FINAL PROPOSED RULE # 22-P18

Final Proposed Filing - Coversheet

Instructions:

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

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

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

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

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

Health Benefits Eligibility and Enrollment Rule, Eligibility-and-Enrollment Procedures (Part 7)

/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, Eligibility-and-Enrollment Procedures (Part 7)

2. PROPOSED NUMBER ASSIGNED BY THE SECRETARY OF STATE
22P018

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

280 State Drive – Center Building
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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

VERMONT

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

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

Jenney Samuelson, Secretary

Date: October 18, 2022

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

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

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

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

PART TWO

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

PART THREE

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

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

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MEMORANDUM

To: Jim Condos, Secretary of State, Vermont Secretary of State Office
Sen. Mark A. MacDonald, Chair, Legislative Committee on Administrative Rules (LCAR)

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

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

Date: October 18, 2022

Re: Agency of Human Services Final Proposed Rule Filing

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

Amended:

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

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

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

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

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

Adopting Page

Instructions:

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

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

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

1. TITLE OF RULE FILING:
   Health Benefits Eligibility and Enrollment Rule, Eligibility-and-Enrollment Procedures (Part 7)
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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[phone] 802-828-3322
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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, Eligibility-and-Enrollment Procedures (Part 7), 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.

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1. TITLE OF RULE FILING:

   Health Benefits Eligibility and Enrollment Rule, Eligibility-and-Enrollment Procedures (Part 7)

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, Eligibility-and-Enrollment Procedures (Part 7)

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, Eligibility-and-Enrollment Procedures (Part 7)

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
Vermont Legal Aid

State of Vermont
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280 State Drive
Waterbury, VT 05671-1000
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Jenney Samuelson, *Secretary*
[phone] 802-241-0440
[fax] 802-241-0450

Date: October 18, 2022

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

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

General Comment

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

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

Comments by Rule Sections

PART TWO

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

Comment 1 from Vermont Legal Aid:

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

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

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

Response:

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

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

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

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

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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.

Annotated Text

Table of Contents

Part Seven
Eligibility-and-Enrollment Procedures

Part Seven sets forth the application processing and enrollment requirements for health benefits, including verification of eligibility factors, determination of premium assistance amounts, billing and collection of Medicaid premiums, and periodic renewals of eligibility.

51.00 Automatic entitlement to Medicaid following a determination of eligibility under other programs[1] (01/15/2017, GCR 16-100)

A separate application for Medicaid is not required from an individual who receives SSI or AABD.

52.00 Application[2] (01/01/2018, GCR 17-048)

52.01 In general (01/15/2017, GCR 16-100)

An individual will be afforded the opportunity to apply for health benefits at any time, without delay.[3]

52.02 Application filing[4] (01/01/2018, GCR 17-048)

(a) The application. A single, streamlined application will be used to determine eligibility and to collect information necessary for:

(1) Enrollment in a QHP;

(2) APTC;

(3) CSR;

(4) Vermont Premium Reduction;

(5) Vermont Cost Sharing Reduction; and

(6) MAGI-based Medicaid. For Medicaid categories that are not based on MAGI methodologies, the single, streamlined application may be supplemented with a form (or forms) to collect additional information, or an appropriate, alternative application may be used.

[1] 42 CFR § 435.909.

[2] 42 CFR § 435.907; 45 CFR §§ 155.310(a) and 155.405.

[3] 42 CFR § 435.906; 45 CFR § 155.310(c).

[4] 42 CFR § 435.907; 45 CFR § 155.405.

(b) Filing the application. AHS will:

(1) Accept the application from an application filer; and

(2) Provide the tools to file an application:

(i) Via an internet website;

(ii) By telephone through a call center;

(iii) By mail;

(iv) Through other commonly available electronic means; and

(v) In person.

(c) Assistance.[5] AHS will provide assistance to any individual seeking help with the application or renewal process, in the manner prescribed in § 5.01.

(d) Application filers. An application will be accepted from:

(1) The applicant;

(2) An adult who is in the applicant's household;

(3) An authorized representative; or

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

(e) Missing information[6]

(1) The applicant's eligibility for health benefits will not be determined before the applicant provides answers to all required questions on the application.

(2) If an incomplete application is received, the applicant will be sent a request for answers to all of the unanswered questions necessary to determine eligibility. The request will include a response due date, which will be no earlier than 15 days after the date the request is sent to the applicant.

(3) If a full response to the request is received on or before the request due date, the eligibility process will be activated for determining:

(i) Coverage, based on the date the application was originally received; or

[5] 42 CFR § 435.908.

[6] 45 CFR § 155.310(k).

(ii) The need to request any corroborative information necessary to determine eligibility.

(4) If responses to all unanswered questions necessary for determining eligibility are not received by the response due date, the applicant will be notified that AHS is unable to determine their eligibility for health benefits. The date that the incomplete application was received will not be used in any subsequent eligibility determinations.

(f) Limits on information.[7] An applicant will be required to provide only the information necessary to make an eligibility determination or for a purpose directly connected to the administration of health-benefits programs.

(g) Information collection from non-applicants.[8] Information regarding citizenship, status as a national, or immigration status will not be requested for an individual who is not seeking health benefits for themselves.

(h) Signature required. An initial application must be signed under penalty of perjury. Electronic, including telephonically-recorded, signatures and handwritten signatures transmitted via any other electronic transmission will be accepted.

(i) Accessibility. Any application or supplemental form must be accessible to individuals who are limited English proficient and individuals who have disabilities, consistent with the provisions of § 5.01.

53.00 Attestation and verification – in general (01/15/2017, GCR 16-100)

(a) Basis and scope. The income and eligibility verification requirements set forth in §§ 53.00 through 56.00 are based on §§ 1137, 1902(a)(4), 1902(a)(19), 1902(a)(46)(B), 1902(ee), 1903(r)(3), 1903(x), and 1943(b)(3) of the Act, and § 1413 of the ACA.

(b) In general. AHS will verify or obtain information as provided in §§ 53.00 through 56.00 before making a determination about an individual's eligibility for health benefits. Such information will be used in making the eligibility determination. See § 58.00 for details on the eligibility determination process.

(c) Attestation.[9] Except where the law requires other procedures (such as for citizenship and immigration-status information), attestation of information needed to determine the eligibility of an individual for health benefits will be accepted (either self-attestation by the individual or attestation by an adult who is in the individual's household, an authorized representative, or, if the individual is under age 18[10] or incapacitated, someone acting responsibly for the individual) without requiring further information (including documentation) from the

[7] 42 CFR § 435.907(e).

[8] 45 CFR § 155.310(a)(2).

[9] 42 CFR § 435.945(a).

[10] In its response to comments on its proposed rule, CMS indicated that "[s]tate law and regulation establish who may file an application for an insurance affordability program on behalf of a child under age 21, and nothing in the Affordable Care Act or these regulations alters State authority or flexibility on this matter." 77 FR 17,156 (March 23, 2012). In Vermont, the age of majority is 18. 1 VSA § 173.

individual.

(d) Use of federal electronic verification service.[11] To the extent that information related to determining eligibility for health benefits is available through an electronic service established by HHS, AHS will obtain the information through such service, unless AHS has secured HHS approval of alternative procedures described in (e) below.[12]

(e) Flexibility in information collection and verification. Subject to approval by HHS, AHS may request and use information from a source or sources alternative to those listed in § 56.01(b), or through a mechanism other than the electronic service described in (d) above, provided that such alternative source or mechanism will reduce the administrative costs and burdens on individuals and the state while maximizing accuracy, minimizing delay, and meeting applicable requirements relating to confidentiality, disclosure, maintenance, or use of information.

(f) Notice of intent to obtain and use information.[13] Before it requests information for an individual from another agency or program, AHS will inform the individual that it will obtain and use information available to it to verify income, resources (when applicable), and eligibility or for other purposes directly connected to the administration of a health-benefits program or to enrollment in a QHP.

(g) Security of electronic information exchanges.[14] Information exchanged electronically between AHS and any other agency or program will be sent and received via secure electronic interfaces, as specified in § 4.09. Any such exchange of data will be made pursuant to written agreements with such other agencies or programs, which will provide for appropriate safeguards limiting the use and disclosure of information as required by federal or state law or regulations.

(h) Limitation on scope of information requests.

(1) An individual will not be required to provide information beyond the minimum necessary to support eligibility and enrollment processes.

(2) An individual will not be required to provide additional information or documentation unless information needed by AHS cannot be obtained electronically or the information obtained electronically is not reasonably compatible, as that term is defined in § 57.00(a), with information provided by or on behalf of the individual.

(i) Limitation on use of evidence of immigration status. Evidence of immigration status may not be used to determine that an individual is not a Vermont resident.

[11] 42 CFR § 435.949(b).

[12] 42 CFR § 435.945(k); 45 CFR § 155.315(h)

[13] 42 CFR § 435.945(f).

[14] 42 CFR § 435.945(i).

54.00 Attestation and verification of citizenship and immigration status (01/15/2019, GCR 18-064)

54.01 Definitions (01/15/2017, GCR 16-100)

For definitions relevant to citizenship and immigration status, see § 17.00.

54.02 Declaration of citizenship or immigration status (01/15/2017, GCR 16-100)

Except as provided in § 54.06 for certain individuals applying for Medicaid, and except for employees enrolling in a qualified employer-sponsored plan, an individual seeking health benefits must sign a declaration that they are:

(a) A citizen or national of the United States (§ 17.01(a) and (c));

(b) A qualified non-citizen (§ 17.01(d)); or

(c) Lawfully present in the United States (§ 17.01(g)).

For the effect that citizenship and immigration status has on eligibility for health benefits, see § 17.00.

54.03 Verification frequency (01/15/2019, GCR 18-064)

(a) Citizenship.[15] Verification or documentation of citizenship is a one-time activity; once an individual's citizenship is documented and recorded, subsequent changes in eligibility should not require repeating the documentation unless later evidence raises a question about the individual's citizenship.

(b) Immigration status.[16] Immigration status, including lawful presence, must be verified or documented at the time of initial application and, for a Medicaid enrollee, at the time of eligibility renewal. In verifying immigration status at the time of renewal, AHS will first rely on information provided at the time of initial application to determine ongoing eligibility. AHS will only require the individual to provide further documentation or to re-verify satisfactory status if it cannot verify continued eligibility based on the information already available to it.

54.04 Electronic verification[17] (01/01/2018, GCR 17-048)

(a) Verification with records from the SSA. For an individual who attests to citizenship and has a Social Security number, AHS will transmit their Social Security number and other identifying information to HHS, which will submit it to the SSA for verification.

(b) Verification with the records of DHS. For an individual who has documentation that can be verified through DHS and who either attests to lawful immigration status or lawful presence, or who attests to citizenship and for whom AHS cannot substantiate a claim of citizenship through SSA, AHS will transmit information from the

[15] 42 CFR § 435.956(a)(4)(ii).

[16] CMS SHO Letter No. 10-006 (July 1, 2010), p. 5.

[17] 42 CFR § 435.956; 45 CFR § 155.315(c).

individual's documentation and other identifying information to HHS, which will submit necessary information to DHS for verification.

54.05 Inconsistencies and inability to verify information[18] (01/01/2018, GCR 17-048)

(a) In general. Except as provided in § 54.06, with respect to citizenship, lawful presence or satisfactory immigration status which cannot be verified through SSA or DHS, AHS will:

(1) Follow the procedures specified in § 57.00 (inconsistencies), except that:

(i) The opportunity period described in § 57.00(c)(2)(ii) during which the individual must submit documentation or resolve the inconsistency begins with the date the notice described in § 57.00(c)(2)(i) is received by, rather than sent to, the individual and, for both QHP and Medicaid purposes, extends 90 days from that date. The date on which the notice is received is considered to be five days after the date on the notice, unless the individual demonstrates that they did not receive the notice within the five-day period.

(ii) The opportunity period may be extended beyond 90 days for QHP purposes, and for Medicaid purposes for individuals declaring to be in satisfactory immigration status, if the individual is making a good-faith effort to resolve any inconsistencies or AHS needs more time to complete the verification process.

(2) If the individual does not have a Social Security number, assist the individual in obtaining a Social Security number;[19]

(3) Attempt to resolve any inconsistencies, including typographical or other clerical errors, between information provided by the individual and data from an electronic data source, and resubmit corrected information to the electronic data source;

(4) Provide the individual with information on how to contact the source of the electronic data so they can attempt to resolve inconsistencies directly with such data source; and

(5) Permit the individual to provide other documentation of citizenship or immigration status.[20]

(b) Eligibility activities during opportunity period.[21] During the opportunity period described in paragraphs (a)(1)(i) and (ii) of this subsection, AHS will:

(1) Not delay, deny, reduce, or terminate benefits for an individual who is otherwise eligible for health

[18] 42 CFR § 435.956; 45 CFR 155.315(c)(3).

[19] 42 CFR § 435.910.

[20] 42 CFR §§ 435.956(b)(1)(iii), 435.406 and 435.407.

[21] 42 CFR § 435.956(a)(5); 45 CFR § 155.315(f)(4).

benefits.

(2) Begin to furnish Medicaid benefits to otherwise eligible individuals effective on the date of the application containing the declaration of citizenship or immigration status by or on behalf of the individual.

(3) If relevant, proceed with respect to QHP enrollment, APTC, and CSR, as provided for in § 57.00(c)(4).[22]

(c) Failure to complete verification during opportunity period. If, by the end of the opportunity period described in paragraphs (a)(1)(i) and (ii) of this subsection, the individual's citizenship or immigration status has not been verified in accordance with paragraph (a) of this subsection, AHS will:

(1) With regard to the individual's eligibility for Medicaid, take action within 30 days to terminate eligibility.[23]

(2) With regard to the individual's eligibility for enrollment in a QHP, APTC and CSR, proceed in accordance with the provisions of § 57.00(c)(4)(ii).[24]

(d) Records of verification. AHS will maintain a record of having verified citizenship or immigration status for each individual in a case record or electronic database.

54.06 Individuals not required to document citizenship or national status for Medicaid[25] (01/01/2018, GCR 17-048)

The following individuals are not required to document citizenship or national status as a condition of receipt of Medicaid benefits:

(a) An individual receiving SSI benefits under Title XVI of the Act;

(b) An individual entitled to or enrolled in any part of Medicare;

(c) An individual receiving Social Security disability insurance benefits under § 223 of the Act or monthly benefits under § 202 of the Act, based on the individual's disability (as defined in § 223(d) of the Act);

(d) An individual who is in foster care and who is assisted under Title IV-B of the Act, and an individual who is a recipient of foster-care maintenance or adoption assistance payments under Title IV-E of the Act; and

(e) A child born in the United States on or after April 1, 2009, who was deemed eligible for Medicaid as a newborn

[22] 45 CFR § 155.315(c)(3).

[23] 42 CFR § 435.956(b)(3).

[24] 45 CFR § 155.315(f)(5).

[25] 42 CFR § 435.406(a)(1)(iii).

(§ 9.03(b)).[26]

54.07 Documentary evidence of citizenship and identity (01/01/2018, GCR 17-048)

(a) Definition: available. Document exists and can be obtained within the period of time specified in § 54.05.

(b) Standalone evidence of citizenship.[27] The following will be accepted as sufficient documentary evidence of citizenship:

(1) A U.S. passport, including a U.S. Passport Card issued by the Department of State, without regard to any expiration date as long as such passport or Card was issued without limitation.

(2) A Certificate of Naturalization.

(3) A Certificate of U.S. Citizenship.

(4) A valid state-issued driver's license if the state issuing the license requires proof of U.S. citizenship, or obtains and verifies a Social Security number from the applicant who is a citizen before issuing such license.

(5) Tribal documents:

(i) Documentary evidence issued by a federally-recognized Indian tribe, as published in the Federal Register by the Bureau of Indian Affairs within the U.S. Department of the Interior, and including tribes located in a State that has an international border, which:

(A) Identifies the federally-recognized Indian tribe that issued the document;

(B) Identifies the individual by name; and

(C) Confirms the individual's membership, enrollment, or affiliation with the tribe.

(ii) Documents described in paragraph (b)(5)(i) of this subsection include, but are not limited to:

(iii) A tribal enrollment card;

(iv) A Certificate of Degree of Indian Blood;

(v) A tribal census document;

(vi) Documents on tribal letterhead, issued under the signature of the appropriate tribal official, that meet the requirements of paragraph (b)(5)(i) of this subsection.

[26] Section 1903(x) of the Act.

[27] 42 CFR § 435.407(a).

(6) A data match with the Social Security Administration.

(c) Other evidence of citizenship.[28] If an applicant does not provide documentary evidence from the list in paragraph (b) of this subsection, the following must be accepted as satisfactory evidence to establish citizenship if also accompanied by an identity document listed in paragraph (d) of this subsection:

(1) A U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam, the Virgin Islands of the U.S., American Samoa, Swain's Island, or the Commonwealth of the Northern Mariana Islands (CNMI) (if born after November 4, 1986, (CNMI local time)). The birth record document may be issued by a State, Commonwealth, Territory, or local jurisdiction. If the document shows the individual was born in Puerto Rico or the CNMI before the applicable date referenced in this paragraph, the individual may be a collectively naturalized citizen. The following will establish U.S. citizenship for collectively naturalized individuals:

(i) Puerto Rico: Evidence of birth in Puerto Rico and the applicant's statement that they were residing in the U.S., a U.S. possession, or Puerto Rico on January 13, 1941.

(ii) CNMI (formerly part of the Trust Territory of the Pacific Islands (TTPI)):

(A) Evidence of birth in the CNMI, TTPI citizenship and residence in the CNMI, the U.S., or a U.S. Territory or possession on November 3, 1986 (CNMI local time) and the applicant's statement that they did not owe allegiance to a foreign state on November 4, 1986 (CNMI local time);

(B) Evidence of TTPI citizenship, continuous residence in the CNMI since before November 3, 1981 (CNMI local time), voter registration before January 1, 1975, and the applicant's statement that they did not owe allegiance to a foreign state on November 4, 1986 (CNMI local time).

(C) Evidence of continuous domicile in the CNMI since before January 1, 1974, and the applicant's statement that they did not owe allegiance to a foreign state on November 4, 1986 (CNMI local time). Note: If a person entered the CNMI as a nonimmigrant and lived in the CNMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.

(2) At state option, a cross-match with a state vital statistics agency documenting a record of birth.

(3) A Certification of Report of Birth, issued to U.S. citizens who were born outside the U.S.

(4) A Report of Birth Abroad of a U.S. Citizen.

(5) A Certification of birth in the United States.

(6) A U.S. Citizen I.D. card.

(7) A Northern Marianas Identification Card, issued by DHS (or predecessor agency).

(8) A final adoption decree showing the child's name and U.S. place of birth, or if an adoption is not final, a

[28] 42 CFR § 435.407(b).

statement from a state-approved adoption agency that shows the child's name and U.S. place of birth.

(9) Evidence of U.S. Civil Service employment before June 1, 1976.

(10) U.S. Military Record showing a U.S. place of birth.

(11) A data match with the Systematic Alien Verification for Entitlements (SAVE) Program or any other process established by DHS to verify that an individual is a citizen.

(12) Documentation that a child meets the requirements of § 101 of the Child Citizenship Act of 2000 (8 USC § 1431).

(13) Medical records, including, but not limited to, hospital, clinic, or doctor records or admission papers from a nursing facility, skilled care facility, or other institution that indicate a U.S. place of birth.

(14) Life, health, or other insurance record that indicates a U.S. place of birth.

(15) Official religious record recorded in the U.S. showing that the birth occurred in the U.S.

(16) School records, including pre-school, Head Start and daycare, showing the child's name and U.S. place of birth.

(17) Federal or State census record showing U.S. citizenship or a U.S. place of birth.

(18) If the individual does not have one of the documents listed in paragraphs (b) or (c)(1) through (17) of this subsection, they may submit an affidavit signed by another individual under penalty of perjury who can reasonably attest to the individual's citizenship, and that contains the individual's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized.

(d) Evidence of identity[29]

(1) The following will be accepted as proof of identity, provided such document has a photograph or other identifying information sufficient to establish identity, including, but not limited to, name, age, sex, race, height, weight, eye color, or address:

(i) Identity documents listed at 8 CFR § 274a.2(b)(1)(v)(B)(1), except a driver's license issued by a Canadian government authority.

(ii) Driver's license issued by a State or Territory.

(iii) School identification card.

(iv) U.S. military card or draft record.

[29] 42 CFR § 435.407(c).

(v) Identification card issued by the federal, state, or local government.

(vi) Military dependent's identification card.

(vii) U.S. Coast Guard Merchant Mariner card.

(viii) A finding of identity from an Express Lane agency, as defined in § 1902(e)(13)(F) of the Act.

(2) For children under age 19, a clinic, doctor, hospital, or school record, including preschool or day care records.

(3) Two documents containing consistent information that corroborates an individual's identity. Such documents include, but are not limited to, employer identification cards, high school and college diplomas (including high school equivalency diplomas), marriage certificates, divorce decrees, and property deeds or titles.

(4) AHS will accept as proof of identity:

(i) A finding of identity from a federal agency or another state agency, including but not limited to a public assistance, law enforcement, internal revenue or tax bureau, or corrections agency, if the agency has verified and certified the identity of the individual.

(ii) [Reserved]

(5) If the individual does not have any document specified in paragraphs (d)(1) through (d)(3) of this subsection and identity is not verified under paragraph (d)(4) of this subsection, the individual may submit an affidavit signed, under penalty of perjury, by another person who can reasonably attest to the individual's identity. Such affidavit must contain the individual's name and other identifying information establishing identity, as described in paragraph (d)(1) of this subsection. The affidavit does not have to be notarized.

(e) Verification of citizenship by a federal agency or another state.[30] AHS may rely, without further documentation of citizenship or identity, on a verification of citizenship made by a federal or state agency, if such verification was done on or after July 1, 2006.

(f) Assistance.[31] AHS will assist individuals who need assistance to secure satisfactory documentary evidence of citizenship in a timely manner.

(g) Documentary evidence.[32] A photocopy, facsimile, scanned, or other copy of a document will be accepted to the same extent as an original document under this subsection, unless information on the submitted document is inconsistent with other information available to AHS, or AHS otherwise has reason to question the validity of

[30] 42 CFR § 435.407(d).

[31] 42 CFR § 435.407(e).

[32] 42 CFR § 435.407(f).

the document or the information on the document.

54.08 Documentation of immigration status for qualified non-citizens (01/15/2017, GCR 16-100)

If verification of immigration status cannot be obtained through the process described in § 54.04, a non-citizen individual seeking health benefits as a qualified non-citizen must provide United States Citizenship and Immigration Services (USCIS) documents to establish immigration status, as specified below:

(a) Lawful Permanent Resident

(1) USCIS Form I-551; or

(2) For recent arrivals, a temporary I-551 stamp on a foreign passport or on Form I-94.

(3) Note: Forms I-151, AR-3 and AR-3A have been replaced by USCIS. If presented as evidence of status, contact USCIS to verify status by filing a G-845 with a copy of the old form. Refer the individual to USCIS to apply for a replacement card.

(b) Refugee

(1) The following documents may be used to document refugee status:

(i) USCIS Form I-94 endorsed to show entry as refugee under § 207 of INA and date of entry to the United States;

(ii) USCIS Form I-688B annotated "274a.12(a)(3)";

(iii) Form I-766 annotated "A3"; or

(iv) Form I-571

(2) Refugees usually change to Lawful Permanent Resident status after 12 months in the United States, but for the purposes of health-benefits eligibility are still considered refugees. They are identified by Form I-551 with codes RE-6, RE-7, RE-8, or RE-9.

(3) The following documents may be used to document that the individual is a "Cuban or Haitian entrant":

(i) An I-94 Arrival/departure card with a stamp showing parole into the United States on or after April 21, 1980. I-94 may refer to §212(d)(5). I-94 may refer to humanitarian or public interest parole. I-94 may be expired.

(ii) An I-94 Arrival/departure card with a stamp showing parole at any time as a "Cuban/Haitian Entrant (Status Pending)." I-94 may refer to §212(d)(5). I-94 may be expired.

(iii) CH6 adjustment code on the I-551. Even after a Cuban/Haitian Entrant (Status Pending) becomes a permanent resident, they technically retain the status Cuban/Haitian Entrant (Status Pending). I-551 may be expired.

(iv) A Cuban or Haitian passport with a §212(d)(5) stamp dated after October 10, 1980. Passport may

be expired.

(c) Asylee

(1) USCIS Form I-94 annotated with stamp showing grant of asylum under § 208 of the INA;

(2) A grant letter from the Asylum Office of the USCIS;

(3) Form I-688B annotated "274a.12(a)(5)";

(4) Form I-766 annotated "A5"; or

(5) An order of the Immigration Judge granting asylum. If a court order is presented, file a G-845 with the local USS district office attaching a copy of the document to verify that the order was not overturned on appeal.

(d) American Indian born outside of the United States

(1) Documentation of LPR status (See I-313.1);

(2) Birth or baptismal certificate issued on a reservation;

(3) Membership card or other tribal records;

(4) Letter from the Canadian Department of Indian Affairs;

(5) School records; or

(6) Contact with the tribe in question.

(e) Non-citizen granted parole for at least one year by the USCIS. USCIS Form I-94 endorsed to show grant of parole under § 212(d)(5) of the INA and a date showing granting of parole for at least one year.

(f) Non-citizen granted conditional entry under the immigration law in effect before April 1, 1980

(1) USCIS Form I-94 with stamp showing admission under § 203(a)(7) of the INA, refugee-conditional entry;

(2) Form I-688B annotated "274a.12 (a)(3)"; or

(3) Form I-766 annotated "A-3."

(g) Non-citizen who has had deportation withheld under § 243(h) of the INA

(1) Order of an Immigration Judge showing deportation withheld under § 243(h) of the INA and date of the grant;

(2) USCIS Form I-688B annotated "247a.12(a)(10)"; or

(3) Form I-766 annotated "A10."

54.09 Documentation of entry date for determining the Medicaid five-year bar for qualified non-citizens (01/15/2017, GCR 16-100)

(a) The following are the documents that may be used to determine the Medicaid five-year bar for qualified non-citizens (§ 17.03):

(1) Form I-94. The date of admission should be found on the refugee stamp. If missing, AHS will contact USCIS to verify the date of admission by filing a G-845 with a copy of the document.

(2) If an individual presents Forms I-688B or I-766 (Employment Authorization Documents), and I-57 (refugee travel document), AHS will ask the individual to present Form I-94. If not available, AHS will contact USCIS by filing a G-845 with a copy of the document presented; or

(3) Grant letters or court orders. AHS will derive the date status is granted from the date of the letter or court order. If missing, AHS will contact USCIS to verify date of grant by filing a G-845 with a copy of the document.

(b) If an individual presents a receipt indicating that they have applied to USCIS for a replacement document for one of the documents identified above, AHS will contact the USCIS to verify status by filing a G-845 with the local USCIS district office with a copy of the receipt. AHS will contact the USCIS any time there is a reason to question the authenticity of a document presented or the information on the document is insufficient to determine whether non-citizen status requirements are met.

54.10 Ineligible non-citizens and non-immigrants (01/15/2017, GCR 16-100)

Some non-citizens may be lawfully admitted but only for a temporary or specified period of time as legal non-immigrants. These non-citizens are never qualified non-citizens. Because of the temporary nature of their admission status, they generally will be unable to establish residency and are not eligible for health benefits as qualified non-citizens. For example, a non-citizen in possession of a student visa is not a qualified non-citizen. In rare instances, an ineligible non-citizen may be able to establish residency and meet all other Medicaid eligibility criteria and therefore be eligible for treatment of emergency medical conditions only (see § 17.02(d)).

54.11 Visitors, tourists, and some workers and diplomats ineligible for Medicaid (01/15/2017, GCR 16-100)

For purposes of Medicaid eligibility, visitors, tourists, and some workers and diplomats are also ineligible non-citizens and non-immigrants. These non-citizens would have the following types of documentation:

(a) Form I-94 Arrival-Departure Record;

(b) Form I-185 Canadian Border Crossing Card;

(c) Form I-186 Mexican Border Crossing Card;

(d) Form SW-434 Mexican Border Visitor's Permit; or

(e) Form I-95A Crewman's Landing Permit.

55.00 Attestation and verification of other nonfinancial information[33] (01/01/2023~~10/01/2021~~, GCR 22-033~~20-004~~)

55.01 Attestation only (01/15/2017, GCR 16-100)

Unless information from an individual is not reasonably compatible with other information provided or otherwise available to AHS, as described in § 57.00(b)(3), attestation of information needed to determine the following eligibility requirements will be accepted without requiring further information from the individual:

(a) Residency;

(b) Age;

(c) Date of birth; and

(d) Pregnancy.

55.02 Verification of attestation (01/01/2023~~10/01/2021~~, GCR 22-033~~20-004~~)

An individual's attestations of information needed to determine the following eligibility requirements will be verified by AHS:

(a) Social Security number[34]

(1) The Social Security number furnished by an individual will be verified with SSA to insure the Social Security number was issued to that individual, and to determine whether any other Social Security numbers were issued to that individual.

(2) For any individual who provides a Social Security number, AHS will transmit the number and other identifying information to HHS, which will submit it to SSA.

(3) To the extent that an individual's Social Security number is not able to be verified through the SSA, or the SSA indicates that the individual is deceased, the procedures specified in § 57.00 will be followed, except that, for purposes of QHP eligibility:

(i) The individual will be provided with a period of 90 days from the date on which the notice described in § 57.00(c)(2)(i) is received, rather than sent, for the individual to provide satisfactory documentary evidence or resolve the inconsistency with the SSA.

(ii) The date on which the notice is received means five days after the date on the notice, unless the

[33] 42 CFR § 435.956; 45 CFR §§ 155.315 and 155.320.

[34] 42 CFR §§ 435.910 and 435.956(d); 45 CFR § 155.315(b).

individual demonstrates that they did not receive the notice within the five-day period.

For more information about Social Security numbers and eligibility for health benefits, see § 16.00.

(b) Incarceration status.[35] When determining an individual's eligibility for enrollment in a QHP, the individual's attestation regarding incarceration status will be verified by:

(1) Relying on any electronic data sources that are available to AHS; or

(2) If an approved data source is unavailable, accepting the individual's attestation, except as provided in (3) below.

(3) To the extent that an individual's attestation is not reasonably compatible with information from available data sources described in (1) above or other information provided by the individual or in AHS's records, AHS will follow the procedures specified in § 57.00.

(c) Eligibility for MEC other than through an eligible employer-sponsored plan.[36] When determining eligibility for APTC and CSR:

(1) AHS will verify whether an individual is eligible for MEC other than through an eligible employer-sponsored plan or Medicaid, using information obtained by transmitting identifying information specified by HHS to HHS.

(2) AHS will also verify whether an individual already has been determined eligible for coverage through Medicaid within the state.

(d) Enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan[37]

(1) General requirement. When determining eligibility for APTC and CSR, AHS will verify whether an individual reasonably expects to be enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested.

(2) Verification procedures[38]

(i) Except as specified in paragraph (d)(2)(ii) of this subsection, an individual's attestation regarding the verification specified in paragraph (d)(1) of this subsection will be accepted without further

[35] 45 CFR § 155.315(e).

[36] 45 CFR § 155.320(b).

[37] 45 CFR § 155.320(d).

[38] 45 CFR § 155.320(d)(4~~iv~~).

verification.

(ii) AHS may~~will~~ select a statistically significant random sample of individuals found eligible for APTC based on their attestation as described in (d)(2)(i) of this subsection and:

(A) Provide notice to the selected individuals indicating that AHS will be contacting any employer identified on the application for the individual and the members of their household to verify whether the individual is enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested;

(B) Proceed with all elements of eligibility determination using the individual's attestation, and provide eligibility for enrollment in a QHP to the extent that an individual is otherwise qualified;

(C) Ensure that APTC and CSR are provided on behalf of an individual who is otherwise qualified for such payments and reductions, if the tax filer for the individual attests that they understand that any APTC paid on their behalf is subject to reconciliation;

(D) Make reasonable attempts to contact any employer identified on the application for the individual and the members of their household, to verify whether the individual is enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested;

(E) If AHS receives any information from an employer relevant to the individual's enrollment in an eligible employer-sponsored plan or eligibility for qualifying coverage in an eligible employer-sponsored plan, AHS will determine the individual's eligibility based on such information and in accordance with the effective dates specified in § 73.06, and if such information changes their eligibility determination, notify the individual of such determination;

(F) If, after a period of 90 days from the date on which the notice described in paragraph (d)(2)(ii)(A) above is sent to the individual, AHS is unable to obtain the necessary information from an employer, the individual's eligibility will be determined based on their attestation regarding coverage provided by that employer.

(G) In order to carry out the process described in this paragraph (d)(2)(ii), AHS will only disclose an individual's information to an employer to the extent necessary for the employer to identify the employee.

56.00 Attestation and verification of financial information[39] (01/15/2019, GCR 18-064)

56.01 Data (01/15/2017, GCR 16-100)

[39] Generally, the ACA's provisions regarding modernization of Medicaid eligibility procedures (*e.g.*, application, renewal, attestation, electronic verification, submission modes, etc.) apply to determination of MAGI- and non-MAGI based eligibility decisions. See, CMS response to comments on proposed rule, 77 FR 17,143 (March 23, 2012). Accordingly, the provisions in this section apply in determining MABD income. However, as the concept of "family size" does not apply in the context of MABD (that program utilizes the concepts of "financial responsibility group" and "Medicaid group" in determining the countable non-MAGI-based income), provisions in this section that refer to "family size" apply only to MAGI-related Medicaid eligibility.

(a) Tax data[40]

(1) For all individuals whose income is counted in making a health-benefits eligibility determination, and for whom Social Security numbers are available, AHS will request tax return data regarding income and family size from the Secretary of the Treasury and data regarding Social Security benefits from the Commissioner of Social Security by transmitting identifying information specified by HHS to HHS.

(2) If the identifying information for one or more individuals does not match a tax record on file with the Secretary of the Treasury that may be disclosed, AHS will proceed in accordance with the provisions in § 57.00(c)(1).

(b) Non-tax data. For all individuals whose income is counted in making a health-benefits eligibility determination, AHS will request non-tax data from other agencies in the state and other state and federal programs, as follows:

(1) To the extent that AHS determines such information is useful in verifying the financial eligibility of an individual, the following will be requested:

(i) Information related to wages, net earnings from self-employment, and unearned income and resources from:

(A) The State Wage Information Collection Agency (SWICA);

(B) The IRS;

(C) The SSA;

(D) The State of Vermont's new-hire database;

(E) The agency or agencies administering the state unemployment compensation laws;

(F) The state-administered supplementary payment program under § 1616(a) of the Act (AABD, See AABD Rule 7.00); and

(G) Any state program administered under a plan approved under Titles I, X, XIV, or XVI of the Act;

(ii) Information related to eligibility or enrollment from the 3SquaresVt Program, the Reach Up Program, other health-benefits programs, and other public-assistance programs that are administered by the State of Vermont; and

(iii) Any other information source bearing upon the individual's financial eligibility.

(2) To the extent that the information identified in this subsection is available through the federal electronic verification service (§ 53.00(d)), the information will be obtained through such service.

(3) The information will be requested by Social Security number, or if a Social Security number is not

[40] 42 CFR § 435.948; 45 CFR § 155.320(c).

available, using other personally-identifying information in the individual's account, if possible.

56.02 Verification process for Medicaid (01/01/2018, GCR 17-048)

In determining an individual's eligibility for Medicaid:

(a) Family size.[41] For purposes of MAGI-based Medicaid eligibility, attestation of information needed to determine family size in accordance with the procedure set forth in § 55.01 will be accepted (attestation only).

(b) Income[42]

(1) Except as stated in paragraph (b)(2) of this subsection, income will be verified by comparing the individual's attestations with tax- and non-tax data obtained pursuant to § 56.01. If the attestations are not reasonably compatible, as that term is defined in § 57.00(a)(2), with such data or if such data is not available, AHS will proceed in accordance with the provisions in § 57.00(c).

(2) For purposes of MAGI-based Medicaid eligibility, an individual's attestation that their income is above the highest income standard under which they may be determined eligible will be accepted without further verification.

(c) Resources. For purposes of MABD (non-MAGI-based Medicaid) eligibility, resources will be verified by comparing the individual's attestations with available data sources. If the attestations are not compatible with such sources, or if no such sources exist, or if sources exist but are not available, AHS will proceed in accordance with the provisions in § 57.00(c).

56.03 Verification process for APTC and CSR – general procedures (01/15/2017, GCR 16-100)

An individual must be eligible for APTC and have household income at or below 300% of the FPL in order for the individual to be eligible for the Vermont Premium Reduction and Vermont CSR. To receive the federal and Vermont CSR, an individual who is not an Indian must be enrolled in a silver-level QHP.

In determining eligibility for APTC and CSR:

(a) Family size[43]

(1) The individual must attest to the persons that comprise a tax filer's family size.

