once every six months, when the provider has not specified an ongoing need for personal care services in the current plan; or

(II) Once every two years, when the physician has specified an ongoing need for personal care services in the current plan.

(D) A new plan must also be submitted:

(I) Whenever the service provider changes, unless the service is performed by a home health agency; and

(II) Whenever the need for services in relation to the individual's condition is expected to change, according to the current plan of care.

(v) Amount deductible

(A) Either standard deductions or actual costs, if greater, may be used for deducting personal-care services. Expenses that have not been incurred yet may be deducted if they are predictable and meet the requirements in § 30.05(h). Expenses also may be deducted if they have actually been incurred by the individual and are not subject to payment by Medicaid or any other third party.

(B) The standard monthly deduction for personal care services shall be deducted for each full or partial calendar month in the accounting period during which the plan of care documents the need for services. The actual documented costs of personal care services may be deducted if they exceed the monthly standard deduction. Deductions may be made for anticipated need through the end of the accounting period.

(C) All changes to these standards that result in lower standard deductions will be made via the Administrative Procedures Act.

(4) Assistive Community-Care Services (ACCS)

(i) Deductible assistive community-care services. A deduction for noncovered assistive community care services (ACCS) provided to an individual residing in a licensed level III residential care home is allowed. The individual may also deduct medically-necessary personal-care services included under the list at DVHA Rule 7406.2 but not part of the list at DVHA Rule 7411.4.

(ii) Qualified Service Providers

(A) Qualified service providers include all level III residential care homes licensed by AHS.

(B) When an individual that is a resident of a level III residential care home becomes eligible for Medicaid by projecting the cost of ACCS across part of the accounting period, the residential care home may agree to function as a Medicaid provider for ACCS with respect to that resident for the remainder of their accounting period. In these cases, the provider may bill for ACCS services no sooner than the ACCS coverage date given to the resident and the provider in a notice from AHS.

(C) When a privately-paying resident of a level III residential care home becomes eligible for Medicaid after having met a spenddown requirement by projecting the cost of ACCS across the entire accounting period, the residential care home shall not function as a Medicaid provider for ACCS with respect to that resident during the period when the resident is meeting the spenddown requirement.

(iii) Documentation

(A) Documentation verifying medical necessity is not required for ACCS. If an individual claims a deduction for medically-necessary personal-care services included under the list at DVHA Rule 7406.2 but not part of the list at DVHA Rule 7411.4 the individual's physician must submit:

(I) A plan of care (form 288B);

(II) A list of the personal care services required;

(III) A statement that the services are necessary in relation to a particular medical condition; and

(IV) A statement that the level of care provided by the particular level III residential care home is appropriate and that the provider is qualified to provide the service.

(B) Upon the initial submission of a plan of care, it is assumed that the individual will continue to need the personal care services for the entire accounting period, unless the plan of care has specified a date by which the individual's need for services is expected to change.

(C) An individual with an approved personal care services deduction must submit new plans at the same frequencies specified under paragraph (c)(3)(iv) of this subsection.

(iv) Amount deductible

(A) The deduction for ACCS may be used for the entire accounting period or part of it. Whether the standard daily or monthly deduction is used depends on the size of the spenddown requirement. The actual documented costs of ACCS may be deducted if they exceed the monthly standard deduction. Deductions may be made for anticipated need through the end of the accounting period. All changes in these standards that result in lower standard deductions will be made via the Administrative Procedures Act.

(B) If the individual's excess income and resources after deduction of all expenses for which Medicaid coverage is not available equal or exceed the deduction for ACCS for the entire accounting period, for the purposes of meeting a spenddown requirement, ACCS are projected and deducted as if they were not Medicaid-covered services for the entire accounting period. Medicaid eligibility for services other than ACCS becomes effective on the day the spenddown requirement is met. Expenses for which Medicaid coverage is not available are:

(I) Medical expenses excluded from coverage;

(II) Covered medical expenses incurred prior to the accounting period, not used to meet a previous spenddown requirement, and remaining unpaid; and

(III) Covered medical expenses incurred and paid during the current accounting period.

(C) If the individual's excess income and resources after deduction of all expenses for which Medicaid coverage is not available are less than the deduction for ACCS for the entire accounting period, ACCS expenses are not projected. Instead, they are deducted as covered expenses on a daily basis. In this case, Medicaid eligibility for all covered services other than ACCS becomes effective the first day of the accounting period. Medicaid coverage for ACCS begins later. It starts the day cumulative daily ACCS deductions exceed the individual's remaining excess income and resources. The individual is not responsible for payment of a portion of the ACCS expense on the first day of ACCS eligibility.

(D) In addition, the amount of the deduction for any services included under the list at DVHA rule 7406.2 but not part of the list at DVHA rule 7411.4 documented as medically necessary by the plan of care is determined based on the number of hours times minimum wage, or actual costs, if greater.

(5) Dental services. Dental services in excess of the allowable annual maximum may be deducted.

(6) Private-duty nursing services. Private-duty nursing services for an individual age 21 and older may be deducted.

(d) Expenses for covered medical services

(1) A covered medical service is any medical or remedial service that Medicaid would pay for if the individual were enrolled in Medicaid (see DVHA Rules 7201–7606).

(2) Deductions for covered medical services are not limited to the Medicaid reimbursement for the service. The actual cost paid or incurred is allowed. A standard deduction may be taken for ACCS (see DVHA Rule 7411.4), as set forth in Vermont's Medicaid Procedures Manual.

(e) Third-party coverage

(1) No deduction is allowed if the medical expense is subject to payment by a third party such as health insurance, worker's compensation, liability award, or other benefit program unless the third party is a state or local program other than Medicaid.

(2) When a third party is liable for all or some medical expenses, only the portion owed by the individual may be deducted. AHS is required to take reasonable measures to determine the legal liability of third parties to pay for incurred expenses. Estimates of payment by the third party may be used if actual third party liability cannot be ascertained within the period for determining Medicaid eligibility. An eligibility determination may not be delayed simply because actual third party liability cannot be ascertained or payment by the third party has not been received.

(3) If an individual is pursuing a liability award, but liability has not yet been established, a deduction is allowed. Eligibility must be based on AHS's estimate of the amount the individual owes for the bill.

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Part Five
Financial Methodologies

Part Five describes the financial standards and methodologies, including income and resource tests, that apply to the various health-benefits programs and categories of assistance.

28.00 Financial eligibility standards – application of modified adjusted gross income (MAGI) (10/01/2021, GCR 20-002)

28.01 Basis, scope, and implementation[1] (01/15/2019, GCR 18-063)

(a) This section implements § 1902(e)(14) of the Act.

(b) The financial methodologies set forth in this section will be applied in determining the financial eligibility of all individuals for health benefits, except for individuals identified in paragraph (i) of § 28.03.

28.02 Definitions (01/15/2017, GCR 16-098)

For purposes of this section:

(a) Family size[2]

(1) The number of persons counted as members of the individual's household. Family size may include individuals who are not subject to or are exempt from penalty for failing to maintain MEC.

(2) Special counting rule for Medicaid: In the case of determining the family size of a pregnant woman, or the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted as herself plus the number of children she is expected to deliver.

(b) Modified Adjusted Gross Income (MAGI).[3] Adjusted gross income (within the meaning of § 62 of the Code) increased by:

(1) Amounts excluded from gross income for citizens or residents of the United States living abroad;

(2) Tax-exempt interest the tax filer receives or accrues during the benefit year; and

(3) Social Security benefits not already included in adjusted gross income.

[1] 42 CFR § 435.603(a).

[2] 26 CFR § 1.36B-1(d); 42 CFR § 435.603(b). Note: The IRS rules do not include unborn children in the determination of family size.

[3] 26 CFR § 1.36B-1(e)(2); 42 CFR 435.4; 45 CFR § 155.300. These sections reference § 36B(d)(2)(B) of the Code. This is the definition found in that provision.

28.03 MAGI-Based Medicaid (10/01/2021, GCR 20-002)

(a) Definition: Tax dependent. For purposes of MAGI-based Medicaid, the term "tax dependent" has the same meaning as the term "dependent" under § 152 of the Code, and also includes an individual for whom another individual claims a deduction for a personal exemption under § 151 of the Code for the benefit year.[4]

(b) Basic rule.[5] Except as specified in paragraphs (h), (i), and (j) of this subsection, financial eligibility for MAGI-based Medicaid is determined based on household income, as defined in paragraph (c) of this subsection. Household composition is determined separately for each individual; see paragraph (e) of this subsection for details on household composition.

(c) Household income[6]

(1) General rule. Except as provided in paragraphs (c)(2) through (c)(4) of this subsection, household income for MAGI-based Medicaid is the sum of the MAGI-based income, as defined in paragraph (d) of this subsection, of every person included in the individual's household, as defined in paragraph (e) of this subsection.

(2) Income of children and tax dependents

(i) The MAGI-based income of a person who is included in the household of their natural, adopted, or step-parent, and is not expected to be required to file a federal tax return[7] for the benefit year in which eligibility for Medicaid is being determined, is not included in household income whether or not such person files a federal tax return.

(ii) The MAGI-based income of a tax dependent described in paragraph (e)(3)(i) of this subsection (individual other than a spouse or child who expects to be claimed as a tax dependent by another tax filer) who is not expected to be required to file a federal tax return[8] for the benefit year in which eligibility for Medicaid is being determined, is not included in the household income of the tax filer whether or not such tax dependent files a federal tax return.

(3) Available cash support not included. In the case of an individual described in paragraph (e)(3)(i) of this subsection (individual other than a spouse or child who expects to be claimed as a tax dependent by another tax filer), household income does not include cash support provided by the person claiming such individual as a tax dependent.

(4) Five-percent disregard. Effective January 1, 2014, in determining the eligibility of an individual for

[4] 42 CFR § 435.4

[5] 42 CFR § 435.603(c).

[6] 42 CFR § 435.603(d).

[7] As required under section 6012(a)(1) of the Code.

[8] *Id*

Medicaid under the eligibility group with the highest income standard under which the individual may be determined eligible using MAGI-based methodologies, an amount equivalent to 5 percentage points of the FPL for the applicable family size is deducted from household income.

(5) Sponsored noncitizens

(i) In determining the financial eligibility of a noncitizen who is admitted to the United States on or after August 22, 1996, based on a sponsorship under § 204 of the INA, the income of the sponsor and the sponsor's spouse, if living with the sponsor, must be counted as available to the noncitizen when all four of the conditions set forth in (A) through (D) below are met. The responsibility of a sponsor continues until the noncitizen is naturalized or credited with 40 qualifying quarters of coverage by the SSA (as described in (ii) below). Children and pregnant women who are exempt from the five-year bar pursuant to § 17.03(c)(6) are not subject to these provisions. The four conditions are as follows:

(A) The sponsor has signed an affidavit of support on a form developed by the United States Attorney General as required by PRWORA to conform to the requirements of § 213A(b) of INA;

(B) The noncitizen is lawfully admitted for permanent residence, and a five-year period of ineligibility for Medicaid following entry to the United States has ended;

(C) The noncitizen is not battered; and

(D) The noncitizen is not indigent, defined as unable to obtain food and shelter without assistance, because his or her sponsor is not providing adequate support.

(ii) *Qualifying quarters of coverage.*

(A) A noncitizen is credited with the following qualifying quarters of coverage (as defined under Title II of the Act);

(I) All of the qualifying quarters of coverage worked by the noncitizen;

(II) All of the qualifying quarters of coverage worked by a parent of such noncitizen while the noncitizen was under age 18; and

(III) All of the qualifying quarters of coverage worked by a spouse of such noncitizen during their marriage as long as the noncitizen remains married to such spouse or such spouse is deceased.

(B) No qualifying quarter of coverage for any period beginning after December 31, 1996 may be credited to a noncitizen under (II) or (III) above if the parent or spouse, as the case may be, of such noncitizen received any federal means-tested public benefit during the period for which the qualifying quarter of coverage is credited. Federal means-tested benefits for this purpose do not include:

(I) Emergency medical assistance;

(II) Short-term, non-cash, in-kind emergency disaster relief;

(III) Assistance under the National School Lunch Act or the Child Nutrition Act of 1966:

(IV) Public health assistance for immunizations or testing and treatment of symptoms of communicable diseases not paid by Medicaid;

(V) Payments for foster care and adoption assistance under parts B and E of Title IV of the Act, under certain conditions;

(VI) Programs, services or assistance specified by the Attorney General;

(VII) Programs of student assistance under Titles IV, V, IX and X of the Higher Education Act of 1965, and Titles III, VII and VIII of the PHS Act;

(VIII) Means-tested programs under the Elementary and Secondary Education Act of 1965;

(IX) Benefits under the Head Start Act; or

(X) Benefits under the Job Training Partnership Act.

(d) MAGI-based income.[9] For the purposes of this subsection, MAGI-based income means income calculated using the same financial methodologies used to determine MAGI, with the following exceptions:

(1) An amount received as a lump sum is counted as income only in the month received unless otherwise required by federal law with respect to qualified lottery and gambling winnings of $80,000 or greater.[10]

(2) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are excluded from income.

(3) *American Indian/Alaska Native exceptions.* The following are excluded from income:

(i) Distributions from Alaska Native Corporations and Settlement Trusts;

(ii) Distributions from any property held in trust, subject to federal restrictions, located within the most recent boundaries of a prior federal reservation, or otherwise under the supervision of the Secretary of the Interior;

(iii) Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from:

(A) Rights of ownership or possession in any lands described in paragraph (d)(3)(ii) of this subsection; or

(B) Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources;

(iv) Distributions resulting from real property ownership interests related to natural resources and improvements:

(A) Located on or near a reservation or within the most recent boundaries of a prior federal reservation; or

[9] 42 CFR § 435.603(e).

[10] Bipartisan Budget Act of 2018, section 53103; CMS SHO Letter No. 19-003 (August 22, 2019).

(B) Resulting from the exercise of federally-protected rights relating to such real property ownership interests;

(v) Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom;

(vi) Student financial assistance provided under the Bureau of Indian Affairs education programs.

(e) Household

(1) In general. For purposes of household composition:

(i) "Child" includes a natural or biological, adopted or step-child.

(ii) "Parent" includes a natural or biological, adopted or step-parent.

(iii) "Sibling" includes a natural or biological, adopted or step-sibling.

(2) Basic rule for tax filers not claimed as a tax dependent. In the case of an individual who expects to file a federal tax return for the benefit year in which an initial determination or renewal of eligibility is being made, and who does not expect to be claimed as a tax dependent by another tax filer, the household consists of the tax filer and, subject to paragraph (e)(6) of this subsection, all persons whom such individual expects to claim as a tax dependent.

(3) Basic rule for individuals claimed as a tax dependent. In the case of an individual who expects to be claimed as a tax dependent by another tax filer for the benefit year in which an initial determination or renewal of eligibility is being made, the household is the household of the tax filer claiming such individual as a tax dependent, except that the household must be determined in accordance with paragraph (e)(4) of this subsection in the case of:

(i) Individuals who expect to be claimed as a tax dependent by a tax filer who is not the individual's spouse or parent;

(ii) Individuals under the age specified under paragraph (e)(4)(iv) of this subsection who expect to be claimed by one parent as a tax dependent and are living with both parents but whose parents do not expect to file a joint federal tax return; and

(iii) Individuals under the age specified under paragraph (e)(4)(iv) of this subsection who expect to be claimed as a tax dependent by a non-custodial parent. For purposes of this paragraph:

(A) The custodial parent is the parent so named in a court order or binding separation, divorce, or custody agreement establishing physical custody; or

(B) If there is no such order or agreement, or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights.

(4) Rules for individuals who neither file a tax return nor are claimed as a tax dependent. In the case of an individual who does not expect to file a federal tax return and does not expect to be claimed as a tax dependent for the benefit year in which an initial determination or renewal of eligibility is being made, or who is described in paragraph (e)(3)(i), (e)(3)(ii), or (e)(3)(iii) of this subsection, the household consists of

the individual and, if living with the individual:

(i) The individual's spouse;

(ii) The individual's children under the age specified in (iv) of this paragraph (e)(4); and

(iii) In the case of an individual under the age specified in (iv) of this paragraph (e)(4), the individual's parents and siblings under the age specified in (iv) of this paragraph (e)(4).

(iv) The age specified in this paragraph (e)(4) is age 19 or, in the case of a full-time student, age 21.

(5) Couples. In the case of a couple living together, each spouse is included in the household of the other spouse, regardless of whether they expect to file a joint federal tax return[11] or whether one spouse expects to be claimed as a tax dependent by the other spouse.

(6) Households of individuals whom tax filer cannot establish as a dependent. For purposes of paragraph (e)(2) of this subsection, if, consistent with the procedures adopted by the state in accordance with § 56.00, a tax filer cannot reasonably establish that another person is a tax dependent of the tax filer for the benefit year in which Medicaid is sought, the inclusion of such person in the household of the tax filer is determined in accordance with paragraph (e)(4) of this subsection.

(f) No resource test or income disregards.[12] In the case of an individual whose financial eligibility for Medicaid is determined in accordance with this subsection, AHS will not:

(1) Apply any resources test; or

(2) Apply any income or expense disregards under §§ 1902(r)(2) or 1931(b)(2)(C), or otherwise under Title XIX of the Act, except as provided in paragraph (c)(4) of this subsection.

(g) Budget period[13]

(1) Applicants and new enrollees. Financial eligibility for Medicaid for applicants, and other individuals not receiving Medicaid benefits at the point at which eligibility for Medicaid is being determined, must be based on current monthly household income and family size.

(2) Current beneficiaries. For an individual who has been determined financially eligible for Medicaid using the MAGI-based methods set forth in this section, AHS will base financial eligibility on projected annual household income and family size for the remainder of the current calendar year.

(h) Alternative methodology to avoid eligibility gap.[14] If an individual who meets the non-financial eligibility

[11] See, § 6013 of the Code.

[12] 42 CFR § 435.603(g).

[13] 42 CFR § 435.603(h).

[14] 42 CFR § 435.603(i).

requirements for Medicaid is determined to be financially ineligible for Medicaid using the MAGI-based Medicaid methodologies set forth in this subsection, but their household income is determined to be less than 100 percent of the FPL using the MAGI methodologies for determining eligibility for APTC and CSR, as set forth in § 28.05, the individual's eligibility for Medicaid will be determined using the MAGI methodologies set forth in § 28.05.

(i) Eligibility groups for which MAGI-based methods do not apply.[15] The financial methodologies described in this subsection are not applied in determining the Medicaid eligibility of individuals described in this paragraph. Except for the individuals described in (1) of this paragraph (i), the financial methodologies described in § 29.00 (MABD financial eligibility standards) will be used to determine Medicaid eligibility for such individuals.

(1) Individuals whose eligibility for Medicaid does not require a determination of income, including, but not limited to, individuals receiving SSI eligible for Medicaid under § 8.05(a) and individuals deemed to be receiving SSI and eligible for Medicaid under § § 8.05(c), (f) and (h).

(2) Individuals who are age 65 or older when age is a condition of eligibility.

(3) Individuals whose eligibility is being determined on the basis of being blind or disabled, or on the basis of being treated as being blind or disabled, including, but not limited to, individuals under § 8.05(k)(6)(Katie Beckett) and individuals receiving state supplements, but only for the purpose of determining eligibility on such basis.

(4) Individuals who request that the financial methods described in § 29.00 be used to determine their eligibility for Medicaid coverage of long-term care services and supports.

(5) Individuals who are being evaluated for eligibility for Medicare cost-sharing assistance under § 8.07, but only for purposes of determining eligibility for such assistance.

(j) Special rule: family planning services.[16] In the case of an individual whose eligibility is being determined under § 9.03(g) (family planning services), AHS will:

(1) Consider the household to consist of only the individual for purposes of paragraph (e) of this subsection;

(2) Count only the MAGI-based income of the individual for purposes of paragraph (c) of this subsection; and

(3) Increase the family size of the individual, as defined in § 28.02, by one.

28.04 Medically-needy MCA – income eligibility (01/01/2018, GCR 17-047)

(a) In general. Income eligibility of an individual requesting medically-needy MCA is determined by calculating the individual's MAGI-based income as described in § 28.03(d). The individual's MAGI-based income is then adjusted, if applicable, by apportioning the income of financially responsible family members according to the

[15] 42 CFR § 435.603(j).

[16] 42 CFR § 435.603(k).

requirements set forth in paragraph (b) of this subsection.

For the individuals who may qualify for medically-needy MCA, see § 7.03(a)(8).

(b) Financial responsibility of relatives and other individuals[17]

(1) Financial responsibility of relatives and other persons for the individual is limited to the following:

(i) A spouse for their spouse when both are living in the same household; and

(ii) A parent, step-parent, or adoptive parent for their unmarried child under the age of 21 living in the same household unless the child is pregnant or a parent whose own child is living in the household and they make a monthly (or more frequent) room or board payment to their parents.

(2) Except for a spouse of an individual or a parent for a child who is under age 21, no income or resources of any other relative will be considered as available to the individual.

(3) When a couple ceases to live together, only the income of the individual spouse will be counted in determining their eligibility, beginning the first month following the month the couple ceases to live together.

(c) Spenddown. The income spenddown provisions set forth in § 30.00 apply to an individual requesting medically-needy MCA. For purposes of the spenddown provisions at § 30.00, anyone identified in paragraph (b) above as financially responsible for the individual is considered a member of the individual's financial responsibility group as that term is used throughout § 30.00.

28.05 APTC and CSR (01/15/2017, GCR 16-098)

(a) Definition: Tax dependent. For purposes of APTC and CSR, the term "tax dependent" has the same meaning as the term "dependent" under § 152 of the Code.

(b) Basic rule. Financial eligibility for APTC and CSR is determined based on household income as defined in paragraph (c) of this subsection.

(c) Household income.[18] Household income is the sum of:

(1) A tax filer's MAGI; plus

(2) The aggregate MAGI of all other individuals who:

(i) Are included in the tax filer's household (as defined in paragraph (d) of this subsection); and

(ii) Are required to file a federal income tax return for the benefit year.

[17] 42 CFR § 435.602.

[18] 26 CFR § 1.36B-1(e).

(d) Household. The household consists of the tax filer, the tax filer's spouse (if married within the meaning of 26 CFR § 1.7703-1), and all individuals claimed as the tax filer's tax dependents. As described in § 58.02(b)(2), married couples must file joint federal tax returns in order to be considered for APTC and CSR, unless the tax filer meets the exception criteria defined in § 12.03(b) (victim of domestic abuse or spousal abandonment). Parties to a civil union may qualify for APTC and CSR by filing separate tax returns.

29.00 Financial eligibility standards – Medicaid for the aged, blind, and disabled (MABD) (01/01/2023, GCR 22-032)

29.01 Introduction (01/15/2017, GCR 16-098)

An individual who meets the nonfinancial and categorical requirements for MABD must also meet the financial requirements specified in this section. AHS determines financial eligibility for MABD, including Medicaid coverage of long-term care services and supports under MABD.

To determine an individual's financial eligibility for MABD, AHS calculates the countable income and countable resources of the individual's financial responsibility group and compares those amounts to standards based on the size of the individual's Medicaid group. The first step in determining financial eligibility is to identify the members of the individual's financial responsibility group and the members of the individual's Medicaid group. An aged, blind, or disabled individual requesting MABD is always a member of both groups.

The rules for forming the financial responsibility group are specified in § 29.03.

The rules for forming the Medicaid group are specified in § 29.04.

The rules on resources are specified in §§ 29.07 through 29.10.

The rules on income are specified in §§ 29.11 through 29.15.

29.02 Definitions (01/15/2017, GCR 16-098)

As used in this § 29.00, the following terms have the following meanings:

(a) Child

(1) An individual who:

(i) Is under age 18 or is a student under age 22;

(ii) Has always been single; and

(iii) Lives with a parent.

(A) A child is not considered living with a parent when:

(I) The parent has relinquished control to a school or vocational facility;

(II) The child is confined to a public institution or is in the custody of a public agency;

(III) The child is a member of the armed forces;

(IV) The child lives in a private nonmedical facility; or

(V) The child has been admitted to long-term care.

(B) A child away at school who returns to a parent's home for vacations, holidays, or some weekends is considered living with that parent.

(2) An individual who qualifies for the Katie Beckett coverage group (see § 8.05(k)(6)) is not considered a child for the purposes of determining their financial eligibility for MABD.

(3) An individual is no longer considered a child on the first day of the month following the calendar month in which they no longer meet the definition of child.

(b) Adult. An individual who is not a child.

(c) Eligible child. For purposes of deeming, as described in § 29.05, a child who is a natural or adopted child under the age of 18, who lives in a household with one or both parents, is not married, and meets the non-financial eligibility requirements for MABD.

(d) Ineligible child. For deeming purposes, a child, as defined in (a) of this subsection, who does not meet the non-financial criteria for MABD, lives in the same household as the individual requesting MABD, and is:

(1) The natural child or adopted child of the individual;

(2) The natural or adopted child of the individual's spouse, or

(3) The natural or adopted child of the individual's parent or of the spouse of the individual's parent.

(e) Ineligible parent. For deeming purposes, a person who does not meet the non-financial criteria for MABD, lives with an eligible child, and is:

(1) A natural or adoptive parent of the child; or

(2) The spouse of a natural or adoptive parent of the child.

(f) Ineligible spouse. For deeming purposes, the spouse who lives with the individual requesting MABD and does not meet the nonfinancial eligibility criteria for MABD.

29.03 Formation of the financial responsibility group (01/15/2017, GCR 16-098)

(a) In general. The financial responsibility group for MABD consists of the individuals whose income and resources are considered available to the Medicaid group in the eligibility determination. With some exceptions, spouses are considered financially responsible for each other, and parents are considered financially responsible for their children. The following paragraphs set forth the rules for determining membership in the financial responsibility group and the portion of the group's income considered available to the Medicaid group.

(b) Financial responsibility group for an adult. The financial responsibility group for an adult requesting MABD, including Medicaid coverage of long-term care services and supports under MABD, is the same as the adult's

Medicaid group.

(c) Financial responsibility group for a child. The financial responsibility group for a child requesting MABD includes the child and any parents living with the child until the child reaches the age of 18.

(d) Financial responsibility group for a sponsored noncitizen

(1) The financial responsibility group for a noncitizen admitted to the United States on or after August 22, 1996, based on a sponsorship under §204 of the INA, includes the income and resources of the sponsor and the sponsor's spouse, if living with the sponsor, when all four of the conditions set forth in (i) through (iv) below are met. Children and pregnant women who are exempt from the five-year bar pursuant to § 17.03(c)(6) are not subject to these provisions. The four conditions are as follows:

(i) The sponsor has signed an affidavit of support on a form developed by the United States Attorney General as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) to conform to the requirements of §213A(b) of the INA;

(ii) The noncitizen is lawfully admitted for permanent residence, and a five-year period of ineligibility for MABD following entry to the United States has ended;

(iii) The noncitizen is not battered; and

(iv) The noncitizen is not indigent, defined as unable to obtain food and shelter without assistance, because their sponsor is not providing adequate support.

(2) The financial responsibility of a sponsor continues until the noncitizen is naturalized or credited with 40 qualifying quarters of coverage by the SSA (see (3) below for crediting of qualifying quarters).

(3) A non-citizen is credited with the following qualifying quarters of coverage as defined under Title II of the Act:

(i) Those worked by the non-citizen;

(ii) Those worked by a parent of such non-citizen while the non-citizen was under age 18 unless the parent received any federal means-tested public benefit during the period for which the qualifying quarter of coverage is credited after December 31, 1996;

(iii) Those worked by a spouse of the non-citizen while they were spouses, as long as the non-citizen remains the spouse or the spouse is deceased and the spouse did not receive any federal means-tested public benefit during the period for which the qualifying quarter of cover is credited after December 31, 1996;

(iv) For this purpose, federal means-tested benefits do not include:

(A) Emergency medical assistance;

(B) Short-term, non-cash, in-kind emergency disaster relief;

(C) Assistance under the National School Lunch Act or the Child Nutrition Act of 1966;

(D) Public health assistance for immunizations or testing and treatment of symptoms of communicable diseases not paid by Medicaid;

(E) Payments for foster care and adoption assistance under parts B and E of Title IV of the Act, under certain conditions;

(F) Programs, services or assistance specified by the Attorney General;

(G) Programs for student assistance under Titles IV, V, IX, and X of the Higher Education Act of 1965, and Titles III, VII, and VIII of the Public Health Service Act;

(H) Means-tested programs under the Elementary and Secondary Education Act of 1965;

(I) Benefits under the Head Start Act; or

(J) Benefits under the WIA.

29.04 Formation of the Medicaid group (01/15/2017, GCR 16-098)

(a) In general. The Medicaid group consists of individuals whose needs are included in the financial eligibility determination for MABD. The following paragraphs set forth the rules for determining membership in the Medicaid group. AHS compares countable income and resources of the financial responsibility group to maximums based on the size of the Medicaid group.

(b) Medicaid group for a single adult. A single adult requesting MABD, including Medicaid coverage of long-term care services and supports under MABD, is treated as a Medicaid group of one.

(c) Medicaid group for an adult with a spouse

(1) When spouses are living together, both the individual requesting MABD and the individual's spouse are considered members of the individual's Medicaid group, a Medicaid group of two, unless one of the exceptions specified in paragraph (d) of this subsection applies. This is true whether or not the individual's spouse is also requesting MABD.

(2) Spouses are considered living together in any of the following circumstances:

(i) Until the first day of the month following the calendar month of death or separation, when one spouse dies or the couple separates.

(ii) When one spouse is likely to need long-term care for fewer than 30 consecutive days.

(iii) When the resources of the couple are assessed and allocated as of the date of initial application for Medicaid coverage of long-term care services and supports under MABD.

(d) Exceptions for an adult with a spouse. An adult requesting MABD with a spouse is treated as a Medicaid group of one in the following circumstances:

(1) When one spouse is applying for Medicaid coverage of long-term care services and supports under MABD, they are considered a Medicaid group of one for:

(i) The determination of their initial and ongoing income eligibility; and

(ii) Resource reviews of their eligibility.

(iii) AHS considers the spouses to be no longer living together as of the first day of the calendar month one spouse begins receiving Medicaid coverage of long-term care services and supports under MABD. This remains true even if the other spouse begins receiving Medicaid coverage of long-term care services and supports in a subsequent month.

(2) When AHS determines the eligibility of one spouse for MABD when the other spouse already receives Medicaid coverage of long-term care services and supports in a home and community-based setting.

(3) When both spouses are admitted to the same residential care home, each spouse is considered a Medicaid group of one if the residential care home is designed for four or more residents.

(4) When both spouses have been admitted to the same institution for long-term care in the same month and have lived there at least six months beginning with the first month following the month of their admission, for purposes of determining each spouse's eligibility for Medicaid coverage of long-term care services and supports under MABD, each spouse is considered a Medicaid group of one for the determination of their initial and ongoing income eligibility and resource reviews of their eligibility. However, if it works to their advantage, they may be considered a Medicaid group of two.

(5) When one spouse is receiving custodial care in their home, as defined in AABD Rule 2766, they are considered a Medicaid group of one.

(e) Medicaid group for a child

(1) A child requesting MABD is treated as a Medicaid group of one.

(2) When a parent and child living together are both requesting MABD, they are treated as two Medicaid groups of one, if the parent is not living with a spouse. If the parent is living with a spouse, the parent and their spouse are treated as a Medicaid group of two and the child as a Medicaid group of one.

29.05 Deeming (01/15/2017, GCR 16-098)

(a) In general. MABD financial eligibility is based on the financial eligibility rules for the SSA's SSI program. Like SSI, the term "deeming" is used to identify countable resources and income from other people as belonging to the individual requesting MABD. When the deeming rules apply, it does not matter whether the resources or income of the other person are actually available to the individual.

(b) Categories of people whose income and resources are counted

(1) Resources and income from two categories of people may be counted as belonging to the individual. These people are members of the individual's financial responsibility group. AHS considers:

(i) Spousal resources and income to decide whether it must deem some of it to the Medicaid group; and

(ii) Parental resources and income for an eligible child to decide whether it must deem some of it to the Medicaid group.

(2) § 29.10 specifies the resources counted when determining MABD financial eligibility.

(3) § 29.14 specifies the income counted when determining MABD financial eligibility.

29.06 Temporary absences and deeming rules (01/15/2017, GCR 16-098)

(a) Effect of temporary absence. For purposes of deeming, during a temporary absence, the absent person continues to be considered a member of the individual's household.

(b) Definition of temporary absence. A temporary absence occurs when the individual or their ineligible spouse, parent, or an ineligible child leaves the household but intends to and does return in the same month or the next month.

(c) Treatment of absences due to schooling. An eligible child is considered temporarily absent from their parent's (or parents') household if they are away at school but come home on some weekends or lengthy holidays and are subject to the control of their parent(s).

(d) Absences related to active duty assignment. If the individual's ineligible spouse or parent is absent from the household due solely to a duty assignment as a member of the armed forces on active duty, that person is considered to be living in the same household as the individual, unless evidence indicates that the individual's spouse or parent should no longer be considered to be living in the same household. When such evidence exists, AHS stops deeming their resources and income beginning with the month after the spouse or parent no longer lived in the same household.

29.07 Resources (01/15/2017, GCR 16-098)

(a) In general

(1) Resources are cash and other property, real or personal, that an individual (or their spouse, if any):

(i) Owns;

(ii) Has the right, authority or power to convert to cash (if not already cash); and

(iii) Is available for their support and maintenance.

(2) Resources are treated in different ways depending on the rules of the coverage group involved and the type and liquidity of the resource.

(3) Resources are counted based upon their availability and the ease with which they can be converted into cash. Availability is often affected when more than one person has an ownership interest in the same resource.

(4) Resource limits vary depending on the type of category and services, and the size of the Medicaid group. Resource eligibility for each coverage group is determined by comparing the resources of the financial responsibility group to the resource limit based on the size of the Medicaid group. Resource maximums are specified in Vermont's Medicaid Procedures Manual.

(5) All resources of the members of the financial responsibility group must be counted except those

specifically excluded. See § 29.08 for the resource exclusion rules.

(6) Equity value as well as availability is considered when determining the amount of a resource that counts. In general, equity value means the price an item can be reasonably expected to sell for on the local open market minus any encumbrances. See § 29.09 for the general rules on valuing countable resources.

(b) Types of resources. This paragraph describes some of the kinds of resources the availability of which are considered in determining MABD eligibility. The descriptions are divided into two categories – nonliquid resources and liquid resources. Except for cash, any kind of property may be either liquid or nonliquid. The liquidity (or nonliquidity) of a resource has no effect on the resource's countability for MABD eligibility purposes.

(1) Definition: Nonliquid resources. A nonliquid resource means property that is not cash, including real and personal property that cannot be converted to cash within 20 work days. Real property, life estates, life insurance and burial funds, described below, are some of the more common kinds of nonliquid resources. Certain other noncash resources, though they may occasionally be liquid, are nearly always nonliquid. These include, but are not limited to, household goods and personal effects, vehicles, livestock, and machinery.

(i) Real property. Land and generally whatever is erected, growing on, or affixed to land. See § 29.08(a) for information on the resource exclusion of real property.

(ii) Life estates. Life estate means a legal arrangement entitling the owner of the life estate (sometimes referred to as the "life tenant") to possess, rent, and otherwise profit from real or personal property during their lifetime. The owner of a life estate sometimes may have the right to sell the life estate, but does not normally have future rights to the property. Ownership of a life estate may be conditioned upon other circumstances, such as a new spouse. The document granting the life estate includes the conditions for the life estate and the right of the owner of the life estate to sell or bequeath it, if these property rights were retained. See § 29.08(a)(6) for information on the resource exclusion of life estates.

(iii) Life insurance. A contract that provides for its purchaser to pay premiums to the insurer, who agrees to pay a specific sum to a designated beneficiary upon the death of the insured. Life insurance is usually sold by an insurance company but may also be sold by other financial institutions, such as brokerage firms. See § 29.08(b) for information on the resource exclusion of life insurance.