(2) To the extent that the individual attests that the tax data described in § 56.01(a) represent an accurate projection of a tax filer's family size for the benefit year for which coverage is requested, the individual's attestation will be accepted without further verification.

[41] 42 CFR § 435.956(f); 45 CFR § 155.320(c)(2)(i).

[42] 42 CFR §§ 435.945, 435.948, and 435.952; 45 CFR § 155.320(c)(2)(ii).

[43] 45 CFR § 155.320(c)(3)(i).

(3) To the extent that tax data are unavailable, or the individual attests that a change in circumstances has occurred or is reasonably expected to occur, and so they do not represent an accurate projection of a tax filer's family size for the benefit year for which coverage is requested, the tax filer's family size will be verified by accepting the individual's attestation without further verification, except as specified in paragraph (a)(4) of this subsection.

(4) If the individual's attestation to a tax filer's family size is not reasonably compatible, as that term is defined in § 57.00(a)(1), with other information provided by the individual or in AHS's records, data obtained through other electronic data sources will be used to verify the attestation. If such data sources are unavailable or information in such data sources is not reasonably compatible with the individual's attestation, additional documentation will be requested to support the attestation within the procedures specified in § 57.00.

(5) *Verification regarding APTC and CSR.* AHS will verify that neither APTC nor CSR is being provided on behalf of an individual by using information obtained by transmitting identifying information specified by HHS to HHS.[44]

(b) Basic verification process for annual household income[45]

(1) The individual must attest to the tax filer's projected annual household income.

(2) AHS will compute annual household income based on the tax data described in § 56.01(a) (tax-based income calculation), if available.

(3) To the extent that the individual's attestation indicates that the tax-based income calculation under paragraph (b)(2) of this subsection represents an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the tax filer's eligibility for APTC and CSR will be determined based on that calculation.

(4) To the extent the tax data described in § 56.01(a) are unavailable or the individual attests that a change in circumstances has occurred or is reasonably expected to occur, and so they do not represent an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, AHS will require the individual to attest to the tax filer's projected household income for the benefit year for which coverage is requested.

(c) Verification process for increases in household income

(1) Except as specified in paragraphs (c)(2) or (3) of this subsection, the individual's attestation for the tax filer's household will be accepted without further verification if:

(i) The individual attests that the tax filer's annual household income has increased or is reasonably expected to increase from the tax-based income calculation under paragraph (b)(2) of this

[44] 45 CFR § 155.320.

[45] 45 CFR § 155.320(c)(3)(ii).

subsection; and

(ii) AHS has not verified the individual's income through the process specified in § 56.02(b) to be within the applicable Medicaid income standard.

(2) If the non-tax data available to AHS, as described in § 56.01(b), indicate that a tax filer's projected annual income is in excess of their attestation by more than twenty-five percent, AHS will proceed in accordance with § 57.00(c)(1)-(4)(i).

(3) If other information provided by the individual indicates that a tax filer's projected annual household income is in excess of the individual's attestation by more than twenty-five percent, the non-tax data will be used to verify the attestation. If such data are unavailable or information in such data is not reasonably compatible with the individual's attestation, AHS will proceed in accordance with § 57.00(c)(1)-(4)(i).

56.04 Eligibility for alternate APTC and CSR verification procedures (01/01/2018, GCR 17-048)

Eligibility for alternate verification procedures for decreases in annual household income and situations in which tax data are unavailable.[46] AHS will determine a tax filer's annual household income for purposes of APTC and CSR based on the alternate APTC and CSR verification procedures described in §§ 56.05 through 56.07 if:

(a) An individual attests to the tax filer's projected annual household income;

(b) The tax filer does not meet the criteria specified in § 56.03(c) (attestation of increase in household income);

(c) The individuals in the tax filer's household have not established income through the process specified in § 56.02(b) (verification of income for Medicaid) that is within the applicable Medicaid income standard; and

(d) One of the following conditions is met:

(1) The Secretary of the Treasury does not have tax data that may be disclosed under § 6103(l)(21) of the Code for the tax filer that are at least as recent as the calendar year two years prior to the calendar year for which APTC or CSR would be effective;

(2) The individual attests that:

(i) The tax filer's applicable family size has changed or is reasonably expected to change for the benefit year for which the individuals in the tax filer's household are requesting coverage; or

(ii) The members of the tax filer's household have changed or are reasonably expected to change for the benefit year for which the individuals in their household are requesting coverage;

(3) The individual attests that a change in circumstances has occurred or is reasonably expected to occur, and so the tax filer's annual household income has decreased or is reasonably expected to decrease from the tax data described in § 56.01(a) for the benefit year for which the individuals in the tax filer's

[46] 45 CFR § 155.320(c)(3)(iv).

household are requesting coverage;

(4) The individual attests that the tax filer's filing status has changed or is reasonably expected to change for the benefit year for which the individual(s) in tax filer's household are requesting coverage; or

(5) An individual in the tax filer's household has filed an application for unemployment benefits.

56.05 Alternate APTC and CSR verification procedure: small decrease in projected household income[47] (01/01/2018, GCR 17-048)

If a tax filer qualifies for an alternate APTC and CSR verification process and the individual's attestation to the tax filer's projected annual household income is no more than twenty-five percent below the tax-based income calculation (§ 56.03(b)(2)), the individual's attestation will be accepted without further verification.

56.06 Alternate APTC and CSR verification procedure: large decrease in projected household income and situations where tax data are unavailable[48] (01/15/2019, GCR 18-064)

(a) In general. AHS will attempt to verify the individual's attestation of the tax filer's projected annual household income with the process specified in paragraph (b) of this subsection and in §§ 56.07 and 56.08 if the tax filer qualifies for an alternate APTC and CSR verification process under § 56.04 and:

(1) The individual's attestation to the tax filer's projected annual household income is greater than twenty-five percent below the tax-based income calculation (§ 56.03(b)(2)); or

(2) The tax data described in § 56.01(a) are unavailable.

(b) Applicable process. The alternate APTC and CSR verification process is as follows:

(1) *Data*. Data from non-tax income sources, as described in § 56.01(b), will be annualized (non-tax-based income calculation).

(2) *Eligibility*. To the extent that the individual's attestation indicates that the non-tax-based income calculation under paragraph (b)(1) of this subsection represents an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the tax filer's eligibility for APTC and CSR will be determined based on such data.

(3) If the individual's attestation indicates that the tax filer's projected annual household income is more than twenty-five percent below the non-tax-based income calculation under paragraph (b)(1) of this subsection, AHS will request additional documentation using the procedures specified in § 57.00(c)(1) through (4)(i). If, following the 90-day period described in § 57.00(c)(2)(ii), the individual has not responded to the request for documentation or AHS remains unable to verify the individual's attestation,

[47] 45 CFR § 155.320(c)(3)(v).

[48] 45 CFR § 155.320(c)(3)(vi).

AHS will follow the applicable procedures described in § 56.08.

56.07 Alternate APTC and CSR verification procedure: Increases in household income when tax data are unavailable[49] (01/15/2017, GCR 16-100)

(a) Attestation sufficient. Except as provided in paragraph (b) of this subsection, the individual's attestation for the tax filer's household will be accepted without further verification if:

(1) The individual's attestation indicates that a tax filer's annual household income has increased or is reasonably expected to increase from the non-tax-based income calculation (§ 56.06(b)(1)); and

(2) AHS has not verified the individual's income through the process specified in § 56.02(b) to be within the applicable Medicaid income standard.

(b) Additional verification required. Additional documentation will be requested using the procedures specified in § 57.00 if AHS finds that an individual's attestation of a tax filer's annual household income is not reasonably compatible with other information provided by the individual or the non-tax data available to AHS under § 56.01(b).

56.08 Alternate APTC and CSR verification procedure: following 90-day period (01/15/2017, GCR 16-100)

(a) Individual does not respond to request/data indicate individual's income within Medicaid standard. If, following the 90-day period described in § 57.00(c)(2)(ii) as required by § 56.06(b)(3), an individual has not responded to a request for additional information and the tax data or non-tax data indicate that an individual in the tax filer's household is eligible for Medicaid, the application for a health-benefits program (for example, Medicaid, APTC or CSR) will be denied.

(b) Attestation cannot be verified/tax data available. If, following the 90-day period described in § 57.00(c)(2)(ii) as required by § 56.06(b)(3), AHS remains unable to verify the individual's attestation, AHS will determine the individual's eligibility based on AHS's tax-based income calculation (§ 56.03(b)(2)), notify the individual of such determination, and implement such determination in accordance with the effective dates specified in § 73.06.

(c) Attestation cannot be verified/tax data unavailable. If, following the 90-day period described in § 57.00(c)(2)(ii) as required by § 56.06(b)(3), AHS remains unable to verify the individual's attestation for the tax filer and tax data necessary for a tax-based income calculation (§ 56.03(b)(2)) are unavailable, AHS will determine the tax filer ineligible for APTC and CSR, notify the individual of such determination, and discontinue any APTC or CSR in accordance with the effective dates specified in § 73.06.

56.09 Verification related to eligibility for enrollment in a catastrophic plan[50] (01/15/2017, GCR 16-100)

[49] 45 CFR § 155.320(c)(3)(vi)(C).

[50] 45 CFR § 155.315(j).

(a) AHS will verify an individual's attestation that they meet the requirements of § 14.00 (eligibility for enrollment in a catastrophic plan) by:

(1) Verifying the individual's attestation of age as follows:

(i) Except as provided in paragraph (a)(1)(iii) of this subsection, accepting their attestation without further verification; or

(ii) Examining electronic data sources that are available and which have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently current and accurate, and minimize administrative costs and burdens.

(iii) If information regarding age is not reasonably compatible with other information provided by the individual or in AHS's records, examining information in data sources that are available and which have been approved by HHS for this purpose based on evidence showing that such data sources are sufficiently current and accurate.

(2) Verifying that an individual has a certificate of exemption in effect as described in § 14.00(b).

(b) To the extent that AHS is unable to verify the information required to determine eligibility for enrollment in a catastrophic plan as described in paragraphs (a)(1) and (2) of this subsection, the procedures specified in § 57.00, except for § 57.00(c)(4) (eligibility for APTC and CSR), will be followed.

56.10 Education and assistance (01/01/2018, GCR 16-100)

Education and assistance will be provided to an individual regarding the processes specified in this section.

57.00 Inconsistencies (01/01/2018, GCR 17-048)

(a) Reasonable compatibility.[51]

(1) For purposes of QHP, information obtained through electronic data sources, other information provided by the individual, or other information in AHS's records will be considered reasonably compatible with an individual's attestation when the difference or discrepancy does not impact the eligibility of the individual or the benefits to which the individual may be entitled, including the APTC amount and CSR category.

(2) For purposes of Medicaid, income information obtained through an electronic data match shall be considered reasonably compatible with income information provided by or on behalf of an individual if both are either above or at or below the applicable income standard or other relevant income threshold. For eligibility criteria other than income, an individual's attestation will be considered reasonably compatible with information obtained through electronic data sources, other information provided by the individual, or other information in AHS's records if the discrepancy does not affect eligibility for a specific Medicaid category.

(b) Applicability of reasonable-compatibility procedures. Except as otherwise specified in this rule, the procedures

[51] 42 CFR § 435.952(c); 45 CFR § 155.300(d).

outlined in this section will be used when:

(1) Information needed in accordance with §§ 53.00 through 56.00 is not available electronically and establishing a data match would not be effective, considering such factors as the administrative costs associated with establishing and using the data match, compared with the administrative costs associated with relying on paper documentation, and the impact on program integrity in terms of the potential for ineligible individuals to be approved as well as for eligible individuals to be denied coverage;

(2) AHS cannot verify information required to determine eligibility for health benefits, including when:

(i) Electronic data sources are required but data for individuals relevant to the eligibility determination are not included in such data sources; or

(ii) Electronic data from IRS, DHS and SSA are required but it is not reasonably expected that data sources will be available within one day of the initial request to the data source, except that an individual's attestation of residency or, for purposes of QHP, eligibility for MEC, may be accepted, and the procedures outlined in this section will not be used, when verification of those criteria would otherwise be required and the electronic data to support the attestation are not reasonably expected to be available within one day of the initial request to the data source; or

(3) Attested information that would not otherwise be verified is not reasonably compatible with other information that is provided by the application filer or that is otherwise available to AHS.

(c) Procedures for determining reasonable compatibility. In circumstances described in paragraph (b) of this section, AHS will:

(1) Make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the application filer to confirm the accuracy of the information submitted by the application filer, and by allowing the individual, or the application filer on the individual's behalf, the opportunity to provide AHS with a statement that reasonably explains the discrepancy.

(2) If unable to resolve the inconsistency as provided in paragraph (c)(1) of this section:

(i) Provide notice to the individual regarding the inconsistency; and

(ii) Provide the individual with an opportunity period, as described in this paragraph (c)(2)(ii), from the date on which such notice is sent to the individual to either present satisfactory documentary evidence via the channels available for the submission of an application, (except for by telephone through a call center), or otherwise resolve the inconsistency.[52] If, because of evidence submitted by the individual, one or more requests for additional evidence is necessary, such additional evidence must be submitted by the individual within the same opportunity period that begins with

[52] The opportunity period described in this paragraph (c)(2)(ii) does not apply to an inconsistency related to citizenship or immigration status. For the opportunity period for citizenship and immigration status, see § 54.05(a)(1).

the first verification request.

(A) For purposes of QHP, the individual's opportunity period is 90 days.

(B) For purposes of Medicaid, the individual's opportunity period is as follows:

(I) If the individual is a new Medicaid applicant, the opportunity period is 20 days, communicated in the form of two separate and sequential notices permitting the individual 10 days within which to respond.

(II) If the individual is a Medicaid enrollee, the opportunity period is 10 days.

(3) Extend the opportunity period described in paragraph (c)(2)(ii) of this section if the individual demonstrates that a good-faith effort has been made to obtain the required documentation during the period.

(4) In connection with the verification of an attestation for QHP eligibility:

(i) During the opportunity period described in paragraph (c)(2)(ii) of this section:

(A) Proceed with all other elements of eligibility determination using the individual's attestation, and provide eligibility for enrollment in a QHP to the extent that an individual is otherwise qualified; and

(B) Ensure that APTC, the Vermont Premium Reduction, and federal and state CSR are provided on behalf of an individual within this period who is otherwise qualified for such payments and reductions, if the tax filer attests that they understand that any APTC paid on their behalf is subject to reconciliation.

(ii) After the period described in paragraph (c)(2)(ii) of this section, determine whether the individual is eligible to enroll in a QHP using the information available from the data sources specified above, if any, if AHS remains unable to verify the attestation. AHS will notify the individual of such determination, including notice that AHS is unable to verify the attestation. For an individual determined eligible for enrollment in a QHP who is seeking financial assistance (APTC/CSR):

(A) If AHS can determine the individual is not eligible for Medicaid based on available information, determine whether the individual is eligible for APTC, the Vermont Premium Reduction, and federal and state CSR based on the information available from the data sources specified above, and notify the individual of such determination, including notice that AHS is unable to verify the attestation.

(B) If AHS cannot determine, based on available information, that the individual is ineligible for Medicaid, deny the application for or terminate the individual's APTC, Vermont Premium Reduction and federal and state CSR on the basis that there is insufficient information to determine the individual's eligibility for Medicaid.[53]

[53] It is a condition of eligibility for APTC and CSR that the individual is not eligible for government-sponsored MEC; 26 CFR § 1.36B-2(a)(2). In this case, the individual's failure to respond to the verification request precludes the determination of this condition of eligibility.

(C) If an individual is determined ineligible for financial assistance, the individual would still be eligible for enrollment in a QHP without financial assistance.

(5) In connection with the verification of an attestation for Medicaid eligibility, if, after the opportunity period described in paragraph (c)(2)(ii) of this section, the individual has not responded to a request for additional information or has not provided information sufficient to resolve the inconsistency, or AHS otherwise remains unable to verify the attestation, deny the application or disenroll the individual on the basis that there is insufficient information to determine the individual's eligibility for Medicaid. Medicaid coverage cannot begin for a new Medicaid applicant until verification of the attestation is received, unless the verification is for purposes of establishing citizenship or immigration status as described in § 54.05(b).

(d) Exception for special circumstances[54]

(1) Except for an inconsistency related to citizenship or immigration status, AHS will provide an exception, on a case-by-case basis, to accept an individual's attestation as to the information which cannot otherwise be verified, because such documentation:

(i) Does not exist; or

(ii) Is not reasonably available.

(2) To receive such an exception:

(i) The inconsistency must not be able to be otherwise resolved; and

(ii) The individual must provide an adequate explanation of the circumstances as to why they cannot obtain the documentation needed to resolve the inconsistency.

(e) Pursuit of additional information in cases where verification data are not reasonably compatible with information provided for or on behalf of an individual.[55] Eligibility will not be denied or terminated nor benefits reduced for any individual on the basis of verification information received in accordance with this part Seven unless additional information from the individual has been sought in accordance with this section, and proper notice and hearing rights have been provided to the individual.

58.00 Determination of eligibility for health-benefits programs[56] (01/01/2018, GCR 17-048)

58.01 In general[57] (01/01/2018, GCR 17-048)

[54] 42 CFR § 435.952(c)(3); 45 CFR § 155.315(g).

[55] 42 CFR § 435.952(d).

[56] 42 CFR § 435.911; 45 CFR § 155.310; 45 CFR § 155.345.

[57] 42 CFR §§ 435.911(c) and 435.1200(e).

(a) MAGI screen.[58] For each individual who has submitted an application for a health- benefits program (i.e., health benefits other than enrollment in a QHP without APTC or CSR), or whose eligibility is being renewed, and who meets the nonfinancial requirements for eligibility (or for whom AHS is providing an opportunity to verify citizenship or immigration status), AHS will do the following:

(1) Promptly and without undue delay, consistent with timeliness standards established under § 61.00, furnish MAGI-based Medicaid to each such individual whose household income is at or below the applicable MAGI-based standard.

(2) For each individual described in paragraph (c) of this subsection (individuals subject to determination of Medicaid eligibility on a basis other than the applicable MAGI-based income standard), collect such additional information as may be needed to determine whether such individual is eligible for Medicaid on any basis other than the applicable MAGI-based income standard, and furnish Medicaid on such basis.

(3) For an individual who submits an application or renewal form which includes sufficient information to determine Medicaid eligibility, or whose eligibility is being renewed pursuant to a change in circumstance, and whom AHS determines is not eligible for Medicaid, promptly and without undue delay, determine eligibility for other health benefits.

(b) MAGI-based income standards for certain individuals enrolled for Medicare benefits.[59] In the case of an individual who has attained at least age 65 and an individual who has attained at least age 19 and who is entitled to or enrolled for Medicare benefits under part A or B or Title XVIII of the Act, non-MAGI-based income standards will be used, except that in the case of such an individual:

(1) Who is also pregnant, the applicable MAGI-based standard is the standard established under § 7.03(a)(2); and

(2) Who is also a parent or caretaker relative (as defined in § 3.00), the applicable MAGI-based standard is the standard established under § 7.03(a)(1).

(c) Individuals subject to determination of Medicaid eligibility on basis other than the applicable MAGI-based income standard.[60] For purposes of paragraph (a)(2) of this subsection, an individual includes:

(1) An individual who is identified, on the basis of information contained in an application or renewal form, or on the basis of other information available, as potentially eligible on a basis other than the applicable MAGI-based standard; and

(2) An individual who otherwise requests a determination of eligibility on a basis other than the applicable MAGI-based standard.

[58] 42 CFR § 435.911(c).

[59] 42 CFR § 435.911(b)(2).

[60] 42 CFR § 435.911(d).

(d) Individuals requesting additional screening.[61] AHS will notify an applicant of the opportunity to request a full determination of eligibility for Medicaid on a basis other than the applicable MAGI-based income standard, and will provide such an opportunity. Such notification will also be made to an enrollee, and such opportunity provided in any redetermination of eligibility.

(e) Determination of eligibility for Medicaid on a basis other than the applicable MAGI-based income standard.[62] If an individual is identified as potentially eligible for Medicaid on a basis other than the applicable MAGI-based income standard or an individual requests a full determination for Medicaid under paragraph (d) of this subsection, and the individual provides all additional information needed to determine eligibility for such benefits, eligibility will be determined promptly and without undue delay, as provided in this section.

(f) Eligibility for APTC and CSR, pending determination of eligibility for Medicaid.[63] An individual who is described in paragraph (e) of this subsection and has not been determined eligible for Medicaid based on MAGI-based income standards will be considered as ineligible for Medicaid for purposes of eligibility for APTC or CSR until the individual is determined eligible for Medicaid.

58.02 Special rules relating to APTC eligibility[64] (01/15/2017, CCR 16-100)

(a) An individual may accept less than the full amount of APTC for which the individual is determined eligible.

(b) Before APTC on behalf of a tax filer may be authorized, the tax filer must provide necessary attestations, including, but not limited to, attestations that:

(1) They will file an income tax return for the benefit year, in accordance with 26 USC §§ 6011 and 6012, and implementing regulations;

(2) If married (within the meaning of 26 CFR § 1.7703-1), they will file a joint tax return for the benefit year unless they meet the exception criteria defined in § 12.03(b) (victim of domestic abuse or spousal abandonment);[65]

(3) No other tax filer will be able to claim them as a tax dependent for the benefit year; and

(4) They will claim a personal exemption deduction on their tax return for the individuals identified as

[61] 45 CFR § 155.345(c).

[62] 42 CFR § 435.911(c); 45 CFR § 155.345(d).

[63] 45 CFR § 155.345(e).

[64] 45 CFR § 155.310(d)(2)(i) and (ii).

[65] Federal tax law does not recognize civil unions. Therefore, a Vermont couple in a civil union may not file a joint tax return; they may qualify for APTC by filing separate returns.

members of their household, including the tax filer and their spouse, in accordance with § 56.03(a).[66]

59.00 Special QHP eligibility standards and process for Indians[67] (01/01/2018, GCR 17-048)

59.01 Eligibility for CSR (01/15/2017, GCR 16-100)

(a) An individual who is an Indian, as defined in § 3.00, will be determined eligible for CSR if they:

(1) Meet the requirements specified in §§ 11.00 and 12.00; and

(2) Are expected to have household income, using MAGI methodologies for purposes of determining eligibility for APTC and CSR, that does not exceed 300 percent of the FPL for the benefit year for which coverage is requested.

(b) CSR may be provided to an individual who is an Indian only if they are enrolled in a QHP through VHC.

59.02 Special cost-sharing rule for Indians regardless of income (01/15/2017, GCR 16-100)

AHS must determine an individual eligible for the special cost-sharing rule described in § 1402(d)(2) of the ACA (items or services furnished through Indian health providers) if the individual is an Indian, without requiring the individual to request an eligibility determination for health-benefits programs in order to qualify for this rule.

59.03 Verification related to Indian status[68] (01/15/2017, GCR 16-100)

To the extent that an individual attests that they are an Indian, such attestation will be verified by:

(a) Utilizing any relevant documentation verified in accordance with § 53.00;

(b) Relying on any electronic data sources that are available and which have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently accurate and offer less administrative complexity than paper verification; or

(c) To the extent that approved data sources are unavailable, an individual is not represented in available data sources, or data sources are not reasonably compatible with an individual's attestation, following the procedures specified in § 57.00 and verifying documentation provided by the individual in accordance with the standards for acceptable documentation provided in § 54.07(b)(5).

[66] 45 CFR § 155.320(c)(3)(i).

[67] 45 CFR § 155.350.

[68] 45 CFR § 155.350.

60.00 Computing the premium-assistance credit amount[69] (01/01/2018, GCR 17-048)

60.01 In general[70] (01/01/2018, GCR 17-048)

This section explains the calculation of the federal and state premium assistance of QHPs. A tax filer's federal premium assistance credit amount for a benefit year is the sum of the premium-assistance amounts determined under § 60.04 for all coverage months for individuals in the tax filer's household.

State premium assistance, referred to throughout this rule as Vermont Premium Reduction, is defined in § 3.00 as a state subsidy paid directly to the QHP issuer to reduce monthly premiums for an eligible individual enrolled in a QHP through VHC. Vermont Premium Reduction is calculated using the same methodology as advance payment of the federal premium assistance credit and, as described in § 60.07, results in the premium contribution from an eligible individual being reduced by 1.5 percent.

60.02 Definition[71] (01/15/2017, GCR 16-100)

For purposes of this section:

Coverage family. The term "coverage family" means, in each month, the members of the tax filer's household for whom the month is a coverage month.

60.03 Coverage month[72] (01/01/2018, GCR 17-048)

(a) In general. A month is a coverage month for an individual if:

(1) As of the first day of the month, the individual is enrolled in a QHP;

(2) The tax filer pays the tax filer's share of the premium for the individual's coverage under the plan for the month by the unextended due date for filing the tax filer's income tax return for that benefit year, or the full premium for the month is paid by APTC and the Vermont Premium Reduction; and

(3) The individual is not eligible for the full calendar month for MEC other than coverage in the individual market.

(b) Certain individuals enrolled during a month. If an individual enrolls in a QHP and the enrollment is effective on the date of the individual's birth, adoption or placement for adoption or in foster care, or on the effective date of a court order, the individual is treated as enrolled as of the first day of that month for purposes of this

[69] 26 CFR § 1.36B-3.

[70] 26 CFR § 1.36B-3(a); 33 VSA § 1812(a).

[71] 26 CFR § 1.36B-3(b).

[72] 26 CFR § 1.36B-3(c).

subsection.

(c) Premiums paid for a tax filer. Premiums another person pays for coverage of the tax filer, tax filer's spouse, or tax dependent are treated as paid by the tax filer.

(d) Appeals of coverage eligibility. A tax filer who is eligible for APTC pursuant to an eligibility appeal decision for coverage of a member of the tax filer's coverage family who, based on the appeal decision, retroactively enrolls in a QHP is considered to have met the requirement in (a)(2) of this subsection for a month if the tax filer pays the tax filer's share of the premiums for coverage under the plan for the month on or before the 120th day following the date of the appeal decision.

(e) Examples. The following examples illustrate the provisions of this § 60.03:

(1) Example 1: Tax filer M is single with no tax dependents

(i) In December 2013, M enrolls in a QHP for 2014 and AHS approves APTC. M pays M's share of the premiums. On May 15, 2014, M enlists in the U.S. Army and is eligible immediately for government-sponsored MEC.

(ii) Under paragraph (a) of this subsection, January through May 2014 are coverage months for M. June through December 2014 are not coverage months because M is eligible for other MEC for those months. Thus, under § 60.03, M's premium assistance credit amount for 2014 is the sum of the premium-assistance amounts for the months January through May.

(2) Example 2: Tax filer N has one tax dependent S

(i) S is eligible for government-sponsored MEC. N is not eligible for MEC other than through VHC. N enrolls in a QHP for 2014 and AHS approves APTCs. On August 1, 2014, S loses eligibility for government-sponsored MEC. N terminates enrollment in the QHP that covers only N and enrolls in a QHP that covers N and S for August through December 2014. N pays all premiums not covered by APTCs.

(ii) Under paragraph (a) of this subsection, January through December of 2014 are coverage months for N and August through December are coverage months for N and S. N's premium assistance credit amount for 2014 is the sum of the premium-assistance amounts for these coverage months.

(3) Example 3: O and P are the divorced parents of T

(i) Under the divorce agreement between O and P, T resides with P and P claims T as a tax dependent. However, O must pay premiums for health insurance for T. P enrolls T in a QHP for 2014. O pays the portion of T's QHP premiums not covered by APTCs.

(ii) Because P claims T as a tax dependent, P (and not O) may claim a premium tax credit for coverage for T. See § 1.36B-2(a) of the Code. Under paragraph (c) of this subsection, the premiums that O pays for coverage for T are treated as paid by P. Thus, the months when T is covered by a QHP and not eligible for other MEC are coverage months under paragraph (a) of this subsection in computing P's premium tax credit under § 60.01.

(4) Example 4: Q, an American Indian, enrolls in a QHP for 2014. Q's tribe pays the portion of Q's QHP premiums not covered by APTCs. Under paragraph (c) of this subsection, the premiums that Q's tribe pays for Q are treated as paid by Q. Thus, the months when Q is covered by a QHP and not eligible for other MEC are coverage months under paragraph (c) of this subsection in computing Q's premium tax credit under § 60.01.

60.04 Federal premium-assistance amount[73] (01/01/2018, GCR 17-048)

(a) Premium assistance amount. The premium assistance amount for a coverage month is the lesser of:

(1) The premiums for the month, reduced by any amounts that were refunded, for one or more QHPs in which a tax filer or a member of the tax filer's household enrolls (enrollment premiums); or

(2) The excess of the monthly premium for the applicable benchmark plan (ABP) (benchmark plan premium) (§ 60.06) over 1/12 of the product of a tax filer's household income and the applicable percentage for the benefit year (the tax filer's contribution amount).

(b) Examples. The following examples illustrate the rules of paragraph (a):

(1) Example 1.

Taxpayer Q is single and has no dependents. Q enrolls in a QHP with a monthly premium of $400. Q's monthly benchmark plan premium is $500, and his monthly contribution amount is $80. Q's premium assistance amount for a coverage month is $400 (the lesser of $400, Q's month enrollment premium, and $420, the difference between Q's monthly benchmark plan premium and Q's contribution amount).

(2) Example 2.

(i) Tax filer R is single and has no dependents. R enrolls in a QHP with a monthly premium of $450. The difference between R's benchmark plan premium and contribution amount for the month is $420. R's premium assistance amount for a coverage month with a full month of coverage is $420 (the lesser of $450 and $420).

(ii) The issuer of R's QHP is notified that R died on September 20. The issuer terminates coverage as of that date and refunds the remaining portion of the September enrollment premiums ($150) for R's coverage.

(iii) R's premium assistance amount for each coverage month from January through August is $420 (the lesser of $450 and $420). Under paragraph (a), R's premium assistance amount for September is the lesser of the enrollment premiums for the month, reduced by any amounts that were refunded ($300 ($450 - $150)) or the difference between the benchmark plan premium and the contribution amount for the month ($420). R's premium assistance amount for September is $300, the lesser of $420 and $300.

[73] 26 CFR § 1.36B-3(d).

(3) Example 3.

The facts are the same as in Example 2 of this paragraph (b), except that the QHP issuer does not refund any enrollment premiums for September. Under paragraph (a), R's premium assistance amount for September is $420, the lesser of $450 and $420.

60.05 Monthly premium for ABP[74] (01/15/2017, GCR 16-100)

The monthly premium for an ABP is the premium an issuer would charge for the ABP to cover all members of the tax filer's coverage family. The monthly premium is determined without regard to any premium discount or rebate under the wellness discount demonstration project under § 2705(d) of the PHS Act (42 USC §§ 300gg-4(d)) and may not include any adjustments for tobacco use. The monthly premium for an ABP for a coverage month is determined as of the first day of the month.

60.06 Applicable benchmark plan (ABP)[75] (01/01/2018, GCR 17-048)

(a) In general. The ABP helps determine the total amount of premium assistance. The ABP is the QHP from which the product of the applicable percentage and household income is subtracted to obtain the subsidy amount that will be provided on behalf of the qualified individual. Except as otherwise provided in this subsection, the ABP for each coverage month is the second-lowest cost silver plan offered to the tax filer's coverage family through VHC for:

(1) Self-only coverage for a tax filer

(i) Who computes tax under § 1(c) of the Code (unmarried individuals other than surviving spouses and heads of household) and is not allowed a deduction under § 151 of the Code for a tax dependent for the benefit year;

(ii) Who purchases only self-only coverage for one individual; or

(iii) Whose coverage family includes only one individual; and

(2) Family coverage for all other tax filers.

(b) Family coverage. The ABP for family coverage is the second-lowest-cost silver plan that would cover the members of the tax filer's coverage family (such as a plan covering two adults if the members of a tax filer's coverage family are two adults).

(c) Silver-level plan not covering pediatric dental benefits. [Reserved]

(d) Family members residing in different locations. If members of a tax filer's coverage family reside in different locations, the tax filer's benchmark plan premium is the sum of the premiums for the ABPs for each group of coverage family members residing in different locations, based on the plans offered to the group through the

[74] 26 CFR § 1.36B-3(e).

[75] 26 CFR § 1.36B-3(f).

Exchange where the group resides. If all members of a tax filer's coverage family reside in a single location that is different from where the tax filer resides, the tax filer's benchmark plan premium is the premium for the ABP for the coverage family, based on the plans offered through the Exchange to the tax filer's coverage family for the rating area where the coverage family resides.

(e) Single or multiple policies needed to cover the family

(1) *Policy covering a tax filer's family.* If a silver-level plan or a stand-alone dental plan offers coverage to all members of a tax filer's coverage family who reside in the same location under a single policy, the premium (or allocable portion thereof, in the case of a stand-alone dental plan) taken into account for the plan for purposes of determining the ABP under paragraphs (a), (b) and (c) of this subsection is the premium for this single policy.

(2) *Policy not covering a tax filer's family.* If a silver-level QHP or a stand-alone dental plan would require multiple policies to cover all members of a tax filer's coverage family who reside in the same location (for example, because of the relationships within the family), the premium (or allocable portion thereof, in the case of a stand-alone dental plan) taken into account for the plan for purposes of determining the ABP under paragraphs (a), (b), and (c) of this subsection is the sum of the premiums (or allocable portion thereof, in the case of a stand-alone dental plan) for self-only policies under the plan for each member of the coverage family who resides in the same location.

(f) Plan not available for enrollment. A silver-level QHP or a stand-alone dental plan that is not open to enrollment by a tax filer or family member at the time the tax filer or family member enrolls in a QHP is disregarded in determining the ABP.

(g) Benchmark plan terminates or closes to enrollment during the year. A silver-level QHP or a stand-alone dental plan that is used for purposes of determining the ABP under this subsection for a tax filer does not cease to be the ABP for a benefit year solely because the plan or a lower cost plan terminates or closes to enrollment during the benefit year.

(h) Only one silver-level plan offered to the coverage family. [Reserved]

(i) Examples[76]

60.07 Applicable percentage[77] (01/01/2018, GCR 17-048)

(a) In general. The applicable percentage multiplied by a tax filer's household income determines the tax filer's required share of premiums for the ABP. This required share is subtracted from the monthly premium for the ABP when computing the premium-assistance amount. The applicable percentage is computed by first determining the percentage that the tax filer's household income bears to the FPL for the tax filer's family size. The resulting FPL percentage is then compared to the income categories described in the table in paragraph (b) of this subsection (or successor tables). An applicable percentage within an income category increases on

[76] Examples to illustrate the rules of this subsection can be found at 26 CFR § 1.36B-3(f)(9).

[77] 26 CFR § 1.36B-3(g).

a sliding scale in a linear manner and is rounded to the nearest one-hundredth of one percent. For taxable years beginning after December 31, 2014, the applicable percentages in the table will be adjusted by the ratio of premium growth to growth in income for the preceding calendar year and may be further adjusted to reflect changes to the data used to compute the ratio of premium growth to income growth for the 2014 calendar year or the data sources used to compute the ratio of premium growth to income growth. Premium growth and income growth will be determined in accordance with IRS-published guidance. In addition, the applicable percentages in the table may be adjusted to taxable years beginning after December 31, 2014, to reflect rates of premium growth relative to growth in the consumer price index.

(b) Applicable percentage table for APTC[78]

Household income percentage of FPL	2014 initial percentage	2014 final percentage
Less than 133%	2.0	2.0
At least 133% but less than 150%	3.0	4.0
At least 150% but less than 200%	4.0	6.3
At least 200% but less than 250%	6.3	8.05
At least 250% but less than 300%	8.05	9.5
At least 300% but not more than 400%	9.5	9.5

(c) Applicable percentage table with the Vermont Premium Reduction.[79] The State reduces the APTC's applicable percentage by 1.5% for an individual expected to have household income, as defined in § 28.05(c), that does not exceed 300 percent of the FPL for the benefit year for which coverage is requested.

Household income percentage of FPL	2014 initial percentage	2014 final percentage

[78] For taxable years after 2014, the applicable percentages in the table will be updated in accordance with IRS-published guidance, available at: www.irs.gov. For example, the applicable percentage table for 2015 is located at: http://www.irs.gov/pub/irs-drop/rp-14-37.pdf.

[79] For updated applicable percentage tables with the Vermont Premium Reduction for taxable years after 2014, go to: http://info.healthconnect.vermont.gov/Thresholds.

Less than 133%	0.5	0.5
At least 133% but less than 150%	1.5	2.5
At least 150% but less than 200%	2.5	4.8
At least 200% but less than 250%	4.8	6.55
At least 250% but not more than 300%	6.55	8.0
More than 300% but not more than 400%	9.5	9.5

(d) Examples. The following examples illustrate the rules of this subsection with respect to the applicable percentage for federal premium assistance:

(1) Example 1. A's household income is 275 percent of the FPL for A's family size for that benefit year. In the table in paragraph (b) of this subsection, the initial percentage for a tax filer with household income of 250 to 300 percent of the FPL is 6.55 and the final percentage is 8.0. A's FPL percentage of 275 percent is halfway between 250 percent and 300 percent. Thus, rounded to the nearest one-hundredth of one percent, A's applicable percentage is 7.28, which is halfway between the initial percentage of 6.55 and the final percentage of 8.0.