The following are terms related to life insurance:

(A) Face value. The amount the life insurance policy pays the designated beneficiary upon the death of the insured.

(B) Term life insurance. A life insurance policy that does not accumulate any cash value as premiums are paid.

(C) Whole life insurance (sometimes called ordinary life, limited payment or endowment insurance). A life insurance policy that accumulates cash value as premiums are paid. It may also pay periodic dividends on this value when all premiums have been paid. These dividends may be paid to the owner, or they may be added to the cash surrender value (defined below) of the policy.

(D) Cash surrender value (CSV) of whole life insurance. The amount the owner would receive if the life insurance policy were terminated before the insured dies. It is a form of equity that accumulates over time as life insurance premiums are paid. The owner may borrow against the CSV according to the terms of the policy. A loan against a policy reduces its CSV.

(E) Group policy. A life insurance policy that is usually issued through a company or organization insuring the participating employees or members and, perhaps, their families. The group policy may be paid partially by the employer. A group insurance policy generally has no CSV.

(iv) Burial Funds

(A) Any separately-identifiable fund clearly designated for burial expenses (which includes expenses for burial spaces, items related to burial spaces and services related to burial spaces) through the title to the fund or by a sworn statement provided. Burial funds include contracts, trusts, or other agreements, accounts, or instruments with a cash value. Some burial funds include accumulated interest, and the value of some burial funds may change through time (e.g., when the fund consists of bonds). See § 29.08(c) for information on the resource exclusion of burial funds.

(B) The cash value of life insurance policies may also be treated as a burial fund if owned by a person whose income and resources are considered in determining an individual's MABD eligibility and if designated as specified above.

(C) For the purposes of determining MABD eligibility, burial spaces, if not fully paid, are considered burial funds and include burial plots, gravesites, crypts, mausoleums, caskets, urns, and other repositories customarily and traditionally used for the deceased's bodily remains. Items related to burial spaces include, but are not limited to, vaults, headstones, markers, plaques, and burial containers for caskets. Services related to burial include, but are not limited to, embalming, opening and closing of the gravesite, and care and maintenance of the gravesite, sometimes called an endowment or perpetual care.

(2) Definition: Liquid resources. A liquid resource means cash or other property that can be converted to cash within 20 work days. Accounts in financial institutions; retirement funds; stocks, bonds, mutual funds, and money market funds; annuities; mortgages and promissory notes; and home equity conversion plans, described below, are some of the more common kinds of liquid resources.

(i) Accounts in financial institutions

(A) Accounts in depository financial institutions such as banks and credit unions include, but are not limited to, savings accounts, checking accounts, joint fiduciary accounts, and certificates of deposit. Depository institutions may also manage mutual fund and money market fund accounts for depositors.

(B) Nondepository financial institutions, such as brokerage firms, investment firms, and finance companies, also offer certificates of deposits as well as accounts and services related to the purchase and sale of stocks, bonds, mutual funds, money market funds, and other investments.

(ii) Stocks, bonds, and funds

(A) Legal instruments authenticating an investment, such as stocks, bonds, mutual funds, and money market funds pay interest at specified intervals, sometimes pay dividends, and are convertible into cash either on demand or at maturity.

(B) U. S. savings bonds are obligations of the federal government. Unlike other government bonds,

they are not tradable in the usual sense through brokers and security traders and, as described below, the value of the bond depends on its type. See § 29.08(i)(11) for information on the resource exclusion of U.S. savings bonds.

(I) Series E and EE bonds are sold at one half of their face value and increase in redemption value as interest accrues.

(II) Series I bonds are sold at their full face value and increase in redemption value as interest accrues.

(III) Series H and HH bonds are sold at their full face value and do not increase in value. Instead, they pay interest to the owner each six months.

(iii) Annuities. A contract reflecting payment to an insurance company, bank, charitable organization, or other registered or licensed entity; it may also be a private contract between two parties. There are two phases to an annuity: An accumulation phase and a pay-out phase, and their countability as a resource for MABD eligibility purposes is impacted by the phase the annuity is in (see below). Annuities vary in how they accumulate and pay out money. Annuities may accumulate money by payment of a single lump sum or by payments on a schedule, which accumulate interest over time. Once an annuity has reached its pay-out phase (often referred to as "matured"), money is paid to the beneficiary according to the terms of the annuity contract.

(A) Parties to an annuity

(I) There are always two parties to an annuity: The writer of the annuity, usually an insurance carrier or charitable organization, and the purchaser who owns the annuity (sometimes referred to as the annuitant). There may also be a third party to the annuity if someone other than the owner is the annuitant.

(II) In addition, annuities also name a beneficiary. The beneficiary is the person who will be paid a regular stream of income from the annuity in equal payments. Anyone can be a beneficiary, including but not limited to, the owner of the annuity, a spouse, dependent, trust, estate, commercial entity, proprietorship, or charitable organization.

(III) Beneficiaries may be revocable or irrevocable. A revocable beneficiary can be changed by the owner of the annuity at any time. An irrevocable beneficiary can be changed only by the written permission of that beneficiary.

(IV) In addition to the beneficiary described in (II) above, annuities can also provide for a contingent beneficiary or residual beneficiary. A contingent or residual beneficiary will receive annuity payments upon the occurrence of a specified condition.

(B) Types of annuities. There are many types of annuities. For MABD purposes, AHS considers whether annuities of any type are available as a liquid resource. Since annuities are trust-like instruments, terminology similar to trusts is used when it describes the availability of cash from annuities.

(I) Annuity naming revocable beneficiaries. An annuity that names revocable beneficiaries is available to the owner because the owner can change the beneficiary. This type of an annuity is considered a countable resource for purposes of the owner's MABD eligibility. See subsection 29.09(d)(1) for information on how to value an annuity when it is a countable resource.

(II) Annuity that can be surrendered, cashed in or assigned. An annuity that can be surrendered, cashed in or assigned by the owner is presumed to be a revocable annuity. A revocable annuity is considered a countable resource for purposes of the owner's MABD eligibility. An annuity is presumed to be revocable when the annuity contract is silent on revocability. See § 29.09(d)(1) for information on how to value an annuity when it is a countable resource.

(III) Annuity owned by someone other than the applicant or spouse. An annuity is an unavailable resource for purposes of MABD eligibility when the owner of the annuity is not the individual requesting MABD or the individual's spouse, or the individual or their spouse has abandoned all rights of ownership. However, if payments from the annuity are being made to the individual (or spouse), those payments may be counted as income to the individual (or spouse).

(C) Standard of review

(I) For the purposes of MABD eligibility:

(i) An annuity in its accumulation phase is considered a countable resource of the owner because it can be liquidated or sold by the owner. See § 29.09(d)(1) for information on how to value an annuity when it is a countable resource.

(ii) An annuity in its pay-out phase may be excluded as a resource of the owner if certain criteria are met. See § 29.08(d)(1) for information on the resource exclusion of an annuity.

(II) For purposes of MABD for long-term care, an annuity purchased, or subjected to certain transactions, by an individual or their spouse on or after February 6, 2006, is subject to transfer review. See § 25.03(h) for information on transfer analysis of annuities.

(iv) Mortgages

(A) The pledging of real estate or conveyance of an interest in land to a creditor as security for repayment of a debt.

(B) A mortgage owned by an individual, as the creditor, may be excluded as a resource if certain criteria are met. See § 29.08(d)(2) for information on the resource exclusion of a mortgage. If a mortgage is a countable resource of the individual, see § 29.09(d)(5) for information about the valuation of the mortgage.

(v) Promissory notes

(A) Written promises to pay a certain sum of money to a certain person, the bearer, upon demand or on a specified date.

(B) A promissory note owned by an individual, as the bearer, may be excluded as a resource if certain criteria are met. See § 29.08(d)(2) for information on the resource exclusion of a promissory note. If a promissory note is a countable resource of the individual, see § 29.09(d)(5) for information about the valuation of the promissory note.

(vi) Retirement funds. Any resource set aside by a member of the individual's financial responsibility group to be used for self-support upon their withdrawal from active life, service, or business.

Retirement funds include but are not limited to IRAs, Keogh plans, 401K plans, pensions, mutual funds, stocks, bonds, securities, money market accounts, whole life insurance, and annuities. The value of a retirement fund is the amount of money that can currently be withdrawn from the fund.

See § 29.08(i)(5) for information on the resource exclusion of retirement funds. See § 29.08(f) for information on the exclusion of early withdrawal and surrender penalties.

(vii) Health savings accounts (HSAs). Accounts used to set aside funds to meet medical expenses. Unless the individual can demonstrate that the funds in their HSA are not available to them, the HSA is a countable resource.

(c) Resources managed by a third party. Resources, liquid and nonliquid, managed by a third party include, but are not limited to, trusts, guardianship accounts, and retirement funds. Resources of a member of the financial responsibility group managed by a third party (e.g., trustee, guardian, conservator, or agent under a power of attorney) are considered available to the member as long as the member can direct the third party to dispose of the resource or the third party has the legal authority to dispose of the resource on the member's behalf without the member's direction.

(1) Definitions

(i) Guardian. A person or institution appointed by a court in any state to act as a legal representative for another person, such as a minor or a person with disabilities. Guardianship funds are presumed to be available for the support and maintenance of the protected person. That person may rebut the presumption of the availability of guardianship funds by presenting evidence to the contrary, including, but not limited to, restrictive language in the court order establishing the account or in a subsequent court order regarding withdrawal of funds.

(ii) Power of attorney. A written document signed by a person giving another person authority to make decisions on behalf of the person signing it, according to the terms of the document. Vermont law requires a power of attorney to be executed according to certain formalities, such as being signed, witnessed, and acknowledged. Funds managed by an agent under a power of attorney are not property of the agent and cannot be counted as resources of the agent.

(iii) Representative payee. An individual, agency, or institution selected by a court or the SSA to receive and manage benefits on behalf of another person. A representative payee has responsibilities to use these payments only for the use and benefit of that person, to notify the payer of any event that will affect the amount of benefits the person receives or circumstances that would affect the performance of the representative payee's responsibilities, and account periodically for the benefits received. Funds managed by a representative payee are not property of the representative payee and cannot be counted as resources of the representative payee.

(iv) Trust. A trust is a property interest where property is held by an individual or an entity (called a "trustee") subject to a fiduciary duty to use the property for the benefit of another person (the "trust beneficiary"). A trust includes a legal instrument or device that is similar to a trust but may not be called a trust. See § 29.08(e) for information on resource exclusion of trusts. The following are terms related to trusts:

(A) Grantor (also known as settler or trustor)

(I) The person who transfers liquid or nonliquid property to another person or entity (the "trustee"), with the intention that it be held, managed, or administered by the trustee for the benefit of one or more persons (the "grantees") In some cases, the grantor is named as a grantee.

(II) A person is considered the grantor of a trust if:

(i) The assets of the person were used to form all or part of the principal of the trust; and

(ii) One of the following established the trust:

(A) The person;

(B) Another person, court, or administrative body, with legal authority to act in place of or on behalf of the person; or

(C) Another person, court, or administrative body, acting at the direction of or upon the request of the person.

(B) Trustee. The person or entity (such as a bank or insurance company) that holds, manages, or administers trust property for the benefit of the trust's grantee(s). In most cases, a trustee does not have the legal right to use the trust property for their own benefit. Some, but not all, trusts grant discretion to the trustee to use judgment as to when or how to handle trust principal or trust income. A trust may provide reasonable compensation to the trustee for managing the trust as well as reimbursement for reasonable costs associated with managing the trust property.

(C) Grantee (also known as beneficiary). The person or entity that receives the benefit of a trust. A trust can have more than one grantee at the same time; it can also have different grantees under different circumstances.

(D) Trust income (also known as trust earnings). Monies earned by the trust property. It may take various forms, such as interest, dividends, or rental payments. These amounts may be countable unearned income to any person legally able to use them for their support and maintenance.

(E) Trust principal (also known as trust corpus). The property that the grantor transfers to the trustee for the benefit of the grantee(s).

(F) Trust property. The sum of the trust principal and the trust income.

(G) Residual beneficiary. The person or entity named in the trust to receive the trust property upon termination of the trust.

29.08 Excluded resources (01/01/2023, GCR 22-032)

This subsection specifies the resources whose value is excluded in determining MABD eligibility.

(a) Real property

(1) Home and contiguous land

(i) Definition. Home means the property in which an individual resides and has an ownership interest and which serves as the individual's principal place of residence. This property includes the shelter

in which the individual resides, the land on which the shelter is located, related outbuildings, and surrounding property not separated from the home by intervening property owned by others. Public rights of way, such as roads that run through the surrounding property and separate it from the home, will not affect the exemption of the property. The home includes contiguous land and any other nonresidential buildings located on the contiguous land that are related to the home.

(ii) Exclusion

(A) Except when determining an individual's eligibility for Medicaid coverage of long-term care services and supports, a home is excluded as a resource, regardless of its value.

(B) For Medicaid coverage of long-term care services and supports, the home is considered a resource when the equity in the home is substantial. See Vermont's Medicaid Procedures Manual for the current substantial home equity limit; see § 29.09(d)(6) for information on exceptions to the application of the substantial home equity limit. The home may also be considered as a resource when determining whether the home has been transferred and should be subject to a penalty period (see § 25.00)

(C) The home exclusion applies even if the owner is making an effort to sell the home.

(D) The home exclusion also applies if the owner is absent from the home due to institutionalization, provided they have not placed the home in a revocable trust, and any one of the following three conditions is satisfied:

(I) The owner intends to return to the home even if the likelihood of return is apparently nil.

(II) The owner has a spouse or dependent relative residing in the home. Dependent relative in this context applies to:

(i) Any kind of dependency (medical, financial, etc.); and

(ii) A relationship to the owner that is one of the following: child, step-child, or grandchild; parent, step-parent, or grandparent; aunt, uncle, niece, or nephew; brother or sister, step-brother or step-sister, half brother or half sister; cousin; or in-law.

(III) The owner has a medical condition that prevented them from residing in the home before institutionalization.

(E) Unless one of the exceptions listed in (D) applies, the home becomes a countable resource when the owner moves out of the home without the intent to return, because it is no longer their principal place of residence.

(F) Temporary absences, such as for hospitalization or convalescence with a relative, do not affect the determination of the owner's principal place of residence.

(2) Proceeds from the sale of an excluded home

(i) Proceeds from the sale of a home is excluded to the extent that the owner intends to use the proceeds and, in fact, uses or obligates them to purchase or construct another home within three months of the date the proceeds are received.

(ii) Use of proceeds from the sale of a home to pay costs of another home will be excluded only if the

other costs are paid within three months of the sale of the home. Such costs are limited to the down payment, settlement costs, loan processing fees and points, moving expenses, necessary repairs to or replacements of the new home's structure or fixtures (e.g., roof, furnace, plumbing, built-in appliances) identified and documented prior to occupancy, and mortgage payments for the new home.

(iii) The value of a promissory note or similar installment sales contract constitutes a "proceed." Other proceeds consist of the down payment and the portion of any installment amount constituting payment against the principal. These are also excluded if used within 3 months to make payment on the replacement home.

(iv) When all of the proceeds are not timely reinvested as specified above, the portion of the proceeds retained by the owner are combined with the value of the promissory note or installment sales contract and counted as a resource beginning with the month following the month the note or contract is executed. If the entire proceeds are fully reinvested in a replacement home at a later date, the value of the note or contract and reinvested proceeds are excluded beginning with the month after the month in which they are reinvested, but any proceeds not reinvested as specified above remain a countable resource until fully reinvested.

(3) Real property up-for-sale

(i) Real property is excluded from being a countable resource as long as the owner verifies that they are making reasonable efforts to sell it. Reasonable efforts to sell property means taking all necessary steps to sell it for fair market value in the geographic area covered by the media serving the area in which property is located, unless the owner is prevented by circumstances beyond their control from taking these steps.

(ii) The steps considered necessary to sell the property depend on the method of sale. An owner may choose to list the real property with a real estate agent or undertake to sell it themselves.

(iii) If the owner chooses to list the property with a real estate agency, they must take the necessary step of listing it and cooperating with the real estate agent's efforts to sell it.

(iv) If the owner chooses to sell the property without an agent, they must take all of the following necessary steps:

(A) Advertise the property in at least one of the appropriate local media continuously;

(B) Place a "For Sale" sign on the property continuously, unless prohibited by zoning regulations;

(C) Conduct open houses or otherwise show the property to prospective buyers; and

(D) Attempt any other appropriate methods of sale.

(v) If any prospective buyer makes a reasonable offer for the property, the owner must accept it or demonstrate why it was not a reasonable offer. Any offer of at least two-thirds of the most recent estimate of the property's fair market value is considered a reasonable offer.

(vi) Fair market value means:

(A) A certified appraisal; or

(B) An amount equal to the price of the property on the open market in its locality at the time of the transfer or contract for sale, if earlier.

(4) Home equity conversion plans

(i) Definition. Home equity conversion plans are financial instruments used to secure loans with real property as collateral. Home equity conversion plans include reverse mortgages, reverse annuity mortgages, sale-leaseback arrangements, time-sale agreements, and deferred payment loans.

(ii) Exclusion as a resource in month received. In the month of receipt, funds an owner of the real property receives from any home equity conversion arrangements on their real property are excluded as a resource. Any funds received from a home equity conversion plan that are retained after the month of receipt are counted as a resource beginning the month after receipt.

For information on the treatment of the funds for purposes of income eligibility, see § 29.13(b)(30).

(5) Jointly-owned real property

(i) Exclusion due to joint owner's refusal to sell

(A) An owner's interest in jointly-owned real property is excluded as a resource as long as:

(I) At least one of the other joint owners refuses to sell the property; and

(II) The joint ownership was created more than 60 months before the date of the MABD application.

(B) The addition of a new joint owner (or joint owners) to a property is considered as the creation of a new joint ownership. The new joint ownership will be evaluated as a countable resource under § 29.09(d)(3) if the addition of the new joint owner was made within 60 months of the date of the MABD application.