(2) Example 2

(i) B's household income is 210 percent of the FPL for B's family size. In the table in paragraph (b) of this subsection, the initial percentage for a tax filer with household income of 200 to 250 percent of the FPL is 4.8 and the final percentage is 6.55. B's applicable percentage is 5.15, computed as follows:

(ii) Determine the excess of B's FPL percentage (210) over the initial household income percentage in B's range (200), which is 10. Determine the difference between the initial household income percentage in the tax filer's range (200) and the ending household income percentage in the tax filer's range (250), which is 50. Divide the first amount by the second amount:

210-200 = 10

250-200 = 50

10/50 = .20.

(iii) Compute the difference between the initial premium percentage (4.8) and the second premium percentage (6.55) in the tax filer's range; 6.55 -4.8 = 1.75.

(iv) Multiply the amount in the first calculation (.20) by the amount in the second calculation (1.75) and add the product (.35) to the initial premium percentage in B's range (4.8), resulting in B's applicable percentage of 6.65:

$$.20 \times 1.75 = .35$$

$$4.8 + .35 = 5.15.$$

60.08 Plan covering more than one household[80] (01/15/2017, GCR 16-100)

(a) In general. If a QHP covers more than one household under a single policy, each applicable tax filer covered by the plan may claim a premium tax credit, if otherwise allowable. Each tax filer computes the credit using that tax filer's applicable percentage, household income, and the ABP that applies to the tax filer under § 60.06. In determining whether the amount computed under § 60.04(a) (the premiums for the QHP in which the tax filer enrolls) is less than the amount computed under § 60.04(b) (the benchmark plan premium minus the product of household income and the applicable percentage), the premiums paid are allocated to each tax filer in proportion to the premiums for each tax filer's ABP.

(b) Example: Tax filers A and B enroll in a single policy under a QHP. The following example illustrates the rules of this subsection:

(1) B is A's 25-year old child who is not A's tax dependent. B has no tax dependents. The plan covers A, B, and A's two additional children who are A's dependents. The premium for the plan in which A and B enroll is $15,000. The premium for the second-lowest-cost silver family plan covering only A and A's tax dependents is $12,000 and the premium for the second-lowest-cost silver plan providing self-only coverage to B is $6,000. A and B are applicable tax filers and otherwise eligible to claim the premium tax credit.

(2) Under paragraph (a) of this subsection, both A and B may claim premium tax credits. A computes her credit using her household income, a family size of three, and a benchmark plan premium of $12,000. B computes his credit using his household income, a family size of one, and a benchmark plan premium of $6,000.

(3) In determining whether the amount in § 60.04(a) (the premiums for the QHP A and B purchase) is less than the amount in § 60.04(b) (the benchmark plan premium minus the product of household income and the applicable percentage), the $15,000 premiums paid are allocated to A and B in proportion to the premiums for their ABPs. Thus, the portion of the premium allocated to A is $10,000 ($15,000 x $12,000/$18,000) and the portion allocated to B is $5,000 ($15,000 x $6,000/$18,000).

60.09 [Reserved] (01/15/2017, GCR 16-100)

60.10 Additional benefits[81] (01/15/2017, GCR 16-100)

[80] 26 CFR § 1.36B-3(h).

[81] 26 CFR § 1.36B-3(j).

(a) In general. If a QHP offers benefits in addition to the essential health benefits a QHP must provide, the portion of the premium for the plan properly allocable to the additional benefits is excluded from the monthly premiums under § 60.04(a) or (b). Premiums are allocated to additional benefits before determining the ABP.

(b) Method of allocation. The portion of the premium properly allocable to additional benefits is determined under guidance issued by the Secretary of HHS.[82]

(c) Examples. The following examples illustrate the rules of this subsection:

(1) Example 1

(i) Tax filer B enrolls in a QHP that provides benefits in addition to the essential health benefits the plan must provide (additional benefits). The monthly premiums for the plan in which B enrolls are $370, of which $35 is allocable to additional benefits. B's benchmark plan premium (determined after allocating premiums to additional benefits for all silver level plans) is $440, of which $40 is allocable to additional benefits. B's monthly contribution amount, which is the product of B's household income and the applicable percentage, is $60.

(ii) Under this subsection, B's enrollment premiums and the benchmark plan premium are reduced by the portion of the premium that is allocable to the additional benefits provided under that plan. Therefore, B's monthly enrollment premiums are reduced to $335 ($370 - $35) and B's benchmark plan premium is reduced to $400 ($440 - $40). B's premium assistance amount for a coverage month is $335, the lesser of $335 (B's enrollment premiums, reduced by the portion of the premium allocable to additional benefits) and $340 (B's benchmark plan premium, reduced by the portion of the premium allocable to additional benefits ($400), minus B' $60 contribution amount).

(2) Example 2. The facts are the same as in Example 1, except that the plan in which B enrolls provides no benefits in addition to the essential health benefits required to be provided by the plan. Thus, under this subsection, B's benchmark plan premium ($440) is reduced by the portion of the premium allocable to the additional benefits provided under that plan ($40). B's enrollment premiums ($370) are not reduced under this subsection. B's premium assistance amount for a coverage month is $340, the lesser of $370 (B's enrollment premiums) and $340 (B's benchmark plan premium, reduced by the portion of the premium allocable to additional benefits ($400), minus B's 60 contribution amount).

60.11 Pediatric dental coverage[83] (01/15/2017, GCR 16-100)

(a) In general. For purposes of determining the amount of the monthly premium a tax filer pays for coverage under § 60.04(a), if an individual enrolls in both a QHP and a stand-alone dental plan, the portion of the premium for the stand-alone dental plan that is properly allocable to pediatric dental benefits that are essential benefits required to be provided by a QHP is treated as a premium payable for the individual's QHP.

[82] See § 36B(b)(3)(D) of the Code.

[83] 26 CFR § 1.36B-3(k).

(b) Method of allocation. The portion of the premium for a stand-alone dental plan properly allocable to pediatric dental benefits is determined under guidance issued by the Secretary of HHS.

(c) Example. The following example illustrates the rules of this subsection:

(1) Tax filer C and C's tax dependent, R, enroll in a QHP. The premium for the plan in which C and R enroll is $7,200 ($600/month) (Amount 1). The plan does not provide dental coverage. C also enrolls in a stand-alone dental plan covering C and R. The portion of the premium for the dental plan allocable to pediatric dental benefits that are essential health benefits is $240 ($20 per month). The excess of the premium for C's ABP over C's contribution amount (the product of C's household income and the applicable percentage) is $7,260 ($605/month) (Amount 2).

(2) Under this subsection, the amount C pays for premiums (Amount 1) for purposes of computing the premium-assistance amount is increased by the portion of the premium for the stand-alone dental plan allocable to pediatric dental benefits that are essential health benefits. Thus, the amount of the premiums for the plan in which C enrolls is treated as $620 for purposes of computing the amount of the premium tax credit. C's premium-assistance amount for each coverage month is $605 (Amount 2), the lesser of Amount 1 (increased by the premiums allocable to pediatric dental benefits) and Amount 2.

60.12 Households that include individuals who are not lawfully present[84] (01/15/2017, GCR 16-100)

(a) In general. If one or more individuals for whom a tax filer is allowed a deduction under § 151 of the Code are not lawfully present (see § 17.01(g) for definition of lawfully present), the percentage a tax filer's household income bears to the FPL for the tax filer's family size for purposes of determining the applicable percentage under § 60.07 is determined by excluding individuals who are not lawfully present from family size and by determining household income in accordance with paragraph (b) of this subsection.

(b) Revised household income computation

(1) Statutory method. For purposes of (a) of this subsection, household income is equal to the product of the tax filer's household income (determined without regard to this paragraph (b)) and a fraction:

(i) The numerator of which is the FPL for the tax filer's family size determined by excluding individuals who are not lawfully present; and

(ii) The denominator of which is the FPL for the tax filer's family size determined by including individuals who are not lawfully present.

(2) Comparable method. The IRS Commissioner may describe a comparable method in additional published guidance.[85]

[84] 26 CFR § 1.36B-3(l).

[85] See § 601.601(d)(2) of chapter one of the Code.

61.00 Timely determination of eligibility[86] (01/15/2019, GCR 18-064)

(a) In general

(1) AHS strives to complete eligibility determinations for health-benefits programs and QHP enrollment promptly and without undue delay. The amount of time needed to complete such determinations will necessarily vary, depending on such factors as:

(i) The capabilities and cost of generally-available systems and technologies;

(ii) The general availability of electronic data matching and ease of connections to electronic sources of authoritative information to determine and verify eligibility; and

(iii) The needs of an individual, including:

(A) Individual preferences for mode of application (such as through an internet Website, telephone, mail, in-person, or other commonly available electronic means); and

(B) The relative complexity of adjudicating the eligibility determination based on household, income or other relevant information.

(2) An eligibility determination is complete once AHS sends written notice of decision to the individual.

(b) Real-time determination of eligibility. When an individual files a complete, accurate and web-based application and relevant data can be fully verified through the use of available electronic means, an individual can expect a real-time or near-real-time eligibility determination.

(c) Normal maximum time for determining eligibility.[87] In cases involving such factors as described in paragraph (a) of this section, eligibility determinations may require additional time to complete. In any event, a decision on a health-benefits application will be made as soon as possible, but no later than:

(1) 90 days after the application date, if the application is based on a person's disability; or

(2) 45 days after the application date for any other health-benefits application.

(d) Extenuating circumstances. A determination may take longer in unusual situations, such as:

(1) An individual delays providing needed verification or other information;

(2) An examining physician delays sending a necessary report; or

(3) An unexpected emergency or administrative problem outside the control of AHS delays action on applications.

[86] 42 CFR § 435.912; 45 CFR § 155.310(e).

[87] 42 CFR § 435.912(c)(3).

(e) Notice of timeliness standards. Individuals will be informed of the timeliness standards set forth in this section.

62.00 Interviews (01/15/2017, GCR 16-100)

An in-person interview will not be required as part of the application process for a determination of eligibility using MAGI-based income. However, an interview may be required for eligibility determinations for which MAGI-based methods do not apply or when an individual is applying for Medicaid coverage of long-term care services and supports.

63.00 Individual choice (01/15/2017, GCR 16-100)

(a) Choice of Medicaid category.[88] If an individual would be eligible under more than one Medicaid category, the individual may choose to have eligibility determined for the category of the individual's choosing.

(b) Choice to determine eligibility for health-benefits programs.[89] An individual may request only an eligibility determination for enrollment in a QHP without APTC or CSR. However, if the individual is requesting an eligibility determination for a health-benefits program, the individual may not request an eligibility determination for less than all of the health-benefits programs. For example, if an individual seeks a subsidy to help pay for the cost of QHP coverage, they may not limit their application to APTC or CSR. Rather, they must likewise submit to a determination of eligibility for Medicaid.

64.00 Premiums (10/01/2021, GCR 20-004)

64.01 In general (10/01/2021, GCR 20-004)

(a) Scope. Some individuals enrolled in Medicaid's Dr. Dynasaur program are required to pay monthly premiums. This section contains AHS's billing and collection processes for those monthly premiums. Monthly premiums for individuals enrolled in QHPs are separately managed by QHP issuers and are subject to separate billing and collection processes administered by those QHP issuers. Nothing in this rule should be construed as applying to the billing and collection processes for QHP premiums.

(b) Medicaid premium methodologies and amounts. The Vermont legislature sets Medicaid premium methodologies and amounts. Premium schedules are made publicly available via website.

(c) Determination of premium obligation for Medicaid eligibility; premium recalculation

(1) As a part of the health-benefits application, redetermination, and renewal processes, AHS will determine whether an individual eligible for Medicaid will be required to pay monthly premiums.

(2) AHS will recalculate the premium amount for an individual enrolled in Medicaid when:

[88] 42 CFR § 435.404.

[89] 45 CFR 155.310(b).

(i) AHS is informed of a change in income, family size, or health-insurance status, or

(ii) An adjustment is made in premium amounts or calculation methodologies.

(3) An individual enrolled in Medicaid will be notified as provided in § 68.01 any time there is a change in their Medicaid premium amount following a recalculation.

(4) A change that increases the Medicaid premium amount will appear on the next regularly-scheduled monthly bill, created after the premium amount is recalculated.

(d) Premium calculation for Medicaid

(1) The premium calculation for an individual on Medicaid will be based on the MAGI-based income of the individual's Medicaid household following the MAGI methodology described in § 28.03, as established on the most recently approved version of eligibility on the case record at the time that the premium bill is generated. If a premium obligation is calculated for an individual and if that individual is living together with, and under the same premium payer account as, one or more other individuals for whom a premium obligation is also calculated, only one premium bill will be generated for those individuals. The bill will be for the highest premium obligation that is calculated.

Example. If A and B live together and are under the same premium payer account, and if A's calculated premium is $60.00 based on A's Medicaid household income and B's calculated premium is $15.00 based on B's Medicaid household income, AHS will not generate separate bills for A and B. Rather, AHS will generate one premium bill for a total of $60.00 and, when paid, the premium payment will cover eligibility for both A and B.

(2) Prior to the start of the coverage month pertaining to the bill in question, the individual may notify AHS to show that, due to changed household circumstances, the individual is eligible for Medicaid without a premium obligation or a lower premium amount.

(i) If the showing indicates that the individual is eligible for Medicaid without a premium obligation for the coverage month, the individual will be enrolled in Medicaid effective the first day of such coverage month.

(ii) If the showing indicates that the individual is eligible for a lower premium amount, the premium amount billed for that coverage month will be adjusted.

(3) No premium adjustments will be made for the coverage month if the individual has already paid the premium for the coverage month and the individual notifies AHS after the start of that coverage month that the individual is eligible for Medicaid without a premium obligation or for a lower premium amount. If the individual is entitled to a premium change, the change will be applied to the following coverage month.

(e) Aggregate limits for Medicaid premiums[90]

(1) Subject to paragraph (e)(2) of this subsection, any Medicaid premiums and cost sharing incurred by all

[90] 42 CFR § 447.56(f).

individuals in the Medicaid household may not exceed an aggregate limit of five percent of the family's income applied on a quarterly basis.

(2) If an individual incurs out-of-pocket expenses in excess of the aggregate limit described in paragraph (e)(1) of this subsection, AHS will refund that excess amount to the individual.

(3) An individual may request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium.

(f) [Reserved]

(g) Medicaid prospective billing and payment. Medicaid premiums are billed, and payments are due, prior to the start of a coverage month. Premium bills will be sent to the person identified on the application as the primary contact or application filer. That person will be responsible for payment of the Medicaid premium (referred to in this rule as the premium payer). AHS will establish an account for the premium payer.

(h) Conditions of Medicaid eligibility and enrollment. Timely payment of a Medicaid premium, if owed, is required as a condition of initial enrollment and ongoing eligibility and enrollment.

(i) Medicaid premium requirement for partial coverage month. The full amount due must be paid to obtain Medicaid coverage for all or part of a month.

(j) Medicaid premiums are nonrefundable. Medicaid premium payments are generally nonrefundable except for the exceptions listed in § 64.11.

(k) [Reserved]

(l) Dr. Dynasaur retroactive island. If an individual advises AHS that they have unpaid medical bills incurred during one or more of the three months prior to their application, they may be able to obtain an island of retroactive Medicaid coverage for any or all of those months (called a "Dr. Dynasaur retroactive island"). If so, AHS will bill the individual for the premium applicable to the Dr. Dynasaur retroactive island. Premium payments for Dr. Dynasaur retroactive islands are subject to allocation as provided under § 64.05(b).

64.02 Public-notice requirements for Medicaid[91] (01/15/2017, GCR 16-100)

(a) Schedule of Medicaid premiums and cost-sharing requirements. A public schedule will be available describing current Medicaid premiums and cost-sharing requirements containing the following information:

(1) The group or groups of individuals who are subject to premiums and cost-sharing requirements and the current amounts;

(2) Mechanisms for making payments for required premiums and cost-sharing charges;

[91] 42 CFR § 447.57.

(3) The consequences for an individual who does not pay a premium or cost-sharing charge;

(4) A list of hospitals charging cost sharing for non-emergency use of the emergency department; and

(5) A list of preferred drugs or a mechanism to access such a list, including the state's health-benefits website.

(b) Schedule availability. The public schedule will be available to the following in a manner that ensures that affected individuals and providers are likely to have access to the notice:

(1) Enrollees, at the time of their enrollment and reenrollment after a redetermination of eligibility, and, when premiums, cost-sharing charges or aggregate limits are revised, notice to enrollees will be in accordance with § 5.01(d);

(2) Applicants, at the time of application;

(3) All participating providers; and

(4) The general public.

(c) [Reserved]

64.03 [Reserved] (01/15/2017, GCR 16-100)

64.04 Ongoing Medicaid premium billing and payment (10/01/2021, GCR 20-004)

(a) After enrollment, ongoing premiums are billed and premium payments are due for an individual enrolled in Medicaid as follows:

(1) A monthly bill for ongoing premiums will be sent by the 5th day of the month or the first non-holiday business day thereafter immediately preceding the month for which the premium covers. Payment is due on or before the last day of the month in which the bill is sent.

(2) For example, a premium bill for coverage in July 2014 will be sent by June 5, 2014. Payment of the premium will be due on or before June 30, 2014.

(b) If the full premium payment is received by the premium payment due date, coverage will continue without further notice.

(c) If the premium payment is made by mail, the payment will be considered received as of the date it is postmarked.

64.05 Partial payments (10/01/2021, GCR 20-004)

(a) Medicaid-only premium billing and payment. When a premium for Medicaid's Dr. Dynasaur program is the only premium billed, payment of the full amount due is required to maintain coverage and eligibility. A payment of less than the full amount due will be considered by AHS as nonpayment.

(b) Allocation of partial payments when multiple premiums billed

(1) Basic rule

(i) When there is a premium for the VPharm program in addition to Medicaid's Dr. Dynasaur program on the same bill, except as provided in paragraph (b)(2) of this subsection, when a payment covers at least one, but fewer than all, of the premiums due on the bill, the payment will be applied as payment of one or more premiums in full rather than as a partial payment of each of the billed premiums. The payment will be allocated by AHS in the following order:

(A) Dr. Dynasaur.

(B) VPharm.

(C) Dr. Dynasaur retroactive island (see § 64.01(l) for definition).

(ii) Coverage will only continue for those for whom the full premium amount due has been received.

(2) Exception. An individual who wishes to specify a different payment allocation for the premiums due than as set forth in paragraph (b)(1) of this subsection may do so by calling AHS at the number listed on the bill. The individual must make such a request prior to the time the payment is applied to a coverage month.

64.06 Late payment/grace period (10/01/2021, GCR 20-004)

(a) Grace Period

(1) An individual enrolled in Dr. Dynasaur is entitled to a premium grace period as described in this paragraph (1) if the individual has not paid their monthly premium by its due date. The grace period starts the day after the due date, extends 60 days and ends on the last day of the month in which the 60-day period ends.[92]

(2) During the grace period described in paragraph (1) of this subsection, Medicaid will pay all appropriate claims for services rendered to the individual.

(b) Notice of premium nonpayment and reinstatement

(1) If a full premium payment is not received by AHS on or before the premium due date, before the fifth business day of the grace period, AHS will send a notice advising that the individual is in a grace period status. The notice will also advise the individual:

(i) Of the Dr. Dynasaur disenrollment protection as provided under § 64.07;

[92] Because of the length of the grace period for an individual enrolled in Dr. Dynasaur, the individual can be in more than one Dr. Dynasaur grace period at the same time. For example, if an individual does not pay their Dr. Dynasaur premium 2 months in a row, they will still be in a grace period for the first unpaid month when the grace period for the second unpaid month starts.

(ii) Of the consequences of being in a grace status;

(iii) The actions the individual must take to resume good standing; and

(iv) The consequences of exhausting the grace period without paying all outstanding premiums.

(2) At least 11 days before the end of the grace period, AHS will send the individual a closure notice advising that enrollment will terminate at the end of the grace period.

(3) Subject to the payment allocation described in (4) below, if AHS receives at least a full premium payment for the grace period on or before the end of the grace period:

(i) The payment will first be applied to cover the premium due for the grace period;

(ii) The individual will be reinstated; and

(iii) The individual will be reenrolled for coverage in the month following the grace period.

(4) *Payment allocation.* If an individual is in grace period status for more than one unpaid premium when AHS receives payment and the payment covers the premium due for at least one, but fewer than all, of the grace periods, the payment will be applied as payment of one or more premiums in full and allocated in chronological order beginning with the oldest grace period.

(5) If AHS receives a full premium payment for the grace period after the end of the grace period, the individual will not be reinstated or reenrolled, and will need to re-apply.

64.07 Dr. Dynasaur disenrollment protection[93] (01/15/2017, GCR 16-100)

(a) Prior to closure, an individual enrolled in Dr. Dynasaur who has received a grace period notice as provided under § 64.06(b)(2)(i) may contact AHS to show that, due to changed household circumstances, the individual is eligible for Medicaid without a premium obligation or with a lower premium amount.

(b) If the showing indicates that the individual is eligible for Medicaid without a premium obligation, AHS will reinstate and reenroll the individual and waive all outstanding premiums.

(c) If the showing indicates that the individual is obligated to pay a premium, but at a lower amount, any outstanding premium amounts due will be adjusted. If the individual pays the adjusted premium amount prior to closure, AHS will reinstate and reenroll the individual.

64.08 [Reserved] (01/15/2017, GCR 16-100)

64.09 Medical incapacity for VPharm (01/15/2017, GCR 16-100)

[93] 42 CFR § 457.570(b) provides CHIP enrollees an opportunity to show that their income has declined before coverage is terminated for non-payment of premium. Vermont has elected to extend this protection to all of the state's premium-based Dr. Dynasaur coverage groups.

(a) "Medical incapacity" means a serious physical or mental infirmity to the health of an individual enrolled in VPharm (§ 10.01) that prevented the individual from paying the premium timely, as verified in a physician's certificate furnished to AHS. Notice by telephone or otherwise by the physician that such certificate will be forthcoming will have the effect of receipt, provided that the certificate is in fact received within seven days.

(b) If an individual's VPharm coverage is terminated solely because of nonpayment of the premium, and the reason is medical incapacity as defined in (a) of this subsection, the individual's representative may request coverage for the period between the day coverage ended and the last day of the month in which they requested coverage. AHS will provide this coverage if it has received verification of medical incapacity and all premiums due for the period of non-coverage. The individual is responsible for all bills incurred during the period of non-coverage until AHS receives the required verification and premium amounts due.

(c) If the health condition related to this medical incapacity is expected to continue or recur, AHS will encourage the individual to sign up for automatic withdrawal of their premium or designate an authorized representative to receive and pay future premiums for as long as the anticipated duration of the condition.

64.10 Medicaid premium payment balances (01/15/2017, GCR 16-100)

Medicaid premium payment balances that result from partial payments or overpayments will be credited to the premium payer's account and will be applied to subsequent Medicaid premium bills.

64.11 Refund of prospective Medicaid premium payments (01/15/2017, GCR 16-100)

(a) Basic rule for Medicaid premiums. A paid Medicaid premium will automatically be refunded to the premium payer when, prior to the beginning of the coverage month associated with the premium payment, no one under the premium payer's account is subject to a premium obligation.

(b) Exception. A paid Medicaid premium will not be refunded if a change occurs after the beginning of the coverage month associated with the premium payment.

64.12 [Reserved] (01/15/2017, GCR 16-100)

64.13 Appeal of Medicaid (10/01/2021, GCR 20-004)

(a) If an individual subject to a premium appeals a decision by AHS that ends their Medicaid eligibility, reduces their benefits or services, or increases the amount of their Medicaid premium, the individual must continue to pay the premium amount in effect prior to the decision that resulted in their appeal in order to have their Medicaid coverage continue pending the outcome of their appeal.

(b) AHS may recover from the individual the difference between the premium level that would have become effective had the individual not appealed AHS's decision and the premium level actually paid during the fair hearing period when the individual withdraws the fair hearing request before the decision is made or following a final disposition of the matter in favor of AHS.

65.00 [Reserved] (01/15/2019, GCR 18-064)

66.00 Presumptive Medicaid eligibility determined by hospitals[94] (01/01/2018, GCR 17-048)

66.01 Basis (01/15/2017, GCR 16-100)

This section implements § 1902(a)(47)(B) of the Act.

66.02 In general (01/15/2017, GCR 16-100)

(a) Basic rule. Medicaid will be provided during a presumptive eligibility period to an individual who is determined by a qualified hospital, on the basis of preliminary information, to be presumptively eligible in accordance with the policies and procedures established by AHS consistent with this section.

(b) Qualified hospital. A qualified hospital is a hospital that:

(1) Participates as a Medicaid provider; notifies AHS of its election to make presumptive eligibility determinations under this section; and agrees to make presumptive eligibility determinations consistent with state policies and procedures;

(2) Assists individuals in completing and submitting the full Medicaid application and understanding any documentation requirements; and

(3) Has not been disqualified by AHS in accordance with paragraph (d) of this subsection.

(c) Scope of authority to make determinations of presumptive eligibility. Hospitals may only make determinations of presumptive eligibility under this section based on income for:

(1) Children under § 7.03(a)(3);

(2) Pregnant women under § 7.03(a)(2);

(3) Parents and caretaker relatives under § 7.03(a)(1);

(4) Adults under § 7.03(a)(5);

(5) Former foster children under § 9.03(e);

(6) Individuals receiving breast and cervical cancer treatment under § 9.03(f); and

(7) Individuals receiving family planning services under § 9.03(g).

(d) Disqualification of hospitals

(1) AHS may establish standards for qualified hospitals related to the proportion of individuals determined presumptively eligible for Medicaid by the hospital who:

[94] 42 CFR § 435.1110.

(i) Submit a regular application before the end of the presumptive eligibility period; or

(ii) Are determined eligible for Medicaid based on such application.

(2) AHS will take action, including, but not limited to, disqualification of a hospital as a qualified hospital under this section, if it determines that the hospital is not:

(i) Making, or is not capable of making, presumptive eligibility determinations in accordance with applicable state policies and procedures; or

(ii) Meeting the standard or standards established under paragraph (d)(1) of this section.

(3) AHS may disqualify a hospital as a qualified hospital under this paragraph only after it has provided the hospital with additional training or taken other reasonable corrective action measures to address the issue.

66.03 Procedures (01/15/2017, GCR 16-100)

(a) In general.[95] AHS will provide Medicaid services to an individual during the presumptive-eligibility period that follows a determination by a qualified hospital that, on the basis of preliminary information, the individual has gross income at or below the Medicaid income standard established for the individual.

(b) AHS's responsibilities.[96] AHS will:

(1) Provide qualified hospitals with application forms for Medicaid and information on how to assist individuals in completing and filing such forms;

(2) Establish oversight mechanisms to ensure that presumptive-eligibility determinations are being made consistent with applicable laws and rules; and

(3) Allow determinations of presumptive eligibility to be made by qualified hospitals on a statewide basis.

(c) Qualified hospital's responsibilities[97]

(1) On the basis of preliminary information, a qualified hospital must determine whether the individual is presumptively eligible under this rule.

(2) For the purpose of the presumptive eligibility determination, a qualified hospital must accept self-declaration of the presumptive-eligibility criteria.

[95] 42 CFR § 435.1102(a).

[96] 42 CFR § 435.1102(b).

[97] 42 CFR § 435.1102(b)(2), as applied to hospital determination of presumptive eligibility by 42 CFR § 435.1110(a).

(3) If the individual is presumptively eligible, a qualified hospital must:

(i) Approve presumptive coverage for the individual;

(ii) Notify the individual within twenty-four hours of the eligibility determination, in writing or orally, if appropriate:

(A) That the individual is eligible for presumptive coverage;

(B) The presumptive eligibility determination date;

(C) That the individual is required to make application for ongoing Medicaid by not later than the last day of the following month; and

(D) That failure to cooperate with the standard eligibility determination process will result in denial of ongoing Medicaid and termination of presumptive coverage on the date described in § 66.04;

(iii) Notify AHS of the presumptive eligibility determination within five working days after the date on which determination is made;

(iv) Provide the individual with a Medicaid application form;

(v) Advise the individual that:

(A) If a Medicaid application on behalf of the individual is not filed by the last day of the following month, the individual's presumptive eligibility will end on that last day; and

(B) If a Medicaid application on behalf of the individual is filed by the last day of the following month, the individual's presumptive eligibility will end on the day that a decision is made on the Medicaid application; and

(vi) Take all reasonable steps to help the individual complete an application for ongoing Medicaid or make contact with AHS.

(4) If the individual is not presumptively eligible, a qualified hospital must notify the individual at the time the determination is made, in writing and orally if appropriate:

(i) Of the reason for the determination;

(ii) That their ineligibility for presumptive coverage does not necessarily mean that they are ineligible for other categories of Medicaid; and

(iii) That the individual may file an application for Medicaid with AHS, and that, if they do so, that the individual's eligibility for other categories of Medicaid will be reviewed.

(5) A qualified hospital may not delegate the authority to determine presumptive eligibility to another entity.[98]

[98] 42 CFR § 435.1102(b), as applied to hospital determination of presumptive eligibility by 42 CFR § 435.1110(a).

(d) Required attestations.[99] For purposes of making a presumptive eligibility determination under this section, an individual (or another person having reasonable knowledge of the individual's status) must attest to the individual being a:

(1) Citizen or national of the United States or in satisfactory immigration status; and

(2) Resident of the state.

(e) Limitation on other conditions[100]

(1) The conditions specified in this subsection are the only conditions that apply in the case of a presumptive-eligibility determination.

(2) Verification of the conditions that apply for presumptive eligibility is not required.

66.04 Presumptive coverage[101] (01/01/2018, GCR 17-048)

(a) Effective dates

(1) Presumptive coverage begins on the date the individual is determined to be presumptively eligible.

(2) Presumptive coverage ends with the earlier of (and includes):

(i) The date that the individual is determined to be eligible or ineligible for ongoing Medicaid.

(ii) If the individual has not applied for ongoing Medicaid, the last day of the month following the month in which the individual was determined to be presumptively eligible.

(b) No retroactive coverage. No retroactive coverage may be provided as a result of a presumptive eligibility determination.

(c) Frequency. An individual may receive only one presumptive Medicaid eligibility period in a calendar year. A pregnant woman may receive only one presumptive Medicaid eligibility period for each pregnancy, even if she has not yet otherwise received a presumptive Medicaid eligibility period during the current calendar year.

66.05 Notice and fair hearing rules[102] (01/15/2017, GCR 16-100)

[99] 42 CFR § 435.1102(d)(1), as applied to hospital determination of presumptive eligibility by 42 CFR § 435.1110(a).

[100] 42 CFR § 435.1102(d)(2), as applied to hospital determination of presumptive eligibility by 42 CFR § 435.1110(a).

[101] 42 CFR § 435.1101, as applied to hospital determination of presumptive eligibility by 42 CFR § 435.1110(a).

[102] 42 CFR § 435.1102(e), as applied to hospital determination of presumptive eligibility by 42 CFR § 435.1110(a).

Notice and fair hearing regulations in Part Eight of this rule do not apply to determinations of presumptive eligibility under this section.

67.00 General notice standards[103] (01/01/202301/01/2018, GCR 22-03317-048)

(a) General requirement. Any notice required to be sent by AHS must be written and include clear statements of the following:

(1) An explanation of the action reflected in the notice, including the effective date of the action;

(2) Any relevant factual findings.

(3) Citations to, or identification of, the relevant regulations.

(4) Contact information for available customer service resources.

(5) An explanation of appeal rights, if applicable.

(b) Accessibility and plain language. All applications, forms, and notices, including the single, streamlined application and notices of decision, will conform to the accessibility and plain language standards outlined in § 5.01(c).

67.01 Use of electronic notices[104] (01/01/202301/01/2018, GCR 22-03317-048)

(a) Choice of notice format. An individual will be provided with a choice to receive notices and information required under these rules in electronic format or by regular mail. If the individual elects to receive communications electronically, AHS will:

(1) Confirm by regular mail the individual's election to receive notices electronically;

(2) Inform the individual of their right to change such election, at any time, to receive notices through regular mail;

(3) Post notices to the individual's electronic account within one business day of notice generation;

(4) Send an email or other electronic communication alerting the individual that a notice has been posted to his or her account. Confidential information will not be included in the email or electronic alert;

(5) Send a notice by regular mail within three business days of the date of a failed electronic communication if an electronic communication is undeliverable; and

[103] 45 CFR § 155.230.

[104] 42 CFR § 435.918; 45 CFR § 155.230. See, also, 45 CFR § 155.230(d)(3) allowing select required notices to be sent through standard mail, even if an election has been made to receive such notices electronically, in the event that an Exchange is unable to send these notices electronically due to technical limitations.

(6) At the individual's request, provide through regular mail any notice posted to the individual's electronic account.

~~(b) [Reserved]Limitation on use of electronic notices and other communications. Notice or other communications will be provided electronically only if the individual:~~

~~(c) Has affirmatively elected to receive electronic communications in accordance with paragraph (a) of this subsection; and~~

~~(d)~~(b) ~~Is permitted to change such election at any time.~~

68.00 Notice of decision and appeal rights (10/01/2021, GCR 20-004)

68.01 Notice of decision concerning eligibility[105] (10/01/2021, GCR 20-004)

(a) In general. AHS will send timely notice of any decision affecting eligibility in accordance with federal and state laws. Any notice issued by a QHP issuer is not a notice of decision.

In general, a notice of a decision that adversely affects an enrollee's eligibility will be sent in advance of its effective date. A notice of a decision that adversely affects a Medicaid enrollee's eligibility, including a notice of termination, reduction, suspension of eligibility, or increase in liability, will comply with the advance notice requirements under § 68.02.

(b) Content of eligibility notice

(1) In general. Any notice of decision will contain clear statements of the following:

(i) AHS's decision and its basis;

(ii) The effective date of the decision, if applicable;

(iii) The specific reasons supporting the decision;

(iv) The specific regulations that support, or the change in federal or state law that requires, the decision;

(v) An explanation of the individual's appeal rights, including the right to request a fair hearing and an explanation of the circumstances under which the individual has the right to an expedited administrative appeal pursuant to § 80.07;

(vi) A description of the methods by which the individual may appeal;

(vii) The time frame in which AHS must make a final administrative decision in a fair hearing and an expedited administrative appeal;

[105] 42 CFR § 435.917; 45 CFR §§ 155.310(g) and 155.355.

(viii) Information on the individual's right to represent themselves at a fair hearing or use legal counsel, a relative, a friend or other spokesperson;

(ix) In cases of a decision based on a change in law, an explanation of the circumstances under which a fair hearing will be granted;

(x) An explanation of the circumstances under which the individual's eligibility for QHP, APTC or CSR or their Medicaid will be continued pending a fair hearing decision; and

(xi) In connection with eligibility for a QHP, an explanation that a fair hearing decision for one household member may result in a change in eligibility for other household members and that change may be handled as a redetermination.

(2) Notice of approved eligibility. In addition to the information in paragraph (b)(1) of this subsection, a notice of approval of eligibility will contain clear statements of the following:

(i) The basis and effective date of the eligibility;

(ii) The circumstances under which the individual must report, and the methods for reporting, any changes that may affect their eligibility;

(iii) For an individual approved for Medicaid, basic information on the level of Medicaid benefits and services approved, including, if applicable, a description of any premiums and cost-sharing required, an explanation of how to request additional detailed information on benefits and financial responsibility, and the right to appeal the level of benefits and services approved; and

(iv) For an individual approved for Medicaid subject to a spenddown, the amount of medical expenses which must be incurred to establish eligibility.

(3) Medicaid notices of decision based on income at or below MAGI-based standard.[106] Whenever an approval, denial or termination of eligibility is based on an individual having a household income at or below the applicable MAGI-based income standard, the eligibility notice will contain clear statements of the following:

(i) Information regarding bases of eligibility other than the MAGI-based income standard and the benefits and services available to individuals eligible on such other bases, sufficient to enable the individual to make an informed choice as to whether to request a determination on such other bases; and

(ii) Information on how to request a determination on such other bases.

(c) Timing of notification of appeal rights.[107] AHS will provide notice of appeal rights as described in paragraph (b)(1) of this subsection:

[106] 42 CFR § 435.917(c).

[107] 42 CFR § 431.206(c).

(1) At the time that the individual applies for health benefits; and

(2) At the time AHS makes a decision affecting the individual's eligibility.

68.02 Advance notice of Medicaid adverse action decision[108] (01/01/2018, GCR 17-048)

(a) In general. AHS will send a notice of a decision that adversely affects an enrollee's Medicaid eligibility, including a notice of termination, reduction, suspension of eligibility, or increase in liability, as described at § 68.01(a), (adverse action) at least 11 days before the date the adverse action is to take effect (date of adverse action), except as permitted under paragraph (b) of this subsection.