(ii) Exclusion due to undue hardship. An owner's interest in jointly-owned real property is excluded as a resource if the sale of the property would cause the other joint owner (or owners) undue hardship due to loss of housing. Undue hardship would result when:

(A) The property serves as the principal place of residence for one or more of the other joint owners;

(B) Sale of the property would result in loss of that residence; and

(C) No other housing would be readily available for the displaced other owner.

(6) Life estates

(i) Treatment of life estate interest created on or after July 1, 2002. For a life estate ownership in real property created on or after July 1, 2002:

(A) The value of the life estate is excluded as a resource when the life estate owner does not retain the power to sell or mortgage the real property. For purposes of eligibility for Medicaid coverage of long term care services and supports, however, the life estate may be considered as a resource when determining whether it has been transferred and should be subject to a penalty period (see § 25.00).

(B) When the life estate owner retains the power to sell or mortgage the real property, including any remainder interest, the value of the life estate is excluded only if the life estate is an interest in the life estate owner's home (§ 29.08(a)(1)). Otherwise, the value of the life estate is counted. For this purpose, the value of the life estate includes the value of the remainder interest.

(C) When an individual transfers their home and retains a life estate with the power to sell or mortgage the property, the transfer is not subject to a transfer penalty analysis under § 25.00. In this situation, no transfer has occurred because the individual's ownership interest in the home has not been reduced or eliminated.

(ii) Treatment of life estate interest created before July 1, 2002. For a life estate ownership created before July 1, 2002:

(A) When the life estate owner retains the power to sell the real property, including any remainder interest, the value of the life estate is excluded only if the life estate is excludable on another basis, such as because it is real property producing significant income. Otherwise, the value of the life estate is counted. For this purpose, the value of the life estate includes the value of the remainder interest.

(B) The life estate ownership is excluded as a resource when the life estate owner does not retain the power to sell the real property.

(7) Income-producing real property

(i) *Non-business real property.* Non-business real property is excluded as a resource if the property produces significant income to the owner. Real property is considered to produce significant income if it generates at least 6 percent of its fair market value in net annual income after allowable expenses related to producing the income are deducted.

(ii) *Real property used in a trade or business.* Real property is excluded as a resource if the real property is essential to the owner's self-support and used by the owner in a trade or business. For purposes of this exclusion, the property must be in current use in the type of activity that qualifies it as essential.

(8) Goods for home consumption. Non-business real property is excluded as a resource of the owner when used by the owner to produce goods for only home consumption (e.g., a garden plot used to raise vegetables to be eaten at home or a wood lot used to provide fuel to heat the home). When real property is used to produce goods for both home consumption and income production, only the part used to produce goods for home consumption is excluded. The part of the property used for income production is evaluated for exclusion under (7) above.

(b) Insurance

(1) Exclusion of life insurance

(i) Whole life insurance

(A) If the combined face values of the whole life insurance policies owned by any one member of the financial responsibility group do not exceed $1500, the cash surrender values of the policies are excluded.

(B) If the combined face values exceed $1500, the cash surrender values, excluding any amounts

up to $1500, and all dividend additions are a countable resource.

(ii) Term life insurance. Regardless of its face value, a term life insurance policy is not a countable resource.

(2) Long-term care insurance partnership

(i) Definition: Qualified State Long-Term Care Insurance Partnership. A state plan amendment that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made under a long-term care insurance policy (including a certificate issued under a group insurance contract), but only if:

(A) The policy covers an insured who, at the time coverage under the policy first becomes effective, is a resident of such State or of a State that maintains a Qualified Long-Term Care Insurance Partnership;

(B) The policy is a qualified long-term care insurance contract within the meaning of § 7702B(b) of the Code;

(C) The policy provides some level of inflation protection as set forth in regulations promulgated by the Department of Financial Regulations (DFR);

(D) The policy satisfies any requirements of State or other applicable law that apply to a long-term care insurance policy as certified by the DFR; and

(E) The issuer of the policy reports:

(I) To the Secretary of HHS such information or data as the Secretary may require; and

(II) To the State, the information or data reported to the Secretary of HHS (if any), the information or data required under the minimum reporting requirements developed under § 2(c)(4) of the State Long-Term Care Partnership Act of 2005, and such additional information or data as the State may require.

(ii) Exclusion

(A) Subject to approval by CMS, assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a qualified State long-term care insurance partnership policy are excluded.

(B) This section is further contingent on the passage of changes to 33 VSA § 1908a necessary to bring the Vermont statute on Long-Term Care Partnership Insurance into conformance with the requirements of § 6021 of the federal Deficit Reduction Act of 2005.

(c) Burial Funds Exclusion

(1) For any person whose income and resources are considered in determining MABD eligibility, up to $10,000 of burial funds are excluded, as long as the person shows that the funds are designated for burial expenses through the title to the funds or by a sworn statement provided. The funds must be separately identifiable and not commingled with other funds.

(2) Burial funds may be excluded as of the first day of the month in which the person whose income and resources are considered in determining MABD eligibility established it. Interest and appreciation accrued

on burial funds are excluded if the funds have been left to accumulate.

(3) The value of certain burial spaces, if not fully paid, may also be excluded under the allowable limit of $10,000 for each person whose income and resources are considered in determining MABD eligibility. Such spaces must be held for the burial of a member of the individual's immediate family. For this purpose, the immediate family includes the individual's spouse, children, brothers, sisters, and parents.

(4) Irrevocable burial trusts established prior to July 1, 2002 and funded in excess of $10,000 are excluded up to the value of the trust as of June 30, 2002.

(d) Other income-producing resources

(1) Annuities

(i) An annuity is excluded as a resource of an individual requesting MABD or of their spouse if the annuity is in its pay-out phase and meets all of the following conditions:

(A) Has no beneficiary (or payee) other than the individual requesting MABD or their spouse;

(B) Provides for payments to the beneficiary in equal intervals and equal amounts;

(C) Does not exceed the life expectancy of the beneficiary as determined by using the actuarial life table published by the Office of the Chief Actuary of the SSA (http://socialsecurity.gov/OACT/STATS/table4c6.html) and set forth in Vermont's Medicaid Procedures Manual;

(D) Returns to the beneficiary at least the amount used to establish the annuity contract and any additional payments plus any earnings, as specified in the contract; and

(E) Except as provided in (ii) below, does not pay anyone else, as residual beneficiary, in the event the beneficiary dies before the payment period ends.

(ii) An annuity will also be considered to meet the requirements of (A) through (E) of (i) above if the individual or their spouse, as the owner of the annuity, elects to designate Vermont Medicaid as the primary residual beneficiary up to the amount of Medicaid payments made on behalf of the individual (or their spouse), and names a contingent residual beneficiary other than the individual or their spouse to receive any surplus after Vermont Medicaid is paid.

(2) Promissory notes and other income-producing resources

(i) A promissory note or similar resource that produces income is excluded as a resource of an individual requesting MABD eligibility or of their spouse if:

(A) It meets the requirements in paragraph (1)(i)(A) through (E) above; or

(B) The owner owned a nonnegotiable or nonassignable promissory note executed before September 1, 2005 and they can expect to receive the full fair market value of the resource within their expected lifetime, as determined by using the actuarial life table published by the Office of the Chief Actuary of the SSA (http://socialsecurity.gov/OACT/STATS/table4c6.html) and set forth in Vermont's Medicaid Procedures Manual.

(ii) All other promissory notes and similar resources that produce income are evaluated for whether they

are a countable resource as specified in § 29.09(d)(5) or, for purposes of Medicaid coverage of long-term care services and supports, subject to a transfer penalty as specified in § 25.00.

(e) Excluded trusts

(1) In general

(i) A trust is excluded as a resource if the member of the financial responsibility group is the grantor or grantee of the trust and cannot revoke the trust or receive trust property, whether or not the trustee exercises their full discretion. Trust property is also excluded as a resource when the grantor is a member of the financial responsibility group and establishes a trust by will (often referred to as a "testamentary trust").

(ii) The following trust property is excluded as a resource when either the grantor or the grantee is a member of the financial responsibility group:

(A) Trust property in a trust established prior to April 7, 1986 for the sole benefit of a person who is developmentally disabled residing in an ICF-DD.

(B) Trust property in a trust for which the grantee is a disabled child under the decision in Sullivan v. Zebley, 493 U. S. 521 (1990).

(C) Trust property or any portion of trust property that cannot be made available to the member of the financial responsibility group, either through full exercise of the trustee's discretion under the terms of the trust or through revocation of the trust by a member of the financial responsibility group.

(D) Trust property in a trust established by persons other than the individual or the individual's spouse (known as a third-party trust) unless the terms of the trust permit the individual (or their spouse) to revoke the trust or to have access to it without trustee intervention.

(E) Trust property in an irrevocable trust, including a home placed in an irrevocable trust by an institutionalized individual who intends to return to it, from which no payment under any circumstances could be made to the individual.

(F) A special needs trust that contains the assets of a disabled individual under the age of 65, and meets all of the criteria below:

(I)

(i) For a trust established on or after December 13, 2016, was established through the actions of the disabled individual, a parent, grandparent or legal guardian of the disabled individual, or by a court; or

(ii) For a trust established before December 13, 2016, was established through the actions of a parent, grandparent, or legal guardian of the disabled individual, or by a court;

(II) Was established for the sole benefit of the disabled individual which means that no person or entity except the disabled individual can benefit from the trust in any way, until after the death of the disabled individual and then not before Vermont Medicaid receives sums owed under the payback provision under (III) below; and

(III) Includes a payback provision which requires that, upon the death of the disabled individual, any amounts remaining in the trust will first be paid to Vermont Medicaid in an amount equal to the total Medicaid payments made on behalf of the disabled individual.

(G) A pooled trust that contains the assets of a disabled individual, and meets all of the criteria below:

(I) Was established and administered by a non-profit association;

(II) Maintains a separate account for the disabled individual, but assets are pooled for investing and management purposes;

(III) The separate account was established for the sole benefit of the disabled individual;

(IV) The account was established through the actions of the disabled individual, their parent, grandparent or legal guardian, or by a court; and

(V) The trust contains a pay-back provision which requires that to the extent any amounts in the separate account for the disabled individual upon their death are not retained by the trust, such amounts will first be paid to Vermont Medicaid in an amount equal to the total Medicaid payments made on behalf of the disabled individual.

(VI) Any asset of the disabled individual that is added to the trust after the disabled individual reaches the age of 65 may be subject to transfer penalty (see § 25.00) for purposes of the disabled individual's eligibility for Medicaid coverage of long-term care services and supports.

(iii) In the case of a trust with more than one grantor, these exclusions apply only to that portion of the trust attributable to the income or resources of a member of the financial responsibility group. In the case of a trust with more than one grantee, the exclusions apply only to that portion of the trust available for the benefit of a member of the financial responsibility group.

(2) Trusts excluded due to hardship

(i) Trust property that has not been distributed may be excluded if counting it as a resource would cause undue hardship to a grantor or grantee who is a member of the financial responsibility group.

(ii) Undue hardship includes situations in which a member of the financial responsibility group or someone in the member's immediate family would be forced to go without life-sustaining services because the trust property could not be made available to pay for the services. For this purpose, the immediate family includes the member's spouse, children, brothers, sisters, and parents.

(iii) The following situations also would cause undue hardship:

(A) Funds can be made available for medical care only if trust property is sold, and this property is the sole source of income for the member or someone in the member's immediate family; and

(B) Funds can be made available for medical care only if income-producing trust property is sold and, as a result of this sale, the member or someone in the member's immediate family would qualify for SSI, Reach Up, AABD, General Assistance, 3SquaresVT, or another public assistance program requiring a comparable showing of financial need.

(iv) Undue hardship does not exist when application of the trust regulations does not cause risk of serious deprivation to the member of someone in the member's immediate family.

(v) An individual claiming undue hardship must submit a written request and any supporting documentation. Required documentation from the individual can include, but is not limited to, the following:

(A) A statement from the individual's attorney, if one was involved;

(B) Verification of medical insurance coverage and statements from medical providers relative to usage not covered by the insurance; or

(C) A statement from the trustee of the trust.

(vi) When application of trust provisions are waived because they would cause the individual undue hardship, only amounts actually distributed from the trust and held for more than a month are counted as a resource.

(vii) Request for consideration of undue hardship does not limit an individual's right to appeal denial of eligibility for any reason, including the determination of undue hardship.

(f) Early withdrawal and surrender penalties

(1) Early withdrawal penalties and surrender fees assessed by a financial institution are excluded to the extent that they reduce the value of a countable resource that has been liquidated. Examples of resources to which this exclusion applies are retirement funds, annuities, bonds, and certificates of deposit.

(2) Income tax withholding and tax penalties for early withdrawal are not excluded.

(g) Jointly-owned accounts. A jointly-owned account in a financial institution is excluded as a resource only if the owner rebuts the presumption of availability by:

(1) Submitting a statement, along with a corroborating statement (or statements) from the other joint owner (or owners) of the account, regarding who owns the funds in the joint account, why there is a joint account, who has made deposits to and withdrawals from the account, and how withdrawals have been spent;

(2) Submitting account records showing deposits, withdrawals, and interest, if any, in the months for which ownership of funds is at issue; and

(3) Taking one of the following two actions:

(i) If the member of the financial responsibility group owns none of the funds in the account, correcting the account title to show that the member is no longer a co-owner of the account; or

(ii) If the member owns only a portion of the funds in the account, separating the funds owned by other account owners from the member's funds and correcting the account title on the member's funds to show they are solely owned by the member.

(h) Fiduciary for a joint fiduciary account[19]

(1) Definition: Joint fiduciary account. A deposit in a financial institution in the name of an owner naming one or more fiduciaries. The owner makes a clear statement about how the money can be used, and the fiduciary is required to follow those instructions and keep track of how the money is spent.

(2) Exclusion. When an individual owns a joint fiduciary account, it is counted as a resource. When an individual is designated a fiduciary of a joint fiduciary account, the joint fiduciary account is an excluded resource for the fiduciary.

(i) Other excluded resources

(1) Household goods, personal effects and other personal property

(i) Except as provided in (ii), home furnishings, apparel, personal effects, and household goods are excluded as resources. Tools, equipment, uniforms and other nonliquid property required by the owner's employer or essential to the owner's self-support are also excluded as resources.

(ii) Items an owner acquires or holds because of their value or as an investment are not excluded.

(2) Vehicles

(i) Except as provided in (ii), all automobiles are excluded as resources. Other vehicles, such as trucks, boats, and snowmobiles, are excluded only if they are used to provide necessary transportation (i.e., an automobile is unavailable or cannot be used to transport the aged, blind or disabled individual).

(ii) Automobiles or other vehicles an owner acquires or holds because of their value or as an investment are not excluded.

(3) Independent living contracts

(i) Definitions

(A) Contracts for medical care, assistive technology devices, and home modifications. Any written agreement, contract, or accord (including modifications) for reasonable and necessary medical care, assistive technology devices, or home modifications not covered by Medicare, private insurance, or Medicaid and determined by AHS to be needed to keep an individual at home and out of a skilled nursing facility.

(B) Medical care. Care not covered under AHS's Choices for Care program, including but not limited to, general supervision when required by the cognitive impairment of the individual and/or unstable medical condition that requires monitoring of the individual.

(C) Assistive technology devices. Any item, piece of equipment or product system whether acquired commercially off the shelf, modified, or customized, to increase, maintain, or improve the individual's functional capabilities.

(D) Home modifications. Physical adaptations to the individual's home that ensure the health and

[19] 8 VSA § 14212

welfare of the individual, or that improve the individual's ability to perform activities of daily living or instrumental activities of daily living.

(ii) Exclusion. Resources set aside under a contract or contracts for medical care, assistive technology devices, or home modifications are considered to be available resources unless all of the following criteria are met:

(A) The contract is in writing and signed before any services are provided;

(B) The funds, not to exceed a total of $30,000, are held in a separate bank account from other resources in the sole name of the individual applying for MABD;

(C) Any amounts due are paid after the services are rendered;

(D) The payments for:

(I) Medical care or assistive technology services do not exceed $500 per month; and

(II) Home modifications do not exceed a one-time expenditure of $7,500;

(E) The payments to nonlicensed individuals or providers do not exceed the fair market value of such services being provided by similarly situated and trained nonlicensed individuals, not to exceed the amount paid under AHS's Choices for Care program.

(F) Periodic accountings, as requested by AHS, must be provided specifying the amount of each expenditure, who was paid, the service given, and the number of hours and dates of service covered;

(G) The individual has the power to modify, revoke or terminate the contract for care;

(H) The contract ceases upon the death of the individual. It also ceases upon the individual's admission to an institution for long term care for more than 45 days if not eligible for the home upkeep deduction under § 24.04(d), or 6 months if eligible for the deduction. In addition, revocation or termination of the contract ceases the agreement.

(I) Upon cessation of the contract as specified above, any remaining balance of funds shall be treated as:

(I) An asset of the individual's estate, if the individual is deceased;

(II) An available resource that may not be converted to an excluded resource and must be applied at the Medicaid pay rate toward long term care services and supports if the individual is admitted to an institution for long-term care for more than 6 months. In cases where the individual dies before the resource is fully expended, the remainder shall become an asset of the individual's estate; or

(III) An excluded resource, if the individual revokes or terminates the contract and continues to receive services under AHS's Choices for Care program.

(4) Cash/liquid resources

(i) Income is excluded as a resource in the month of receipt, such as an automatic deposit of a social security check into a checking account.

(ii) Liquid resources used in the operation of the owner's trade or business as property essential to self-support are excluded.

(5) Exclusion of retirement funds

(i) Any retirement fund owned by a member of the financial responsibility group is excluded when:

(A) The member must terminate employment in order to obtain any payment from the fund;

(B) The member is not eligible for periodic payments from the fund and does not have the option of withdrawing a lump sum from the fund; or

(C) The member is drawing on the retirement fund at a rate consistent with their life expectancy, as specified in § 25.03(b).

(ii) If the member is eligible for periodic payments or a lump sum, the member must choose the periodic payments. If the member receives a denial on a claim for periodic retirement benefits, but can withdraw the funds in a lump sum, the lump sum value is counted in the resources determination for the month following that in which the member receives the denial notice.

(iii) When a member of the financial responsibility group is seeking Medicaid coverage of long-term care services and supports under MABD and has a spouse, any retirement fund held by the member in an individual retirement account (IRA) or in a work-related pension plan (including Keogh plans) as defined by the Code, does not require a change in the title of ownership in order for the fund to be treated as an excluded resource for the benefit of the spouse.

(6) Tax refunds. Tax refunds on real property, income, and food are excluded as resources.

(7) Student benefits. Any portion of any grant, scholarship, or fellowship used to pay fees, tuition, or other expenses necessary to securing an education is excluded. Portions used to defray costs of food or shelter must be counted.

(8) Savings from excluded income. Savings from excluded income and resources are excluded as resources. This includes, but is not limited to, the following:

(i) Liquid resources, including interest earned by the resources accumulated from earnings by a person working with disabilities (see § 8.05(d)) on or after January 1, 2000, and kept in a separate bank account from other liquid resources, unless no bank within a reasonable distance from the person's residence or place of work permits the person working with disabilities to establish a separate account without charging fees; and

(ii) Nonliquid resources purchased by a person working with disabilities on or after January 1, 2000, with savings from earnings or with a combination of savings from earnings and other excluded income or resources.

(9) Resources excluded by federal law. The following are excluded by federal law from both income and resources:

(i) The value of meals and food commodities distributed under the National School Lunch Act and the Child Nutrition Act.

(ii) The value of 3SquaresVT or 3SquaresVT cash-out checks.

(iii) The value of food or vouchers received through the WIC Program.

(iv) The value of food or meals received under the Older Americans Act.

(v) Compensation or remuneration received for volunteer work in ACTION programs including foster grandparents, RSVP, SCORE, ACV, ACE, VISTA, Senior Companion Program and UYA.

(vi) The value of assistance received under the U. S. Housing Act, U. S. Housing Authorization Act and the Housing and Urban Development Act.

(vii) The value of relocation assistance to displaced persons under the Uniform Relocation and Real Property Acquisition Policies Act.

(viii) Per capita distributions to certain Indian Tribes and receipts from lands held in trust for certain Indian Tribes.

(ix) Payments received under the Alaskan Native Claims Settlement Act.

(x) Grants or loans received for educational purposes under any U. S. Department of Education program.

(xi) Any assistance received under the Emergency Energy Conservation or Energy Crisis Program.

(xii) Any assistance received under the Low-Income Home Energy Assistance Act, either in cash or through vendor payments.

(xiii) Compensation paid to Americans of Japanese or Aleut ancestry as restitution for their incarceration during World War II.

(xiv) Agent Orange Settlement payments.

(xv) German reparations to concentration camp survivors, slave laborers, partisans, and other victims of the Holocaust. Settlement payments to victims of Nazi persecution or their legal heirs resulting from the confiscation of assets during World War II.

(xvi) War reparations paid under the Austrian government's pension system.

(xvii) Radiation Exposure Compensation Trust Fund payments.

(xviii) Assistance received under the Disaster Relief and Emergency Assistance Act or other assistance provided under a Federal statute because of a catastrophe which is declared to be a major disaster by the President of the United States. Comparable assistance received from a State or local government, or from a disaster assistance organization is also excluded. Interest earned on the assistance is also excluded.

(xix) Netherlands' Act on Benefits for Victims of Persecution 1940-1945 payments.

(xx) Any account, including interest or other earnings on the account, established and maintained in accordance with § 1631(a)(2)(F) of the Act. These accounts are established with retroactive SSI

payments made to a child under age 18 and used in ways specified in the Act. The exclusion continues after the child has reached age 18.

(xxi) Earnings deposited in a special savings account under the Tangible Assets project managed by the Central Vermont Community Action Council and authorized by PRWORA.

(xxii) Payments as the result of a settlement in the case of Susan Walker v. Bayer Corporation, et al. made to hemophiliacs who contracted the HIV virus from contaminated blood products.

(xxiii) Any resource of a blind or disabled individual that is necessary for them to carry out their approved Plan for Achieving Self-Support (PASS). The plan must be approved by the SSA.

(xxiv) An account established under the Achieving a Better Life Experience Act (ABLE Act), as permitted by that Act.[20]

(10) Exclusions for limited periods. The following resources are excluded for specific periods:

(i) Retroactive Social Security and SSI/AABD. Retroactive payments of SSI, the AABD supplement to SSI, or Social Security benefits for nine months beginning with the month after the month of receipt. These payments are also excluded as resources during the month of receipt.

(ii) Funds for replacing excluded resources. Cash and interest earned on that cash received from any source, including casualty insurance, for the purpose of repairing or replacing an excluded resource that is lost, stolen, or damaged, if used to replace or repair that resource. The exclusion is allowed for nine months from the month of receipt. An extension of an additional nine months can be granted for good cause.

(iii) Earned income tax credit. State and federal earned income tax credit refunds and advance payments for nine months beginning with the month after the month of receipt.

(iv) Medical or Social Services payments. Cash received for medical or social services for the calendar month following the month of receipt. In the second month following the month of receipt, it is counted as a resource if it has been retained.

(v) Victim's compensation payments. State-administered victims' compensation payments for nine months after the month of receipt.

(vi) Relocation payments. State and local government relocation payments for nine months after the month of receipt.

(vii) Expenses from last illness and burial. Payments, gifts, and inheritances occasioned by the death of another person provided that they are spent on costs resulting from the last illness and burial of the deceased by the end of the calendar month following the month of receipt.

(11) Exclusion of U. S. savings bonds

(i) A U. S. savings bond is excluded as a resource during its minimum retention period if the owner of

[20] Stephen Beck, Jr., ABLE Act of 2014.

the savings bond requested a hardship waiver based on financial need due to medical expenses and received a denial from the United States Department of the Treasury, Bureau of Public Debt, Accrual Services Division in Parkersburg, P. O. Box 1328, Parkersburg, West Virginia 26106-1328.

(ii) Upon verification of a denial of a hardship waiver, as described above, a U. S. savings bond is considered an available resource of the owner following the expiration of the minimum retention period. Once the minimum retention period expires, the denial of a hardship waiver is not a basis for exclusion of new bond purchases or other excluded assets purchased with the proceeds.

(iii) A U. S. savings bond purchased before June 15, 2004, that has its minimum retention period expire after that date, continues to be an excluded resource if it is not redeemed, exchanged, surrendered, reissued, used to purchase or fund other excluded assets, or otherwise becomes available.

(12) Home-based long-term care disregard. An additional resource disregard of $3,000 to the standard $2,000 resource disregard is allowed for an aged or disabled individual without a spouse who resides in and has an ownership interest in their principal place of residence and chooses Medicaid coverage of long-term care services and supports under MABD to be provided in their residence provided all other eligibility criteria are met. This additional resource disregard remains available until the individual begins receiving Medicaid coverage of long term care services and supports under MABD in an institution or in a residential care home that provides enhanced residential care services. Thereafter, if the individual meets the requirements for a home upkeep deduction (see § 24.04(d)), they are eligible to continue this resource disregard for up to 6 months.

(13) Burial spaces. The value of fully paid burial spaces for the individual, the individual's spouse or any member of the individual's immediate family is excluded as a resource. For this purpose, the immediate family means the individual's children, brothers, sisters, parents and the spouses of those individuals.

29.09 Value of resources counted toward the Medicaid resource limit (01/01/2018, GCR 17-047)

(a) In general. Unless an exception under paragraph (d) below applies, the ownership interests of resources of the members of the financial responsibility group are valued according to these general rules.

(1) Resources not excluded under § 29.08 are valued at their equity value (see (b) below for definition of equity value).

(2) The portion of jointly-owned resources not excluded and countable toward the MABD resource limit is determined according to the rules in paragraph (c) below.

(3) The equity value of any resource owned entirely by members of the financial responsibility group and not excluded under § 29.08 is counted toward the MABD resource limit.

(b) Definition: Equity value

(1) The fair market value of the resource minus the total amount owed on it in mortgages, liens, or other encumbrances.

(2) The original estimate of the equity value of a resource is used unless the owner submits evidence from a disinterested, knowledgeable source that, in AHS's judgment, establishes a reasonable lower value.

(c) Counting jointly-owned resources

(1) In general

(i) This paragraph defines each type of joint ownership and the amount of the resource that is counted when ownership is shared.

(ii) When two or more parties share rights to sell, transfer, or dispose of part or all of personal or real property, the ownership share held by members of the financial responsibility group is counted as prescribed by state law. Shared ownership or control occurs in different forms, including tenancy-in-common, joint tenancy, and tenancy-by-the-entirety. The type of shared ownership involved is determined and used to compute the countable value of the resource. If an individual submits evidence supporting another type of shared ownership, AHS will make a decision about which type applies. If AHS decides not to use the type submitted by the individual, it will provide the individual with a written notice stating the basis for its decision.

(iii) Under Vermont law, a co-owner may demand partition, the dividing of lands held by more than one person. For this reason, AHS counts the individual's proportionate share of the lands as an available resource, unless excluded as a home or property up for sale.

(2) Definition: Tenancy-in-common

(i) In tenancy-in-common, two or more parties each have an undivided fractional interest in the whole property. These interests are not necessarily equal. One owner may sell, transfer or otherwise dispose of their share of the property without permission of the other owner(s) but cannot take these actions with respect to the entire property.

(ii) When a tenant-in-common dies, the surviving tenant(s) has no automatic survivorship rights to the deceased's ownership interest in the property. Upon a tenant's death, their interest passes to their estate or heirs.

(iii) Tenancy-in-common applies to all jointly-owned resources when title to the resource does not specify joint tenancy or tenancy-by-the-entirety.

(iv) See (c)(5) below for how a resource owned by a member of the financial responsibility group as a tenant-in-common is counted.

(3) Definition: Joint tenancy

(i) In joint tenancy, each of two or more parties has an undivided ownership interest in the whole property. In effect, each joint tenant owns all of the property. When the property is personal property, the interests of the joint tenants are equal. When the property is real property, the interests of the joint tenants can be equal or unequal (unless the instrument creating the joint tenancy contains language indicating a contrary intent, the joint tenants' interests are presumed to be equal).[21]

(ii) Upon the death of only one of two joint tenants, the survivor becomes the sole owner. Upon the

[21] 27 VSA § 2(b)

death of one of three or more joint tenants, the survivors become joint tenants of the entire interest. For real property, the deceased joint tenant's interest is allocated among the surviving joint tenants in proportion to their respective interests at the time of the deceased joint tenant's death unless the instrument creating the joint tenancy contains language indicating a contrary intent.[22]

(iii) See (c)(5) below for how a resource owned by a member of the financial responsibility group as a joint tenant is counted.

(4) Definition: Tenancy-by-the-entirety

(i) Tenancy-by-the-entirety can only exist between members of a married couple, including parties to a civil union.

(ii) The couple, as a unit, owns the entire property which can be sold only with the consent of both parties.

(iii) Upon the death of one tenant-by-the-entirety, the survivor takes the whole. Upon legal dissolution, the former couple become tenants-in-common (see (c)(2) above), and one can sell their share without the consent of the other.

(iv) When a member of the financial responsibility group owns a resource as a tenant-by-the-entirety, the entire equity value of the resource is counted as available to the member.

(5) Countability

(i) General rule for tenancy-in-common and joint tenancy. With the exception noted in (ii) below and subject to the presumption under § 29.09(d)(3) regarding real property joint ownerships created within 60 months prior to the date of the MABD application, AHS assumes, absent evidence to the contrary, that each owner of shared property owns only their fractional interest in the property. The total value of the property is divided among all of the owners in direct proportion to the ownership share held by each.

(ii) Exception: Accounts in financial institutions. For an account in a financial institution, AHS assumes that all of the funds in the account belong to the individual. If another member (or members) of the individual's financial responsibility group is on the account, AHS assumes the funds in the account belong to those account owners in equal shares.

(d) Exceptions to general valuation rule. The following paragraphs describe exceptions to the general valuation rules described in paragraph (a) above.

(1) Annuities. Unless an annuity is excluded as a resource under § 29.08(d)(1) or, for purposes of Medicaid coverage of long term care services and supports, treated as a transfer under § 25.03(h), the fair market value of an annuity is counted. The fair market value is equal to the amount of money used to establish the annuity and any additional payments used to fund the annuity, plus any earnings and minus any early withdrawals and surrender fees. If evidence is furnished from a reliable source showing that the annuity is worth a lesser amount, AHS will consider a lower value. Reliable sources include banks, other financial

[22] Id.

institutions, insurance companies, and brokers, as well as any other source AHS considers, in its discretion, to be reliable.

(2) Life estates. Unless a life estate interest in property is excluded under § 29.08(a)(6) or the fair market value of the entire property (the life estate and the remainder) is counted as a resource, the fair market value of a life estate interest in property is established by multiplying the fair market value of the property at the time the life estate interest was created by the number in the life expectancy table that corresponds with the individual's age at that time. The life estate table is found in the SSA's POMS at SI 01140.120 (https://secure.ssa.gov/apps10/poms.nsf/lnx/0501140120). If an individual submits evidence supporting another method of establishing the fair market value of a life estate, AHS will make a decision about what method to use. If AHS decides not to use the method submitted, it will provide the individual with a written notice stating the basis for its decision.

(3) Jointly-owned real property. Regardless of a co-owner's refusal to sell jointly-owned real property pursuant to the resource exclusion under § 29.08(a)(5)(i), AHS presumes that a member of the financial responsibility group that owns real property jointly with another person (or persons) owns the entire equity value of the real property if the joint ownership was created less than 60 months prior to the date of the MABD application. This presumption may be rebutted by a showing, through reliable sources, that the other joint owner (or owners) purchased shares of the property at fair market value. Reliable sources include cancelled checks or property transfer tax returns. When it has been established that one or more other co-owners purchased their shares of the property, the proportional interest owned by the member is counted.

(4) U. S. savings bonds. Unless a U. S. savings bond is excluded under § 29.08(i)(11), it is counted as a resource beginning on the date of purchase. To establish the value of the bond, the Savings Bond Calculator or the Comprehensive Savings Bond Value Table on the U. S. Bureau of Public Debt's internet website is used. Alternately, AHS obtains the value by telephone from a local bank. The following general rules apply to valuation:

(i) Series E and EE bonds are valued at their purchase price.

(ii) Series I bonds are valued at their face value.

(iii) Service HH bonds are valued at their face value.

(5) Income-producing promissory notes and contracts

(i) Unless the promissory note or other income-producing resource (contract) is excluded under § 29.08(d)(2) or, for purposes of Medicaid coverage of long-term care services and supports, treated as a transfer under § 25.03(i), the fair market value of a promissory note or contract is counted. Regardless of negotiability, fair market value equals the amount of money used to establish the note or contract and any additional payments used to fund it, plus any earnings and minus any payments already received. If evidence is furnished to AHS of a good faith effort to sell the note or contract by obtaining three independent appraisals by reliable sources which reflect that the value of the note or contract is less than fair market value, AHS will consider the note or contract available to its owner only in the amount of this discounted value. Reliable sources include banks, other financial institutions, insurance companies, and brokers, as well as any other source AHS considers, in its discretion, to be reliable.

(ii) For an individual requesting Medicaid coverage of long-term care services and supports under MABD, a note or contract valued at a discount will be treated as an available resource at the discounted amount and may also be subject to a transfer penalty to the extent of the amount discounted from the fair market value, in the discretion of AHS. Where the note or contract is determined to have no value on the open market, a transfer penalty will be applied for the full value used to establish the note or contract and any additional payments used to fund it, plus any earnings and minus any payments already received.

(6) Substantial home equity

(i) Definition: Home equity. The value of a home based on the town's assessment adjusted by the common level of appraisal (CLA), minus the total amount owed on it in mortgages, liens, or other encumbrances. When an individual requesting Medicaid owns their home in a joint ownership with someone other than their spouse, absent evidence to the contrary, the individual's equity interest in the home is reduced by the amount of the other joint owner's equity interest when the other joint owner resides in the home.

(ii) Counting rule

(A) A home is considered a resource, for purposes of eligibility for Medicaid coverage of long term care services and supports, when the owner's equity in the home is substantial. See Vermont's Medicaid Procedures Manual for the current substantial home equity limit. The substantial home equity limit increases from calendar year to year based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average) rounded to the nearest $1,000.

(B) Substantial home equity precludes payment for Medicaid coverage of long-term care services and supports unless one of the following individuals lawfully resides in the home:

(I) The owner's spouse;

(II) The owner's child who is under age 21; or

(III) The owner's child who is blind or permanently and totally disabled, regardless of age.

(C) An individual with excess equity in their home who is found ineligible for Medicaid coverage of long-term care services and supports may receive other Medicaid services besides long-term care services and supports if they meet the eligibility criteria for a coverage group that covers services other than long-term care services and supports.

(iii) Hardship waivers. An individual who is ineligible for Medicaid coverage of long-term care services and supports due to excess equity in their home may request an undue hardship waiver based on the criteria specified at § 25.05.

(iv) Home equity conversion plans (reverse mortgages) and home equity loans. An individual is permitted to use a home equity conversion plan (reverse mortgage) or a home equity loan to reduce their equity interest in their home. In such circumstances, the funds are valued as follows:

(A) The existence of a line of credit is not considered to diminish the equity value except in amounts from the line of credit actually paid to the borrower.

(B) In the month of receipt, lump-sum payments from a home equity conversion plan or from a home

equity loan are excluded as a resource and proceeds paid in a stream of income are excludable income.

(C) Lump sum payments from home equity loans retained for more than a month continue to be an excluded resource.

Lump sum payments and streams of income are subject to transfer penalties if given away in the month of receipt or thereafter.

29.10 Determination of countable resources (01/01/2018, GCR 17-047)

(a) In general. Countable resources are determined by combining the resources of the members of the financial responsibility group, as described in § 29.03, and comparing them to the resource standard of the Medicaid group, as described in § 29.04. Countable resources are determined for different types of Medicaid groups: adults without spouses, adults with spouses, children, and individuals requesting Medicaid coverage of long-term care services and supports. If the resources of the Medicaid group fall below or are equal to the applicable resource standard, the resource test is passed. If an excess resource amount remains after all exclusions have been applied (see § 29.08), the individual has not passed the resource test. An individual may become eligible for MABD by spending down or giving away excess resources as provided in § 30.00 subject to transfer of resource rules (see § 25.00) for those seeking Medicaid coverage of long-term care services and supports.