(b) Exception.[109] A notice may be sent not later than the date of adverse action if:

(1) There is factual information confirming the death of an enrollee;

(2) A clear written statement signed by an enrollee is received that:

(i) The enrollee no longer wishes eligibility; or

(ii) Gives information that requires termination or reduction of eligibility and indicates that the enrollee understands that this must be the result of supplying that information;

(3) The enrollee has been admitted to an institution where they are ineligible;

(4) The enrollee's whereabouts are unknown and the post office returns mail directed to the enrollee indicating no forwarding address; or

(5) AHS establishes the fact that the enrollee has been accepted for Medicaid eligibility by another state, territory, or commonwealth.

(c) Exception: probable fraud.[110] The period of advance notice may be shortened to 5 days before the date of adverse action if:

(1) There are facts indicating that adverse action should be taken because of probable fraud by the enrollee; and

(2) The facts have been verified, if possible, through secondary sources.

[108] 42 CFR § 431.211.

[109] 42 CFR § 431.213.

[110] 42 CFR § 431.214.

69.00 Medicaid corrective payment[111] (10/01/2021, GCR 20-004)

Corrective payments will be promptly made, retroactive to the date an incorrect Medicaid action was taken if:

(a) A fair hearing decision is favorable to an individual; or

(b) An issue is decided in an individual's favor before a fair hearing.

70.00 Medicaid enrollment (01/01/2023~~01/01/2018~~, GCR 22-03~~17-048~~)

70.01 Enrollment when no premium obligation (01/01/2023~~01/15/2017~~, GCR 22-03~~16-100~~)

(a) Prospective enrollment. Except when a spenddown is necessary, an individual approved for Medicaid without a premium obligation will be enrolled in Medicaid on the first day of the month within which their application is received by AHS provided they are eligible for that month.

(b) Retroactive eligibility[112]

(1) Retroactive eligibility is effective no earlier than the first day of the third month before the month an individual's application is received by AHS, regardless of whether the individual is alive when application is made, if the following conditions are met:

(i) Eligibility is determined and a budget computed separately for each of the three months;

(ii) A medical need exists, as evidenced by the receipt of Medicaid services, at any time during the retroactive period, of a type covered under the state's Medicaid State plan; and

(iii) Elements of eligibility were met at some time during each month.

(2) An individual may be eligible for the retroactive period (or any single month(s) of the retroactive period) even though ineligible for the prospective period.

(3) If an individual, at the time of application, declares that they incurred medical expenses during the retroactive period and eligibility is not approved, the individual's case record must contain documentation of the reason the individual was not eligible in one or more months of the retroactive period.

70.02 Premium obligation; initial billing and payment (01/01/2018, GCR 17-048)

(a) Initial billing. An individual who is approved for Medicaid with a premium obligation will be notified of the premium obligation and premium amount in a bill that will be sent at the time of approval. The individual will not be enrolled in Medicaid until AHS receives payment of the initial premium. The bill will include payment instructions. If the premium payment is made by mail, the payment will be considered received as of the date

[111] 42 CFR § 431.246.

[112] § 1902(a)(34) of the Act; 42 CFR § 435.915.

it is postmarked.

(b) Initial premium bill amount

(1) The initial bill will include premium charges for the month in which the individual's application was received (the application month) and the month following the application month if eligibility is approved in the same month as the application month. The premium due date is the last day of the month following the application month. If the month eligibility is approved is different than the application month, the initial bill will include the application month, the approval month, any month (or months) between the application month and the approval month, and the month following the approval month. The premium due date is the last day of the month following the approval month.

(2) If the individual is eligible for, and requests, retroactive coverage at the time of their initial application, the initial bill will include premium charges for each month of retroactive coverage. See § 70.01(b) for details on the requirements that must be met for retroactive eligibility.

(c) Payment allocation. When a premium payment is made for the initial months of coverage, and the payment covers the premiums due for at least one, but fewer than all, of the months included in the bill, the payment will be allocated in reverse chronological order, beginning with the latest month included in the bill and extending back as follows: (1) each month between the latest month and the application month, (2) the application month, and (3) any retroactive coverage months included in the bill.

Coverage will begin on the first day of the earliest month for which a full premium has been paid in accordance with the allocation method described above.

Once an individual is in an ongoing billing cycle due to the issuance of a bill for a subsequent month not included in the bill for the initial months, payments will be applied to the coverage month for which the latest bill was issued and to future coverage months. See § 64.04 for a description of the ongoing billing and payment process.

(d) Coverage islands; premiums paid after enrollment

(1) Individuals who initially pay the premiums due for fewer than all of the months included in the initial bill may subsequently obtain coverage islands for any or all of the remaining months (a "coverage island" is a period of eligibility with specific beginning and end dates).

(2) To obtain one or more coverage islands, the individual must pay the full premium amount that was initially billed for each of the desired months of coverage.

(3) Payments of coverage islands will be allocated in the order specified in paragraph (c) of this § 70.02.

71.00 Enrollment of qualified individuals in QHPs[113] (01/01/2023~~10/01/2021~~, GCR 22-033~~20-004~~)

[113] 45 CFR § 155.400.

71.01 In general (01/01/2023~~10/01/2021~~, GCR 22-033~~20-004~~)

(a) General requirements.[114] AHS will accept a QHP selection from an individual who is determined eligible for enrollment in a QHP in accordance with § 11.00, and will:

(1) Notify the issuer of the individual's selected QHP; and

(2) Transmit information necessary to enable the QHP issuer to enroll the individual.

(b) Timing of data exchange.[115] AHS will:

(1) Send eligibility and enrollment information to QHP issuers and HHS promptly and without undue delay;

(2) Establish a process by which a QHP issuer acknowledges the receipt of such information; and

(3) Send updated eligibility and enrollment information to HHS promptly and without undue delay, in a manner and timeframe specified by HHS.

(c) Records.[116] Records of all enrollments in QHPs will be maintained.

(d) Reconcile files.[117] AHS will reconcile enrollment information with QHP issuers and HHS no less than on a monthly basis.

(e) Notice of employee's receipt of APTCs and CSRs to an employer.[118] AHS may~~will~~ notify an employer that an employee has been determined eligible for advance payments of the premium tax credit and cost-sharing reductions and has enrolled in a qualified health plan through VHC within a reasonable timeframe following a determination that the employee is eligible for advance payments of the premium tax credit and cost-sharing reductions and enrollment by the employee in a qualified health plan through VHC. Such notice must:

(1) Identify the employee;

(2) Indicate that the employee has been determined eligible for advance payments of the premium tax credit and cost-sharing reductions and has enrolled in a qualified health plan through VHC;

(3) Indicate that, if the employer has 50 or more full-time employees, the employer may be liable for the payment assessed under § 4980H of the Code; and

[114] 45 CFR § 155.400(a).

[115] 45 CFR § 155.400(b).

[116] 45 CFR § 155.400(c).

[117] 45 CFR § 155.400(d).

[118] 45 CFR § 155.310(h).

(4) Notify the employer of the right to appeal the determination and where to file the appeal as described in § 45.00(b).

71.02 Annual open enrollment periods[119] (01/01/2023~~01/15/2017~~, GCR 22-03316-~~100~~)

(a) General requirements[120]

(1) Annual open enrollment periods (AOEPs) will be provided consistent with this subsection, during which qualified individuals may enroll in a QHP and enrollees may change QHPs.

(2) A qualified individual may only be permitted to enroll in a QHP or an enrollee to change QHPs during the AOEP specified in paragraph (e) of this subsection, or a special enrollment period (SEP) described in § 71.03 for which the qualified individual has been determined eligible.

(b) [Reserved]

(c) [Reserved]

(d) Notice of AOEP.[121] AHS will provide a written AOEP notification to each enrollee no earlier than the first day of the month before the open enrollment period begins and no later than the first day of the open enrollment period.

(e) AOEP.[122] The AOEP begins on November 1 of the calendar year preceding the benefit year and extends through January 15 of the benefit year~~will be in accordance with federal law~~.

(f) Coverage effective dates during the AOEP[123]

(1) Coverage will be effective January 1, for a QHP selection received on or before December 15 of the calendar year preceding the benefit year.

~~(2) To the extent the AOEP extends beyond December 15, for a QHP selection received:~~

~~Between the first and the fifteenth day of a month during the AOEP,~~ cCoverage will be effective February 1, for a QHP selection received from December 16 of the calendar year preceding the benefit year through January 15 of the benefit year~~on the first day of the following month~~.

[119] 45 CFR § 155.410.

[120] 45 CFR § 155.410(a).

[121] 45 CFR § 155.410(d).

[122] 45 CFR § 155.410(e).

[123] 45 CFR § 155.410(f).

~~(3)~~(2)

~~(iv) Between the sixteenth and the last day of a month during the AOEP, coverage will be effective on the first day of second following month.~~

~~(v) For example, coverage will be effective February 1 for a QHP selection received from December 16 through January 15.~~

71.03 Special enrollment periods (SEP)[124] (01/01/2023~~10/01/2021~~, GCR 22-03320-004)

(a) General requirements[125]

(1) AHS will provide SEP consistent with this subsection, during which qualified individuals may enroll in QHPs and enrollees may change QHPs.

(2) For the purpose of this subsection, "dependent" has the same meaning as it does in 26 CFR § 54.9801-2, referring to any individual who is or who may become eligible for coverage under the terms of a QHP because of a relationship to a qualified individual or enrollee.

(3) The requirement to have coverage in the 60 days prior to a triggering event is met if the qualified individual either had minimum essential coverage as described in § 23.00 for one or more days during the 60 days preceding the date of the triggering event; lived in a foreign country or in a United States territory for one or more days during the 60 days preceding the date of the triggering event; or meets other criteria established under federal law.[126]

(b) Effective dates[127]

(1) Regular effective dates. Except as specified in paragraphs (b)(2) and (3) of this subsection, for a QHP selection received by AHS ~~from a qualified individual~~:

(i) Between the first and the fifteenth day of any month, the coverage effective date will be the first day of the following month; and

(ii) Between the sixteenth and the last day of any month, the coverage effective date will be the first day of the second following month.

(2) Special effective dates

(i) In the case of birth, adoption, placement for adoption, or placement in foster care, coverage is

[124] 45 CFR § 155.420.

[125] 45 CFR § 155.420.

[126] See, e.g., 45 CFR §§ 155.420(a)(5) and 155.420(d)(6)(iv).

[127] 45 CFR § 155.420(b).

effective for a qualified individual or enrollee on the date of birth, adoption, placement for adoption, or placement in foster care or, if elected by the qualified individual or enrollee, in accordance with paragraph (b)(1) of this subsection.

(ii) In the case of marriage, as described in paragraph (d)(2) of this subsection, coverage is effective for a qualified individual or enrollee on the first day of the month following plan selection.

(iii) In the case of a qualified individual or enrollee eligible for a special enrollment period as described in paragraphs (d)(4), (d)(5), (d)(9), (d)(10), (d)(11), (d)(12), or (d)(13) of this subsection, coverage is effective on an appropriate date based on the circumstances of the special enrollment period.

(iv) In a case where an individual loses coverage as described in paragraph (d)(1) or (d)(6)(iii) of this subsection, if the plan selection is made before or on the day of the loss of coverage, the coverage effective date is on the first day of the month following the loss of coverage. If the plan selection is made after the loss of coverage, the coverage is effective on the first day of the following month.

(v) In the case of a court order as described in paragraph (d)(2)(i) of this subsection, coverage is effective for a qualified individual or enrollee on the date the court order is effective.

(vi) In a case where an enrollee or their dependent dies as described in paragraph (d)(2)(ii) of this subsection, coverage is effective on the first day of the month following the plan selection.

(vii) In a case where an individual gains access to a new QHP as described in paragraph (d)(7) of this subsection or becomes newly eligible for enrollment in a QHP through VHC in accordance with § 19.01 as described in paragraph (d)(3) of this subsection, if the plan selection is made on or before the date of the triggering event, coverage is effective on the first day of the month following the date of the triggering event. If the plan selection is made after the date of the triggering event, coverage is effective in accordance with paragraph (b)(1) of this subsection.

(viii) In a case where an individual becomes pregnant as described in paragraph (d)(14) of this subsection, coverage is effective on the first day of the month following plan selection.

(ix) In a case where an individual is enrolled in COBRA continuation coverage and employer contributions to or government subsidies of this coverage completely cease as described in paragraph (d)(16) of this subsection, if the plan selection is made on or before the date of the triggering event, coverage is effective on the first day of the month following the date of the triggering event. If the plan selection is made after the date of the triggering event, coverage is effective on the first day of the following month.

(3) Option for earlier effective dates. Subject to demonstrating to HHS that all of the participating QHP issuers agree to effectuate coverage in a timeframe shorter than discussed in paragraph (b)(1) or (b)(2)(ii) of this subsection, one or both of the following may be done for all applicable individuals:

(i) For a QHP selection received from a qualified individual in accordance with the dates specified in paragraph (b)(1) or (b)(2)(ii) of this section, a coverage effective date for a qualified individual may be provided earlier than specified in such paragraphs.

(ii) For a QHP selection received from a qualified individual on a date set by the state after the

fifteenth of the month, a coverage effective date of the first of the following month may be provided.

(4) APTC and CSR. Notwithstanding the standards of this subsection, APTC, Vermont Premium Reduction and federal and state CSR will adhere to the effective dates specified in § 73.06.

(c) Availability and length of SEP[128]

(1) *General rule.* Unless specifically stated otherwise herein, a qualified individual or enrollee has 60 days from the date of a triggering event to select a QHP.

(2) *Advanced availability.*

A qualified individual or their dependent who is described in one of the following paragraphs of this subsection has 60 days before and after the date of the triggering event to select a QHP:

(i) (d)(1);

(ii) (d)(3) if they become newly eligible for enrollment in a QHP through VHC because they newly satisfy the requirements under § 19.01;

(iii) (d)(6)(iii);

(iv) (d)(7); or

(v) (d)(16).

(3) *Special rule.* In the case of a qualified individual or enrollee who is eligible for an SEP as described in paragraphs (d)(4), (d)(5), or (d)(9) of this subsection, AHS may define the length of the SEP as appropriate based on the circumstances of the SEP, but in no event will the length of the SEP exceed 60 days.

(d) SEPs.[129] AHS will allow a qualified individual or enrollee, and, when specified below, their dependent, to enroll in or change from one QHP to another if one of the following triggering events occur:

(1) The qualified individual or their dependent either:

(i) Loses MEC. The date of the loss of coverage is the last day the individual would have coverage under their previous plan or coverage;

(ii) Is enrolled in any non-calendar year group health plan or individual health insurance coverage, even if the qualified individual or their dependent has the option to renew such coverage. The date of the loss of coverage is the last day of the plan or policy year; or

[128] 45 CFR § 155.420(c).

[129] 45 CFR § 155.420(d).

(iii) Loses medically needy coverage only once per calendar year. The date of the loss of coverage is the last day the individual would have medically needy coverage.

(2) *Gain or loss of dependent*

(i) The qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order.[130] In the case of marriage, at least one spouse must have had coverage for one or more days during the 60 days preceding the date of marriage, as described in paragraph (a)(3) of this subsection.

(ii) The enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by state law in the state in which the divorce or legal separation occurs, or if the enrollee or their dependent dies.

(3) The qualified individual, or their dependent, becomes newly eligible for enrollment in a QHP through VHC because they newly satisfy the requirements under § 17.02 (citizenship, status as a national, lawful presence) or § 19.01 (incarceration);

(4) The qualified individual's or their dependent's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct or inaction of an officer, employee, or agent of AHS or HHS, its instrumentalities, or an individual or entity authorized by AHS to provide enrollment assistance or conduct enrollment activities, as evaluated and determined by AHS. For purposes of this provision, misconduct includes, but is not limited to, the failure to comply with applicable standards under this rule or other applicable federal or state laws, as determined by AHS. In such cases, AHS may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, misconduct or inaction. See § 76.00(e)(3) regarding correction of an erroneous termination or cancellation of coverage;

(5) The enrollee or their dependent adequately demonstrates to AHS that the QHP in which they are enrolled substantially violated a material provision of its contract in relation to the enrollee;

(6) *Newly eligible or ineligible for APTC, or change in eligibility for CSR.*

(i) The enrollee is determined newly eligible or newly ineligible for APTC or has a change in eligibility for CSR;

(ii) The enrollee's dependent enrolled in the same plan is determined newly eligible or newly ineligible for APTC or has a change in eligibility for CSR; or

(iii) A qualified individual or their dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for APTC based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan, including as a result of their employer discontinuing or changing available coverage within the next 60 days, provided that such individual

[130] See, 8 VSA § 4100b.

is allowed to terminate existing coverage.

(iv) For purposes of subsections (i) and (ii), enrollee includes an individual enrolled in a qualified health plan or reflective health benefit plan[131] directly through a QHP issuer.[132]

(7) The qualified individual or enrollee, or their dependent, gains access to new QHPs as a result of a permanent move and had coverage for one or more days during the 60 days preceding the date of the permanent move, as described in paragraph (a)(3) of this subsection.

(8) The qualified individual:

(i) Who gains or maintains status as an Indian, as defined by § 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month; or

(ii) Who is or becomes a dependent of an Indian, as defined by § 4 of the Indian Health Care Improvement Act and is enrolled or is enrolling in a QHP through VHC on the same application as the Indian, may change from one QHP to another one time per month, at the same time as the Indian;

(9) The qualified individual or enrollee, or their dependent, demonstrates to AHS, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as AHS may provide.[133]

(10) The qualified individual or enrollee is a victim of domestic abuse or spousal abandonment as described in § 12.03(b). This special enrollment period is available to any member of a household who is a victim of domestic abuse, including unmarried and dependent victims within the household, as well as victims of spousal abandonment, including their dependents.

(11) The qualified individual or their dependent applies for coverage during the AOEP or due to a triggering event, is assessed as potentially eligible for Medicaid, and is determined ineligible for Medicaid either after the AOEP has ended or more than 60 days after the triggering event.

(12) The qualified individual or enrollee, or their dependent, adequately demonstrates to AHS that a material error related to plan benefits, service area, or premium influenced the qualified individual's or enrollee's decision to purchase a QHP.

(13) The qualified individual provides satisfactory documentary evidence to verify their eligibility for enrollment in a QHP through VHC following termination of enrollment due to a failure to verify such status within the

[131] See, 33 VSA § 1813.

[132] See, 45 CFR § 155.420(d)(6)(v).

[133] See Vermont Health Connect's website for more information on these triggering events.

time period specified in § 57.00(c)(2)(ii).[134]

(14) The qualified individual, who is not an enrollee, becomes pregnant. Any individual who is eligible for coverage under the terms of the health benefit plan because of a relationship to the pregnant individual may enroll through this SEP provided the pregnant individual does so. This SEP is available at any time after the commencement of the pregnancy for the duration of the pregnancy.[135]

(15) The qualified individual is in possession of a certificate of exemption as described in § 23.06 and

(i) Is notified by HHS that they are no longer eligible for the exemption; or

(ii) Is eligible for enrollment in a QHP that is a catastrophic plan as described in § 14.00(b). When this triggering event occurs, the individual may only enroll in a catastrophic plan.

(16) *Loss of assistance paying for COBRA*

(i) The qualified individual or their dependent is enrolled in COBRA continuation coverage[136] for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions to the qualified individual's or dependent's COBRA continuation coverage or government subsidies completely cease.

(ii) The triggering event is the last day of the period for which COBRA continuation coverage is paid for or subsidized, in whole or in part, by an employer or government entity.

(17) *Household income expected to be at or below 200 percent of the FPL*

(i) The qualified individual, or their dependent, is eligible for advance payments of the premium tax credit and their household income, as defined in § 28.05(c), is expected to be at or below 200 percent of the FPL for the benefit year for which coverage is requested.

(ii) The enrollee, or their dependent, is eligible for advance payments of the premium tax credit and their household income, as defined in § 28.05(c), is expected to be at or below 200 percent of the FPL for the benefit year for which coverage is requested. Plan selection for the enrollee or their dependent will be limited to a silver level QHP.

(e) Loss of coverage[137]

(1) Loss of coverage described in paragraph (d)(1) of this subsection includes those circumstances

[134] See, § 11.02 regarding QHP eligibility.

[135] 33 VSA § 1811(l).

[136] See, 45 CFR § 144.103.

[137] 45 CFR § 155.420(e).

described in paragraphs (d)(1)(ii) and (iii) of this subsection and in paragraphs (3)(i) through (iii) below. Loss of coverage does not include voluntary termination of coverage or other loss due to:

(i) Failure to pay premiums on a timely basis, including COBRA continuation coverage premiums prior to expiration of COBRA continuation coverage, except for circumstances in which an employer completely ceases its contributions to COBRA continuation coverage or government subsidies of COBRA continuation coverage completely cease as described in paragraph (d)(16) of this section; or

(ii) Termination of an individual's coverage for cause (which could include, but not be limited to, termination because of an action by the individual that constituted fraud or because the individual made an intentional misrepresentative of a material fact).[138]

(2) Eligibility for COBRA when the qualified individual or their dependent loses coverage does not disqualify the individual or their dependent from a special enrollment period under this subsection.

(3) The following conditions also qualify an employee for a special enrollment period under (d)(1) of this subsection:[139]

(i) *Loss of eligibility for coverage.* In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time the coverage is terminated as a result of loss of eligibility. Loss of eligibility under this paragraph does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage under this paragraph includes (but is not limited to):

(A) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;

(B) In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);

(C) In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, loss of coverage because an individual no longer resides, lives or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual; and

(D) A situation in which a plan no longer offers any benefits to the class of similarly situated

[138] See, 45 CFR § 147.128.

[139] 26 CFR § 54.9801-6(a)(3)(i) through (iii).

individuals [140]that includes the individual.

(ii) *Termination of employer contributions.* In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent.

(iii) *Exhaustion of COBRA continuation coverage.*[141] In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions are satisfied at the time the COBRA continuation coverage is exhausted. An individual who satisfies the conditions of paragraph (e)(3)(i) of this subsection, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions of this paragraph.

72.00 Duration of QHP eligibility determinations without enrollment[142] (01/01/2018, GCR 17-048)

To the extent that an individual who is determined eligible for enrollment in a QHP does not select a QHP within their enrollment period, or is not eligible for an enrollment period in accordance with § 71.00, and seeks a new enrollment period prior to the date on which their eligibility is redetermined in accordance with § 75.00 (annual redetermination), AHS will require the individual to attest as to whether information affecting their eligibility has changed since their most recent eligibility determination before determining their eligibility for a special enrollment period, and will process any changes reported in accordance with the procedures specified in § 73.00 (mid-year redetermination).

73.00 Eligibility redetermination during a benefit year[143] (01/01/2018, GCR 17-048)

73.01 General requirement (01/15/2017, GCR 16-100)

AHS must redetermine the eligibility of an individual in a health-benefits program or for enrollment in a QHP during the benefit year if it receives and verifies new information reported by the individual or identifies updated information through the data matching described in § 73.04, and such new information may affect eligibility.

73.02 Verification of reported changes (01/15/2017, GCR 16-100)

In general[144] AHS will:

(a) Verify any information reported by an individual in accordance with the processes specified in §§ 53.00 through

[140] See, 26 CFR § 54.9802-1(d).

[141] See, also, 26 CFR § 54.9801-2.

[142] 45 CFR § 155.310(j).

[143] 42 CFR § 435.916(d); 45 CFR § 155.330.

[144] 42 CFR § 435.916(d); 45 CFR § 155.330(c).

56.00 prior to using such information in an eligibility redetermination; and

(b) Provide periodic electronic notifications regarding the requirements for reporting changes and an individual's opportunity to report any changes as described in § 4.03(b), to an individual who has elected to receive electronic notifications, unless the individual has declined to receive notifications under this paragraph (b).

73.03 Reestablishment of annual renewal date for Medicaid enrollees[145] (01/15/2017, GCR 16-100)

(a) If a redetermination is made during a benefit year for a Medicaid enrollee because of a change in the individual's circumstances and, subject to the limitation under (b) of this subsection, there is enough information available to renew eligibility with respect to all eligibility criteria, a new 12-month renewal period may begin.

(b) *Limitation on AHS's ability to request additional information.* For renewal of a Medicaid enrollee whose financial eligibility is determined using MAGI-based income, any requests by AHS for additional information from the individual will be limited to information relating to such change in circumstance.

73.04 Periodic examination of data sources[146] (01/01/2018, GCR 17-048)

AHS will periodically examine the available data sources described in § 56.01.

For QHP enrollees:

(a) This periodic examination will be to identify the following changes:

(1) Death; and

(2) For an individual on whose behalf APTC or CSR is being provided, eligibility for or enrollment in Medicare or Medicaid.

(b) AHS may make additional efforts to identify and act on other changes that may affect an individual's eligibility for enrollment in a health-benefits program or in a QHP, provided that such efforts:

(1) Would reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delay, and that applicable requirements with respect to the confidentiality, disclosure, maintenance, or use of such information will be met; and

(2) Comply with the standards specified in § 73.05(b).[147]

[145] 42 CFR § 435.916(d)(1)(ii).

[146] 45 CFR § 155.330(d)(1).

[147] 45 CFR § 155.330(d)(2).

73.05 Redetermination and notification of eligibility[148] (01/01/2018, GCR 17-048)

(a) Enrollee-reported data.[149] If AHS verifies updated information reported by an individual, AHS will:

(1) Promptly redetermine the individual's eligibility in accordance with eligibility standards;

(2) Notify the individual regarding the redetermination in accordance with the requirements specified in § 68.00; and

(3) Notify the individual's employer, as applicable, in accordance with § 71.01(e).

(b) Data matching[150]

(1) For QHP enrollees:

(i) Except as provided in (iii) below, if AHS identifies updated information regarding death, in accordance with § 73.04(a)(1), or regarding any factor of eligibility not regarding income, family size, family composition, or tax filing status AHS will:

(A) Notify the individual regarding the updated information, as well as the individual's projected eligibility determination after considering such information;

(B) Allow the individual 30 days from the date of the notice to notify AHS that such information is inaccurate; and

(C) If the individual responds contesting the updated information, proceed in accordance with § 57.00 (inconsistencies).

(D) If the individual does not respond within the 30-day period, proceed in accordance with paragraphs (a)(1) and (2) of this subsection.

(ii) If AHS identifies updated information regarding income, family size or family composition, with the exception of information regarding death, AHS will:

(A) Follow procedures described in paragraphs (b)(1)(i)(A) and (B) of this subsection; and

(B) If the individual responds confirming the updated information, proceed in accordance with paragraphs (a)(1) and (2) of this subsection.

(C) If the individual does not respond within the 30-day period, maintain the individual's existing eligibility determination without considering the updated information.

(D) If the individual provides more up-to-date information, proceed in accordance with § 73.02.

[148] 45 CFR § 155.330(e).

[149] 45 CFR § 155.330(e)(1).

[150] 45 CFR § 155.330(e)(2).

(iii) If AHS receives information from the Secretary of the Treasury that the tax filer for the enrollee's household or the tax filer's spouse did not comply with the requirements described in § 12.05, AHS when redetermining and providing notification of eligibility for advance payments of the premium tax credit will:

(A) Follow the procedures specified in paragraph (a) of this subsection.

(B) After a redetermination under this subsection, allow a tax filer to re-attest to compliance with the requirements described in § 12.05 and request a redetermination of eligibility.

(2) For Medicaid enrollees, if AHS identifies updated information regarding any factor of eligibility, AHS will proceed in accordance with the provisions of § 57.00(c).

73.06 Effective dates for QHP eligibility redeterminations[151] (01/15/2017, GCR 16-100)

(a) Except as specified in paragraphs (b) through (e) of this subsection, AHS will implement changes for QHP eligibility redeterminations as follows:

(1) Resulting from a redetermination under this section, on the first day of the month following the date of the notice described in § 73.05(a)(2); or

(2) Resulting from an appeal decision, on the date specified in the appeal decision; or

(3) Affecting enrollment or premiums only, on the first day of the month following the date on which AHS is notified of the change;

(b) Except as specified in paragraphs (c) through (e) of this subsection, AHS may determine a reasonable point in a month after which a change described in paragraph (a) of this subsection will not be effective until the first day of the month after the month specified in paragraph (a). Such reasonable point in a month must be no earlier than the 15th of the month.

(c) Except as specified in paragraphs (d) and (e) of this subsection, AHS will implement a change described in paragraph (a) of this subsection that results in a decreased amount of APTC or a change in the level of CSR and for which the date of the notices described in paragraphs (a) (1) and (2) of this subsection, or the date on which AHS is notified in accordance with paragraph (a)(3) of this subsection is after the 15th of the month, on the first day of the month after the month specified in (a) of this subsection.

(d) AHS will implement a change associated with the events described in § 71.03(b)(2)(i) and (ii) on the coverage effective dates described in § 71.03(b)(2)(i) and (ii), respectively.

(e) Notwithstanding paragraphs (a) through (d) of this subsection, AHS will provide the effective date of a change associated with the events described in § 71.03(d)(4), (d)(5) and (d)(9) based on the specific circumstances of each situation.

[151] 45 CFR § 155.330(f).

73.07 Recalculation of APTC/CSR[152] (01/01/2018, GCR 17-048)

(a) When an eligibility redetermination in accordance with this section results in a change in the amount of APTC for the benefit year, AHS will recalculate the amount of APTC in such a manner as to:

(1) Account for any APTC made on behalf of the tax filer for the benefit year for which information is available to AHS, such that the recalculated APTC is projected to result in total advance payments for the benefit year that correspond to the tax filer's total projected premium tax credit for the benefit year, calculated in accordance with § 60.00, and

(2) Ensure that the APTC provided on the tax filer's behalf is greater than or equal to zero and is calculated in accordance with § 60.03.

(b) When an eligibility redetermination in accordance with this section results in a change in CSR, AHS will determine an individual eligible for the category of CSR that corresponds to their expected annual household income for the benefit year (subject to the special rule for family policies under § 13.03).

74.00 [Reserved] (01/15/2017, GCR 16-100)

75.00 Eligibility renewal[153] (10/01/2021, GCR 20-004)

75.01 In general (10/01/2021, GCR 20-004)

(a) Renewal occurs annually. Eligibility of an individual in a health-benefits program or for enrollment in a QHP will be renewed on an annual basis.

(b) Updated income and family size information. In the case of an individual who requested an eligibility determination for a health-benefits program (i.e., health benefits other than enrollment in a QHP without APTC or CSR), AHS will request updated tax return information, if the individual has authorized the request of such tax return information, data regarding Social Security benefits, and data regarding income (as described in § 56.01) for use in the individual's eligibility renewal.

(c) Authorization of the release of tax data to support annual redetermination[154]

(1) AHS must have authorization from an individual in order to obtain updated tax return information described in paragraph (b) of this subsection for purposes of conducting an annual redetermination.

(2) AHS is authorized to obtain the updated tax return information described in paragraph (b) of this subsection for a period of no more than five years based on a single authorization, provided that:

[152] 45 CFR § 155.330(g).

[153] 42 CFR § 435.916(a) and (b); 45 CFR § 155.335.

[154] 45 CFR § 155.335(k).

(i) An individual may decline to authorize AHS to obtain updated tax return information; or

(ii) An individual may authorize AHS to obtain updated tax return information for fewer than five years; and

(iii) AHS must allow an individual to discontinue, change, or renew his or her authorization at any time.

75.02 Renewal procedures for QHP enrollment (10/01/2021, GCR 20-004)

(a) Procedures for annual renewals. AHS will conduct annual renewals of QHPs using procedures derived from 45 CFR § 155.335 and approved annually by HHS based on a showing by AHS that these procedures facilitate continued enrollment in coverage for which the individual remains eligible, provide clear information about the process to the individual (including regarding any action by the individual necessary to obtain the most accurate redetermination of eligibility), and provide adequate program integrity protections.

(b) AHS will publish the approved renewal procedures for QHP enrollment.

(c) Continuation of coverage. An individual who is enrolled in a QHP and whose QHP remains available will not be required to reapply or take other actions to renew coverage for the following year.

75.03 Renewal procedures for Medicaid (01/15/2017, GCR 16-100)

(a) Renewal on basis of available information

(1) A redetermination of eligibility for Medicaid will be made without requiring information from the individual if AHS is able to do so based on reliable information contained in the individual's account or other more current information available, including but not limited to information accessed through any data bases.

(2) If eligibility can be renewed based on such information, the individual will be notified:

(i) Of the eligibility determination, and basis; and

(ii) That the individual must inform AHS if any of the information contained in such notice is inaccurate, but that the individual is not required to sign and return such notice if all information provided on such notice is accurate.

(b) Eligibility renewal using pre-populated renewal form. If eligibility cannot be renewed in accordance with paragraph (a)(2) of this subsection, AHS will:

(1) Provide the individual with:

(i) A renewal form containing information available to AHS that is needed to renew eligibility;

(ii) At least 30 days from the date of the renewal form to respond and provide any necessary information through any of the modes of submission specified in § 52.02(b), and to sign the renewal form in a manner consistent with § 52.02(h);

(iii) Notice in a timely manner of the decision concerning the renewal of eligibility in accordance with the requirements specified in § 68.00;

(2) Verify any information provided by the individual in accordance with §§ 53.00 through 56.00;

(3) Reconsider in a timely manner the eligibility of an individual who is terminated for failure to submit the renewal form or necessary information, if the individual subsequently submits the renewal form within 90 days after the date of termination without requiring a new application;

(4) Not require an individual to complete an in-person interview as part of the renewal process; and

(5) Include in its renewal forms its toll-free customer service number and a request that individuals call if they need assistance.

(c) Medicaid continues for all individuals until they are found to be ineligible. When a Medicaid enrollee has done everything they were asked to do, Medicaid will not be closed even though a decision cannot be made within the required review frequency.[155]

76.00 Termination of QHP enrollment or coverage[156] (10/01/2021, GCR 20-004)

(a) General requirements. AHS will determine the form and manner in which enrollment in a QHP may be terminated.

(b) Termination events[157]

(1) Enrollee-initiated terminations

(i) An individual will be permitted to terminate their coverage or enrollment in a QHP, including as a result of the individual obtaining other MEC, with appropriate notice to AHS.

(ii) An individual will be provided an opportunity at the time of plan selection to choose to remain enrolled in a QHP if they become eligible for other MEC and the individual does not request termination in accordance with paragraph (b)(1)(i) of this section. If an individual does not choose to remain enrolled in a QHP in such a situation, AHS will initiate termination of their enrollment upon completion of the redetermination process specified in § 73.00.

(iii) AHS will establish a process to permit individuals, including enrollees' authorized representatives, to report the death of an enrollee for purposes of initiating termination of the enrollee's enrollment. AHS may require the reporting party to submit documentation of the death.

(iv) AHS will permit an enrollee to retroactively terminate or cancel their coverage or enrollment in a QHP in the following circumstances:

(A) The enrollee demonstrates to AHS that they attempted to terminate their coverage or enrollment

[155] Former Medicaid Rule 4142.

[156] 45 CFR § 155.430.

[157] 45 CFR § 155.430(b).

in a QHP and experienced a technical error that did not allow the enrollee to terminate their coverage or enrollment through VHC, and requests retroactive termination within 60 days after they discovered the technical error.

(B) The enrollee demonstrates to AHS that their enrollment in a QHP through VHC was unintentional, inadvertent, or erroneous and was the result of the error or misconduct of an officer, employee, or agent of AHS or HHS, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities. Such enrollee must request cancellation within 60 days of discovering the unintentional, inadvertent or erroneous enrollment. For purposes of this paragraph, misconduct includes the failure to comply with applicable standards under this rule or other applicable federal or state laws as determined by AHS.

(C) The enrollee demonstrates to AHS that they were enrolled in a QHP without their knowledge or consent by any third party, including third parties who have no connection with AHS, and requests cancellation within 60 days of discovering of the enrollment.

(2) AHS or issuer-initiated termination. AHS may initiate termination of an individual's enrollment in a QHP, and must permit a QHP issuer to terminate such coverage or enrollment, in the following circumstances:

(i) The individual is no longer eligible for coverage in a QHP;

(ii) Non-payment of premiums for coverage of the individual, and

(A) The 3-month grace period required for individuals who when first failing to timely pay premiums are receiving APTC[158] has been exhausted; or

(B) Any other grace period not described in paragraph (b)(2)(ii)(A) of this section has been exhausted;

(iii) The individual's coverage is rescinded;

(iv) The QHP terminates or is decertified;

(v) The individual changes from one QHP to another during an AOEP or SEP in accordance with § 71.02 or § 71.03; or

(vi) The enrollee was enrolled in a QHP without their knowledge or consent by a third party, including a third party with no connection with AHS.