(b) Determining countable resources for individuals other than children. The general rule in paragraph (a) above is followed to determine whether total resources, after exclusions, of an individual other than a child falls below the resource maximum for one.

(c) Determining countable resources for individuals with spouses and not in long-term care. The general rule in paragraph (a) above is followed to determine whether the total resources, after exclusions, of an individual living with their spouse and requesting MABD, other than Medicaid coverage of long-term care services and supports under MABD, falls below the resource maximum for two.

(d) Determining countable resources for children

(1) Unless otherwise specified in the coverage group rules at §§ 8.05 and 8.06, the countable resources of an eligible child are determined by:

(i) Combining the resources of the parents living with the child with the child's resources, until the child reaches the age of 18;

(ii) Subtracting the resource maximum for one, if one parent, or two, if two parents, from the parent's countable resources; and

(iii) Deeming and adding the remainder to the child's own countable resources.

(2) If the child's total countable resources fall below the resource maximum for one, the resource test is passed.

(e) Determining countable resources for individuals requesting Medicaid coverage of long term care services and supports under MABD who have spouses. For an individual requesting Medicaid coverage of long-term care

services and supports under MABD who has a spouse, the resource evaluation process of assessment and allocation is performed as set forth in this paragraph at the beginning of the first continuous period of long-term care. An individual discharged from long-term care and readmitted later does not undergo these steps again; only the resources of, and any new transfers by, the readmitted individual are counted. An institutionalized spouse (sometimes referred to in this rule as the "IS") who receives additional resources after allocating less than the community spouse resource allocation (CSRA) maximum to their community spouse (sometimes referred to in this rule as the "CS") and being found eligible for Medicaid coverage of long-term care services and supports under MABD, may, until the first annual review of their eligibility, continue to transfer resources to the CS up to a combined total transfer of no more than the CSRA maximum. After the IS's first regularly-scheduled annual redetermination of eligibility, no further transfers are allowed even if the CSRA maximum has not been allocated to the CS; the rules regarding transfers apply after the IS's first regularly-scheduled annual redetermination (see § 25.00).

See Vermont's Medicaid Procedures Manual for the current CSRA maximum.

(1) Assessment of resources for individuals with community spouses. At the time of admission to long-term care and application for Medicaid coverage of long-term care services and supports under MABD, including long-term care services and supports in a home and community-based setting, AHS completes an assessment of resources. An individual or their spouse may also request a resource assessment prior to admission to long-term care. AHS provides a copy of the assessment to each spouse and retains a copy. The assessment must include at least:

(i) The total value of countable resources in which either spouse has an ownership interest;

(ii) The basis for determining total value;

(iii) The spousal share of one-half the total;

(iv) Conclusion as to whether the IS would be eligible for MABD based on resources;

(v) The highest amount of resources the IS and CS may retain and still permit the IS to be eligible;

(vi) Information regarding the transfer of assets policy; and

(vii) The right of the IS or the CS to a fair hearing at the time of application for MABD.

(2) Allocation of resources for individuals with community spouses

(i) An allocation of resources is completed at the time of the IS's application for Medicaid coverage of long-term care services and supports under MABD, as follows:

(A) The total countable resources of the couple are determined at the time of the application for Medicaid coverage of long-term care services and supports under MABD, regardless of which spouse has an ownership interest in the resource;

(B) The greatest of the following is deducted:

(I) CSRA maximum;

(II) Amount set by a fair hearing, or

(III) Amount transferred from the IS to the CS under a court order.

(ii) The remaining resources allocated to the IS are compared to the resource maximum for one to determine whether or not the IS passes the MABD resource test. If the IS does not pass the resource test, see the spenddown provisions at § 30.00.

(iii) The resources of the CS are considered available to the IS until the month after the month in which the IS becomes eligible for Medicaid coverage of long-term care services and supports under MABD. If the CS fails to make the resources accessible to the IS, after AHS has determined that they are available, AHS may still grant the IS Medicaid coverage of long-term care services and supports under MABD if:

(A) The IS assigns any rights to support from the CS to AHS; or

(B) Denial of Medicaid coverage of long-term care services and supports would work an undue hardship, as specified in § 25.05.

(iv) The CS is provided with the amount determined to be the share of the CS (or to someone else for the sole benefit of the CS). Any transfer of resources from the IS to the CS must be completed by the next review of eligibility of the IS. The transfer will be verified at the next regularly scheduled redetermination of the IS's eligibility.

(v) For purposes of allocation, an "assisted living" facility is considered a community setting and not an institution for long term care provided that the assisted living facility does not include 24-hour care, has privacy, a lockable door, and is a homelike setting. An IS is permitted to allocate income and resources to a CS when the CS resides in an assisted living facility.

29.11 Overview of income requirements (01/15/2017, GCR 16-098)

(a) Definition: Income. Any form of cash payment from any source received by an individual or by a member of the individual's financial responsibility group. Income is considered available and counted in the month it is received or credited to the individual with the exception of a lump sum receipt of earnings such as sale of crops or livestock. These receipts are only counted if received during the six-month accounting period and are averaged over the six-month period.

(b) Counting rules

(1) All earned and unearned income of an individual who is aged, blind or disabled and of the members of the individual's financial responsibility group is counted except income that is specifically excluded (see § 29.13) or deducted (see § 29.15). All countable income is verified.

(2) Countable income depends on the coverage group for which an individual is eligible. It is determined according to the rules at § 29.14 and compared to the highest applicable income standard. If total countable income for the Medicaid group exceeds the income standard for every coverage group in §§ 8.05 and 8.06, the individual is denied eligibility and given a spenddown (see § 30.00).

29.12 Types of income (01/15/2017, GCR 16-098)

(a) In general. This subsection describes the kinds of income considered when determining MABD eligibility.

(b) Earned income. Earned income includes the following:

(1) Gross salary, wages, commissions, bonuses, severance pay received as a result of employment.

(2) Income from self-employment (see (c) below for more information about self-employment income).

(3) Payments from Economic Opportunity Act of 1964 programs as recipients or employees, such as:

(i) Youth Employment Demonstration Act Programs;

(ii) Job Corps Program (Title I, Part A);

(iii) Work Training Programs (Title I, Part B);

(iv) Work Study Programs (Title I, Part C);

(v) Community Action Programs (Title II); and

(vi) Voluntary Assistance Program for Needy Children (Title II); and

(4) Income from:

(i) Employment under Title I of the Elementary and Secondary Education Act (e.g., as a teacher's aide, lunch room worker, etc.);

(ii) Wages from participation in the Limited Work Experience Program under the Workforce Investment Act of 1998 (29 U. S. C. §794d); and

(iii) Earnings from the Senior Community Service Employment (SCSE) program.

(c) Self-employment income

(1) Net earnings from self-employment are counted. Net earnings means gross income from any trade or business less the allowable deductions specified in § 29.15(a)(1).

(2) Tax forms are used to determine countable income from self-employment. An individual who states that the income on their tax forms is no longer reflective of their situation may submit alternate documentation.

(3) When the individual's business has been the same for several years, income reported on tax forms from the last year is used.

(4) When the individual's business was new in the previous or current year and the individual has business records, income reported on tax forms and other available business records is divided by the number of months the individual has had the business.

(5) When the individual's business has no records, is seasonal or has unusual income peaks, income reported on the individual's signed statement estimating annual income is included.

(d) Unearned income

(1) Any payment other than earned income from any source received by an individual or by a member of the individual's financial responsibility group. It is the gross payment, less allowable deductions at § 29.15(b). Periodic benefits received by an individual as unearned income are counted.

(2) Unearned income includes income from capital investments in which the individual is not actively engaged in managerial effort. This includes rent received for the use of real or personal property. Ordinary and necessary expenses of rental property such as interest on debts, state and local taxes, the expenses of managing or maintaining the property, etc. are deducted in determining the countable unearned income from this source. The deduction is permitted as of the date the expense is paid. Depreciation or depletion of property is not a deductible expense.

(3) Unearned income also includes, but is not limited to, the following:

(i) Social Security retirement, disability, SSI, or survivor benefits for surviving spouses, children of a decedent, and dependent parents;

(ii) Railroad Retirement;

(iii) Unemployment compensation;

(iv) Private pension plans;

(v) Annuities;

(vi) Interest earned on life insurance dividends;

(vii) Regular and predictable voluntary cash contributions received from friends or relatives;

(viii) Cash prizes or awards;

(ix) Withheld overpayments of unearned income, unless the overpayment was counted as income in determining Medicaid eligibility in the month received;

(x) Royalty payments to holders of patents or copyrights for which no past or present work was or is involved;

(xi) Retroactive Retirement, Survivors and Disability Insurance (RSDI) benefits for an individual with drug addiction or alcoholism (such benefits are treated as if they had all been received in a lump sum payment, even if paid in installments);

(xii) Veteran's Administration (VA) pension, compensation and educational payments that are not part of a VA program of vocational rehabilitation and do not include any funds which the veteran contributed;

(xiii) Interest payments received by the individual on an income-producing promissory note or contract (such as a property agreement or loan agreement) when the individual is the lender and the note or contract is excluded as a resource under § 29.08(d)(2).

(xiv) Alimony and support payments received; and

(xv) Death benefits received by an individual to the extent the benefits exceed what was paid by the individual for the expenses of the deceased person's last illness and burial.

29.13 Income exclusions[23] (01/15/2019, GCR 18-063)

(a) Earned income exclusions. The following are excluded from earned income:

(1) Support service payments made directly to the providers of services in the Limited Work Experience Program under the Workforce Investment Act of 1998 (29 USC § 794d) or needs-based payments of $10 per day made to participants in the program.

(2) The earned income of an individual under the age of 22 who is a student regularly attending school. This applies to wages received from regular employment, self-employment, or payments from the Neighborhood Youth Corps, Work Study and similar programs.

(3) Infrequent or irregular earned income received, not to exceed $30 per calendar quarter.

(4) Any in-kind assistance received from others.

(5) Earned Income Tax Credit payments (both refunds and advance payments).

(6) Earned income of a working disabled individual when performing the second step of the categorically-needy eligibility test redetermining net income, set forth in § 8.05(d).

(7) Earned income of a child under the age of 18.

(8) Wages paid by the Census Bureau for temporary employment.

(b) Unearned income exclusions. Unearned income exclusions are limited to the following:

(1) Expenses incurred as a condition of receiving the unearned income. For example, guardianship fees may be deducted from unearned income if having a guardian is a requirement for receiving the income, or attorney fees and court costs may be deducted from unearned income if they were incurred in order to establish a right to the income.

(2) The following VA payments:

(i) Portion of pension or compensation payment for aid and attendance and housebound allowances, even when the provider is a spouse or a parent of the veteran;

(ii) Augmented portion of pensions, compensation or other benefits for a dependent of a veteran or a veteran's spouse;

(iii) $20 from educational benefits to the veteran funded by the government;

(iv) Educational benefits paid as either part of a plan of vocational rehabilitation or by withdrawals from

[23] See, also, § 29.08(i)(9) for income excluded by federal law.

the veteran's own educational fund;

(v) Clothing allowance; and

(vi) Payment adjustments for unusual medical expenses.

(3) Ordinary and necessary expenses of rental property and other capital investments except depreciation or depletion of property. This includes, but is not limited to, interest on debts, state and local taxes. The expenses of managing or maintaining the property, as of the date the expense is paid, are deductible.

(4) The first $20 per month of any unearned income unless all of the unearned income is from a source that gives assistance based on financial need.

(5) Any public agency's refund of taxes on food or real property.

(6) Infrequent or irregular unearned income received, not to exceed $60 per calendar quarter.

(7) Bills paid directly to vendors by a third party.

(8) Replacement of lost, stolen or destroyed income.

(9) Weatherization assistance.

(10) Receipts from the sale, exchange or replacement of a resource.

(11) Any assistance based on need which is funded wholly by the state, such as General Assistance.

(12) Public assistance benefits of any person who is living with the individual, as well as any income that was used to determine the amount of those benefits.

(13) Any portion of a grant, scholarship or fellowship used to pay tuition, fees or other necessary educational expenses.

(14) Home produce used for personal consumption.

(15) Assistance and interest earned on assistance for a catastrophe from the Disaster Relief and Emergency Assistance Act or other comparable assistance provided by the federal, state or local government.

(16) Irregular and unpredictable voluntary cash contributions or gifts received from friends or relatives.

(17) Payments for providing foster care for children or adults placed in the individual's home by a public or private non-profit placement agency.

(18) One-third of child support payments received for a child in the household of the individual. The remaining two-thirds of the support payments are considered the unearned income of the child received from the absent parent.

(19) Income paid for chore, attendant or homemaker services under a government program, such as Title XX personal services payments or the $90 VA Aid and Attendance payments to veterans in nursing homes.

(20) Any "in-kind" assistance received from others.

(21) Assistance provided in cash or in kind (including food, clothing, or shelter) under a government program that provides medical care or services (including vocational rehabilitation).

(22) That portion of a benefit intended to cover the financial need of other individuals, such as AABD-EP grants.

(23) Retroactive payments of SSI, AABD or OASDI benefits if the payments were included in determining financial eligibility for Medicaid in the month it was actually owed to the individual.

(24) Home energy assistance provided by a private nonprofit organization or a regulated supplier of home energy.

(25) State-administered victims' compensation payments.

(26) State or local government relocation payments.

(27) Payments occasioned by the death of another person to the extent that they are used to pay for the deceased person's last illness and burial, including gifts and inheritances.

(28) Earned Income Tax Credit payments (both refunds and advance payments).

(29) Social security disability insurance benefits (SSDI) and veterans disability benefits provided to working disabled persons when determining categorically-needy eligibility, specified in § 8.05(d).

(30) Income from a home equity conversion plan in the month received.

(31) Dividends paid on life insurance policies.

(32) Payments made by someone other than the individual to a third-party trust for the benefit of the individual.

(33) Interest and dividend income from a countable resource or from a resource excluded under a federal statute other than § 1613 of the SSA.

(34) Any interest on an excluded burial space purchase agreement if left to accumulate as part of the value of the agreement.

(35) Any amount refunded on income taxes that the individual has already paid.

(36) Proceeds of a loan in the month received when the individual is the borrower because of the borrower's obligation to repay.

(37) Exclusions based on federal law as set forth in § 29.08(i)(9).

29.14 Determination of countable income (01/01/2018, GCR 17-047)

(a) In general

(1) The earned and unearned income of the members of the financial responsibility group is counted. Income is considered available and counted in the month it is received or credited to the member.

(2) The general approach AHS follows when it determines countable income for MABD is set forth below. These general rules apply to all individuals.

(i) Determine income of the financial responsibility group.

(ii) The income of all members of the financial responsibility group is combined, and the appropriate exclusions (see § 29.13) and standard deductions applied (see § 29.14).

(iii) Compare countable income to the applicable income standard.

(iv) An individual passes the income test when their Medicaid group's income does not exceed the appropriate PIL, or the applicable income maximum, whichever is higher. An individual with income greater than the applicable income standard may establish financial eligibility by incurring eligible medical expenses that at least equal the difference between their countable income and the applicable PIL.

(3) The following subsections specify how income is allocated and deemed based on the type of coverage sought and the size of the financial responsibility group.

(b) Financial responsibility group of one individual seeking MABD other than Medicaid coverage of long-term care services and supports under MABD. Common financial responsibility groups of one include a single adult, an individual residing in a residential care home, and a child seeking Katie Beckett coverage. AHS determines countable income for an individual seeking MABD, other than Medicaid coverage of long-term care services and supports under MABD, with a financial responsibility group of one as follows:

(1) Determine and combine the total countable unearned income of the individual.

(2) Subtract a $20 disregard (pursuant to § 29.13(b)(4)), if applicable.

(3) Deduct an allocation for each ineligible child in the household for whom the individual is financially responsible. The amount of each allocation is equal to the maximum allocation amount minus any countable income of the child. If the unearned income is not at least equal to the applicable allocation amount, any remaining allocation may be deducted from earned income.

(4) Deduct from unearned income amounts used to comply with the terms of court-ordered support or Title IV-D support payments (pursuant to § 29.15(b)), if applicable. If unearned income is insufficient, any remaining amounts may be deducted from earned income.

(5) Determine and combine the individual's countable earned income.

(6) Deduct any remaining amount of the $20 disregard, allocations for children and child support payments from the earned income.

(7) Deduct $65 from the remaining earned income.

(8) Deduct allowable work expenses for the disabled (§ 29.15(a)(3)).

(9) Deduct one-half of the remaining earned income.

(10) Deduct any allowable work expenses for the blind (§ 29.15(a)(2)).

(11) Combine the remaining earned income with any remaining unearned income.

(12) Deduct the amount of any income of a blind or disabled individual that is necessary for them to carry out a Plan to Achieve Self-Support (PASS), if applicable.

(13) The result is the individual's countable income for the month. For a child seeking Katie Beckett coverage, compare it to the institutional income standard (IIS). For all others, compare it to the protected income level (PIL) or the SSI/AABD payment standard for one, whichever is higher.

(c) Financial responsibility group of two seeking MABD other than Medicaid coverage of long-term care services and supports under MABD. Countable income for MABD for any individual with a financial responsibility group of two is determined according to the rules under paragraph (b) above, as well as the following additional rules:

(1) *Deem income at step (1).* Earned and unearned income is deemed to the individual at step (1) from their ineligible spouse or ineligible parent, except no income is deemed to an individual from their ineligible children.

(2) *Allocate income at step (3).* Income is allocated from the financial responsibility group to each member of the financial responsibility group who is not applying for MABD at step (3) in the following amounts:

(i) For a child, the difference between the SSI federal payment rate for one and the SSI federal payment rate for a couple is allocated. The allocation is reduced for ineligible children if they have income, unless the ineligible children are students with earned income. No allocation is made to children receiving public assistance.

(ii) For a parent in a one-parent financial responsibility group, the SSI federal payment for one is allocated.

(iii) For parents in two-parent financial responsibility groups, the SSI federal payment for two is allocated.

(3) *Count income at step (13) for an individual requesting MABD who has a spouse.* Countable income for an individual whose spouse is not requesting MABD is determined, according to the rules under paragraph (b) above, except at step (13) the countable income of the Medicaid group is compared to the PIL or the SSI/AABD payment standard for two, whichever is higher.

(d) Parent and child living together seeking MABD, other than Medicaid coverage of long-term care services and supports under MABD. These groups include a parent who is aged, blind, or disabled and a child who is blind or disabled. When a parent and a child in the same household both request MABD, countable income is determined as a financial responsibility group of two as follows:

(1) Determine the net income available to the parent following the steps under paragraph (b) if the parent is single, or under paragraph (c) if the parent has a spouse, except do not allocate any income to the

eligible child. Compare the parent's income to the PIL for one or, if married, the SSI/AABD payment standard for two. If the parent's countable income is below the highest applicable income standard, the parent has passed the income test for eligibility. If the parent's income exceeds the highest applicable income standard, deem the amount of income in excess of the highest applicable income standard to the eligible child as unearned income.

(2) Determine the child's countable income by deeming any income from (1) above and then following the steps in paragraphs (e)(3)(iv) through (xiv). If the child's income is less than the PIL, both the parent and the child pass the income test for MABD eligibility.

(3) When both a parent and child have a spenddown requirement, the parent and child will pass the income test once the child's spenddown requirement has been met because the parent's excess income was deemed to the child. If the parent's spenddown requirement is less than the child's and the parent meets their spenddown requirement, the parent will become eligible. The child, however, will remain ineligible until the remainder of the child's spenddown is met. The parent's incurred eligible medical expenses are deducted from the spenddown requirements of both the parent and child because the parent's income was included in both income computations.

(e) Children seeking MABD, other than Medicaid coverage of long-term care services and supports under MABD (excluding Katie Beckett)

(1) The provisions of this paragraph generally apply when countable income for an eligible child is determined as a financial responsibility group of one. They do not apply in the following contexts:

(i) Katie Beckett (see paragraph (b) above);

(ii) A child whose parent also requests Medicaid (see paragraph (d) above); or

(iii) Medicaid coverage of long-term care services and supports under MABD (see paragraph (f) below).

(2) Since parents are financially responsible for their children, their income must be considered available to their child requesting MABD, until the child reaches the age of 18.

(3) AHS determines countable income in applicable cases as follows:

(i) Determine the total countable income, both earned and unearned, of the parents living with the child.

(ii) Deduct an allocation specified in paragraph (c)(2)(ii)(B) of (C) for the needs of the parents living in the household from the total countable income of the parents.

(iii) Deem the remaining amount to the child. If there is more than one blind or disabled child in the household, divide the remainder by the number of blind or disabled children and deem an equal portion to each. Do not deem more income to a child than the amount which, when combined with the child's own income, would bring their countable income to the PIL. If the share of parental income that would be deemed to a child makes that child ineligible because that child has other countable income, deem parental income to other blind and disabled children under age 18 in the household and no portion to the child.

(iv) Add the child's own unearned income. This is the total unearned income.

(v) Deduct the $20 disregard. This is the total countable unearned income.

(vi) Determine the earned income of the child.

(vii) Deduct the balance of the $20 disregard.

(viii) Deduct the $65 earned income exclusion from any earned income.

(ix) Deduct any allowable work expenses of a disabled child (§ 29.15(a)(3).

(x) Deduct one-half of the remaining earned income.

(xi) Deduct any allowable work expenses of a blind child (§ 29.15(a)(2).

(xii) Combine the remaining earned and unearned income.

(xiii) Deduct the amount of any income that is necessary to carry out a Plan to Achieve Self-Support (PASS), if applicable.

(xiv) The result is the child's countable income. Compare it to the PIL for one. A child with income below the PIL passes the income test.

(f) Individuals seeking Medicaid coverage of long-term care services and supports under MABD. Countable income for an individual requesting Medicaid coverage of long-term care services and supports under MABD is determined as follows:

(1) The countable income of the individual is compared to the applicable income standard for their coverage group beginning with the date of admission to long-term care.

(2) The institutional income standard (IIS) for an individual equals 300 percent of the maximum SSI federal payment to an individual living independently in the community. The IIS for a couple equals twice the IIS for an individual.

(3) When an individual is in a nursing facility and AHS has an indication that they will need long-term care for fewer than 30 days, AHS uses the PIL for the month of admission, and applies the rules for MABD other than the rules for Medicaid coverage of long-term care services and supports under MABD.

(g) Long-term care individuals in an institution

(1) Countable income for an individual seeking Medicaid coverage of long-term care services and supports under MABD in an institution is determined according to the rules under paragraph (b) above, except AHS:

(i) Allocates income to the individual's community spouse, other family members and for home upkeep, according to the rules in § 24.04;

(ii) Allocates a personal needs allowance to the individual; and

(iii) Compares the countable income of the Medicaid group to the IIS beginning with the date of admission to long-term care.

(2) For an individual whose gross income exceeds the IIS, AHS determines whether they may spend down their excess income to the PIL to establish their financial eligibility as medically needy, according to the rules at § 30.00. AHS determines whether the individual has incurred eligible medical expenses that equal the difference between their countable income and the PIL.

(h) Long-term care individuals seeking services in a home and community-based setting

(1) Countable income for an individual seeking Medicaid coverage of long-term care services and supports under MABD in a home and community-based setting is determined according to the rules under paragraph (b) above, except AHS:

(i) Allocates income to the individual's community spouse and other family members according to the rules in § 24.04; and

(ii) Allocates a community maintenance allowance to the individual; and

(iii) Approves income eligibility if the individual:

(A) Has gross income that does not exceed the IIS; or

(B) Passes the net income test for an individual working with disabilities (see § 8.05(d)).

(2) For an individual whose gross income exceeds the IIS, AHS determines whether they may spend down their excess income to the PIL to establish their income eligibility as medically needy using the rules at § 30.00. AHS determines whether the individual has incurred eligible medical expenses that equal the difference between their countable income and the PIL.

29.15 Income deductions (01/15/2017, GCR 16-098)

Deductions from earned income, including self employment, and from unearned income are allowed.

(a) Earned income deductions. A deduction of $65.00 and one-half of the remainder applies to all determinations of earned income.

(1) Business expenses. Deductions of business expenses from self-employment income are limited to the following:

(i) Operating costs necessary to produce cash receipts, such as office or shop rental; taxes on farm or business property; hired help; interest on business loans; cost of materials, livestock and equipment required for the production of income; and any business depreciation.

(ii) The cost of any meals provided to children for whom an individual provides day care in their own home, at the currently allowed rate per meal.

(iii) The actual operating expenses necessary to produce cash receipts for commercial boarding houses: an establishment licensed as a commercial enterprise that offers meals and lodging for compensation, or, in areas without licensing requirements, a commercial establishment that offers meals and lodging with the intention of making a profit.

(iv) Room and board, alone or as part of custodial care, provided that the amount shall not exceed the

payment the household receives for room and board.

(v) Foster care payments made by AHS to licensed foster homes, including room and board of children in the custody of and placed by AHS when the Medicaid group includes a foster parent.

(vi) Ordinary and necessary expenses for active management of capital investments, like rental property. These may include fire insurance, water and sewer charges, property taxes, minor repairs which do not increase the value of the property, lawn care, snow removal, advertising for tenants and the interest portion of a mortgage payment.

(2) Work expenses of blind individuals. In addition to other allowable deductions, work expenses from income of a blind individual include the following[24]:

(i) Cost of purchasing and caring for a guide dog;

(ii) Work-related fees such as licenses, professional association dues or union fees;

(iii) Transportation to and from work including vehicle modifications;

(iv) Training to use an impairment-related item such as Braille or a work-related item such as a computer;

(v) Federal, state and local income taxes;

(vi) Social Security taxes and mandatory pension contributions;

(vii) Meals consumed during work hours;

(viii) Attendant care services;

(ix) Structural modifications to the home; and

(x) Medical devices such as wheelchairs.

(3) Work expenses of disabled individuals. In addition to other allowable deductions, work expenses from income of a disabled individual include the following[25]:

(i) Transportation to and from work, including vehicle modifications;

(ii) Impairment-related training;

[24] Rates for mileage reimbursement are the rates established by the U.S. General Services Administration. The rates fluctuate periodically. For the current rate, refer to the U.S. General Services Administration's website at www.gsa.gov/mileage.

[25] Rates for mileage reimbursement are the rates established by the U.S. General Services Administration. The rates fluctuate periodically. For the current rate, refer to the U.S. General Services Administration's website at www.gsa.gov/mileage.

(iii) Attendant care;

(iv) Structural modifications to the home; and

(v) Medical devices such as wheelchairs.

(b) Unearned income deduction

Amounts used to comply with the terms of court-ordered support or Title IV-D support payments are deducted from unearned income.

30.00 Spenddowns (10/01/2021, GCR 20-002)

(a) When the total countable income or, if applicable, resources of an individual exceeds the applicable income or resource standard for eligibility after allocations are made, and exclusions and disregards, if applicable, are applied, an individual requesting Medicaid, including Medicaid coverage of long-term care services and supports, may use the spenddown provisions set forth in this section to attain financial eligibility.

As stated in § 28.04(c), the income spenddown provisions under this section apply to an individual requesting MCA, including Medicaid coverage of long-term care services and supports under MCA, whose income exceeds the applicable income standard for eligibility for MCA and who is seeking MCA eligibility as medically needy and is subject to an income spenddown in order to be eligible. For this purpose, all references to "countable income" in this section shall mean the individual's MAGI-based income as described in § 28.03(d) adjusted, if applicable, by apportioning the income of financially responsible family members according to the requirements set forth in § 28.04(b). Since there is no resource test for MCA eligibility, none of the resource spenddown provisions under this section apply.

See § 7.03(a)(8)(i) for the individuals who may qualify for MCA as medically needy.

(b) Spending down is the process by which an individual incurs allowable expenses to be deducted from their income or spends resources to meet financial eligibility requirements.

(c) Spenddown is calculated using an accounting period of either one or six months, depending on the type of Medicaid services requested (see § 30.02). For purposes of calculating the spenddown for an individual requesting MCA eligibility as medically needy, other than Medicaid coverage of long-term care services and supports under MCA, a six month accounting period is used.

30.01 Definitions (01/15/2019, GCR 18-063)

(a) Accounting period. The one-month or six-month span of time used to budget the income of an individual requesting Medicaid.

(b) Community living arrangement

(1) A community living arrangement includes any residence, such as a house, apartment, residential care home, assisted living facility, boarding house, or rooming house. In a community living arrangement, the individual requesting Medicaid obtains and pays for basic maintenance items, such as food, shelter, clothing, personal needs, separately from medical care. The individual requesting Medicaid may live alone, as a member of a family, or with non-relatives.

(2) An individual requesting Medicaid coverage of long-term care services and supports is not considered to be in a community living arrangement.

(c) [Reserved]

(d) Long-term care living arrangement. An individual requesting Medicaid coverage of long-term care services and supports, including services and supports in a home and community-based setting, is considered to be in a long-term care living arrangement. Medicaid eligibility is determined according to the applicable long-term care Medicaid eligibility rules.

An individual receiving hospice services is considered to be in a long-term care living arrangement.[26] An individual receiving hospice services is:

(1) Terminally ill;

(2) Would be eligible for Medicaid coverage of long-term care services and supports if they lived in a medical institution; and

(3) Needs additional interdisciplinary medical care and support services to enable them and their families to maintain personal involvement and quality of life in their choice of care setting and site of death.

(e) Income spenddown. The amount of qualifying medical expenses an individual must incur to reduce their excess income to the maximum applicable to their Medicaid coverage category.

(f) Resource spenddown. The amount an individual must spend to reduce their excess resources to the resource standard applicable to the appropriate Medicaid coverage category.

30.02 Accounting periods (01/15/2017, GCR 16-098)

(a) Accounting periods are based on living arrangements. The length of the accounting period used to compute spenddown requirements depends on the living arrangement of the individual requesting Medicaid. For the purposes of Medicaid eligibility, an individual may be in a community living arrangement or a long-term care living arrangement.

(b) Six-month accounting period for community living arrangement

(1) A six-month accounting period is used to determine spenddown requirements for an individual in a community living arrangement.

(2) The six-month period begins with the first month for which Medicaid is requested, usually the month of application. If Medicaid is requested for expenses incurred during any one or more of the three months preceding the month of application, the six-month period begins with the earliest of these three months in which expenses were incurred and the individual met all other eligibility requirements.

(3) To determine the amount of income an individual must spend down, AHS makes reasonable estimates of

[26] For information about hospice services, see Health Care Administrative Rules (HCAR) at § 4.227.

future income, subject to review and adjustment if the individual's circumstances change during the remainder of the six-month accounting period.

(c) One-month accounting period for long-term care living arrangement

(1) A one-month accounting period is used to determine spenddown requirements for an individual in a long-term care living arrangement.

(2) The one-month accounting period begins with the first calendar month during which the individual is in a long-term care living arrangement for any part of the month, applies for Medicaid coverage of long-term care services and supports for that month, and meets the general and categorical requirements for eligibility for Medicaid coverage of long-term care services and supports.

(3) The one-month accounting period ends with the last calendar month during which the individual is in a long-term care living arrangement for any part of the month and passes all other eligibility tests for Medicaid coverage of long-term care services and supports.

30.03 Spend down of excess resources and income – in general (01/15/2017, GCR 16-098)

An individual who passes all nonfinancial eligibility tests may qualify for Medicaid by spending down the income or resources, if applicable, that are in excess of the maximums applicable to them. The income and resource maximums for each MABD eligibility category are specified in the descriptions found in §§ 8.05 and 8.06. Income and resource maximums can also be found in Vermont's Medicaid Procedures Manual. The income maximums for the MCA categories are specified in the descriptions found in § 7.03(a).

30.04 Resource spenddowns (01/15/2017, GCR 16-098)

(a) Spending down excess resources

(1) An individual requesting MABD with excess resources is determined to have passed the resource test upon proof that the excess resources are no longer held as a resource and have actually been spent or given away. However, an individual with excess resources seeking Medicaid coverage of long-term care services and supports under MABD is subject to the transfer-of-resource provisions at § 25.00 if they spend or give away excess resources within the penalty period specified in § 25.04.

(2) MABD may be granted for the month of application if the resource test is passed at any point in the month and all other eligibility criteria are met. Resources may rise above the resource maximum, for example, due to interest added to bank accounts or failure to use the full monthly income amount protected for maintenance expenses during the month it is received. An individual enrolled in MABD may maintain MABD eligibility for any month in which resources exceed the resource maximum by taking any action that reduces the excess amount, including giving the excess to AHS to repay expenditures on the individual's care. As long as resources are reduced to the resource maximum before the end of the month during which resources exceed the limit, MABD continues without interruption.

(3) When a third party who handles any resources of an individual receiving MABD or of a member of the individual's financial responsibility group is unaware of a resource or its value, AHS provides uninterrupted MABD to the individual as long as the excess amount is paid to AHS as a recovery of Medicaid payments. Excess resources reimbursed to AHS in these situations will not result in ineligibility.

(b) Retroactive coverage. One or more of the following actions may be taken to reduce excess resources in order to qualify for MABD up to three months prior to the month of application as long as all other eligibility tests are passed:

(1) Set up a burial fund that meets the requirements specified in § 29.08 for an excluded resource.

(2) If countable income is less than the applicable PIL, spend resources on maintenance expenses, such as housing, food, clothing and fuel, up to a maximum per month of the difference between the countable income and the applicable PIL.

(3) Spend excess resources on covered or noncovered medical expenses.

30.05 Income spenddowns (10/01/2021, GCR 20-002)

(a) Spending down excess income on medical expenses. AHS determines that an individual requesting Medicaid with excess income has passed the income test upon proof that medical expenses have been paid or incurred at least equal to the difference between the countable income and the applicable income maximum for the accounting period.

(b) Allowable uses of excess income. Medical expenses of any member of the individual's financial responsibility group, whether they are paid or incurred but not paid, may be used to meet the individual's income spenddown requirement; references in § 30.06 to the medical expenses of the "individual" include the medical expenses of any member of the individual's financial responsibility group.

(c) Income spenddown methodology

(1) An individual requesting Medicaid may spend their excess income down to the PIL on medical expenses following the methodology specified below to receive Medicaid as part of the medically-needy coverage group.

(2) The spenddown methodology is the same for all living arrangements, except that a one-month accounting period applies to an individual in a long-term care living arrangement and a six-month accounting period applies to an individual in a community living arrangement.

(d) Eligibility date

(1) An individual with excess income passes their income test on the first day within their accounting period that deductible medical expenses meet or exceed their spenddown requirement. Sometimes this allows for retroactive coverage.

(2) Eligibility becomes effective:

(i) On the first day of the month when a spenddown requirement is met using health insurance expenses and noncovered medical expenses.

(ii) Later than the first day of the month when a spenddown requirement is met using covered medical expenses.

(3) Special eligibility dates apply, as set forth in § 30.06, for an individual who meets their spenddown requirement using noncovered assistive community care services (ACCS).

(4) Medicaid pays for covered services on the first day that the individual's medical expenses exceed the amount of their spenddown requirement. Medicaid continues until the end of the accounting period unless the individual's situation or PIL changes.

(e) Continuing responsibility for medical expenses incurred before the eligibility date

(1) An individual remains responsible for medical expenses they incurred before the date of eligibility.

(2) When services are received from more than one provider on the day that Medicaid begins, the individual must decide which services they will be responsible for paying and which ones Medicaid will cover.

(f) Deduction sequence. Medical expenses are deducted from income in the following order:

(1) Health insurance expenses (see § 30.06(b)).

(2) Noncovered medical expenses (see § 30.06(c)).

(3) Covered medical expenses (see § 30.06(d)) that exceed limitations on amount, duration, or scope of services covered (see DVHA Rules 7201-7606).