(c) Termination of coverage or enrollment tracking and approval.[159] AHS will:

(1) Establish mandatory procedures for QHP issuers to maintain records of termination of enrollment;

(2) Send termination information to the QHP issuer and HHS, promptly and without undue delay, at such time and in such manner as HHS may specify;

[158] 45 CFR §§ 156.270(d) and (g).

[159] 45 CFR § 155.430(c).

(3) Require QHP issuers to make reasonable accommodations for all individuals with disabilities (as defined by the ADA) before terminating enrollment of such individuals; and

(4) Retain records in order to facilitate audit functions.

(d) Effective dates for termination of coverage or enrollment[160]

(1) For purposes of this section:

(i) Reasonable notice is defined as at least fourteen days from the requested effective date of termination; and

(ii) Changes in eligibility for APTC and CSR, including terminations, must adhere to the effective dates specified in § 73.06.

(2) In the case of a termination in accordance with paragraph (b)(1) of this section, the last day of enrollment is the last day of the month during which the termination is requested by the individual, unless the individual requests a different termination date. If an individual requests a different termination date, the last day of enrollment is:

(i) The termination date specified by the individual, if the individual provides reasonable notice.

(ii) If the individual does not provide reasonable notice, fourteen days after the termination is requested by the individual.

(iii) If the individual is newly eligible for Medicaid or other MEC, and the individual so requests, the last day of the month prior to the month during which the termination is requested by the individual, subject to the determination of the individual's QHP issuer.

(3) In the case of a termination in accordance with paragraph (b)(2)(i) of this section, the last day of enrollment is the last day of eligibility, as described in § 73.06, unless the individual requests an earlier termination effective date per paragraph (b)(1)(i) of this section.

(4) In the case of a termination in accordance with paragraph (b)(2)(ii)(A) of this section, the last day of enrollment will be the last day of the first month of the 3-month grace period.

(5) In the case of a termination in accordance with paragraph (b)(2)(ii)(B) of this section, the last day of enrollment should be consistent with existing State laws regarding grace periods.

(6) In the case of a termination in accordance with paragraph (b)(2)(v) of this section, the last day of coverage in an individual's prior QHP is the day before the effective date of coverage in their new QHP, including any retroactive enrollments.

(7) In the case of termination due to death, the last day of enrollment is the date of death.

[160] 45 CFR § 155.430(d).

(8) In cases of retroactive termination dates, AHS will ensure that appropriate actions are taken to make necessary adjustments to APTC, CSR, premiums and claims.

(9) In case of a retroactive termination in accordance with paragraph (b)(1)(iv)(A) of this section, the termination date will be no sooner than 14 days after the date that the enrollee can demonstrate they contacted AHS to terminate their coverage or enrollment through VHC, unless the issuer agrees to an earlier effective date as set forth in paragraph (d)(2)(iii) of this section.

(10) In case of a retroactive cancellation or termination in accordance with paragraph (b)(1)(iv)(B) or (C) of this section, the cancellation date or termination date will be the original coverage effective date or a later date, as determined appropriate by AHS, based on the circumstances of the cancellation or termination.

(11) In the case of cancellation in accordance with paragraph (b)(2)(vi) of this section, AHS may cancel the enrollee's enrollment upon its determination that the enrollment was performed without the enrollee's knowledge or consent and following reasonable notice to the enrollee (where possible). The termination date will be the original coverage effective date.

(12) In the case of retroactive cancellations or terminations in accordance with paragraphs (b)(1)(iv)(A), (B) and (C) of this section, such terminations or cancellations for the preceding coverage year must be initiated within a timeframe established by AHS based on a balance of operational needs and consumer protection. This timeframe will not apply to cases adjudicated through the appeals process.

(e) Termination, cancellation, reinstatement defined

(1) *Termination.* A termination is an action taken after a coverage effective date that ends an enrollee's enrollment through VHC for a date after the original coverage effective date, resulting in a period during which the individual was enrolled in coverage through VHC.

(2) *Cancellation.* A cancellation is specific type of termination action that ends a qualified individual's enrollment on the date such enrollment became effective resulting in enrollment never having been effective.

(3) *Reinstatement.* A reinstatement is a correction of an erroneous termination or cancellation action and results in restoration of an enrollment with no break in coverage.

77.00 Administration of APTC and CSR[161] (10/01/2021, GCR 20-004)

(a) Requirement to provide information to enable APTC and CSR.[162] In the event that a tax filer is determined eligible for APTC and the Vermont Premium Reduction, if applicable, or an individual is eligible for federal or state CSR, or that such eligibility for such programs has changed, AHS will, simultaneously:

(1) Transmit eligibility and enrollment information to HHS necessary to enable HHS to begin, end, or change

[161] 45 CFR § 155.340.

[162] 45 CFR § 155.340(a).

APTC or federal CSR; and

(2) Notify and transmit information necessary to enable the issuer of the QHP to implement, discontinue the implementation, or modify the level of APTC, the Vermont Premium Reduction or federal or state CSR, as applicable, including:

(i) The dollar amount of the advance payment including the Vermont Premium Reduction; and

(ii) The CSR eligibility category.

(b) Requirement to provide information related to employer responsibility[163]

(1) AHS will transmit the individual's name and tax filer identification number to HHS in the event that it determines that an individual is eligible for APTC or CSR based in part on a finding that an individual's employer:

(i) Does not provide MEC;

(ii) Provides MEC that is unaffordable, within the standard of § 23.02; or

(iii) Provides MEC that does not meet the minimum value requirement specified in § 23.03.

(2) If an individual for whom APTC are made or who is receiving CSR notifies AHS that they have changed employers, AHS must transmit the individual's name and tax filer identification number to HHS.

(3) In the event that an individual for whom APTC are made or who is receiving CSR terminates coverage from a QHP during a benefit year:

(i) AHS will transmit the individual's name and tax filer identification number, and the effective date of coverage termination, to HHS, which will transmit it to the Secretary of the Treasury; and

(ii) AHS may transmit the individual's name and the effective date of the termination of coverage to their employer.

(c) Requirement to provide information related to reconciliation of APTC.[164] AHS will comply with the requirements of § 78.00 regarding reporting to the IRS and to tax filers.

(d) Timeliness standard.[165] All information required in accordance with paragraphs (a) and (b) of this section will be transmitted promptly and without undue delay.

[163] 45 CFR § 155.340(b).

[164] 45 CFR § 155.340(c).

[165] 45 CFR § 155.340(d).

(e) Allocation of APTC and the Vermont Premium Reduction among policies.[166] If one or more advance payments of the premium tax credit, including the Vermont Premium Reduction, if applicable, are to be made on behalf of a tax filer (or two tax filers covered by the same plan(s)), and individuals in the tax filers' households are enrolled in more than one QHP or stand-alone dental plan, then that portion of the APTC, including the Vermont Premium Reduction, that is less than or equal to the aggregate monthly premiums, as defined in § 60.05, for the QHP policies properly allocated to essential health benefits must be allocated among the QHP policies based on the number of enrollees covered under the QHP.

(f) If either or both APTC and the Vermont Premium Reduction are received for a partial coverage month consistent with § 73.06, APTC and the Vermont Premium Reduction amounts are prorated by the number of days of coverage in the month.[167]

78.00 Information reporting by AHS[168] (01/15/2017, GCR 16-100)

(a) Information required to be reported[169]

(1) *Information reported annually.*

AHS will report to the IRS the following information for each QHP:

(i) The name, address and taxpayer identification number (TIN), or date of birth if a TIN is not available, of the tax filer or responsible adult (an individual on behalf of whom APTC is not paid);

(ii) The name and TIN, or date of birth if a TIN is not available, of a tax filer's spouse;

(iii) The amount of advance credit payments paid for coverage under the plan each month;

(iv) For plans for which advance credit payments are made, the premium (excluding the premium allocated to benefits in excess of essential health benefits) for the ABP for purposes of computing advance credit payments;

(v) For plans for which advance credit payments are not made, the premium (excluding the premium allocated to benefits in excess of essential health benefits) for the ABP that would apply to all individuals enrolled in the QHP if advance credit payments were made for the coverage;

(vi) The name and TIN, or date of birth if a TIN is not available, and dates of coverage for each individual covered under the plan;

[166] 45 CFR § 155.340(e).

[167] See, also, 45 CFR § 155.240(e).

[168] 26 CFR § 1.36B-5.

[169] 26 CFR § 1.36B-5(c).

(vii) The coverage start and end dates of the QHP;

(viii) The monthly premium for the plan in which the individuals enroll, excluding the premium allocated to benefits in excess of essential health benefits:

(ix) The name of the QHP issuer;

(x) The AHS-assigned policy identification number;

(xi) AHS's unique identifier; and

(xii) Any other information required in published guidance.

(2) *Information reported monthly.*

For each calendar month, AHS will report to the IRS for each QHP, the information described in (1) above and the following information:

(i) For plans for which advance credits are made:

(A) The names, TINs, or dates of birth if no TIN is available, of the individuals enrolled in the QHP who are expected to be the tax filer's dependent; and

(B) Information on employment (to the extent this information is provided to AHS) consisting of:

(I) The name, address and employer identification number (EIN) of each employer of the tax filer, the tax filer's spouse, and each individual covered by the plan; and

(II) An indication of whether an employer offered affordable minimum essential coverage that provided minimum value, and, if so, the amount of the employee's required contribution for self-only coverage;

(ii) The unique identifying number AHS uses to report data that enables the IRS to associate the data with the proper account from month to month;

(iii) The issuer's EIN; and

(iv) Any other information specified in published guidance.

(b) Time for reporting. AHS will submit the annual report required under § 78.00(a)(1) on or before January 31 of the year following the calendar year of coverage. AHS will submit the monthly reports required under § 78.00(a)(2) as required by federal law.

(c) Annual statement to be furnished to individuals. On or before January 31 of the year following the calendar year of coverage, AHS will furnish to each tax filer or responsible adult a written statement showing the name and address of the recipient and the information described in (a)(1) of this section.

(d) Manner of reporting. AHS will comply with all guidance published by the Commissioner of the IRS[170] for the manner of reporting under this section.

79.00 [Reserved] (01/15/2017, GCR 16-100)

[170] See § 601.601(d)(2) of chapter one of the Code.

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Part Seven
Eligibility-and-Enrollment Procedures

Part Seven sets forth the application processing and enrollment requirements for health benefits, including verification of eligibility factors, determination of premium assistance amounts, billing and collection of Medicaid premiums, and periodic renewals of eligibility.

51.00 Automatic entitlement to Medicaid following a determination of eligibility under other programs[1] (01/15/2017, GCR 16-100)

A separate application for Medicaid is not required from an individual who receives SSI or AABD.

52.00 Application[2] (01/01/2018, GCR 17-048)

52.01 In general (01/15/2017, GCR 16-100)

An individual will be afforded the opportunity to apply for health benefits at any time, without delay.[3]

52.02 Application filing[4] (01/01/2018, GCR 17-048)

(a) The application. A single, streamlined application will be used to determine eligibility and to collect information necessary for:

(1) Enrollment in a QHP;

(2) APTC;

(3) CSR;

(4) Vermont Premium Reduction;

(5) Vermont Cost Sharing Reduction; and

(6) MAGI-based Medicaid. For Medicaid categories that are not based on MAGI methodologies, the single, streamlined application may be supplemented with a form (or forms) to collect additional information, or an appropriate, alternative application may be used.

[1] 42 CFR § 435.909.

[2] 42 CFR § 435.907; 45 CFR §§ 155.310(a) and 155.405.

[3] 42 CFR § 435.906; 45 CFR § 155.310(c).

[4] 42 CFR § 435.907; 45 CFR § 155.405.

(b) Filing the application. AHS will:

(1) Accept the application from an application filer; and

(2) Provide the tools to file an application:

(i) Via an internet website;

(ii) By telephone through a call center;

(iii) By mail;

(iv) Through other commonly available electronic means; and

(v) In person.

(c) Assistance.[5] AHS will provide assistance to any individual seeking help with the application or renewal process, in the manner prescribed in § 5.01.

(d) Application filers. An application will be accepted from:

(1) The applicant;

(2) An adult who is in the applicant's household;

(3) An authorized representative; or

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

(e) Missing information[6]

(1) The applicant's eligibility for health benefits will not be determined before the applicant provides answers to all required questions on the application.

(2) If an incomplete application is received, the applicant will be sent a request for answers to all of the unanswered questions necessary to determine eligibility. The request will include a response due date, which will be no earlier than 15 days after the date the request is sent to the applicant.

(3) If a full response to the request is received on or before the request due date, the eligibility process will be activated for determining:

(i) Coverage, based on the date the application was originally received; or

[5] 42 CFR § 435.908.

[6] 45 CFR § 155.310(k).

(ii) The need to request any corroborative information necessary to determine eligibility.

(4) If responses to all unanswered questions necessary for determining eligibility are not received by the response due date, the applicant will be notified that AHS is unable to determine their eligibility for health benefits. The date that the incomplete application was received will not be used in any subsequent eligibility determinations.

(f) Limits on information.[7] An applicant will be required to provide only the information necessary to make an eligibility determination or for a purpose directly connected to the administration of health-benefits programs.

(g) Information collection from non-applicants.[8] Information regarding citizenship, status as a national, or immigration status will not be requested for an individual who is not seeking health benefits for themselves.

(h) Signature required. An initial application must be signed under penalty of perjury. Electronic, including telephonically-recorded, signatures and handwritten signatures transmitted via any other electronic transmission will be accepted.

(i) Accessibility. Any application or supplemental form must be accessible to individuals who are limited English proficient and individuals who have disabilities, consistent with the provisions of § 5.01.

53.00 Attestation and verification – in general (01/15/2017, GCR 16-100)

(a) Basis and scope. The income and eligibility verification requirements set forth in §§ 53.00 through 56.00 are based on §§ 1137, 1902(a)(4), 1902(a)(19), 1902(a)(46)(B), 1902(ee), 1903(r)(3), 1903(x), and 1943(b)(3) of the Act, and § 1413 of the ACA.

(b) In general. AHS will verify or obtain information as provided in §§ 53.00 through 56.00 before making a determination about an individual's eligibility for health benefits. Such information will be used in making the eligibility determination. See § 58.00 for details on the eligibility determination process.

(c) Attestation.[9] Except where the law requires other procedures (such as for citizenship and immigration-status information), attestation of information needed to determine the eligibility of an individual for health benefits will be accepted (either self-attestation by the individual or attestation by an adult who is in the individual's household, an authorized representative, or, if the individual is under age 18[10] or incapacitated, someone acting responsibly for the individual) without requiring further information (including documentation) from the

[7] 42 CFR § 435.907(e).

[8] 45 CFR § 155.310(a)(2).

[9] 42 CFR § 435.945(a).

[10] In its response to comments on its proposed rule, CMS indicated that "[s]tate law and regulation establish who may file an application for an insurance affordability program on behalf of a child under age 21, and nothing in the Affordable Care Act or these regulations alters State authority or flexibility on this matter." 77 FR 17,156 (March 23, 2012). In Vermont, the age of majority is 18. 1 VSA § 173.

individual.

(d) Use of federal electronic verification service.[11] To the extent that information related to determining eligibility for health benefits is available through an electronic service established by HHS, AHS will obtain the information through such service, unless AHS has secured HHS approval of alternative procedures described in (e) below.[12]

(e) Flexibility in information collection and verification. Subject to approval by HHS, AHS may request and use information from a source or sources alternative to those listed in § 56.01(b), or through a mechanism other than the electronic service described in (d) above, provided that such alternative source or mechanism will reduce the administrative costs and burdens on individuals and the state while maximizing accuracy, minimizing delay, and meeting applicable requirements relating to confidentiality, disclosure, maintenance, or use of information.

(f) Notice of intent to obtain and use information.[13] Before it requests information for an individual from another agency or program, AHS will inform the individual that it will obtain and use information available to it to verify income, resources (when applicable), and eligibility or for other purposes directly connected to the administration of a health-benefits program or to enrollment in a QHP.

(g) Security of electronic information exchanges.[14] Information exchanged electronically between AHS and any other agency or program will be sent and received via secure electronic interfaces, as specified in § 4.09. Any such exchange of data will be made pursuant to written agreements with such other agencies or programs, which will provide for appropriate safeguards limiting the use and disclosure of information as required by federal or state law or regulations.

(h) Limitation on scope of information requests.

(1) An individual will not be required to provide information beyond the minimum necessary to support eligibility and enrollment processes.

(2) An individual will not be required to provide additional information or documentation unless information needed by AHS cannot be obtained electronically or the information obtained electronically is not reasonably compatible, as that term is defined in § 57.00(a), with information provided by or on behalf of the individual.

(i) Limitation on use of evidence of immigration status. Evidence of immigration status may not be used to determine that an individual is not a Vermont resident.

[11] 42 CFR § 435.949(b).

[12] 42 CFR § 435.945(k); 45 CFR § 155.315(h)

[13] 42 CFR § 435.945(f).

[14] 42 CFR § 435.945(i).

54.00 Attestation and verification of citizenship and immigration status (01/15/2019, GCR 18-064)

54.01 Definitions (01/15/2017, GCR 16-100)

For definitions relevant to citizenship and immigration status, see § 17.00.

54.02 Declaration of citizenship or immigration status (01/15/2017, GCR 16-100)

Except as provided in § 54.06 for certain individuals applying for Medicaid, and except for employees enrolling in a qualified employer-sponsored plan, an individual seeking health benefits must sign a declaration that they are:

(a) A citizen or national of the United States (§ 17.01(a) and (c));

(b) A qualified non-citizen (§ 17.01(d)); or

(c) Lawfully present in the United States (§ 17.01(g)).

For the effect that citizenship and immigration status has on eligibility for health benefits, see § 17.00.

54.03 Verification frequency (01/15/2019, GCR 18-064)

(a) Citizenship.[15] Verification or documentation of citizenship is a one-time activity; once an individual's citizenship is documented and recorded, subsequent changes in eligibility should not require repeating the documentation unless later evidence raises a question about the individual's citizenship.

(b) Immigration status.[16] Immigration status, including lawful presence, must be verified or documented at the time of initial application and, for a Medicaid enrollee, at the time of eligibility renewal. In verifying immigration status at the time of renewal, AHS will first rely on information provided at the time of initial application to determine ongoing eligibility. AHS will only require the individual to provide further documentation or to re-verify satisfactory status if it cannot verify continued eligibility based on the information already available to it.

54.04 Electronic verification[17] (01/01/2018, GCR 17-048)

(a) Verification with records from the SSA. For an individual who attests to citizenship and has a Social Security number, AHS will transmit their Social Security number and other identifying information to HHS, which will submit it to the SSA for verification.

(b) Verification with the records of DHS. For an individual who has documentation that can be verified through DHS and who either attests to lawful immigration status or lawful presence, or who attests to citizenship and for whom AHS cannot substantiate a claim of citizenship through SSA, AHS will transmit information from the

[15] 42 CFR § 435.956(a)(4)(ii).

[16] CMS SHO Letter No. 10-006 (July 1, 2010), p. 5.

[17] 42 CFR § 435.956; 45 CFR § 155.315(c).

individual's documentation and other identifying information to HHS, which will submit necessary information to DHS for verification.

54.05 Inconsistencies and inability to verify information[18] (01/01/2018, GCR 17-048)

(a) In general. Except as provided in § 54.06, with respect to citizenship, lawful presence or satisfactory immigration status which cannot be verified through SSA or DHS, AHS will:

(1) Follow the procedures specified in § 57.00 (inconsistencies), except that:

(i) The opportunity period described in § 57.00(c)(2)(ii) during which the individual must submit documentation or resolve the inconsistency begins with the date the notice described in § 57.00(c)(2)(i) is received by, rather than sent to, the individual and, for both QHP and Medicaid purposes, extends 90 days from that date. The date on which the notice is received is considered to be five days after the date on the notice, unless the individual demonstrates that they did not receive the notice within the five-day period.

(ii) The opportunity period may be extended beyond 90 days for QHP purposes, and for Medicaid purposes for individuals declaring to be in satisfactory immigration status, if the individual is making a good-faith effort to resolve any inconsistencies or AHS needs more time to complete the verification process.

(2) If the individual does not have a Social Security number, assist the individual in obtaining a Social Security number;[19]

(3) Attempt to resolve any inconsistencies, including typographical or other clerical errors, between information provided by the individual and data from an electronic data source, and resubmit corrected information to the electronic data source;

(4) Provide the individual with information on how to contact the source of the electronic data so they can attempt to resolve inconsistencies directly with such data source; and

(5) Permit the individual to provide other documentation of citizenship or immigration status.[20]

(b) Eligibility activities during opportunity period.[21] During the opportunity period described in paragraphs (a)(1)(i) and (ii) of this subsection, AHS will:

(1) Not delay, deny, reduce, or terminate benefits for an individual who is otherwise eligible for health

[18] 42 CFR § 435.956; 45 CFR 155.315(c)(3).

[19] 42 CFR § 435.910.

[20] 42 CFR §§ 435.956(b)(1)(iii), 435.406 and 435.407.

[21] 42 CFR § 435.956(a)(5); 45 CFR § 155.315(f)(4).

benefits.

(2) Begin to furnish Medicaid benefits to otherwise eligible individuals effective on the date of the application containing the declaration of citizenship or immigration status by or on behalf of the individual.

(3) If relevant, proceed with respect to QHP enrollment, APTC, and CSR, as provided for in § 57.00(c)(4).[22]

(c) Failure to complete verification during opportunity period. If, by the end of the opportunity period described in paragraphs (a)(1)(i) and (ii) of this subsection, the individual's citizenship or immigration status has not been verified in accordance with paragraph (a) of this subsection, AHS will:

(1) With regard to the individual's eligibility for Medicaid, take action within 30 days to terminate eligibility.[23]

(2) With regard to the individual's eligibility for enrollment in a QHP, APTC and CSR, proceed in accordance with the provisions of § 57.00(c)(4)(ii).[24]

(d) Records of verification. AHS will maintain a record of having verified citizenship or immigration status for each individual in a case record or electronic database.

54.06 Individuals not required to document citizenship or national status for Medicaid[25] (01/01/2018, GCR 17-048)

The following individuals are not required to document citizenship or national status as a condition of receipt of Medicaid benefits:

(a) An individual receiving SSI benefits under Title XVI of the Act;

(b) An individual entitled to or enrolled in any part of Medicare;

(c) An individual receiving Social Security disability insurance benefits under § 223 of the Act or monthly benefits under § 202 of the Act, based on the individual's disability (as defined in § 223(d) of the Act);

(d) An individual who is in foster care and who is assisted under Title IV-B of the Act, and an individual who is a recipient of foster-care maintenance or adoption assistance payments under Title IV-E of the Act; and

(e) A child born in the United States on or after April 1, 2009, who was deemed eligible for Medicaid as a newborn

[22] 45 CFR § 155.315(c)(3).

[23] 42 CFR § 435.956(b)(3).

[24] 45 CFR § 155.315(f)(5).

[25] 42 CFR § 435.406(a)(1)(iii).

(§ 9.03(b)).[26]

54.07 Documentary evidence of citizenship and identity (01/01/2018, GCR 17-048)

(a) Definition: available. Document exists and can be obtained within the period of time specified in § 54.05.

(b) Standalone evidence of citizenship.[27] The following will be accepted as sufficient documentary evidence of citizenship:

(1) A U.S. passport, including a U.S. Passport Card issued by the Department of State, without regard to any expiration date as long as such passport or Card was issued without limitation.

(2) A Certificate of Naturalization.

(3) A Certificate of U.S. Citizenship.

(4) A valid state-issued driver's license if the state issuing the license requires proof of U.S. citizenship, or obtains and verifies a Social Security number from the applicant who is a citizen before issuing such license.

(5) Tribal documents:

(i) Documentary evidence issued by a federally-recognized Indian tribe, as published in the Federal Register by the Bureau of Indian Affairs within the U.S. Department of the Interior, and including tribes located in a State that has an international border, which:

(A) Identifies the federally-recognized Indian tribe that issued the document;

(B) Identifies the individual by name; and

(C) Confirms the individual's membership, enrollment, or affiliation with the tribe.

(ii) Documents described in paragraph (b)(5)(i) of this subsection include, but are not limited to:

(iii) A tribal enrollment card;

(iv) A Certificate of Degree of Indian Blood;

(v) A tribal census document;

(vi) Documents on tribal letterhead, issued under the signature of the appropriate tribal official, that meet the requirements of paragraph (b)(5)(i) of this subsection.

[26] Section 1903(x) of the Act.

[27] 42 CFR § 435.407(a).

(6) A data match with the Social Security Administration.

(c) Other evidence of citizenship.[28] If an applicant does not provide documentary evidence from the list in paragraph (b) of this subsection, the following must be accepted as satisfactory evidence to establish citizenship if also accompanied by an identity document listed in paragraph (d) of this subsection:

(1) A U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam, the Virgin Islands of the U.S., American Samoa, Swain's Island, or the Commonwealth of the Northern Mariana Islands (CNMI) (if born after November 4, 1986, (CNMI local time)). The birth record document may be issued by a State, Commonwealth, Territory, or local jurisdiction. If the document shows the individual was born in Puerto Rico or the CNMI before the applicable date referenced in this paragraph, the individual may be a collectively naturalized citizen. The following will establish U.S. citizenship for collectively naturalized individuals:

(i) Puerto Rico: Evidence of birth in Puerto Rico and the applicant's statement that they were residing in the U.S., a U.S. possession, or Puerto Rico on January 13, 1941.

(ii) CNMI (formerly part of the Trust Territory of the Pacific Islands (TTPI)):

(A) Evidence of birth in the CNMI, TTPI citizenship and residence in the CNMI, the U.S., or a U.S. Territory or possession on November 3, 1986 (CNMI local time) and the applicant's statement that they did not owe allegiance to a foreign state on November 4, 1986 (CNMI local time);

(B) Evidence of TTPI citizenship, continuous residence in the CNMI since before November 3, 1981 (CNMI local time), voter registration before January 1, 1975, and the applicant's statement that they did not owe allegiance to a foreign state on November 4, 1986 (CNMI local time).

(C) Evidence of continuous domicile in the CNMI since before January 1, 1974, and the applicant's statement that they did not owe allegiance to a foreign state on November 4, 1986 (CNMI local time). Note: If a person entered the CNMI as a nonimmigrant and lived in the CNMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.

(2) At state option, a cross-match with a state vital statistics agency documenting a record of birth.

(3) A Certification of Report of Birth, issued to U.S. citizens who were born outside the U.S.

(4) A Report of Birth Abroad of a U.S. Citizen.

(5) A Certification of birth in the United States.

(6) A U.S. Citizen I.D. card.

(7) A Northern Marianas Identification Card, issued by DHS (or predecessor agency).

(8) A final adoption decree showing the child's name and U.S. place of birth, or if an adoption is not final, a

[28] 42 CFR § 435.407(b).

statement from a state-approved adoption agency that shows the child's name and U.S. place of birth.

(9) Evidence of U.S. Civil Service employment before June 1, 1976.

(10) U.S. Military Record showing a U.S. place of birth.

(11) A data match with the Systematic Alien Verification for Entitlements (SAVE) Program or any other process established by DHS to verify that an individual is a citizen.

(12) Documentation that a child meets the requirements of § 101 of the Child Citizenship Act of 2000 (8 USC § 1431).

(13) Medical records, including, but not limited to, hospital, clinic, or doctor records or admission papers from a nursing facility, skilled care facility, or other institution that indicate a U.S. place of birth.

(14) Life, health, or other insurance record that indicates a U.S. place of birth.

(15) Official religious record recorded in the U.S. showing that the birth occurred in the U.S.

(16) School records, including pre-school, Head Start and daycare, showing the child's name and U.S. place of birth.

(17) Federal or State census record showing U.S. citizenship or a U.S. place of birth.

(18) If the individual does not have one of the documents listed in paragraphs (b) or (c)(1) through (17) of this subsection, they may submit an affidavit signed by another individual under penalty of perjury who can reasonably attest to the individual's citizenship, and that contains the individual's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized.

(d) Evidence of identity[29]

(1) The following will be accepted as proof of identity, provided such document has a photograph or other identifying information sufficient to establish identity, including, but not limited to, name, age, sex, race, height, weight, eye color, or address:

(i) Identity documents listed at 8 CFR § 274a.2(b)(1)(v)(B)(1), except a driver's license issued by a Canadian government authority.

(ii) Driver's license issued by a State or Territory.

(iii) School identification card.

(iv) U.S. military card or draft record.

[29] 42 CFR § 435.407(c).

(v) Identification card issued by the federal, state, or local government.

(vi) Military dependent's identification card.

(vii) U.S. Coast Guard Merchant Mariner card.

(viii) A finding of identity from an Express Lane agency, as defined in § 1902(e)(13)(F) of the Act.

(2) For children under age 19, a clinic, doctor, hospital, or school record, including preschool or day care records.

(3) Two documents containing consistent information that corroborates an individual's identity. Such documents include, but are not limited to, employer identification cards, high school and college diplomas (including high school equivalency diplomas), marriage certificates, divorce decrees, and property deeds or titles.

(4) AHS will accept as proof of identity:

(i) A finding of identity from a federal agency or another state agency, including but not limited to a public assistance, law enforcement, internal revenue or tax bureau, or corrections agency, if the agency has verified and certified the identity of the individual.

(ii) [Reserved]

(5) If the individual does not have any document specified in paragraphs (d)(1) through (d)(3) of this subsection and identity is not verified under paragraph (d)(4) of this subsection, the individual may submit an affidavit signed, under penalty of perjury, by another person who can reasonably attest to the individual's identity. Such affidavit must contain the individual's name and other identifying information establishing identity, as describe in paragraph (d)(1) of this subsection. The affidavit does not have to be notarized.

(e) Verification of citizenship by a federal agency or another state.[30] AHS may rely, without further documentation of citizenship or identity, on a verification of citizenship made by a federal or state agency, if such verification was done on or after July 1, 2006.

(f) Assistance.[31] AHS will assist individuals who need assistance to secure satisfactory documentary evidence of citizenship in a timely manner.

(g) Documentary evidence.[32] A photocopy, facsimile, scanned, or other copy of a document will be accepted to the same extent as an original document under this subsection, unless information on the submitted document is inconsistent with other information available to AHS, or AHS otherwise has reason to question the validity of

[30] 42 CFR § 435.407(d).

[31] 42 CFR § 435.407(e).

[32] 42 CFR § 435.407(f).

the document or the information on the document.

54.08 Documentation of immigration status for qualified non-citizens (01/15/2017, GCR 16-100)

If verification of immigration status cannot be obtained through the process described in § 54.04, a non-citizen individual seeking health benefits as a qualified non-citizen must provide United States Citizenship and Immigration Services (USCIS) documents to establish immigration status, as specified below:

(a) Lawful Permanent Resident

(1) USCIS Form I-551; or

(2) For recent arrivals, a temporary I-551 stamp on a foreign passport or on Form I-94.

(3) Note: Forms I-151, AR-3 and AR-3A have been replaced by USCIS. If presented as evidence of status, contact USCIS to verify status by filing a G-845 with a copy of the old form. Refer the individual to USCIS to apply for a replacement card.

(b) Refugee

(1) The following documents may be used to document refugee status:

(i) USCIS Form I-94 endorsed to show entry as refugee under § 207 of INA and date of entry to the United States;

(ii) USCIS Form I-688B annotated "274a.12(a)(3)";

(iii) Form I-766 annotated "A3"; or

(iv) Form I-571.

(2) Refugees usually change to Lawful Permanent Resident status after 12 months in the United States, but for the purposes of health-benefits eligibility are still considered refugees. They are identified by Form I-551 with codes RE-6, RE-7, RE-8, or RE-9.

(3) The following documents may be used to document that the individual is a "Cuban or Haitian entrant":

(i) An I-94 Arrival/departure card with a stamp showing parole into the United States on or after April 21, 1980. I-94 may refer to §212(d)(5). I-94 may refer to humanitarian or public interest parole. I-94 may be expired.

(ii) An I-94 Arrival/departure card with a stamp showing parole at any time as a "Cuban/Haitian Entrant (Status Pending)." I-94 may refer to §212(d)(5). I-94 may be expired.

(iii) CH6 adjustment code on the I-551. Even after a Cuban/Haitian Entrant (Status Pending) becomes a permanent resident, they technically retain the status Cuban/Haitian Entrant (Status Pending). I-551 may be expired.

(iv) A Cuban or Haitian passport with a §212(d)(5) stamp dated after October 10, 1980. Passport may

be expired.

(c) Asylee

(1) USCIS Form I-94 annotated with stamp showing grant of asylum under § 208 of the INA;

(2) A grant letter from the Asylum Office of the USCIS;

(3) Form I-688B annotated "274a.12(a)(5)";

(4) Form I-766 annotated "A5"; or

(5) An order of the Immigration Judge granting asylum. If a court order is presented, file a G-845 with the local USS district office attaching a copy of the document to verify that the order was not overturned on appeal.

(d) American Indian born outside of the United States

(1) Documentation of LPR status (See I-313.1);

(2) Birth or baptismal certificate issued on a reservation;

(3) Membership card or other tribal records;

(4) Letter from the Canadian Department of Indian Affairs;

(5) School records; or

(6) Contact with the tribe in question.

(e) Non-citizen granted parole for at least one year by the USCIS. USCIS Form I-94 endorsed to show grant of parole under § 212(d)(5) of the INA and a date showing granting of parole for at least one year.

(f) Non-citizen granted conditional entry under the immigration law in effect before April 1, 1980

(1) USCIS Form I-94 with stamp showing admission under § 203(a)(7) of the INA, refugee-conditional entry;

(2) Form I-688B annotated "274a.12 (a)(3)"; or

(3) Form I-766 annotated "A-3."

(g) Non-citizen who has had deportation withheld under § 243(h) of the INA

(1) Order of an Immigration Judge showing deportation withheld under § 243(h) of the INA and date of the grant;

(2) USCIS Form I-688B annotated "247a.12(a)(10)"; or

(3) Form I-766 annotated "A10."

54.09 Documentation of entry date for determining the Medicaid five-year bar for qualified non-citizens (01/15/2017, GCR 16-100)

(a) The following are the documents that may be used to determine the Medicaid five-year bar for qualified non-citizens (§ 17.03):

(1) Form I-94. The date of admission should be found on the refugee stamp. If missing, AHS will contact USCIS to verify the date of admission by filing a G-845 with a copy of the document.

(2) If an individual presents Forms I-688B or I-766 (Employment Authorization Documents), and I-57 (refugee travel document), AHS will ask the individual to present Form I-94. If not available, AHS will contact USCIS by filing a G-845 with a copy of the document presented.

(3) Grant letters or court orders. AHS will derive the date status is granted from the date of the letter or court order. If missing, AHS will contact USCIS to verify date of grant by filing a G-845 with a copy of the document.

(b) If an individual presents a receipt indicating that they have applied to USCIS for a replacement document for one of the documents identified above, AHS will contact the USCIS to verify status by filing a G-845 with the local USCIS district office with a copy of the receipt. AHS will contact the USCIS any time there is a reason to question the authenticity of a document presented or the information on the document is insufficient to determine whether non-citizen status requirements are met.

54.10 Ineligible non-citizens and non-immigrants (01/15/2017, GCR 16-100)

Some non-citizens may be lawfully admitted but only for a temporary or specified period of time as legal non-immigrants. These non-citizens are never qualified non-citizens. Because of the temporary nature of their admission status, they generally will be unable to establish residency and are not eligible for health benefits as qualified non-citizens. For example, a non-citizen in possession of a student visa is not a qualified non-citizen. In rare instances, an ineligible non-citizen may be able to establish residency and meet all other Medicaid eligibility criteria and therefore be eligible for treatment of emergency medical conditions only (see § 17.02(d)).

54.11 Visitors, tourists, and some workers and diplomats ineligible for Medicaid (01/15/2017, GCR 16-100)

For purposes of Medicaid eligibility, visitors, tourists, and some workers and diplomats are also ineligible non-citizens and non-immigrants. These non-citizens would have the following types of documentation:

(a) Form I-94 Arrival-Departure Record;

(b) Form I-185 Canadian Border Crossing Card;

(c) Form I-186 Mexican Border Crossing Card;

(d) Form SW-434 Mexican Border Visitor's Permit; or

(e) Form I-95A Crewman's Landing Permit.

55.00 Attestation and verification of other nonfinancial information[33] (01/01/2023, GCR 22-033)

55.01 Attestation only (01/15/2017, GCR 16-100)

Unless information from an individual is not reasonably compatible with other information provided or otherwise available to AHS, as described in § 57.00(b)(3), attestation of information needed to determine the following eligibility requirements will be accepted without requiring further information from the individual:

(a) Residency;

(b) Age;

(c) Date of birth; and

(d) Pregnancy.

55.02 Verification of attestation (01/01/2023, GCR 22-033)

An individual's attestations of information needed to determine the following eligibility requirements will be verified by AHS:

(a) Social Security number[34]

(1) The Social Security number furnished by an individual will be verified with SSA to insure the Social Security number was issued to that individual, and to determine whether any other Social Security numbers were issued to that individual.

(2) For any individual who provides a Social Security number, AHS will transmit the number and other identifying information to HHS, which will submit it to SSA.

(3) To the extent that an individual's Social Security number is not able to be verified through the SSA, or the SSA indicates that the individual is deceased, the procedures specified in § 57.00 will be followed, except that, for purposes of QHP eligibility:

(i) The individual will be provided with a period of 90 days from the date on which the notice described in § 57.00(c)(2)(i) is received, rather than sent, for the individual to provide satisfactory documentary evidence or resolve the inconsistency with the SSA.

(ii) The date on which the notice is received means five days after the date on the notice, unless the

[33] 42 CFR § 435.956; 45 CFR §§ 155.315 and 155.320.

[34] 42 CFR §§ 435.910 and 435.956(d); 45 CFR § 155.315(b).

individual demonstrates that they did not receive the notice within the five-day period.

For more information about Social Security numbers and eligibility for health benefits, see § 16.00.

(b) Incarceration status.[35] When determining an individual's eligibility for enrollment in a QHP, the individual's attestation regarding incarceration status will be verified by:

(1) Relying on any electronic data sources that are available to AHS; or

(2) If an approved data source is unavailable, accepting the individual's attestation, except as provided in (3) below.

(3) To the extent that an individual's attestation is not reasonably compatible with information from available data sources described in (1) above or other information provided by the individual or in AHS's records, AHS will follow the procedures specified in § 57.00.

(c) Eligibility for MEC other than through an eligible employer-sponsored plan.[36] When determining eligibility for APTC and CSR:

(1) AHS will verify whether an individual is eligible for MEC other than through an eligible employer-sponsored plan or Medicaid, using information obtained by transmitting identifying information specified by HHS to HHS.

(2) AHS will also verify whether an individual already has been determined eligible for coverage through Medicaid within the state.

(d) Enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan[37]

(1) General requirement. When determining eligibility for APTC and CSR, AHS will verify whether an individual reasonably expects to be enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested.

(2) Verification procedures[38]

(i) Except as specified in paragraph (d)(2)(ii) of this subsection, an individual's attestation regarding the verification specified in paragraph (d)(1) of this subsection will be accepted without further

[35] 45 CFR § 155.315(e).

[36] 45 CFR § 155.320(b).

[37] 45 CFR § 155.320(d).

[38] 45 CFR § 155.320(d)(4).

verification.

(ii) AHS may select a statistically significant random sample of individuals found eligible for APTC based on their attestation as described in (d)(2)(i) of this subsection and:

(A) Provide notice to the selected individuals indicating that AHS will be contacting any employer identified on the application for the individual and the members of their household to verify whether the individual is enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested;

(B) Proceed with all elements of eligibility determination using the individual's attestation, and provide eligibility for enrollment in a QHP to the extent that an individual is otherwise qualified;

(C) Ensure that APTC and CSR are provided on behalf of an individual who is otherwise qualified for such payments and reductions, if the tax filer for the individual attests that they understand that any APTC paid on their behalf is subject to reconciliation;

(D) Make reasonable attempts to contact any employer identified on the application for the individual and the members of their household, to verify whether the individual is enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested;

(E) If AHS receives any information from an employer relevant to the individual's enrollment in an eligible employer-sponsored plan or eligibility for qualifying coverage in an eligible employer-sponsored plan, AHS will determine the individual's eligibility based on such information and in accordance with the effective dates specified in § 73.06, and if such information changes their eligibility determination, notify the individual of such determination;

(F) If, after a period of 90 days from the date on which the notice described in paragraph (d)(2)(ii)(A) above is sent to the individual, AHS is unable to obtain the necessary information from an employer, the individual's eligibility will be determined based on their attestation regarding coverage provided by that employer.

(G) In order to carry out the process described in this paragraph (d)(2)(ii), AHS will only disclose an individual's information to an employer to the extent necessary for the employer to identify the employee.

56.00 Attestation and verification of financial information[39] (01/15/2019, GCR 18-064)

56.01 Data (01/15/2017, GCR 16-100)

[39] Generally, the ACA's provisions regarding modernization of Medicaid eligibility procedures (*e.g.,* application, renewal, attestation, electronic verification, submission modes, etc.) apply to determination of MAGI- and non-MAGI based eligibility decisions. See, CMS response to comments on proposed rule, 77 FR 17,143 (March 23, 2012). Accordingly, the provisions in this section apply in determining MABD income. However, as the concept of "family size" does not apply in the context of MABD (that program utilizes the concepts of "financial responsibility group" and "Medicaid group" in determining the countable non-MAGI-based income), provisions in this section that refer to "family size" apply only to MAGI-related Medicaid eligibility.

(a) Tax data[40]

(1) For all individuals whose income is counted in making a health-benefits eligibility determination, and for whom Social Security numbers are available, AHS will request tax return data regarding income and family size from the Secretary of the Treasury and data regarding Social Security benefits from the Commissioner of Social Security by transmitting identifying information specified by HHS to HHS.

(2) If the identifying information for one or more individuals does not match a tax record on file with the Secretary of the Treasury that may be disclosed, AHS will proceed in accordance with the provisions in § 57.00(c)(1).

(b) Non-tax data. For all individuals whose income is counted in making a health-benefits eligibility determination, AHS will request non-tax data from other agencies in the state and other state and federal programs, as follows:

(1) To the extent that AHS determines such information is useful in verifying the financial eligibility of an individual, the following will be requested:

(i) Information related to wages, net earnings from self-employment, and unearned income and resources from:

(A) The State Wage Information Collection Agency (SWICA);

(B) The IRS;

(C) The SSA;

(D) The State of Vermont's new-hire database;

(E) The agency or agencies administering the state unemployment compensation laws;

(F) The state-administered supplementary payment program under § 1616(a) of the Act (AABD, See AABD Rule 2700); and

(G) Any state program administered under a plan approved under Titles I, X, XIV, or XVI of the Act;

(ii) Information related to eligibility or enrollment from the 3SquaresVt Program, the Reach Up Program, other health-benefits programs, and other public-assistance programs that are administered by the State of Vermont; and

(iii) Any other information source bearing upon the individual's financial eligibility.

(2) To the extent that the information identified in this subsection is available through the federal electronic verification service (§ 53.00(d)), the information will be obtained through such service.

(3) The information will be requested by Social Security number, or if a Social Security number is not

[40] 42 CFR § 435.948; 45 CFR § 155.320(c).

available, using other personally-identifying information in the individual's account, if possible.

56.02 Verification process for Medicaid (01/01/2018, GCR 17-048)

In determining an individual's eligibility for Medicaid:

(a) Family size.[41] For purposes of MAGI-based Medicaid eligibility, attestation of information needed to determine family size in accordance with the procedure set forth in § 55.01 will be accepted (attestation only).

(b) Income[42]

(1) Except as stated in paragraph (b)(2) of this subsection, income will be verified by comparing the individual's attestations with tax- and non-tax data obtained pursuant to § 56.01. If the attestations are not reasonably compatible, as that term is defined in § 57.00(a)(2), with such data or if such data is not available, AHS will proceed in accordance with the provisions in § 57.00(c).

(2) For purposes of MAGI-based Medicaid eligibility, an individual's attestation that their income is above the highest income standard under which they may be determined eligible will be accepted without further verification.

(c) Resources. For purposes of MABD (non-MAGI-based Medicaid) eligibility, resources will be verified by comparing the individual's attestations with available data sources. If the attestations are not compatible with such sources, or if no such sources exist, or if sources exist but are not available, AHS will proceed in accordance with the provisions in § 57.00(c).

56.03 Verification process for APTC and CSR – general procedures (01/15/2017, GCR 16-100)

An individual must be eligible for APTC and have household income at or below 300% of the FPL in order for the individual to be eligible for the Vermont Premium Reduction and Vermont CSR. To receive the federal and Vermont CSR, an individual who is not an Indian must be enrolled in a silver-level QHP.

In determining eligibility for APTC and CSR:

(a) Family size[43]

(1) The individual must attest to the persons that comprise a tax filer's family size.

(2) To the extent that the individual attests that the tax data described in § 56.01(a) represent an accurate projection of a tax filer's family size for the benefit year for which coverage is requested, the individual's attestation will be accepted without further verification.

[41] 42 CFR § 435.956(f); 45 CFR § 155.320(c)(2)(i).

[42] 42 CFR §§ 435.945, 435.948, and 435.952; 45 CFR § 155.320(c)(2)(ii).

[43] 45 CFR § 155.320(c)(3)(i).

(3) To the extent that tax data are unavailable, or the individual attests that a change in circumstances has occurred or is reasonably expected to occur, and so they do not represent an accurate projection of a tax filer's family size for the benefit year for which coverage is requested, the tax filer's family size will be verified by accepting the individual's attestation without further verification, except as specified in paragraph (a)(4) of this subsection.

(4) If the individual's attestation to a tax filer's family size is not reasonably compatible, as that term is defined in § 57.00(a)(1), with other information provided by the individual or in AHS's records, data obtained through other electronic data sources will be used to verify the attestation. If such data sources are unavailable or information in such data sources is not reasonably compatible with the individual's attestation, additional documentation will be requested to support the attestation within the procedures specified in § 57.00.

(5) *Verification regarding APTC and CSR.* AHS will verify that neither APTC nor CSR is being provided on behalf of an individual by using information obtained by transmitting identifying information specified by HHS to HHS.[44]

(b) Basic verification process for annual household income[45]

(1) The individual must attest to the tax filer's projected annual household income.

(2) AHS will compute annual household income based on the tax data described in § 56.01(a) (tax-based income calculation), if available.

(3) To the extent that the individual's attestation indicates that the tax-based income calculation under paragraph (b)(2) of this subsection represents an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the tax filer's eligibility for APTC and CSR will be determined based on that calculation.

(4) To the extent the tax data described in § 56.01(a) are unavailable or the individual attests that a change in circumstances has occurred or is reasonably expected to occur, and so they do not represent an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, AHS will require the individual to attest to the tax filer's projected household income for the benefit year for which coverage is requested.

(c) Verification process for increases in household income

(1) Except as specified in paragraphs (c)(2) or (3) of this subsection, the individual's attestation for the tax filer's household will be accepted without further verification if:

(i) The individual attests that the tax filer's annual household income has increased or is reasonably expected to increase from the tax-based income calculation under paragraph (b)(2) of this

[44] 45 CFR § 155.320.

[45] 45 CFR § 155.320(c)(3)(ii).

subsection; and

(ii) AHS has not verified the individual's income through the process specified in § 56.02(b) to be within the applicable Medicaid income standard.

(2) If the non-tax data available to AHS, as described in § 56.01(b), indicate that a tax filer's projected annual income is in excess of their attestation by more than twenty-five percent, AHS will proceed in accordance with § 57.00(c)(1)-(4)(i).

(3) If other information provided by the individual indicates that a tax filer's projected annual household income is in excess of the individual's attestation by more than twenty-five percent, the non-tax data will be used to verify the attestation. If such data are unavailable or information in such data is not reasonably compatible with the individual's attestation, AHS will proceed in accordance with § 57.00(c)(1)-(4)(i).

56.04 Eligibility for alternate APTC and CSR verification procedures (01/01/2018, GCR 17-048)

Eligibility for alternate verification procedures for decreases in annual household income and situations in which tax data are unavailable.[46] AHS will determine a tax filer's annual household income for purposes of APTC and CSR based on the alternate APTC and CSR verification procedures described in §§ 56.05 through 56.07 if:

(a) An individual attests to the tax filer's projected annual household income;

(b) The tax filer does not meet the criteria specified in § 56.03(c) (attestation of increase in household income);

(c) The individuals in the tax filer's household have not established income through the process specified in § 56.02(b) (verification of income for Medicaid) that is within the applicable Medicaid income standard; and

(d) One of the following conditions is met:

(1) The Secretary of the Treasury does not have tax data that may be disclosed under § 6103(l)(21) of the Code for the tax filer that are at least as recent as the calendar year two years prior to the calendar year for which APTC or CSR would be effective;

(2) The individual attests that:

(i) The tax filer's applicable family size has changed or is reasonably expected to change for the benefit year for which the individuals in the tax filer's household are requesting coverage; or

(ii) The members of the tax filer's household have changed or are reasonably expected to change for the benefit year for which the individuals in their household are requesting coverage;

(3) The individual attests that a change in circumstances has occurred or is reasonably expected to occur, and so the tax filer's annual household income has decreased or is reasonably expected to decrease from the tax data described in § 56.01(a) for the benefit year for which the individuals in the tax filer's

[46] 45 CFR § 155.320(c)(3)(iv).

household are requesting coverage;

(4) The individual attests that the tax filer's filing status has changed or is reasonably expected to change for the benefit year for which the individual(s) in tax filer's household are requesting coverage; or

(5) An individual in the tax filer's household has filed an application for unemployment benefits.

56.05 Alternate APTC and CSR verification procedure: small decrease in projected household income[47] (01/01/2018, GCR 17-048)

If a tax filer qualifies for an alternate APTC and CSR verification process and the individual's attestation to the tax filer's projected annual household income is no more than twenty-five percent below the tax-based income calculation (§ 56.03(b)(2)), the individual's attestation will be accepted without further verification.

56.06 Alternate APTC and CSR verification procedure: large decrease in projected household income and situations where tax data are unavailable[48] (01/15/2019, GCR 18-064)

(a) In general. AHS will attempt to verify the individual's attestation of the tax filer's projected annual household income with the process specified in paragraph (b) of this subsection and in §§ 56.07 and 56.08 if the tax filer qualifies for an alternate APTC and CSR verification process under § 56.04 and:

(1) The individual's attestation to the tax filer's projected annual household income is greater than twenty-five percent below the tax-based income calculation (§ 56.03(b)(2)); or

(2) The tax data described in § 56.01(a) are unavailable.

(b) Applicable process. The alternate APTC and CSR verification process is as follows:

(1) *Data*. Data from non-tax income sources, as described in § 56.01(b), will be annualized (non-tax-based income calculation).

(2) *Eligibility*. To the extent that the individual's attestation indicates that the non-tax-based income calculation under paragraph (b)(1) of this subsection represents an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the tax filer's eligibility for APTC and CSR will be determined based on such data.

(3) If the individual's attestation indicates that the tax filer's projected annual household income is more than twenty-five percent below the non-tax-based income calculation under paragraph (b)(1) of this subsection, AHS will request additional documentation using the procedures specified in § 57.00(c)(1) through (4)(i). If, following the 90-day period described in § 57.00(c)(2)(ii), the individual has not responded to the request for documentation or AHS remains unable to verify the individual's attestation,

[47] 45 CFR § 155.320(c)(3)(v).

[48] 45 CFR § 155.320(c)(3)(vi).

AHS will follow the applicable procedures described in § 56.08.

56.07 Alternate APTC and CSR verification procedure: Increases in household income when tax data are unavailable[49] (01/15/2017, GCR 16-100)

(a) Attestation sufficient. Except as provided in paragraph (b) of this subsection, the individual's attestation for the tax filer's household will be accepted without further verification if:

(1) The individual's attestation indicates that a tax filer's annual household income has increased or is reasonably expected to increase from the non-tax-based income calculation (§ 56.06(b)(1)); and

(2) AHS has not verified the individual's income through the process specified in § 56.02(b) to be within the applicable Medicaid income standard.

(b) Additional verification required. Additional documentation will be requested using the procedures specified in § 57.00 if AHS finds that an individual's attestation of a tax filer's annual household income is not reasonably compatible with other information provided by the individual or the non-tax data available to AHS under § 56.01(b).

56.08 Alternate APTC and CSR verification procedure: following 90-day period (01/15/2017, GCR 16-100)

(a) Individual does not respond to request/data indicate individual's income within Medicaid standard. If, following the 90-day period described in § 57.00(c)(2)(ii) as required by § 56.06(b)(3), an individual has not responded to a request for additional information and the tax data or non-tax data indicate that an individual in the tax filer's household is eligible for Medicaid, the application for a health-benefits program (for example, Medicaid, APTC or CSR) will be denied.

(b) Attestation cannot be verified/tax data available. If, following the 90-day period described in § 57.00(c)(2)(ii) as required by § 56.06(b)(3), AHS remains unable to verify the individual's attestation, AHS will determine the individual's eligibility based on AHS's tax-based income calculation (§ 56.03(b)(2)), notify the individual of such determination, and implement such determination in accordance with the effective dates specified in § 73.06.

(c) Attestation cannot be verified/tax data unavailable. If, following the 90-day period described in § 57.00(c)(2)(ii) as required by § 56.06(b)(3), AHS remains unable to verify the individual's attestation for the tax filer and tax data necessary for a tax-based income calculation (§ 56.03(b)(2)) are unavailable, AHS will determine the tax filer ineligible for APTC and CSR, notify the individual of such determination, and discontinue any APTC or CSR in accordance with the effective dates specified in § 73.06.

56.09 Verification related to eligibility for enrollment in a catastrophic plan[50] (01/15/2017, GCR 16-100)

[49] 45 CFR § 155.320(c)(3)(vi)(C).

[50] 45 CFR § 155.315(j).

(a) AHS will verify an individual's attestation that they meet the requirements of § 14.00 (eligibility for enrollment in a catastrophic plan) by:

(1) Verifying the individual's attestation of age as follows:

(i) Except as provided in paragraph (a)(1)(iii) of this subsection, accepting their attestation without further verification; or

(ii) Examining electronic data sources that are available and which have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently current and accurate, and minimize administrative costs and burdens.

(iii) If information regarding age is not reasonably compatible with other information provided by the individual or in AHS's records, examining information in data sources that are available and which have been approved by HHS for this purpose based on evidence showing that such data sources are sufficiently current and accurate.

(2) Verifying that an individual has a certificate of exemption in effect as described in § 14.00(b).

(b) To the extent that AHS is unable to verify the information required to determine eligibility for enrollment in a catastrophic plan as described in paragraphs (a)(1) and (2) of this subsection, the procedures specified in § 57.00, except for § 57.00(c)(4) (eligibility for APTC and CSR), will be followed.

56.10 Education and assistance (01/01/2018, GCR 16-100)

Education and assistance will be provided to an individual regarding the processes specified in this section.

57.00 Inconsistencies (01/01/2018, GCR 17-048)

(a) Reasonable compatibility.[51]

(1) For purposes of QHP, information obtained through electronic data sources, other information provided by the individual, or other information in AHS's records will be considered reasonably compatible with an individual's attestation when the difference or discrepancy does not impact the eligibility of the individual or the benefits to which the individual may be entitled, including the APTC amount and CSR category.

(2) For purposes of Medicaid, income information obtained through an electronic data match shall be considered reasonably compatible with income information provided by or on behalf of an individual if both are either above or at or below the applicable income standard or other relevant income threshold. For eligibility criteria other than income, an individual's attestation will be considered reasonably compatible with information obtained through electronic data sources, other information provided by the individual, or other information in AHS's records if the discrepancy does not affect eligibility for a specific Medicaid category.

(b) Applicability of reasonable-compatibility procedures. Except as otherwise specified in this rule, the procedures

[51] 42 CFR § 435.952(c); 45 CFR § 155.300(d).

outlined in this section will be used when:

(1) Information needed in accordance with §§ 53.00 through 56.00 is not available electronically and establishing a data match would not be effective, considering such factors as the administrative costs associated with establishing and using the data match, compared with the administrative costs associated with relying on paper documentation, and the impact on program integrity in terms of the potential for ineligible individuals to be approved as well as for eligible individuals to be denied coverage;

(2) AHS cannot verify information required to determine eligibility for health benefits, including when:

(i) Electronic data sources are required but data for individuals relevant to the eligibility determination are not included in such data sources; or

(ii) Electronic data from IRS, DHS and SSA are required but it is not reasonably expected that data sources will be available within one day of the initial request to the data source, except that an individual's attestation of residency or, for purposes of QHP, eligibility for MEC, may be accepted, and the procedures outlined in this section will not be used, when verification of those criteria would otherwise be required and the electronic data to support the attestation are not reasonably expected to be available within one day of the initial request to the data source; or

(3) Attested information that would not otherwise be verified is not reasonably compatible with other information that is provided by the application filer or that is otherwise available to AHS.

(c) Procedures for determining reasonable compatibility. In circumstances described in paragraph (b) of this section, AHS will:

(1) Make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the application filer to confirm the accuracy of the information submitted by the application filer, and by allowing the individual, or the application filer on the individual's behalf, the opportunity to provide AHS with a statement that reasonably explains the discrepancy.

(2) If unable to resolve the inconsistency as provided in paragraph (c)(1) of this section:

(i) Provide notice to the individual regarding the inconsistency; and

(ii) Provide the individual with an opportunity period, as described in this paragraph (c)(2)(ii), from the date on which such notice is sent to the individual to either present satisfactory documentary evidence via the channels available for the submission of an application, (except for by telephone through a call center), or otherwise resolve the inconsistency.[52] If, because of evidence submitted by the individual, one or more requests for additional evidence is necessary, such additional evidence must be submitted by the individual within the same opportunity period that begins with

[52] The opportunity period described in this paragraph (c)(2)(ii) does not apply to an inconsistency related to citizenship or immigration status. For the opportunity period for citizenship and immigration status, see § 54.05(a)(1).

the first verification request.

(A) For purposes of QHP, the individual's opportunity period is 90 days.

(B) For purposes of Medicaid, the individual's opportunity period is as follows:

(I) If the individual is a new Medicaid applicant, the opportunity period is 20 days, communicated in the form of two separate and sequential notices permitting the individual 10 days within which to respond.

(II) If the individual is a Medicaid enrollee, the opportunity period is 90 days.

(3) Extend the opportunity period described in paragraph (c)(2)(ii) of this section if the individual demonstrates that a good-faith effort has been made to obtain the required documentation during the period.

(4) In connection with the verification of an attestation for QHP eligibility:

(i) During the opportunity period described in paragraph (c)(2)(ii) of this section:

(A) Proceed with all other elements of eligibility determination using the individual's attestation, and provide eligibility for enrollment in a QHP to the extent that an individual is otherwise qualified; and

(B) Ensure that APTC, the Vermont Premium Reduction, and federal and state CSR are provided on behalf of an individual within this period who is otherwise qualified for such payments and reductions, if the tax filer attests that they understand that any APTC paid on their behalf is subject to reconciliation.

(ii) After the period described in paragraph (c)(2)(ii) of this section, determine whether the individual is eligible to enroll in a QHP using the information available from the data sources specified above, if any, if AHS remains unable to verify the attestation. AHS will notify the individual of such determination, including notice that AHS is unable to verify the attestation. For an individual determined eligible for enrollment in a QHP who is seeking financial assistance (APTC/CSR):

(A) If AHS can determine the individual is not eligible for Medicaid based on available information, determine whether the individual is eligible for APTC, the Vermont Premium Reduction, and federal and state CSR based on the information available from the data sources specified above, and notify the individual of such determination, including notice that AHS is unable to verify the attestation.

(B) If AHS cannot determine, based on available information, that the individual is ineligible for Medicaid, deny the application for or terminate the individual's APTC, Vermont Premium Reduction and federal and state CSR on the basis that there is insufficient information to determine the individual's eligibility for Medicaid.[53]

[53] It is a condition of eligibility for APTC and CSR that the individual is not eligible for government-sponsored MEC; 26 CFR § 1.36B-2(a)(2). In this case, the individual's failure to respond to the verification request precludes the determination of this condition of eligibility.

(C) If an individual is determined ineligible for financial assistance, the individual would still be eligible for enrollment in a QHP without financial assistance.

(5) In connection with the verification of an attestation for Medicaid eligibility, if, after the opportunity period described in paragraph (c)(2)(ii) of this section, the individual has not responded to a request for additional information or has not provided information sufficient to resolve the inconsistency, or AHS otherwise remains unable to verify the attestation, deny the application or disenroll the individual on the basis that there is insufficient information to determine the individual's eligibility for Medicaid. Medicaid coverage cannot begin for a new Medicaid applicant until verification of the attestation is received, unless the verification is for purposes of establishing citizenship or immigration status as described in § 54.05(b).

(d) Exception for special circumstances[54]

(1) Except for an inconsistency related to citizenship or immigration status, AHS will provide an exception, on a case-by-case basis, to accept an individual's attestation as to the information which cannot otherwise be verified, because such documentation:

(i) Does not exist; or

(ii) Is not reasonably available.

(2) To receive such an exception:

(i) The inconsistency must not be able to be otherwise resolved; and

(ii) The individual must provide an adequate explanation of the circumstances as to why they cannot obtain the documentation needed to resolve the inconsistency.

(e) Pursuit of additional information in cases where verification data are not reasonably compatible with information provided for or on behalf of an individual.[55] Eligibility will not be denied or terminated nor benefits reduced for any individual on the basis of verification information received in accordance with this part Seven unless additional information from the individual has been sought in accordance with this section, and proper notice and hearing rights have been provided to the individual.

58.00 Determination of eligibility for health-benefits programs[56] (01/01/2018, GCR 17-048)

58.01 In general[57] (01/01/2018, GCR 17-048)

[54] 42 CFR § 435.952(c)(3); 45 CFR § 155.315(g).

[55] 42 CFR § 435.952(d).

[56] 42 CFR § 435.911; 45 CFR § 155.310; 45 CFR § 155.345.

[57] 42 CFR §§ 435.911(c) and 435.1200(e).

(a) MAGI screen.[58] For each individual who has submitted an application for a health- benefits program (i.e., health benefits other than enrollment in a QHP without APTC or CSR), or whose eligibility is being renewed, and who meets the nonfinancial requirements for eligibility (or for whom AHS is providing an opportunity to verify citizenship or immigration status), AHS will do the following:

(1) Promptly and without undue delay, consistent with timeliness standards established under § 61.00, furnish MAGI-based Medicaid to each such individual whose household income is at or below the applicable MAGI-based standard.

(2) For each individual described in paragraph (c) of this subsection (individuals subject to determination of Medicaid eligibility on a basis other than the applicable MAGI-based income standard), collect such additional information as may be needed to determine whether such individual is eligible for Medicaid on any basis other than the applicable MAGI-based income standard, and furnish Medicaid on such basis.

(3) For an individual who submits an application or renewal form which includes sufficient information to determine Medicaid eligibility, or whose eligibility is being renewed pursuant to a change in circumstance, and whom AHS determines is not eligible for Medicaid, promptly and without undue delay, determine eligibility for other health benefits.

(b) MAGI-based income standards for certain individuals enrolled for Medicare benefits.[59] In the case of an individual who has attained at least age 65 and an individual who has attained at least age 19 and who is entitled to or enrolled for Medicare benefits under part A or B or Title XVIII of the Act, non-MAGI-based income standards will be used, except that in the case of such an individual:

(1) Who is also pregnant, the applicable MAGI-based standard is the standard established under § 7.03(a)(2); and

(2) Who is also a parent or caretaker relative (as defined in § 3.00), the applicable MAGI-based standard is the standard established under § 7.03(a)(1).

(c) Individuals subject to determination of Medicaid eligibility on basis other than the applicable MAGI-based income standard.[60] For purposes of paragraph (a)(2) of this subsection, an individual includes:

(1) An individual who is identified, on the basis of information contained in an application or renewal form, or on the basis of other information available, as potentially eligible on a basis other than the applicable MAGI-based standard; and

(2) An individual who otherwise requests a determination of eligibility on a basis other than the applicable MAGI-based standard.

[58] 42 CFR § 435.911(c).

[59] 42 CFR § 435.911(b)(2).

[60] 42 CFR § 435.911(d).

(d) Individuals requesting additional screening.[61] AHS will notify an applicant of the opportunity to request a full determination of eligibility for Medicaid on a basis other than the applicable MAGI-based income standard, and will provide such an opportunity. Such notification will also be made to an enrollee, and such opportunity provided in any redetermination of eligibility.

(e) Determination of eligibility for Medicaid on a basis other than the applicable MAGI-based income standard.[62] If an individual is identified as potentially eligible for Medicaid on a basis other than the applicable MAGI-based income standard or an individual requests a full determination for Medicaid under paragraph (d) of this subsection, and the individual provides all additional information needed to determine eligibility for such benefits, eligibility will be determined promptly and without undue delay, as provided in this section.

(f) Eligibility for APTC and CSR, pending determination of eligibility for Medicaid.[63] An individual who is described in paragraph (e) of this subsection and has not been determined eligible for Medicaid based on MAGI-based income standards will be considered as ineligible for Medicaid for purposes of eligibility for APTC or CSR until the individual is determined eligible for Medicaid.

58.02 Special rules relating to APTC eligibility[64] (01/15/2017, CCR 16-100)

(a) An individual may accept less than the full amount of APTC for which the individual is determined eligible.

(b) Before APTC on behalf of a tax filer may be authorized, the tax filer must provide necessary attestations, including, but not limited to, attestations that:

(1) They will file an income tax return for the benefit year, in accordance with 26 USC §§ 6011 and 6012, and implementing regulations;

(2) If married (within the meaning of 26 CFR § 1.7703-1), they will file a joint tax return for the benefit year unless they meet the exception criteria defined in § 12.03(b) (victim of domestic abuse or spousal abandonment);[65]

(3) No other tax filer will be able to claim them as a tax dependent for the benefit year; and

(4) They will claim a personal exemption deduction on their tax return for the individuals identified as

[61] 45 CFR § 155.345(c).

[62] 42 CFR § 435.911(c); 45 CFR § 155.345(d).

[63] 45 CFR § 155.345(e).

[64] 45 CFR § 155.310(d)(2)(i) and (ii).

[65] Federal tax law does not recognize civil unions. Therefore, a Vermont couple in a civil union may not file a joint tax return; they may qualify for APTC by filing separate returns.

members of their household, including the tax filer and their spouse, in accordance with § 56.03(a).[66]

59.00 Special QHP eligibility standards and process for Indians[67] (01/01/2018, GCR 17-048)

59.01 Eligibility for CSR (01/15/2017, GCR 16-100)

(a) An individual who is an Indian, as defined in § 3.00, will be determined eligible for CSR if they:

(1) Meet the requirements specified in §§ 11.00 and 12.00; and

(2) Are expected to have household income, using MAGI methodologies for purposes of determining eligibility for APTC and CSR, that does not exceed 300 percent of the FPL for the benefit year for which coverage is requested.

(b) CSR may be provided to an individual who is an Indian only if they are enrolled in a QHP through VHC.

59.02 Special cost-sharing rule for Indians regardless of income (01/15/2017, GCR 16-100)

AHS must determine an individual eligible for the special cost-sharing rule described in § 1402(d)(2) of the ACA (items or services furnished through Indian health providers) if the individual is an Indian, without requiring the individual to request an eligibility determination for health-benefits programs in order to qualify for this rule.

59.03 Verification related to Indian status[68] (01/15/2017, GCR 16-100)

To the extent that an individual attests that they are an Indian, such attestation will be verified by:

(a) Utilizing any relevant documentation verified in accordance with § 53.00;

(b) Relying on any electronic data sources that are available and which have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently accurate and offer less administrative complexity than paper verification; or

(c) To the extent that approved data sources are unavailable, an individual is not represented in available data sources, or data sources are not reasonably compatible with an individual's attestation, following the procedures specified in § 57.00 and verifying documentation provided by the individual in accordance with the standards for acceptable documentation provided in § 54.07(b)(5).

[66] 45 CFR § 155.320(c)(3)(i).

[67] 45 CFR § 155.350.

[68] 45 CFR § 155.350.

60.00 Computing the premium-assistance credit amount[69] (01/01/2018, GCR 17-048)

60.01 In general[70] (01/01/2018, GCR 17-048)

This section explains the calculation of the federal and state premium assistance of QHPs. A tax filer's federal premium assistance credit amount for a benefit year is the sum of the premium-assistance amounts determined under § 60.04 for all coverage months for individuals in the tax filer's household.

State premium assistance, referred to throughout this rule as Vermont Premium Reduction, is defined in § 3.00 as a state subsidy paid directly to the QHP issuer to reduce monthly premiums for an eligible individual enrolled in a QHP through VHC. Vermont Premium Reduction is calculated using the same methodology as advance payment of the federal premium assistance credit and, as described in § 60.07, results in the premium contribution from an eligible individual being reduced by 1.5 percent.

60.02 Definition[71] (01/15/2017, GCR 16-100)

For purposes of this section:

Coverage family. The term "coverage family" means, in each month, the members of the tax filer's household for whom the month is a coverage month.

60.03 Coverage month[72] (01/01/2018, GCR 17-048)

(a) In general. A month is a coverage month for an individual if:

(1) As of the first day of the month, the individual is enrolled in a QHP;

(2) The tax filer pays the tax filer's share of the premium for the individual's coverage under the plan for the month by the unextended due date for filing the tax filer's income tax return for that benefit year, or the full premium for the month is paid by APTC and the Vermont Premium Reduction; and

(3) The individual is not eligible for the full calendar month for MEC other than coverage in the individual market.

(b) Certain individuals enrolled during a month. If an individual enrolls in a QHP and the enrollment is effective on the date of the individual's birth, adoption or placement for adoption or in foster care, or on the effective date of a court order, the individual is treated as enrolled as of the first day of that month for purposes of this

[69] 26 CFR § 1.36B-3.

[70] 26 CFR § 1.36B-3(a); 33 VSA § 1812(a).

[71] 26 CFR § 1.36B-3(b).

[72] 26 CFR § 1.36B-3(c).

subsection.

(c) Premiums paid for a tax filer. Premiums another person pays for coverage of the tax filer, tax filer's spouse, or tax dependent are treated as paid by the tax filer.

(d) Appeals of coverage eligibility. A tax filer who is eligible for APTC pursuant to an eligibility appeal decision for coverage of a member of the tax filer's coverage family who, based on the appeal decision, retroactively enrolls in a QHP is considered to have met the requirement in (a)(2) of this subsection for a month if the tax filer pays the tax filer's share of the premiums for coverage under the plan for the month on or before the 120th day following the date of the appeal decision.

(e) Examples. The following examples illustrate the provisions of this § 60.03:

(1) Example 1: Tax filer M is single with no tax dependents

(i) In December 2013, M enrolls in a QHP for 2014 and AHS approves APTC. M pays M's share of the premiums. On May 15, 2014, M enlists in the U.S. Army and is eligible immediately for government-sponsored MEC.

(ii) Under paragraph (a) of this subsection, January through May 2014 are coverage months for M. June through December 2014 are not coverage months because M is eligible for other MEC for those months. Thus, under § 60.01, M's premium assistance credit amount for 2014 is the sum of the premium-assistance amounts for the months January through May.

(2) Example 2: Tax filer N has one tax dependent S

(i) S is eligible for government-sponsored MEC. N is not eligible for MEC other than through VHC. N enrolls in a QHP for 2014 and AHS approves APTCs. On August 1, 2014, S loses eligibility for government-sponsored MEC. N terminates enrollment in the QHP that covers only N and enrolls in a QHP that covers N and S for August through December 2014. N pays all premiums not covered by APTCs.

(ii) Under paragraph (a) of this subsection, January through December of 2014 are coverage months for N and August through December are coverage months for N and S. N's premium assistance credit amount for 2014 is the sum of the premium-assistance amounts for these coverage months.

(3) Example 3: O and P are the divorced parents of T

(i) Under the divorce agreement between O and P, T resides with P and P claims T as a tax dependent. However, O must pay premiums for health insurance for T. P enrolls T in a QHP for 2014. O pays the portion of T's QHP premiums not covered by APTCs.

(ii) Because P claims T as a tax dependent, P (and not O) may claim a premium tax credit for coverage for T. See § 1.36B-2(a) of the Code. Under paragraph (c) of this subsection, the premiums that O pays for coverage for T are treated as paid by P. Thus, the months when T is covered by a QHP and not eligible for other MEC are coverage months under paragraph (a) of this subsection in computing P's premium tax credit under § 60.01.

(4) Example 4: Q, an American Indian, enrolls in a QHP for 2014. Q's tribe pays the portion of Q's QHP premiums not covered by APTCs. Under paragraph (c) of this subsection, the premiums that Q's tribe pays for Q are treated as paid by Q. Thus, the months when Q is covered by a QHP and not eligible for other MEC are coverage months under paragraph (c) of this subsection in computing Q's premium tax credit under § 60.01.

60.04 Federal premium-assistance amount[73] (01/01/2018, GCR 17-048)

(a) Premium assistance amount. The premium assistance amount for a coverage month is the lesser of:

(1) The premiums for the month, reduced by any amounts that were refunded, for one or more QHPs in which a tax filer or a member of the tax filer's household enrolls (enrollment premiums); or

(2) The excess of the monthly premium for the applicable benchmark plan (ABP) (benchmark plan premium) (§ 60.06) over 1/12 of the product of a tax filer's household income and the applicable percentage for the benefit year (the tax filer's contribution amount).

(b) Examples. The following examples illustrate the rules of paragraph (a):

(1) Example 1.

Taxpayer Q is single and has no dependents. Q enrolls in a QHP with a monthly premium of $400. Q's monthly benchmark plan premium is $500, and his monthly contribution amount is $80. Q's premium assistance amount for a coverage month is $400 (the lesser of $400, Q's month enrollment premium, and $420, the difference between Q's monthly benchmark plan premium and Q's contribution amount).