(4) Covered medical expenses (see § 30.06(d)) that do not exceed limitations on amount, duration or scope of services covered. These must be deducted in chronological order of the date the service was received beginning with the oldest expense.

(g) Time frames for deductions

(1) Deductible medical expenses include medical expenses incurred:

(i) During the current accounting period, whether paid or unpaid;

(ii) Before the current accounting period and paid in the current accounting period, or

(iii) Before the current accounting period, remaining unpaid, and for which continuing liability can be established (see paragraph (i) of this § 30.05 for details on how to establish continuing liability).

(2) Deductible medical expenses also include medical expenses paid during the current accounting period by a state or local program other than a program that receives Medicaid funding.

(3) Medical expenses incurred before or during the accounting period and paid for by a bona fide loan, as described in (4) below, may be deducted if the expense has not been previously used to meet a spenddown requirement and the individual establishes continuing liability for the loan (see paragraph (i) of this § 30.05 for details on how to establish continuing liability) and documents that all or part of the principal amount of the loan remains outstanding at any time during the accounting period. Only the amount of the principal outstanding during the accounting period, including payments made on the principal during the accounting period, may be deducted.

(4) For purposes of this subsection, a "bona fide loan" is an obligation documented from its outset by a written contract and a specified repayment schedule.

(h) Predictable expenses. In general, an expense is incurred on the date liability for the expense begins. However, there are four types of predictable medical expenses that may be deducted before they are incurred, if it can be reasonably assumed that the expense will continue during the accounting period:

(1) Premiums on health insurance (see § 30.06(b));

(2) Medically necessary over-the-counter drugs and supplies (see § 30.06(c)(1));

(3) Ongoing, noncovered personal care services (see § 30.06(c)(3)); and

(4) ACCS provided to an individual residing in a level III residential care home which is either:

(i) Not enrolled as a Medicaid provider; or

(ii) With an admission agreement specifying the resident's financial status as a privately-paying resident (see § 30.06(c)(4)).

(i) Establishing continuing liability for prior medical expenses. Continuing liability for unpaid medical expenses, including liability on a bona fide loan used to pay medical expenses, incurred before the current accounting period is established when any of the following conditions is met. The liability was incurred:

(1) Within six months of the date of application or the first day of the accounting period, whichever is later.

(2) More than six months before the date of application or the first day of the accounting period, whichever is later, and there is a bill for the liability dated within 90 days of that date.

(3) More than six months before the date of application or the first day of the accounting period, whichever is later, and the service provider or lender has confirmed that the unpaid liability has not been forgiven and is not expected to be forgiven at any time within the current accounting period.

30.06 Allowable medical expenses (01/15/2017, GCR 16-098)

(a) In general

(1) Medical expenses that are the current liability of the individual and for which no third party is legally liable may be deducted from total excess income or resources for the accounting period.

(2) No medical expense may be used more than once to meet a spenddown requirement.

(3) A medical expense may be used to spend down either income or resources.

(4) If only a portion of a medical expense is used to meet the spenddown requirement for a given accounting period, that portion of the medical expense that was not used and remains a current liability may be applied toward a spenddown requirement in a future accounting period.

(5) Upon receiving coverage, the individual remains directly responsible to providers for expenses incurred

before the spenddown was met.

(b) Health insurance expenses

(1) Health insurance is insurance that covers medical care and services, such as Medicare part B, and similar group or individual policies. A deduction is allowed for health insurance premiums paid by the individual if it can be reasonably assumed that health insurance coverage will continue during the accounting period. Deductions may also be allowed for other health insurance expenses, including enrollment fees and deductibles or coinsurance imposed by Medicare or other health insurance not subject to payment by a third party (such as another insurance policy). Health insurance coverage, the amount of the premium for the coverage, and any other deductible expense amounts must be verified.

(2) Premiums, or other expenses, for the following types of insurance are not deductible:

(i) Income protection or similar insurance plans designed to replace or supplement income lost due to sickness or accident; or

(ii) Automobile or other liability insurance, although these may include medical benefits for the insured or their family.

(c) Expenses not covered by Medicaid. A deduction is allowed for necessary medical and remedial expenses recognized by state law but not covered by Medicaid in the absence of an exception for Medicaid coverage under DVHA Rule 7104. In determining whether a medical expense meets these criteria, AHS may require medical or other related information to verify that the service or item for which the expense was incurred was medically necessary and was a medical or remedial expense. The patient's physician shall verify medical necessity with a written statement or prescription specifying the need, quantity, and time period covered. Examples of medical expenses not covered by Medicaid include, but are not limited to, expenses for the services and items listed in (1) through (6) below. Any medical bills, including those incurred during a period of Medicaid eligibility, that are the current liability of the individual and have not been used to meet a previous spenddown requirement may be deducted from excess income. Generally, the individual is required to present a bill or receipt to verify that medical expenses have been incurred or paid.

(1) Over-the-counter drugs

(i) In general. Either standard deductions or actual costs, if greater, may be used to deduct noncovered over-the-counter drugs and supplies.

(ii) Documentation

(A) Documentation verifying medical necessity is not required when AHS determines that an over-the-counter drug or supply is a common remedy for the medical condition of the individual or of the member of the individual's financial responsibility group and the usage is within the maximum amount for common over-the-counter drugs and supplies.

(B) Documentation verifying medical necessity may be required whenever one or both of the following two situations apply:

(I) When the drug or supply is not a common remedy for the medical condition, or

(II) When the reported usage exceeds the maximum amount.

(iii) Amount deductible

(A) Instead of actual expenses, a reasonable estimate of ongoing expenses for over-the-counter drugs and supplies may be applied prospectively to the accounting period. Reasonable estimates of unit sizes, costs and maximums for common over-the-counter drugs and supplies used to meet the spenddown requirement are found in Vermont's Medicaid Procedures Manual.

(B) If an individual uses an ongoing expense to meet their spenddown requirement, they are not eligible to receive Medicaid coverage during that accounting period for the same expense.

(2) Transportation. Noncovered commercial and private transportation costs may be deducted.

(i) For commercial transportation, the actual cost of the transportation, verified by receipt, may be deducted.

(ii) For private transportation, either a standard deduction or the actual cost, if greater, may be used. The process set forth in Vermont's Medicaid Procedures Manual determines the deductible expense for private transportation.

(iii) The cost of transportation may be deducted without verification of medical necessity provided that:

(A) The transportation was essential to secure the medical service; and

(B) The individual was responsible for the cost and was charged an agreed-upon fee or purchased fuel to use a family-owned vehicle or other non-commercial vehicle.

(iv) Mileage reimbursement rates are the rates established by the U.S. General Services Administration. The rates fluctuate periodically. It is important to refer to the federal website in order to determine the current rate. The website is www.gsa.gov/mileage.

(3) Personal care services

(i) In general. A deduction for noncovered personal care services provided in an individual's own home or in a level V residential care home is allowed when they are medically necessary in relation to an individual's medical condition.

(ii) Deductible personal care services. Deductible personal care services include the personal care services described in DVHA Rule 7406.2 and assistance with managing money. They also include general supervision of physical and mental well-being where a physician states such care is required due to a specific diagnosis, such as Alzheimer's disease or dementia or like debilitating diseases or injuries. Room and board is not a personal care service.

(iii) Qualified personal-care service providers

(A) Except as stated in (B) below, services may be deducted when performed by a home-health agency or other provider identified by the individual's physician as qualified to provide the service.

(B) When the service provider is living in the home, deductions may not be based on payments for personal care services provided to an individual:

(I) Under age 21 by the individual's parent, stepparent, or legal guardian, unless the

individual is 18, 19, or 20 years old and payment for personal care services is made from and does not exceed the individual's own income or assets;

(II) By the individual's spouse;

(III) By the individual's sibling, child, or grandchild when the person providing the services is under age 18; or

(IV) By a parent of the individual's minor child.

(iv) Documentation

(A) To document the need for personal care services, the provider must submit:

(I) A plan of care;

(II) A list of the personal care services required;

(III) A statement that the services are necessary in relation to a particular medical condition; and

(IV) A statement that the level of care provided by the particular level IV residential care home is appropriate or, if the individual is not living in a level IV residential care home and the services are not provided by a home health agency, that the provider is qualified to provide the service.

(B) Upon the initial submission of a plan of care, it is assumed that the individual will continue to need the personal care services for the entire accounting period, unless the plan of care has specified a date by which the individual's need for services is expected to change.

A plan of care can be submitted to AHS using a form provided by AHS or using a statement, signed by the physician, that contains information sufficient, as determined by AHS, to document the individual's need for personal care services.

(C) A new plan must be submitted:

(I) Once every six months, when the provider has not specified an ongoing need for personal care services in the current plan; or

(II) Once every two years, when the physician has specified an ongoing need for personal care services in the current plan.

(D) A new plan must also be submitted:

(I) Whenever the service provider changes, unless the service is performed by a home health agency; and

(II) Whenever the need for services in relation to the individual's condition is expected to change, according to the current plan of care.

(v) Amount deductible

(A) Either standard deductions or actual costs, if greater, may be used for deducting personal-care services. Expenses that have not been incurred yet may be deducted if they are predictable and

meet the requirements in § 30.05(h). Expenses also may be deducted if they have actually been incurred by the individual and are not subject to payment by Medicaid or any other third party.

(B) The standard monthly deduction for personal care services shall be deducted for each full or partial calendar month in the accounting period during which the plan of care documents the need for services. The actual documented costs of personal care services may be deducted if they exceed the monthly standard deduction. Deductions may be made for anticipated need through the end of the accounting period.

(C) All changes to these standards that result in lower standard deductions will be made via the Administrative Procedures Act.

(4) Assistive Community-Care Services (ACCS)

(i) Deductible assistive community-care services. A deduction for noncovered assistive community care services (ACCS) provided to an individual residing in a licensed level III residential care home is allowed. The individual may also deduct medically-necessary personal-care services included under the list at DVHA Rule 7406.2 but not part of the list at DVHA Rule 7411.4.

(ii) Qualified Service Providers

(A) Qualified service providers include all level III residential care homes licensed by AHS.

(B) When an individual that is a resident of a level III residential care home becomes eligible for Medicaid by projecting the cost of ACCS across part of the accounting period, the residential care home may agree to function as a Medicaid provider for ACCS with respect to that resident for the remainder of their accounting period. In these cases, the provider may bill for ACCS services no sooner than the ACCS coverage date given to the resident and the provider in a notice from AHS.

(C) When a privately-paying resident of a level III residential care home becomes eligible for Medicaid after having met a spenddown requirement by projecting the cost of ACCS across the entire accounting period, the residential care home shall not function as a Medicaid provider for ACCS with respect to that resident during the period when the resident is meeting the spenddown requirement.

(iii) Documentation

(A) Documentation verifying medical necessity is not required for ACCS. If an individual claims a deduction for medically-necessary personal-care services included under the list at DVHA Rule 7406.2 but not part of the list at DVHA Rule 7411.4 the individual's physician must submit:

(I) A plan of care (form 288B);

(II) A list of the personal care services required;

(III) A statement that the services are necessary in relation to a particular medical condition; and

(IV) A statement that the level of care provided by the particular level III residential care home is appropriate and that the provider is qualified to provide the service.

(B) Upon the initial submission of a plan of care, it is assumed that the individual will continue to need the personal care services for the entire accounting period, unless the plan of care has

specified a date by which the individual's need for services is expected to change.

(C) An individual with an approved personal care services deduction must submit new plans at the same frequencies specified under paragraph (c)(3)(iv) of this subsection.

(iv) Amount deductible

(A) The deduction for ACCS may be used for the entire accounting period or part of it. Whether the standard daily or monthly deduction is used depends on the size of the spenddown requirement. The actual documented costs of ACCS may be deducted if they exceed the monthly standard deduction. Deductions may be made for anticipated need through the end of the accounting period. All changes in these standards that result in lower standard deductions will be made via the Administrative Procedures Act.

(B) If the individual's excess income and resources after deduction of all expenses for which Medicaid coverage is not available equal or exceed the deduction for ACCS for the entire accounting period, for the purposes of meeting a spenddown requirement, ACCS are projected and deducted as if they were not Medicaid-covered services for the entire accounting period. Medicaid eligibility for services other than ACCS becomes effective on the day the spenddown requirement is met. Expenses for which Medicaid coverage is not available are:

(I) Medical expenses excluded from coverage;

(II) Covered medical expenses incurred prior to the accounting period, not used to meet a previous spenddown requirement, and remaining unpaid; and

(III) Covered medical expenses incurred and paid during the current accounting period.

(C) If the individual's excess income and resources after deduction of all expenses for which Medicaid coverage is not available are less than the deduction for ACCS for the entire accounting period, ACCS expenses are not projected. Instead, they are deducted as covered expenses on a daily basis. In this case, Medicaid eligibility for all covered services other than ACCS becomes effective the first day of the accounting period. Medicaid coverage for ACCS begins later. It starts the day cumulative daily ACCS deductions exceed the individual's remaining excess income and resources. The individual is not responsible for payment of a portion of the ACCS expense on the first day of ACCS eligibility.

(D) In addition, the amount of the deduction for any services included under the list at DVHA rule 7406.2 but not part of the list at DVHA rule 7411.4 documented as medically necessary by the plan of care is determined based on the number of hours times minimum wage, or actual costs, if greater.

(5) Dental services. Dental services in excess of the allowable annual maximum may be deducted.

(6) Private-duty nursing services. Private-duty nursing services for an individual age 21 and older may be deducted.

(d) Expenses for covered medical services

(1) A covered medical service is any medical or remedial service that Medicaid would pay for if the individual were enrolled in Medicaid (see DVHA Rules 7201–7606).

(2) Deductions for covered medical services are not limited to the Medicaid reimbursement for the service.

The actual cost paid or incurred is allowed. A standard deduction may be taken for ACCS (see DVHA Rule 7411.4), as set forth in Vermont's Medicaid Procedures Manual.

(e) Third-party coverage

(1) No deduction is allowed if the medical expense is subject to payment by a third party such as health insurance, worker's compensation, liability award, or other benefit program unless the third party is a state or local program other than Medicaid.

(2) When a third party is liable for all or some medical expenses, only the portion owed by the individual may be deducted. AHS is required to take reasonable measures to determine the legal liability of third parties to pay for incurred expenses. Estimates of payment by the third party may be used if actual third party liability cannot be ascertained within the period for determining Medicaid eligibility. An eligibility determination may not be delayed simply because actual third party liability cannot be ascertained or payment by the third party has not been received.

(3) If an individual is pursuing a liability award, but liability has not yet been established, a deduction is allowed. Eligibility must be based on AHS's estimate of the amount the individual owes for the bill.

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.)

VERMONT

Proposed Rules Postings
A Service of the Office of the Secretary of State

Search Rules

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:	22P017
Title:	Health Benefits Eligibility and Enrollment Rule, Financial Methodologies (Part 5).
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.

Persons Affected:	Medicaid applicants/enrollees; Individuals who wish to purchase health coverage including those who apply for premium and cost-sharing assistance; Health insurance issuers; Eligibility and enrollment assisters, including agents and brokers; Health care providers; Health law, policy and related advocacy and community-based organizations and groups including the Office of the Health Care Advocate; Agency of Human Services including its departments; and Department of Financial Regulation.
Economic Impact:	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.
Posting date:	Jul 13,2022

Hearing Information

Information for Hearing # 1

Hearing date:	08-17-2022 2:00 PM ADD TO YOUR CALENDAR
Location:	Waterbury State Office Complex, Cherry A Conference Room
Address:	280 State Drive
City:	Waterbury
State:	VT
Zip:	05671
Hearing Notes:	Also via MS Teams: Call in (audio only) 802-522-8456 Conference ID: 738063547# or visit: https://teams.microsoft.com/l/meetup-join/193ameeting_NzJjZWJjOTUtMjVlMS00ZTJkLTk4YzAtZjFkYTU3MTUxZmEw40thread.v2/0?context7b22Tid223a2220b4933b-baad-433c-9c02-70edcc7559c6222c22Oid223a22beb0dd2a-7ce6-4285-9bad-e79977845027227d

Contact Information

Information for Primary Contact

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

Level:	Primary
Name:	Danielle Fuoco
Agency:	Agency of Human Services
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City:	Waterbury
State:	VT
Zip:	05671

Telephone:	802-585-4265
Fax:	802-241-0450
Email:	danielle.fuoco@vermont.gov SEND A COMMENT
Website Address:	https://humanservices.vermont.gov/rules-policies/health-care-rules VIEW WEBSITE

Information for Secondary Contact

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

Level:	Secondary
Name:	Jessica Ploesser
Agency:	Agency of Human Services
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Fax:	802-241-0450
Email:	Jessica.ploesser@vermont.gov 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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	The Valley News (advertising@vnews.com)	Tel: 603-298-8711 FAX: 603-298-0212
	The Addison Independent (legals@addisonindependent.com)	Tel: 388-4944 FAX: 388-3100 Attn: Display Advertising
	The Bennington Banner / Brattleboro Reformer Lylah Wright (lwright@reformer.com)	Tel: 254-2311 ext. 132 FAX: 447-2028 Attn: Lylah Wright
	The Chronicle (ads@bartonchronicle.com)	Tel: 525-3531 FAX: 525-3200
	Herald of Randolph (ads@ourherald.com)	Tel: 728-3232 FAX: 728-9275 Attn: Brandi Comette
	Newport Daily Express (jlafoe@newportvermontdailyexpress.com)	Tel: 334-6568 FAX: 334-6891 Attn: Jon Lafoe
	News & Citizen (mike@stowereporter.com) Irene Nuzzo (irene@newsandcitizen.com and ads@stowereporter .com removed from distribution list per Lisa Stearns.	Tel: 888-2212 FAX: 888-2173 Attn: Bryan
	St. Albans Messenger Ben Letourneau (ben.letourneau@samessenger.com)	Tel: 524-9771 ext. 117 FAX: 527-1948 Attn: Ben Letourneau
	The Islander (islander@vermontislander.com)	Tel: 802-372-5600 FAX: 802-372-3025
	Vermont Lawyer (hunter.press.vermont@gmail.com)	Attn: Will Hunter

FROM: APA Coordinator, VSARA **Date of Fax:** 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.