(2) Example 2.

(i) Tax filer R is single and has no dependents. R enrolls in a QHP with a monthly premium of $450. The difference between R's benchmark plan premium and contribution amount for the month is $420. R's premium assistance amount for a coverage month with a full month of coverage is $420 (the lesser of $450 and $420).

(ii) The issuer of R's QHP is notified that R died on September 20. The issuer terminates coverage as of that date and refunds the remaining portion of the September enrollment premiums ($150) for R's coverage.

(iii) R's premium assistance amount for each coverage month from January through August is $420 (the lesser of $450 and $420). Under paragraph (a), R's premium assistance amount for September is the lesser of the enrollment premiums for the month, reduced by any amounts that were refunded ($300 ($450 - $150)) or the difference between the benchmark plan premium and the contribution amount for the month ($420). R's premium assistance amount for September is $300, the lesser of $420 and $300.

[73] 26 CFR § 1.36B-3(d).

(3) Example 3.

The facts are the same as in Example 2 of this paragraph (b), except that the QHP issuer does not refund any enrollment premiums for September. Under paragraph (a), R's premium assistance amount for September is $420, the lesser of $450 and $420.

60.05 Monthly premium for ABP[74] (01/15/2017, GCR 16-100)

The monthly premium for an ABP is the premium an issuer would charge for the ABP to cover all members of the tax filer's coverage family. The monthly premium is determined without regard to any premium discount or rebate under the wellness discount demonstration project under § 2705(d) of the PHS Act (42 USC §§ 300gg-4(d)) and may not include any adjustments for tobacco use. The monthly premium for an ABP for a coverage month is determined as of the first day of the month.

60.06 Applicable benchmark plan (ABP)[75] (01/01/2018, GCR 17-048)

(a) In general. The ABP helps determine the total amount of premium assistance. The ABP is the QHP from which the product of the applicable percentage and household income is subtracted to obtain the subsidy amount that will be provided on behalf of the qualified individual. Except as otherwise provided in this subsection, the ABP for each coverage month is the second-lowest-cost silver plan offered to the tax filer's coverage family through VHC for:

(1) Self-only coverage for a tax filer:

(i) Who computes tax under § 1(c) of the Code (unmarried individuals other than surviving spouses and heads of household) and is not allowed a deduction under § 151 of the Code for a tax dependent for the benefit year;

(ii) Who purchases only self-only coverage for one individual; or

(iii) Whose coverage family includes only one individual; and

(2) Family coverage for all other tax filers.

(b) Family coverage. The ABP for family coverage is the second-lowest-cost silver plan that would cover the members of the tax filer's coverage family (such as a plan covering two adults if the members of a tax filer's coverage family are two adults).

(c) Silver-level plan not covering pediatric dental benefits. [Reserved]

(d) Family members residing in different locations. If members of a tax filer's coverage family reside in different locations, the tax filer's benchmark plan premium is the sum of the premiums for the ABPs for each group of coverage family members residing in different locations, based on the plans offered to the group through the

[74] 26 CFR § 1.36B-3(e).

[75] 26 CFR § 1.36B-3(f).

Exchange where the group resides. If all members of a tax filer's coverage family reside in a single location that is different from where the tax filer resides, the tax filer's benchmark plan premium is the premium for the ABP for the coverage family, based on the plans offered through the Exchange to the tax filer's coverage family for the rating area where the coverage family resides.

(e) Single or multiple policies needed to cover the family

(1) *Policy covering a tax filer's family.* If a silver-level plan or a stand-alone dental plan offers coverage to all members of a tax filer's coverage family who reside in the same location under a single policy, the premium (or allocable portion thereof, in the case of a stand-alone dental plan) taken into account for the plan for purposes of determining the ABP under paragraphs (a), (b) and (c) of this subsection is the premium for this single policy.

(2) *Policy not covering a tax filer's family.* If a silver-level QHP or a stand-alone dental plan would require multiple policies to cover all members of a tax filer's coverage family who reside in the same location (for example, because of the relationships within the family), the premium (or allocable portion thereof, in the case of a stand-alone dental plan) taken into account for the plan for purposes of determining the ABP under paragraphs (a), (b), and (c) of this subsection is the sum of the premiums (or allocable portion thereof, in the case of a stand-alone dental plan) for self-only policies under the plan for each member of the coverage family who resides in the same location.

(f) Plan not available for enrollment. A silver-level QHP or a stand-alone dental plan that is not open to enrollment by a tax filer or family member at the time the tax filer or family member enrolls in a QHP is disregarded in determining the ABP.

(g) Benchmark plan terminates or closes to enrollment during the year. A silver-level QHP or a stand-alone dental plan that is used for purposes of determining the ABP under this subsection for a tax filer does not cease to be the ABP for a benefit year solely because the plan or a lower cost plan terminates or closes to enrollment during the benefit year.

(h) Only one silver-level plan offered to the coverage family. [Reserved]

(i) Examples[76]

60.07 Applicable percentage[77] (01/01/2018, GCR 17-048)

(a) In general. The applicable percentage multiplied by a tax filer's household income determines the tax filer's required share of premiums for the ABP. This required share is subtracted from the monthly premium for the ABP when computing the premium-assistance amount. The applicable percentage is computed by first determining the percentage that the tax filer's household income bears to the FPL for the tax filer's family size. The resulting FPL percentage is then compared to the income categories described in the table in paragraph (b) of this subsection (or successor tables). An applicable percentage within an income category increases on

[76] Examples to illustrate the rules of this subsection can be found at 26 CFR § 1.36B-3(f)(9).

[77] 26 CFR § 1.36B-3(g).

a sliding scale in a linear manner and is rounded to the nearest one-hundredth of one percent. For taxable years beginning after December 31, 2014, the applicable percentages in the table will be adjusted by the ratio of premium growth to growth in income for the preceding calendar year and may be further adjusted to reflect changes to the data used to compute the ratio of premium growth to income growth for the 2014 calendar year or the data sources used to compute the ratio of premium growth to income growth. Premium growth and income growth will be determined in accordance with IRS-published guidance. In addition, the applicable percentages in the table may be adjusted to taxable years beginning after December 31, 2018, to reflect rates of premium growth relative to growth in the consumer price index.

(b) Applicable percentage table for APTC[78]

Household income percentage of FPL	2014 initial percentage	2014 final percentage
Less than 133%	2.0	2.0
At least 133% but less than 150%	3.0	4.0
At least 150% but less than 200%	4.0	6.3
At least 200% but less than 250%	6.3	8.05
At least 250% but less than 300%	8.05	9.5
At least 300% but not more than 400%	9.5	9.5

(c) Applicable percentage table with the Vermont Premium Reduction.[79] The State reduces the APTC's applicable percentages by 1.5% for an individual expected to have household income, as defined in § 28.05(c), that does not exceed 300 percent of the FPL for the benefit year for which coverage is requested.

Household income percentage of FPL	2014 initial percentage	2014 final percentage

[78] For taxable years after 2014, the applicable percentages in the table will be updated in accordance with IRS-published guidance, available at: www.irs.gov. For example, the applicable percentage table for 2015 is located at: http://www.irs.gov/pub/irs-drop/rp-14-37.pdf.

[79] For updated applicable percentage tables with the Vermont Premium Reduction for taxable years after 2014, go to: http://info.healthconnect.vermont.gov/Thresholds.

Less than 133%	0.5	0.5
At least 133% but less than 150%	1.5	2.5
At least 150% but less than 200%	2.5	4.8
At least 200% but less than 250%	4.8	6.55
At least 250% but not more than 300%	6.55	8.0
More than 300% but not more than 400%	9.5	9.5

(d) Examples. The following examples illustrate the rules of this subsection with respect to the applicable percentage for federal premium assistance:

(1) Example 1. A's household income is 275 percent of the FPL for A's family size for that benefit year. In the table in paragraph (b) of this subsection, the initial percentage for a tax filer with household income of 250 to 300 percent of the FPL is 6.55 and the final percentage is 8.0. A's FPL percentage of 275 percent is halfway between 250 percent and 300 percent. Thus, rounded to the nearest one-hundredth of one percent, A's applicable percentage is 7.28, which is halfway between the initial percentage of 6.55 and the final percentage of 8.0.

(2) Example 2

(i) B's household income is 210 percent of the FPL for B's family size. In the table in paragraph (b) of this subsection, the initial percentage for a tax filer with household income of 200 to 250 percent of the FPL is 4.8 and the final percentage is 6.55. B's applicable percentage is 5.15, computed as follows:

(ii) Determine the excess of B's FPL percentage (210) over the initial household income percentage in B's range (200), which is 10. Determine the difference between the initial household income percentage in the tax filer's range (200) and the ending household income percentage in the tax filer's range (250), which is 50. Divide the first amount by the second amount:

210-200 = 10

250-200 = 50

10/50 = .20.

(iii) Compute the difference between the initial premium percentage (4.8) and the second premium percentage (6.55) in the tax filer's range; 6.55 -4.8 = 1.75.

(iv) Multiply the amount in the first calculation (.20) by the amount in the second calculation (1.75) and add the product (.35) to the initial premium percentage in B's range (4.8), resulting in B's applicable percentage of 6.65:

$$.20 \times 1.75 = .35$$

$$4.8 + .35 = 5.15.$$

60.08 Plan covering more than one household[80] (01/15/2017, GCR 16-100)

(a) In general. If a QHP covers more than one household under a single policy, each applicable tax filer covered by the plan may claim a premium tax credit, if otherwise allowable. Each tax filer computes the credit using that tax filer's applicable percentage, household income, and the ABP that applies to the tax filer under § 60.06. In determining whether the amount computed under § 60.04(a) (the premiums for the QHP in which the tax filer enrolls) is less than the amount computed under § 60.04(b) (the benchmark plan premium minus the product of household income and the applicable percentage), the premiums paid are allocated to each tax filer in proportion to the premiums for each tax filer's ABP.

(b) Example: Tax filers A and B enroll in a single policy under a QHP. The following example illustrates the rules of this subsection:

(1) B is A's 25-year old child who is not A's tax dependent. B has no tax dependents. The plan covers A, B, and A's two additional children who are A's dependents. The premium for the plan in which A and B enroll is $15,000. The premium for the second-lowest-cost silver family plan covering only A and A's tax dependents is $12,000 and the premium for the second-lowest-cost silver plan providing self-only coverage to B is $6,000. A and B are applicable tax filers and otherwise eligible to claim the premium tax credit.

(2) Under paragraph (a) of this subsection, both A and B may claim premium tax credits. A computes her credit using her household income, a family size of three, and a benchmark plan premium of $12,000. B computes his credit using his household income, a family size of one, and a benchmark plan premium of $6,000.

(3) In determining whether the amount in § 60.04(a) (the premiums for the QHP A and B purchase) is less than the amount in § 60.04(b) (the benchmark plan premium minus the product of household income and the applicable percentage), the $15,000 premiums paid are allocated to A and B in proportion to the premiums for their ABPs. Thus, the portion of the premium allocated to A is $10,000 ($15,000 x $12,000/$18,000) and the portion allocated to B is $5,000 ($15,000 x $6,000/$18,000).

60.09 [Reserved] (01/15/2017, GCR 16-100)

60.10 Additional benefits[81] (01/15/2017, GCR 16-100)

[80] 26 CFR § 1.36B-3(h).

[81] 26 CFR § 1.36B-3(j).

(a) In general. If a QHP offers benefits in addition to the essential health benefits a QHP must provide, the portion of the premium for the plan properly allocable to the additional benefits is excluded from the monthly premiums under § 60.04(a) or (b). Premiums are allocated to additional benefits before determining the ABP.

(b) Method of allocation. The portion of the premium properly allocable to additional benefits is determined under guidance issued by the Secretary of HHS.[82]

(c) Examples. The following examples illustrate the rules of this subsection:

(1) Example 1

(i) Tax filer B enrolls in a QHP that provides benefits in addition to the essential health benefits the plan must provide (additional benefits). The monthly premiums for the plan in which B enrolls are $370, of which $35 is allocable to additional benefits. B's benchmark plan premium (determined after allocating premiums to additional benefits for all silver level plans) is $440, of which $40 is allocable to additional benefits. B's monthly contribution amount, which is the product of B's household income and the applicable percentage, is $60.

(ii) Under this subsection, B's enrollment premiums and the benchmark plan premium are reduced by the portion of the premium that is allocable to the additional benefits provided under that plan. Therefore, B's monthly enrollment premiums are reduced to $335 ($370 - $35) and B's benchmark plan premium is reduced to $400 ($440 - $40). B's premium assistance amount for a coverage month is $335, the lesser of $335 (B's enrollment premiums, reduced by the portion of the premium allocable to additional benefits) and $340 (B's benchmark plan premium, reduced by the portion of the premium allocable to additional benefits ($400), minus B' $60 contribution amount).

(2) Example 2. The facts are the same as in Example 1, except that the plan in which B enrolls provides no benefits in addition to the essential health benefits required to be provided by the plan. Thus, under this subsection, B's benchmark plan premium ($440) is reduced by the portion of the premium allocable to the additional benefits provided under that plan ($40). B's enrollment premiums ($370) are not reduced under this subsection. B's premium assistance amount for a coverage month is $340, the lesser of $370 (B's enrollment premiums) and $340 (B's benchmark plan premium, reduced by the portion of the premium allocable to additional benefits ($400), minus B's 60 contribution amount).

60.11 Pediatric dental coverage[83] (01/15/2017, GCR 16-100)

(a) In general. For purposes of determining the amount of the monthly premium a tax filer pays for coverage under § 60.04(a), if an individual enrolls in both a QHP and a stand-alone dental plan, the portion of the premium for the stand-alone dental plan that is properly allocable to pediatric dental benefits that are essential benefits required to be provided by a QHP is treated as a premium payable for the individual's QHP.

[82] See § 36B(b)(3)(D) of the Code.

[83] 26 CFR § 1.36B-3(k).

(b) Method of allocation. The portion of the premium for a stand-alone dental plan properly allocable to pediatric dental benefits is determined under guidance issued by the Secretary of HHS.

(c) Example. The following example illustrates the rules of this subsection:

(1) Tax filer C and C's tax dependent, R, enroll in a QHP. The premium for the plan in which C and R enroll is $7,200 ($600/month) (Amount 1). The plan does not provide dental coverage. C also enrolls in a stand-alone dental plan covering C and R. The portion of the premium for the dental plan allocable to pediatric dental benefits that are essential health benefits is $240 ($20 per month). The excess of the premium for C's ABP over C's contribution amount (the product of C's household income and the applicable percentage) is $7,260 ($605/month) (Amount 2).

(2) Under this subsection, the amount C pays for premiums (Amount 1) for purposes of computing the premium-assistance amount is increased by the portion of the premium for the stand-alone dental plan allocable to pediatric dental benefits that are essential health benefits. Thus, the amount of the premiums for the plan in which C enrolls is treated as $620 for purposes of computing the amount of the premium tax credit. C's premium-assistance amount for each coverage month is $605 (Amount 2), the lesser of Amount 1 (increased by the premiums allocable to pediatric dental benefits) and Amount 2.

60.12 Households that include individuals who are not lawfully present[84] (01/15/2017, GCR 16-100)

(a) In general. If one or more individuals for whom a tax filer is allowed a deduction under § 151 of the Code are not lawfully present (see § 17.01(g) for definition of lawfully present), the percentage a tax filer's household income bears to the FPL for the tax filer's family size for purposes of determining the applicable percentage under § 60.07 is determined by excluding individuals who are not lawfully present from family size and by determining household income in accordance with paragraph (b) of this subsection.

(b) Revised household income computation

(1) Statutory method. For purposes of (a) of this subsection, household income is equal to the product of the tax filer's household income (determined without regard to this paragraph (b)) and a fraction:

(i) The numerator of which is the FPL for the tax filer's family size determined by excluding individuals who are not lawfully present; and

(ii) The denominator of which is the FPL for the tax filer's family size determined by including individuals who are not lawfully present.

(2) Comparable method. The IRS Commissioner may describe a comparable method in additional published guidance.[85]

[84] 26 CFR § 1.36B-3(l).

[85] See § 601.601(d)(2) of chapter one of the Code.

61.00 Timely determination of eligibility[86] (01/15/2019, GCR 18-064)

(a) In general

(1) AHS strives to complete eligibility determinations for health-benefits programs and QHP enrollment promptly and without undue delay. The amount of time needed to complete such determinations will necessarily vary, depending on such factors as:

(i) The capabilities and cost of generally-available systems and technologies;

(ii) The general availability of electronic data matching and ease of connections to electronic sources of authoritative information to determine and verify eligibility; and

(iii) The needs of an individual, including:

(A) Individual preferences for mode of application (such as through an internet Website, telephone, mail, in-person, or other commonly available electronic means); and

(B) The relative complexity of adjudicating the eligibility determination based on household, income or other relevant information.

(2) An eligibility determination is complete once AHS sends written notice of decision to the individual.

(b) Real-time determination of eligibility. When an individual files a complete, accurate and web-based application and relevant data can be fully verified through the use of available electronic means, an individual can expect a real-time or near-real-time eligibility determination.

(c) Normal maximum time for determining eligibility.[87] In cases involving such factors as described in paragraph (a) of this section, eligibility determinations may require additional time to complete. In any event, a decision on a health-benefits application will be made as soon as possible, but no later than:

(1) 90 days after the application date, if the application is based on a person's disability; or

(2) 45 days after the application date for any other health-benefits application.

(d) Extenuating circumstances. A determination may take longer in unusual situations, such as:

(1) An individual delays providing needed verification or other information;

(2) An examining physician delays sending a necessary report; or

(3) An unexpected emergency or administrative problem outside the control of AHS delays action on applications.

[86] 42 CFR § 435.912; 45 CFR § 155.310(e).

[87] 42 CFR § 435.912(c)(3).

(e) Notice of timeliness standards. Individuals will be informed of the timeliness standards set forth in this section.

62.00 Interviews (01/15/2017, GCR 16-100)

An in-person interview will not be required as part of the application process for a determination of eligibility using MAGI-based income. However, an interview may be required for eligibility determinations for which MAGI-based methods do not apply or when an individual is applying for Medicaid coverage of long-term care services and supports.

63.00 Individual choice (01/15/2017, GCR 16-100)

(a) Choice of Medicaid category.[88] If an individual would be eligible under more than one Medicaid category, the individual may choose to have eligibility determined for the category of the individual's choosing.

(b) Choice to determine eligibility for health-benefits programs.[89] An individual may request only an eligibility determination for enrollment in a QHP without APTC or CSR. However, if the individual is requesting an eligibility determination for a health-benefits program, the individual may not request an eligibility determination for less than all of the health-benefits programs. For example, if an individual seeks a subsidy to help pay for the cost of QHP coverage, they may not limit their application to APTC or CSR. Rather, they must likewise submit to a determination of eligibility for Medicaid.

64.00 Premiums (10/01/2021, GCR 20-004)

64.01 In general (10/01/2021, GCR 20-004)

(a) Scope. Some individuals enrolled in Medicaid's Dr. Dynasaur program are required to pay monthly premiums. This section contains AHS's billing and collection processes for those monthly premiums. Monthly premiums for individuals enrolled in QHPs are separately managed by QHP issuers and are subject to separate billing and collection processes administered by those QHP issuers. Nothing in this rule should be construed as applying to the billing and collection processes for QHP premiums.

(b) Medicaid premium methodologies and amounts. The Vermont legislature sets Medicaid premium methodologies and amounts. Premium schedules are made publicly available via website.

(c) Determination of premium obligation for Medicaid eligibility; premium recalculation

(1) As a part of the health-benefits application, redetermination, and renewal processes, AHS will determine whether an individual eligible for Medicaid will be required to pay monthly premiums.

(2) AHS will recalculate the premium amount for an individual enrolled in Medicaid when:

[88] 42 CFR § 435.404.

[89] 45 CFR 155.310(b).

(i) AHS is informed of a change in income, family size, or health-insurance status, or

(ii) An adjustment is made in premium amounts or calculation methodologies.

(3) An individual enrolled in Medicaid will be notified as provided in § 68.01 any time there is a change in their Medicaid premium amount following a recalculation.

(4) A change that increases the Medicaid premium amount will appear on the next regularly-scheduled monthly bill, created after the premium amount is recalculated.

(d) Premium calculation for Medicaid

(1) The premium calculation for an individual on Medicaid will be based on the MAGI-based income of the individual's Medicaid household following the MAGI methodology described in § 28.03, as established on the most recently approved version of eligibility on the case record at the time that the premium bill is generated. If a premium obligation is calculated for an individual and if that individual is living together with, and under the same premium payer account as, one or more other individuals for whom a premium obligation is also calculated, only one premium bill will be generated for those individuals. The bill will be for the highest premium obligation that is calculated.

Example. If A and B live together and are under the same premium payer account, and if A's calculated premium is $60.00 based on A's Medicaid household income and B's calculated premium is $15.00 based on B's Medicaid household income, AHS will not generate separate bills for A and B. Rather, AHS will generate one premium bill for a total of $60.00 and, when paid, the premium payment will cover eligibility for both A and B.

(2) Prior to the start of the coverage month pertaining to the bill in question, the individual may notify AHS to show that, due to changed household circumstances, the individual is eligible for Medicaid without a premium obligation or a lower premium amount.

(i) If the showing indicates that the individual is eligible for Medicaid without a premium obligation for the coverage month, the individual will be enrolled in Medicaid effective the first day of such coverage month.

(ii) If the showing indicates that the individual is eligible for a lower premium amount, the premium amount billed for that coverage month will be adjusted.

(3) No premium adjustments will be made for the coverage month if the individual has already paid the premium for the coverage month and the individual notifies AHS after the start of that coverage month that the individual is eligible for Medicaid without a premium obligation or for a lower premium amount. If the individual is entitled to a premium change, the change will be applied to the following coverage month.

(e) Aggregate limits for Medicaid premiums[90]

(1) Subject to paragraph (e)(2) of this subsection, any Medicaid premiums and cost sharing incurred by all

[90] 42 CFR § 447.56(f).

individuals in the Medicaid household may not exceed an aggregate limit of five percent of the family's income applied on a quarterly basis.

(2) If an individual incurs out-of-pocket expenses in excess of the aggregate limit described in paragraph (e)(1) of this subsection, AHS will refund that excess amount to the individual.

(3) An individual may request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium.

(f) [Reserved]

(g) Medicaid prospective billing and payment. Medicaid premiums are billed and payments are due, prior to the start of a coverage month. Premium bills will be sent to the person identified on the application as the primary contact or application filer. That person will be responsible for payment of the Medicaid premium (referred to in this rule as the premium payer). AHS will establish an account for the premium payer.

(h) Conditions of Medicaid eligibility and enrollment. Timely payment of a Medicaid premium, if owed, is required as a condition of initial enrollment and ongoing eligibility and enrollment.

(i) Medicaid premium requirement for partial coverage month. The full amount due must be paid to obtain Medicaid coverage for all or part of a month.

(j) Medicaid premiums are nonrefundable. Medicaid premium payments are generally nonrefundable except for the exceptions listed in § 64.11.

(k) [Reserved]

(l) Dr. Dynasaur retroactive island. When an individual advises AHS that they have unpaid medical bills incurred during one or more of the three months prior to their application, they may be able to obtain an island of retroactive Medicaid coverage for any or all of those months (called a "Dr. Dynasaur retroactive island"). If so, AHS will bill the individual for the premium applicable to the Dr. Dynasaur retroactive island. Premium payments for Dr. Dynasaur retroactive islands are subject to allocation as provided under § 64.05(b).

64.02 Public-notice requirements for Medicaid[91] (01/15/2017, GCR 16-100)

(a) Schedule of Medicaid premiums and cost-sharing requirements. A public schedule will be available describing current Medicaid premiums and cost-sharing requirements containing the following information:

(1) The group or groups of individuals who are subject to premiums and cost-sharing requirements and the current amounts;

(2) Mechanisms for making payments for required premiums and cost-sharing charges;

[91] 42 CFR § 447.57.

(3) The consequences for an individual who does not pay a premium or cost-sharing charge;

(4) A list of hospitals charging cost sharing for non-emergency use of the emergency department; and

(5) A list of preferred drugs or a mechanism to access such a list, including the state's health-benefits website.

(b) Schedule availability. The public schedule will be available to the following in a manner that ensures that affected individuals and providers are likely to have access to the notice:

(1) Enrollees, at the time of their enrollment and reenrollment after a redetermination of eligibility, and, when premiums, cost-sharing charges or aggregate limits are revised, notice to enrollees will be in accordance with § 5.01(d);

(2) Applicants, at the time of application;

(3) All participating providers; and

(4) The general public.

(c) [Reserved]

64.03 [Reserved] (01/15/2017, GCR 16-100)

64.04 Ongoing Medicaid premium billing and payment (10/01/2021, GCR 20-004)

(a) After enrollment, ongoing premiums are billed and premium payments are due for an individual enrolled in Medicaid as follows:

(1) A monthly bill for ongoing premiums will be sent by the 5th day of the month or the first non-holiday business day thereafter immediately preceding the month for which the premium covers. Payment is due on or before the last day of the month in which the bill is sent.

(2) For example, a premium bill for coverage in July 2014 will be sent by June 5, 2014. Payment of the premium will be due on or before June 30, 2014.

(b) If the full premium payment is received by the premium payment due date, coverage will continue without further notice.

(c) If the premium payment is made by mail, the payment will be considered received as of the date it is postmarked.

64.05 Partial payments (10/01/2021, GCR 20-004)

(a) Medicaid-only premium billing and payment. When a premium for Medicaid's Dr. Dynasaur program is the only premium billed, payment of the full amount due is required to maintain coverage and eligibility. A payment of less than the full amount due will be considered by AHS as nonpayment.

(b) Allocation of partial payments when multiple premiums billed

(1) Basic rule

(i) When there is a premium for the VPharm program in addition to Medicaid's Dr. Dynasaur program on the same bill, except as provided in paragraph (b)(2) of this subsection, when a payment covers at least one, but fewer than all, of the premiums due on the bill, the payment will be applied as payment of one or more premiums in full rather than as a partial payment of each of the billed premiums. The payment will be allocated by AHS in the following order:

(A) Dr. Dynasaur.

(B) VPharm.

(C) Dr. Dynasaur retroactive island (see § 64.01(l) for definition).

(ii) Coverage will only continue for those for whom the full premium amount due has been received.

(2) Exception. An individual who wishes to specify a different payment allocation for the premiums due than as set forth in paragraph (b)(1) of this subsection may do so by calling AHS at the number listed on the bill. The individual must make such a request prior to the time the payment is applied to a coverage month.

64.06 Late payment/grace period (10/01/2021, GCR 20-004)

(a) Grace Period

(1) An individual enrolled in Dr. Dynasaur is entitled to a premium grace period as described in this paragraph (1) if the individual has not paid their monthly premium by its due date. The grace period starts the day after the due date, extends 60 days and ends on the last day of the month in which the 60-day period ends.[92]

(2) During the grace period described in paragraph (1) of this subsection, Medicaid will pay all appropriate claims for services rendered to the individual.

(b) Notice of premium nonpayment and reinstatement

(1) If a full premium payment is not received by AHS on or before the premium due date, before the fifth business day of the grace period, AHS will send a notice advising that the individual is in a grace period status. The notice will also advise the individual:

(i) Of the Dr. Dynasaur disenrollment protection as provided under § 64.07;

[92] Because of the length of the grace period for an individual enrolled in Dr. Dynasaur, the individual can be in more than one Dr. Dynasaur grace period at the same time. For example, if an individual does not pay their Dr. Dynasaur premium 2 months in a row, they will still be in a grace period for the first unpaid month when the grace period for the second unpaid month starts.

(ii) Of the consequences of being in a grace status;

(iii) The actions the individual must take to resume good standing; and

(iv) The consequences of exhausting the grace period without paying all outstanding premiums.

(2) At least 11 days before the end of the grace period, AHS will send the individual a closure notice advising that enrollment will terminate at the end of the grace period.

(3) Subject to the payment allocation described in (4) below, if AHS receives at least a full premium payment for the grace period on or before the end of the grace period:

(i) The payment will first be applied to cover the premium due for the grace period;

(ii) The individual will be reinstated; and

(iii) The individual will be reenrolled for coverage in the month following the grace period.

(4) *Payment allocation.* If an individual is in grace period status for more than one unpaid premium when AHS receives payment and the payment covers the premium due for at least one, but fewer than all, of the grace periods, the payment will be applied as payment of one or more premiums in full and allocated in chronological order beginning with the oldest grace period.

(5) If AHS receives a full premium payment for the grace period after the end of the grace period, the individual will not be reinstated or reenrolled, and will need to re-apply.

64.07 Dr. Dynasaur disenrollment protection[93] (01/15/2017, GCR 16-100)

(a) Prior to closure, an individual enrolled in Dr. Dynasaur who has received a grace period notice as provided under § 64.06(b)(2)(i) may contact AHS to show that, due to changed household circumstances, the individual is eligible for Medicaid without a premium obligation or with a lower premium amount.

(b) If the showing indicates that the individual is eligible for Medicaid without a premium obligation, AHS will reinstate and reenroll the individual and waive all outstanding premiums.

(c) If the showing indicates that the individual is obligated to pay a premium, but at a lower amount, any outstanding premium amounts due will be adjusted. If the individual pays the adjusted premium amount prior to closure, AHS will reinstate and reenroll the individual.

64.08 [Reserved] (01/15/2017, GCR 16-100)

64.09 Medical incapacity for VPharm (01/15/2017, GCR 16-100)

[93] 42 CFR § 457.570(b) provides CHIP enrollees an opportunity to show that their income has declined before coverage is terminated for non-payment of premium. Vermont has elected to extend this protection to all of the state's premium-based Dr. Dynasaur coverage groups.

(a) "Medical incapacity" means a serious physical or mental infirmity to the health of an individual enrolled in VPharm (§ 10.01) that prevented the individual from paying the premium timely, as verified in a physician's certificate furnished to AHS. Notice by telephone or otherwise by the physician that such certificate will be forthcoming will have the effect of receipt, provided that the certificate is in fact received within seven days.

(b) If an individual's VPharm coverage is terminated solely because of nonpayment of the premium, and the reason is medical incapacity as defined in (a) of this subsection, the individual's representative may request coverage for the period between the day coverage ended and the last day of the month in which they requested coverage. AHS will provide this coverage if it has received verification of medical incapacity and all premiums due for the period of non-coverage. The individual is responsible for all bills incurred during the period of non-coverage until AHS receives the required verification and premium amounts due.

(c) If the health condition related to this medical incapacity is expected to continue or recur, AHS will encourage the individual to sign up for automatic withdrawal of their premium or designate an authorized representative to receive and pay future premiums for as long as the anticipated duration of the condition.

64.10 Medicaid premium payment balances (01/15/2017, GCR 16-100)

Medicaid premium payment balances that result from partial payments or overpayments will be credited to the premium payer's account and will be applied to subsequent Medicaid premium bills.

64.11 Refund of prospective Medicaid premium payments (01/15/2017, GCR 16-100)

(a) Basic rule for Medicaid premiums. A paid Medicaid premium will automatically be refunded to the premium payer when, prior to the beginning of the coverage month associated with the premium payment, no one under the premium payer's account is subject to a premium obligation.

(b) Exception. A paid Medicaid premium will not be refunded if a change occurs after the beginning of the coverage month associated with the premium payment.

64.12 [Reserved] (01/15/2017, GCR 16-100)

64.13 Appeal of Medicaid (10/01/2021, GCR 20-004)

(a) If an individual subject to a premium appeals a decision by AHS that ends their Medicaid eligibility, reduces their benefits or services, or increases the amount of their Medicaid premium, the individual must continue to pay the premium amount in effect prior to the decision that resulted in their appeal in order to have their Medicaid coverage continue pending the outcome of their appeal.

(b) AHS may recover from the individual the difference between the premium level that would have become effective had the individual not appealed AHS's decision and the premium level actually paid during the fair hearing period when the individual withdraws the fair hearing request before the decision is made or following a final disposition of the matter in favor of AHS.

65.00 [Reserved] (01/15/2019, GCR 18-064)

66.00 Presumptive Medicaid eligibility determined by hospitals[94] (01/01/2018, GCR 17-048)

66.01 Basis (01/15/2017, GCR 16-100)

This section implements § 1902(a)(47)(B) of the Act.

66.02 In general (01/15/2017, GCR 16-100)

(a) Basic rule. Medicaid will be provided during a presumptive eligibility period to an individual who is determined by a qualified hospital, on the basis of preliminary information, to be presumptively eligible in accordance with the policies and procedures established by AHS consistent with this section.

(b) Qualified hospital. A qualified hospital is a hospital that:

(1) Participates as a Medicaid provider; notifies AHS of its election to make presumptive eligibility determinations under this section; and agrees to make presumptive eligibility determinations consistent with state policies and procedures;

(2) Assists individuals in completing and submitting the full Medicaid application and understanding any documentation requirements; and

(3) Has not been disqualified by AHS in accordance with paragraph (d) of this subsection.

(c) Scope of authority to make determinations of presumptive eligibility. Hospitals may only make determinations of presumptive eligibility under this section based on income for:

(1) Children under § 7.03(a)(3);

(2) Pregnant women under § 7.03(a)(2);

(3) Parents and caretaker relatives under § 7.03(a)(1);

(4) Adults under § 7.03(a)(5);

(5) Former foster children under § 9.03(e);

(6) Individuals receiving breast and cervical cancer treatment under § 9.03(f); and

(7) Individuals receiving family planning services under § 9.03(g).

(d) Disqualification of hospitals

(1) AHS may establish standards for qualified hospitals related to the proportion of individuals determined presumptively eligible for Medicaid by the hospital who:

[94] 42 CFR § 435.1110.

(i) Submit a regular application before the end of the presumptive eligibility period; or

(ii) Are determined eligible for Medicaid based on such application.

(2) AHS will take action, including, but not limited to, disqualification of a hospital as a qualified hospital under this section, if it determines that the hospital is not:

(i) Making, or is not capable of making, presumptive eligibility determinations in accordance with applicable state policies and procedures; or

(ii) Meeting the standard or standards established under paragraph (d)(1) of this section.

(3) AHS may disqualify a hospital as a qualified hospital under this paragraph only after it has provided the hospital with additional training or taken other reasonable corrective action measures to address the issue.

66.03 Procedures (01/15/2017, GCR 16-100)

(a) In general.[95] AHS will provide Medicaid services to an individual during the presumptive-eligibility period that follows a determination by a qualified hospital that, on the basis of preliminary information, the individual has gross income at or below the Medicaid income standard established for the individual.

(b) AHS's responsibilities.[96] AHS will:

(1) Provide qualified hospitals with application forms for Medicaid and information on how to assist individuals in completing and filing such forms;

(2) Establish oversight mechanisms to ensure that presumptive-eligibility determinations are being made consistent with applicable laws and rules; and

(3) Allow determinations of presumptive eligibility to be made by qualified hospitals on a statewide basis.

(c) Qualified hospital's responsibilities[97]

(1) On the basis of preliminary information, a qualified hospital must determine whether the individual is presumptively eligible under this rule.

(2) For the purpose of the presumptive eligibility determination, a qualified hospital must accept self-declaration of the presumptive-eligibility criteria.

[95] 42 CFR § 435.1102(a).

[96] 42 CFR § 435.1102(b).

[97] 42 CFR § 435.1102(b)(2), as applied to hospital determination of presumptive eligibility by 42 CFR § 435.1110(a).

(3) If the individual is presumptively eligible, a qualified hospital must:

(i) Approve presumptive coverage for the individual;

(ii) Notify the individual within twenty-four hours of the eligibility determination, in writing or orally, if appropriate:

(A) That the individual is eligible for presumptive coverage;

(B) The presumptive eligibility determination date;

(C) That the individual is required to make application for ongoing Medicaid by not later than the last day of the following month; and

(D) That failure to cooperate with the standard eligibility determination process will result in denial of ongoing Medicaid and termination of presumptive coverage on the date described in § 66.04;

(iii) Notify AHS of the presumptive eligibility determination within five working days after the date on which determination is made;

(iv) Provide the individual with a Medicaid application form;

(v) Advise the individual that:

(A) If a Medicaid application on behalf of the individual is not filed by the last day of the following month, the individual's presumptive eligibility will end on that last day; and

(B) If a Medicaid application on behalf of the individual is filed by the last day of the following month, the individual's presumptive eligibility will end on the day that a decision is made on the Medicaid application; and

(vi) Take all reasonable steps to help the individual complete an application for ongoing Medicaid or make contact with AHS.

(4) If the individual is not presumptively eligible, a qualified hospital must notify the individual at the time the determination is made, in writing and orally if appropriate:

(i) Of the reason for the determination;

(ii) That their ineligibility for presumptive coverage does not necessarily mean that they are ineligible for other categories of Medicaid; and

(iii) That the individual may file an application for Medicaid with AHS, and that, if they do so, that the individual's eligibility for other categories of Medicaid will be reviewed.

(5) A qualified hospital may not delegate the authority to determine presumptive eligibility to another entity.[98]

[98] 42 CFR § 435.1102(b), as applied to hospital determination of presumptive eligibility by 42 CFR § 435.1110(a).

(d) Required attestations.[99] For purposes of making a presumptive eligibility determination under this section, an individual (or another person having reasonable knowledge of the individual's status) must attest to the individual being a:

(1) Citizen or national of the United States or in satisfactory immigration status; and

(2) Resident of the state.

(e) Limitation on other conditions[100]

(1) The conditions specified in this subsection are the only conditions that apply in the case of a presumptive-eligibility determination.

(2) Verification of the conditions that apply for presumptive eligibility is not required.

66.04 Presumptive coverage[101] (01/01/2018, GCR 17-048)

(a) Effective dates

(1) Presumptive coverage begins on the date the individual is determined to be presumptively eligible.

(2) Presumptive coverage ends with the earlier of (and includes):

(i) The date that the individual is determined to be eligible or ineligible for ongoing Medicaid.

(ii) If the individual has not applied for ongoing Medicaid, the last day of the month following the month in which the individual was determined to be presumptively eligible.

(b) No retroactive coverage. No retroactive coverage may be provided as a result of a presumptive eligibility determination.

(c) Frequency. An individual may receive only one presumptive Medicaid eligibility period in a calendar year. A pregnant woman may receive only one presumptive Medicaid eligibility period for each pregnancy, even if she has not yet otherwise received a presumptive Medicaid eligibility period during the current calendar year.

66.05 Notice and fair hearing rules[102] (01/15/2017, GCR 16-100)

[99] 42 CFR § 435.1102(d)(1), as applied to hospital determination of presumptive eligibility by 42 CFR § 435.1110(a).

[100] 42 CFR § 435.1102(d)(2), as applied to hospital determination of presumptive eligibility by 42 CFR § 435.1110(a).

[101] 42 CFR § 435.1101, as applied to hospital determination of presumptive eligibility by 42 CFR § 435.1110(a).

[102] 42 CFR § 435.1102(e), as applied to hospital determination of presumptive eligibility by 42 CFR § 435.1110(a).

Notice and fair hearing regulations in Part Eight of this rule do not apply to determinations of presumptive eligibility under this section.

67.00 General notice standards[103] (01/01/2023, GCR 22-033)

(a) General requirement. Any notice required to be sent by AHS must be written and include clear statements of the following:

(1) An explanation of the action reflected in the notice, including the effective date of the action.

(2) Any relevant factual findings.

(3) Citations to, or identification of, the relevant regulations.

(4) Contact information for available customer service resources.

(5) An explanation of appeal rights, if applicable.

(b) Accessibility and plain language. All applications, forms, and notices, including the single, streamlined application and notices of decision, will conform to the accessibility and plain language standards outlined in § 5.01(c).

67.01 Use of electronic notices[104] (01/01/2023, GCR 22-033)

(a) Choice of notice format. An individual will be provided with a choice to receive notices and information required under these rules in electronic format or by regular mail. If the individual elects to receive communications electronically, AHS will:

(1) Confirm by regular mail the individual's election to receive notices electronically;

(2) Inform the individual of their right to change such election, at any time, to receive notices through regular mail;

(3) Post notices to the individual's electronic account within one business day of notice generation;

(4) Send an email or other electronic communication alerting the individual that a notice has been posted to his or her account. Confidential information will not be included in the email or electronic alert;

(5) Send a notice by regular mail within three business days of the date of a failed electronic communication if an electronic communication is undeliverable; and

[103] 45 CFR § 155.230.

[104] 42 CFR § 435.918; 45 CFR § 155.230. See, also, 45 CFR § 155.230(d)(3) allowing select required notices to be sent through standard mail, even if an election has been made to receive such notices electronically, in the event that an Exchange is unable to send these notices electronically due to technical limitations.

(6) At the individual's request, provide through regular mail any notice posted to the individual's electronic account.

(b) [Reserved]

68.00 Notice of decision and appeal rights (10/01/2021, GCR 20-004)

68.01 Notice of decision concerning eligibility[105] (10/01/2021, GCR 20-004)

(a) In general. AHS will send timely notice of any decision affecting eligibility in accordance with federal and state laws. Any notice issued by a QHP issuer is not a notice of decision.

In general, a notice of a decision that adversely affects an enrollee's eligibility will be sent in advance of its effective date. A notice of a decision that adversely affects a Medicaid enrollee's eligibility, including a notice of termination, reduction, suspension of eligibility, or increase in liability, will comply with the advance notice requirements under § 68.02.

(b) Content of eligibility notice

(1) In general. Any notice of decision will contain clear statements of the following:

(i) AHS's decision and its basis;

(ii) The effective date of the decision, if applicable;

(iii) The specific reasons supporting the decision;

(iv) The specific regulations that support, or the change in federal or state law that requires, the decision;

(v) An explanation of the individual's appeal rights, including the right to request a fair hearing and an explanation of the circumstances under which the individual has the right to an expedited administrative appeal pursuant to § 80.07;

(vi) A description of the methods by which the individual may appeal;

(vii) The time frame in which AHS must make a final administrative decision in a fair hearing and an expedited administrative appeal;

(viii) Information on the individual's right to represent themselves at a fair hearing or use legal counsel, a relative, a friend or other spokesperson;

(ix) In cases of a decision based on a change in law, an explanation of the circumstances under which a fair hearing will be granted;

(x) An explanation of the circumstances under which the individual's eligibility for QHP, APTC or CSR

[105] 42 CFR § 435.917; 45 CFR §§ 155.310(g) and 155.355.

or their Medicaid will be continued pending a fair hearing decision; and

(xi) In connection with eligibility for a QHP, an explanation that a fair hearing decision for one household member may result in a change in eligibility for other household members and that change may be handled as a redetermination.

(2) Notice of approved eligibility. In addition to the information in paragraph (b)(1) of this subsection, a notice of approval of eligibility will contain clear statements of the following:

(i) The basis and effective date of the eligibility;

(ii) The circumstances under which the individual must report, and the methods for reporting, any changes that may affect their eligibility;

(iii) For an individual approved for Medicaid, basic information on the level of Medicaid benefits and services approved, including, if applicable, a description of any premiums and cost-sharing required, an explanation of how to request additional detailed information on benefits and financial responsibility, and the right to appeal the level of benefits and services approved; and

(iv) For an individual approved for Medicaid subject to a spenddown, the amount of medical expenses which must be incurred to establish eligibility.

(3) Medicaid notices of decision based on income at or below MAGI-based standard.[106] Whenever an approval, denial or termination of eligibility is based on an individual having a household income at or below the applicable MAGI-based income standard, the eligibility notice will contain clear statements of the following:

(i) Information regarding bases of eligibility other than the MAGI-based income standard and the benefits and services available to individuals eligible on such other bases, sufficient to enable the individual to make an informed choice as to whether to request a determination on such other bases; and

(ii) Information on how to request a determination on such other bases.

(c) Timing of notification of appeal rights.[107] AHS will provide notice of appeal rights as described in paragraph (b)(1) of this subsection:

(1) At the time that the individual applies for health benefits; and

(2) At the time AHS makes a decision affecting the individual's eligibility.

[106] 42 CFR § 435.917(c).

[107] 42 CFR § 431.206(c).

68.02 Advance notice of Medicaid adverse action decision[108] (01/01/2018, GCR 17-048)

(a) In general. AHS will send a notice of a decision that adversely affects an enrollee's Medicaid eligibility, including a notice of termination, reduction, suspension of eligibility, or increase in liability, as described at § 68.01(a), (adverse action) at least 11 days before the date the adverse action is to take effect (date of adverse action), except as permitted under paragraph (b) of this subsection.

(b) Exception.[109] A notice may be sent not later than the date of adverse action if:

(1) There is factual information confirming the death of an enrollee;

(2) A clear written statement signed by an enrollee is received that:

(i) The enrollee no longer wishes eligibility; or

(ii) Gives information that requires termination or reduction of eligibility and indicates that the enrollee understands that this must be the result of supplying that information;

(3) The enrollee has been admitted to an institution where they are ineligible;

(4) The enrollee's whereabouts are unknown and the post office returns mail directed to the enrollee indicating no forwarding address; or

(5) AHS establishes the fact that the enrollee has been accepted for Medicaid eligibility by another state, territory, or commonwealth.

(c) Exception: probable fraud.[110] The period of advance notice may be shortened to 5 days before the date of adverse action if:

(1) There are facts indicating that adverse action should be taken because of probable fraud by the enrollee; and

(2) The facts have been verified, if possible, through secondary sources.

69.00 Medicaid corrective payment[111] (10/01/2021, GCR 20-004)

Corrective payments will be promptly made, retroactive to the date an incorrect Medicaid action was taken if:

[108] 42 CFR § 431.211.

[109] 42 CFR § 431.213.

[110] 42 CFR § 431.214.

[111] 42 CFR § 431.246.

(a) A fair hearing decision is favorable to an individual; or

(b) An issue is decided in an individual's favor before a fair hearing.

70.00 Medicaid enrollment (01/01/2023, GCR 22-033)

70.01 Enrollment when no premium obligation (01/01/2023, GCR 22-033)

(a) Prospective enrollment. Except when a spenddown is necessary, an individual approved for Medicaid without a premium obligation will be enrolled in Medicaid on the first day of the month within which their application is received by AHS provided they are eligible for that month.

(b) Retroactive eligibility[112]

(1) Retroactive eligibility is effective no earlier than the first day of the third month before the month an individual's application is received by AHS, regardless of whether the individual is alive when application is made, if the following conditions are met:

(i) Eligibility is determined and a budget computed separately for each of the three months;

(ii) A medical need exists, as evidenced by the receipt of Medicaid services, at any time during the retroactive period, of a type covered under the state's Medicaid State plan; and

(iii) Elements of eligibility were met at some time during each month.

(2) An individual may be eligible for the retroactive period (or any single month(s) of the retroactive period) even though ineligible for the prospective period.

(3) If an individual, at the time of application, declares that they incurred medical expenses during the retroactive period and eligibility is not approved, the individual's case record must contain documentation of the reason the individual was not eligible in one or more months of the retroactive period.

70.02 Premium obligation; initial billing and payment (01/01/2018, GCR 17-048)

(a) Initial billing. An individual who is approved for Medicaid with a premium obligation will be notified of the premium obligation and premium amount in a bill that will be sent at the time of approval. The individual will not be enrolled in Medicaid until AHS receives payment of the initial premium. The bill will include payment instructions. If the premium payment is made by mail, the payment will be considered received as of the date it is postmarked.

(b) Initial premium bill amount

(1) The initial bill will include premium charges for the month in which the individual's application was received (the application month) and the month following the application month if eligibility is approved in the same month as the application month. The premium due date is the last day of the month following

[112] § 1902(a)(34) of the Act; 42 CFR § 435.915.

the application month. If the month eligibility is approved is different than the application month, the initial bill will include the application month, the approval month, any month (or months) between the application month and the approval month, and the month following the approval month. The premium due date is the last day of the month following the approval month.

(2) If the individual is eligible for, and requests, retroactive coverage at the time of their initial application, the initial bill will include premium charges for each month of retroactive coverage. See § 70.01(b) for details on the requirements that must be met for retroactive eligibility.

(c) Payment allocation. When a premium payment is made for the initial months of coverage, and the payment covers the premiums due for at least one, but fewer than all, of the months included in the bill, the payment will be allocated in reverse chronological order, beginning with the latest month included in the bill and extending back as follows: (1) each month between the latest month and the application month, (2) the application month, and (3) any retroactive coverage months included in the bill.

Coverage will begin on the first day of the earliest month for which a full premium has been paid in accordance with the allocation method described above.

Once an individual is in an ongoing billing cycle due to the issuance of a bill for a subsequent month not included in the bill for the initial months, payments will be applied to the coverage month for which the latest bill was issued and to future coverage months. See § 6[illegible]04 for a description of the ongoing billing and payment process.

(d) Coverage islands; premiums paid after enrollment

(1) Individuals who initially pay the premiums due for fewer than all of the months included in the initial bill may subsequently obtain coverage islands for any or all of the remaining months (a "coverage island" is a period of eligibility with specific beginning and end dates).

(2) To obtain one or more coverage islands, the individual must pay the full premium amount that was initially billed for each of the applied months of coverage.

(3) Payments of coverage islands will be allocated in the order specified in paragraph (c) of this § 70.02.

71.00 Enrollment of qualified individuals in QHPs[113] (01/01/2023, GCR 22-033)

71.01 In general (01/01/2023, GCR 22-033)

(a) General requirements.[114] AHS will accept a QHP selection from an individual who is determined eligible for enrollment in a QHP in accordance with § 11.00, and will:

[113] 45 CFR § 155.400.

[114] 45 CFR § 155.400(a).

(1) Notify the issuer of the individual's selected QHP; and

(2) Transmit information necessary to enable the QHP issuer to enroll the individual.

(b) Timing of data exchange.[115] AHS will:

(1) Send eligibility and enrollment information to QHP issuers and HHS promptly and without undue delay;

(2) Establish a process by which a QHP issuer acknowledges the receipt of such information; and

(3) Send updated eligibility and enrollment information to HHS promptly and without undue delay, in a manner and timeframe specified by HHS.

(c) Records.[116] Records of all enrollments in QHPs will be maintained.

(d) Reconcile files.[117] AHS will reconcile enrollment information with QHP issuers and HHS no less than on a monthly basis.

(e) Notice of employee's receipt of APTCs and CSRs to an employer.[118] AHS may notify an employer that an employee has been determined eligible for advance payments of the premium tax credit and cost-sharing reductions and has enrolled in a qualified health plan through VHC within a reasonable timeframe following a determination that the employee is eligible for advance payments of the premium tax credit and cost-sharing reductions and enrollment by the employee in a qualified health plan through VHC. Such notice must:

(1) Identify the employee;

(2) Indicate that the employee has been determined eligible for advance payments of the premium tax credit and cost-sharing reductions and has enrolled in a qualified health plan through VHC;

(3) Indicate that, if the employer has 50 or more full-time employees, the employer may be liable for the payment assessed under § 4980H of the Code; and

(4) Notify the employer of the right to appeal the determination and where to file the appeal as described in § 45.00(b).

71.02 Annual open enrollment periods[119] (01/01/2023, GCR 22-033)

[115] 45 CFR § 155.400(b).

[116] 45 CFR § 155.400(c).

[117] 45 CFR § 155.400(d).

[118] 45 CFR § 155.310(h).

[119] 45 CFR § 155.410.

(a) General requirements[120]

(1) Annual open enrollment periods (AOEPs) will be provided consistent with this subsection, during which qualified individuals may enroll in a QHP and enrollees may change QHPs.

(2) A qualified individual may only be permitted to enroll in a QHP or an enrollee to change QHPs during the AOEP specified in paragraph (e) of this subsection, or a special enrollment period (SEP) described in § 71.03 for which the qualified individual has been determined eligible.

(b) [Reserved]

(c) [Reserved]

(d) Notice of AOEP.[121] AHS will provide a written AOEP notification to each enrollee no earlier than the first day of the month before the open enrollment period begins and no later than the first day of the open enrollment period.

(e) AOEP.[122] The AOEP begins on November 1 of the calendar year preceding the benefit year and extends through January 15 of the benefit year.

(f) Coverage effective dates during the AOEP[123]

(1) Coverage will be effective January 1, for a QHP selection received on or before December 15 of the calendar year preceding the benefit year.

(2) Coverage will be effective February 1, for a QHP selection received from December 16 of the calendar year preceding the benefit year through January 15 of the benefit year.

71.03 Special enrollment periods (SEP)[124] (01/01/2023, GCR 22-033)

(a) General requirements[125]

(1) AHS will provide SEP consistent with this subsection, during which qualified individuals may enroll in QHPs and enrollees may change QHPs.

[120] 45 CFR § 155.410(a).

[121] 45 CFR § 155.410(d).

[122] 45 CFR § 155.410(e).

[123] 45 CFR § 155.410(f).

[124] 45 CFR § 155.420.

[125] 45 CFR § 155.420.

(2) For the purpose of this subsection, "dependent" has the same meaning as it does in 26 CFR § 54.9801-2, referring to any individual who is or who may become eligible for coverage under the terms of a QHP because of a relationship to a qualified individual or enrollee.

(3) The requirement to have coverage in the 60 days prior to a triggering event is met if the qualified individual either had minimum essential coverage as described in § 23.00 for one or more days during the 60 days preceding the date of the triggering event; lived in a foreign country or in a United States territory for one or more days during the 60 days preceding the date of the triggering event; or meets other criteria established under federal law.[126]

(b) Effective dates[127]

(1) Regular effective dates. Except as specified in paragraphs (b)(2) and (3) of this subsection, for a QHP selection received by AHS:

(i) Between the first and the fifteenth day of any month, the coverage effective date will be the first day of the following month; and

(ii) Between the sixteenth and the last day of any month, the coverage effective date will be the first day of the second following month.

(2) Special effective dates

(i) In the case of birth, adoption, placement for adoption, or placement in foster care, coverage is effective for a qualified individual or enrollee on the date of birth, adoption, placement for adoption, or placement in foster care or, if elected by the qualified individual or enrollee, in accordance with paragraph (b)(1) of this subsection.

(ii) In the case of marriage, as described in paragraph (d)(2) of this subsection, coverage is effective for a qualified individual or enrollee on the first day of the month following plan selection.

(iii) In the case of a qualified individual or enrollee eligible for a special enrollment period as described in paragraphs (d)(4), (d)(5), (d)(9), (d)(10), (d)(11), (d)(12), or (d)(13) of this subsection, coverage is effective on an appropriate date based on the circumstances of the special enrollment period.

(iv) In a case where an individual loses coverage as described in paragraph (d)(1) or (d)(6)(iii) of this subsection, if the plan selection is made before or on the day of the loss of coverage, the coverage effective date is on the first day of the month following the loss of coverage. If the plan selection is made after the loss of coverage, the coverage is effective on the first day of the following month.

(v) In the case of a court order as described in paragraph (d)(2)(i) of this subsection, coverage is effective for a qualified individual or enrollee on the date the court order is effective.

[126] See, e.g., 45 CFR §§ 155.420(a)(5) and 155.420(d)(6)(iv).

[127] 45 CFR § 155.420(b).

(vi) In a case where an enrollee or their dependent dies as described in paragraph (d)(2)(ii) of this subsection, coverage is effective on the first day of the month following the plan selection.

(vii) In a case where an individual gains access to a new QHP as described in paragraph (d)(7) of this subsection or becomes newly eligible for enrollment in a QHP through VHC in accordance with § 19.01 as described in paragraph (d)(3) of this subsection, if the plan selection is made on or before the date of the triggering event, coverage is effective on the first day of the month following the date of the triggering event. If the plan selection is made after the date of the triggering event, coverage is effective in accordance with paragraph (b)(1) of this subsection.

(viii) In a case where an individual becomes pregnant as described in paragraph (d)(14) of this subsection, coverage is effective on the first day of the month following plan selection.

(ix) In a case where an individual is enrolled in COBRA continuation coverage and employer contributions to or government subsidies of this coverage completely cease as described in paragraph (d)(16) of this subsection, if the plan selection is made on or before the date of the triggering event, coverage is effective on the first day of the month following the date of the triggering event. If the plan selection is made after the date of the triggering event, coverage is effective on the first day of the following month.

(3) Option for earlier effective dates. Subject to demonstrating to HHS that all of the participating QHP issuers agree to effectuate coverage in a timeframe shorter than discussed in paragraph (b)(1) or (b)(2)(ii) of this subsection, one or both of the following may be done for all applicable individuals:

(i) For a QHP selection received from a qualified individual in accordance with the dates specified in paragraph (b)(1) or (b)(2)(ii) of this section, a coverage effective date for a qualified individual may be provided earlier than specified in such paragraphs.

(ii) For a QHP selection received from a qualified individual on a date set by the state after the fifteenth of the month, a coverage effective date of the first of the following month may be provided.

(4) APTC and CSR. Notwithstanding the standards of this subsection, APTC, Vermont Premium Reduction and federal and state CSR will adhere to the effective dates specified in § 73.06.

(c) Availability and length of SEP[128]

(1) *General rule.* Unless specifically stated otherwise herein, a qualified individual or enrollee has 60 days from the date of a triggering event to select a QHP.

(2) *Advanced availability.*

A qualified individual or their dependent who is described in one of the following paragraphs of this subsection has 60 days before and after the date of the triggering event to select a QHP:

[128] 45 CFR § 155.420(c).

(i) (d)(1);

(ii) (d)(3) if they become newly eligible for enrollment in a QHP through VHC because they newly satisfy the requirements under § 19.01;

(iii) (d)(6)(iii);

(iv) (d)(7); or

(v) (d)(16).

(3) *Special rule.* In the case of a qualified individual or enrollee who is eligible for an SEP as described in paragraphs (d)(4), (d)(5), or (d)(9) of this subsection, AHS may define the length of the SEP as appropriate based on the circumstances of the SEP, but in no event will the length of the SEP exceed 60 days.

(d) SEPs.[129] AHS will allow a qualified individual or enrollee, and, when specified below, their dependent, to enroll in or change from one QHP to another if one of the following triggering events occur:

(1) The qualified individual or their dependent either:

(i) Loses MEC. The date of the loss of coverage is the last day the individual would have coverage under their previous plan or coverage;

(ii) Is enrolled in any non-calendar year group health plan or individual health insurance coverage, even if the qualified individual or their dependent has the option to renew such coverage. The date of the loss of coverage is the last day of the plan or policy year; or

(iii) Loses medically needy coverage only once per calendar year. The date of the loss of coverage is the last day the individual would have medically needy coverage.

(2) *Gain or loss of dependent.*

(i) The qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order.[130] In the case of marriage, at least one spouse must have had coverage for one or more days during the 60 days preceding the date of marriage, as described in paragraph (a)(3) of this subsection.

(ii) The enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by state law in the state in which the divorce or legal separation occurs, or if the enrollee or their dependent dies.

(3) The qualified individual, or their dependent, becomes newly eligible for enrollment in a QHP through VHC

[129] 45 CFR § 155.420(d).

[130] See, 8 VSA § 4100b.

because they newly satisfy the requirements under § 17.02 (citizenship, status as a national, lawful presence) or § 19.01 (incarceration);

(4) The qualified individual's or their dependent's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct or inaction of an officer, employee, or agent of AHS or HHS, its instrumentalities, or an individual or entity authorized by AHS to provide enrollment assistance or conduct enrollment activities, as evaluated and determined by AHS. For purposes of this provision, misconduct includes, but is not limited to, the failure to comply with applicable standards under this rule or other applicable federal or state laws, as determined by AHS. In such cases, AHS may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, misconduct or inaction. See § 76.00(e)(3) regarding correction of an erroneous termination or cancellation of coverage;

(5) The enrollee or their dependent adequately demonstrates to AHS that the QHP in which they are enrolled substantially violated a material provision of its contract in relation to the enrollee;

(6) *Newly eligible or ineligible for APTC, or change in eligibility for CSR*

(i) The enrollee is determined newly eligible or newly ineligible for APTC or has a change in eligibility for CSR;

(ii) The enrollee's dependent enrolled in the same plan is determined newly eligible or newly ineligible for APTC or has a change in eligibility for CSR; or

(iii) A qualified individual or their dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for APTC based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan, including as a result of their employer discontinuing or changing available coverage within the next 60 days, provided that such individual is allowed to terminate existing coverage.

(iv) For purposes of subsections (i) and (ii), enrollee includes an individual enrolled in a qualified health plan or reflective health benefit plan[131] directly through a QHP issuer.[132]

(7) The qualified individual or enrollee, or their dependent, gains access to new QHPs as a result of a permanent move and had coverage for one or more days during the 60 days preceding the date of the permanent move, as described in paragraph (a)(3) of this subsection.

(8) The qualified individual:

(i) Who gains or maintains status as an Indian, as defined by § 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month; or

(ii) Who is or becomes a dependent of an Indian, as defined by § 4 of the Indian Health Care

[131] See, 33 VSA § 1813.

[132] See, 45 CFR § 155.420(d)(6)(v).

Improvement Act and is enrolled or is enrolling in a QHP through VHC on the same application as the Indian, may change from one QHP to another one time per month, at the same time as the Indian;

(9) The qualified individual or enrollee, or their dependent, demonstrates to AHS, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as AHS may provide.[133]

(10) The qualified individual or enrollee is a victim of domestic abuse or spousal abandonment as described in § 12.03(b). This special enrollment period is available to any member of a household who is a victim of domestic abuse, including unmarried and dependent victims within the household, as well as victims of spousal abandonment, including their dependents.

(11) The qualified individual or their dependent applies for coverage during the AOEP or due to a triggering event, is assessed as potentially eligible for Medicaid, and is determined ineligible for Medicaid either after the AOEP has ended or more than 60 days after the triggering event.

(12) The qualified individual or enrollee, or their dependent, adequately demonstrates to AHS that a material error related to plan benefits, service area, or premium influenced the qualified individual's or enrollee's decision to purchase a QHP.

(13) The qualified individual provides satisfactory documentary evidence to verify their eligibility for enrollment in a QHP through VHC following termination of enrollment due to a failure to verify such status within the time period specified in § 57.00(c)(2)(ii).[134]

(14) The qualified individual, who is not an enrollee, becomes pregnant. Any individual who is eligible for coverage under the terms of the health benefit plan because of a relationship to the pregnant individual may enroll through this SEP provided the pregnant individual does so. This SEP is available at any time after the commencement of the pregnancy for the duration of the pregnancy.[135]

(15) The qualified individual is in possession of a certificate of exemption as described in § 23.06 and

(i) Is notified by HHS that they are no longer eligible for the exemption; or

(ii) Is eligible for enrollment in a QHP that is a catastrophic plan as described in § 14.00(b). When this triggering event occurs, the individual may only enroll in a catastrophic plan.

(16) *Loss of assistance paying for COBRA*

[133] See Vermont Health Connect's website for more information on these triggering events.

[134] See, § 11.02 regarding QHP eligibility.

[135] 33 VSA § 1811(l).

(i) The qualified individual or their dependent is enrolled in COBRA continuation coverage[136] for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions to the qualified individual's or dependent's COBRA continuation coverage or government subsidies completely cease.

(ii) The triggering event is the last day of the period for which COBRA continuation coverage is paid for or subsidized, in whole or in part, by an employer or government entity.

(17) *Household income expected to be at or below 200 percent of the FPL*

(i) The qualified individual, or their dependent, is eligible for advance payments of the premium tax credit and their household income, as defined in § 28.05(c), is expected to be at or below 200 percent of the FPL for the benefit year for which coverage is requested.

(ii) The enrollee, or their dependent, is eligible for advance payments of the premium tax credit and their household income, as defined in § 28.05(c), is expected to be at or below 200 percent of the FPL for the benefit year for which coverage is requested. Plan selection for the enrollee or their dependent will be limited to a silver level QHP.

(e) Loss of coverage[137]

(1) Loss of coverage described in paragraph (d)(1) of this subsection includes those circumstances described in paragraphs (d)(1)(ii) and (iii) of this subsection and in paragraphs (3)(i) through (iii) below. Loss of coverage does not include voluntary termination of coverage or other loss due to:

(i) Failure to pay premiums on a timely basis, including COBRA continuation coverage premiums prior to expiration of COBRA continuation coverage, except for circumstances in which an employer completely ceases its contributions to COBRA continuation coverage, or government subsidies of COBRA continuation coverage completely cease as described in paragraph (d)(16) of this section; or

(ii) Termination of an individual's coverage for cause (which could include, but not be limited to, termination because of an action by the individual that constituted fraud or because the individual made an intentional misrepresentative of a material fact).[138]

(2) Eligibility for COBRA when the qualified individual or their dependent loses coverage does not disqualify the individual or their dependent from a special enrollment period under this subsection.

(3) The following conditions also qualify an employee for a special enrollment period under (d)(1) of this

[136] See, 45 CFR § 144.103.

[137] 45 CFR § 155.420(e).

[138] See, 45 CFR § 147.128.

subsection:[139]

(i) *Loss of eligibility for coverage.* In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time the coverage is terminated as a result of loss of eligibility. Loss of eligibility under this paragraph does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage under this paragraph includes (but is not limited to):

(A) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;

(B) In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);

(C) In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, loss of coverage because an individual no longer resides, lives or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual; and

(D) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals [140]that includes the individual.

(ii) *Termination of employer contributions.* In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent.

(iii) *Exhaustion of COBRA continuation coverage.*[141] In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions are satisfied at the time the COBRA continuation coverage is exhausted. An individual who satisfies the conditions of paragraph (e)(3)(i) of this subsection, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions of this paragraph.

[139] 26 CFR § 54.9801-6(a)(3)(i) through (iii).

[140] See, 26 CFR § 54.9802-1(d).

[141] See, also, 26 CFR § 54.9801-2.

72.00 Duration of QHP eligibility determinations without enrollment[142] (01/01/2018, GCR 17-048)

To the extent that an individual who is determined eligible for enrollment in a QHP does not select a QHP within their enrollment period, or is not eligible for an enrollment period, in accordance with § 71.00, and seeks a new enrollment period prior to the date on which their eligibility is redetermined in accordance with § 75.00 (annual redetermination), AHS will require the individual to attest as to whether information affecting their eligibility has changed since their most recent eligibility determination before determining their eligibility for a special enrollment period, and will process any changes reported in accordance with the procedures specified in § 73.00 (mid-year redetermination).

73.00 Eligibility redetermination during a benefit year[143] (01/01/2018, GCR 17-048)

73.01 General requirement (01/15/2017, GCR 16-100)

AHS must redetermine the eligibility of an individual in a health-benefits program for enrollment in a QHP during the benefit year if it receives and verifies new information reported by the individual or identifies updated information through the data matching described in § 73.04, and such new information may affect eligibility.

73.02 Verification of reported changes (01/15/2017, GCR 16-100)

In general.[144] AHS will:

(a) Verify any information reported by an individual in accordance with the processes specified in §§ 53.00 through 56.00 prior to using such information in an eligibility redetermination; and

(b) Provide periodic electronic notifications regarding the requirements for reporting changes and an individual's opportunity to report any changes as described in § 4.03(b), to an individual who has elected to receive electronic notifications, unless the individual has declined to receive notifications under this paragraph (b).

73.03 Reestablishment of annual renewal date for Medicaid enrollees[145] (01/15/2017, GCR 16-100)

(a) If a redetermination is made during a benefit year for a Medicaid enrollee because of a change in the individual's circumstances and, subject to the limitation under (b) of this subsection, there is enough information available to renew eligibility with respect to all eligibility criteria, a new 12-month renewal period may begin.

(b) *Limitation on AHS's ability to request additional information.* For renewal of a Medicaid enrollee whose financial eligibility is determined using MAGI-based income, any requests by AHS for additional information

[142] 45 CFR § 155.310(j).

[143] 42 CFR § 435.916(d); 45 CFR § 155.330.

[144] 42 CFR § 435.916(d); 45 CFR § 155.330(c).

[145] 42 CFR § 435.916(d)(1)(ii).

from the individual will be limited to information relating to such change in circumstance.

73.04 Periodic examination of data sources[146] (01/01/2018, GCR 17-048)

AHS will periodically examine the available data sources described in § 56.01.

For QHP enrollees:

(a) This periodic examination will be to identify the following changes:

(1) Death; and

(2) For an individual on whose behalf APTC or CSR is being provided, eligibility for or enrollment in Medicare or Medicaid.

(b) AHS may make additional efforts to identify and act on other changes that may affect an individual's eligibility for enrollment in a health-benefits program or in a QHP, provided that such efforts:

(1) Would reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delay, and that applicable requirements with respect to the confidentiality, disclosure, maintenance, or use of such information will be met; and

(2) Comply with the standards specified in § 73.05(b).[147]

73.05 Redetermination and notification of eligibility[148] (01/01/2018, GCR 17-048)

(a) Enrollee-reported data.[149] If AHS verifies updated information reported by an individual, AHS will:

(1) Promptly redetermine the individual's eligibility in accordance with eligibility standards;

(2) Notify the individual regarding the redetermination in accordance with the requirements specified in § 68.00; and

(3) Notify the individual's employer, as applicable, in accordance with § 71.01(e).

(b) Data matching[150]

[146] 45 CFR § 155.330(d)(1).

[147] 45 CFR § 155.330(d)(2).

[148] 45 CFR § 155.330(e).

[149] 45 CFR § 155.330(e)(1).

[150] 45 CFR § 155.330(e)(2).

(1) For QHP enrollees:

(i) Except as provided in (iii) below, if AHS identifies updated information regarding death, in accordance with § 73.04(a)(1), or regarding any factor of eligibility not regarding income, family size, family composition, or tax filing status AHS will:

(A) Notify the individual regarding the updated information, as well as the individual's projected eligibility determination after considering such information;

(B) Allow the individual 30 days from the date of the notice to notify AHS that such information is inaccurate; and

(C) If the individual responds contesting the updated information, proceed in accordance with § 57.00 (inconsistencies).

(D) If the individual does not respond within the 30-day period, proceed in accordance with paragraphs (a)(1) and (2) of this subsection.

(ii) If AHS identifies updated information regarding income, family size or family composition, with the exception of information regarding death, AHS will:

(A) Follow procedures described in paragraphs (b)(1)(i)(A) and (B) of this subsection; and

(B) If the individual responds confirming the updated information, proceed in accordance with paragraphs (a)(1) and (2) of this subsection.

(C) If the individual does not respond within the 30-day period, maintain the individual's existing eligibility determination without considering the updated information.

(D) If the individual provides more up-to-date information, proceed in accordance with § 73.02.

(iii) If AHS receives information from the Secretary of the Treasury that the tax filer for the enrollee's household or the tax filer's spouse did not comply with the requirements described in § 12.05, AHS when redetermining and providing notification of eligibility for advance payments of the premium tax credit will:

(A) Follow the procedures specified in paragraph (a) of this subsection.

(B) After a redetermination under this subsection, allow a tax filer to re-attest to compliance with the requirements described in § 12.05 and request a redetermination of eligibility.

(2) For Medicaid enrollees, if AHS identifies updated information regarding any factor of eligibility, AHS will proceed in accordance with the provisions of § 57.00(c).

73.06 Effective dates for QHP eligibility redeterminations[151] (01/15/2017, GCR 16-100)

(a) Except as specified in paragraphs (b) through (e) of this subsection, AHS will implement changes for QHP eligibility redeterminations as follows:

[151] 45 CFR § 155.330(f).

(1) Resulting from a redetermination under this section, on the first day of the month following the date of the notice described in § 73.05(a)(2); or

(2) Resulting from an appeal decision, on the date specified in the appeal decision; or

(3) Affecting enrollment or premiums only, on the first day of the month following the date on which AHS is notified of the change;

(b) Except as specified in paragraphs (c) through (e) of this subsection, AHS may determine a reasonable point in a month after which a change described in paragraph (a) of this subsection will not be effective until the first day of the month after the month specified in paragraph (a). Such reasonable point in a month must be no earlier than the 15th of the month.

(c) Except as specified in paragraphs (d) and (e) of this subsection, AHS will implement a change described in paragraph (a) of this subsection that results in a decreased amount of APTC or a change in the level of CSR and for which the date of the notices described in paragraphs (a)(1) and (2) of this subsection, or the date on which AHS is notified in accordance with paragraph (a)(3) of this subsection is after the 15th of the month, on the first day of the month after the month specified in (a) of this subsection.

(d) AHS will implement a change associated with the events described in § 71.03(b)(2)(i) and (ii) on the coverage effective dates described in § 71.03(b)(2)(i) and (ii), respectively.

(e) Notwithstanding paragraphs (a) through (d) of this subsection, AHS will provide the effective date of a change associated with the events described in § 71.03(d)(4), (d)(5) and (d)(9) based on the specific circumstances of each situation.

73.07 Recalculation of APTC/CSR[152] (01/01/2018, GCR 17-048)

(a) When an eligibility redetermination in accordance with this section results in a change in the amount of APTC for the benefit year, AHS will recalculate the amount of APTC in such a manner as to:

(1) Account for any APTC made on behalf of the tax filer for the benefit year for which information is available to AHS, such that the recalculated APTC is projected to result in total advance payments for the benefit year that correspond to the tax filer's total projected premium tax credit for the benefit year, calculated in accordance with § 60.00, and

(2) Ensure that the APTC provided on the tax filer's behalf is greater than or equal to zero and is calculated in accordance with § 60.03.

(b) When an eligibility redetermination in accordance with this section results in a change in CSR, AHS will determine an individual eligible for the category of CSR that corresponds to their expected annual household income for the benefit year (subject to the special rule for family policies under § 13.03).

[152] 45 CFR § 155.330(g).

74.00 [Reserved] (01/15/2017, GCR 16-100)

75.00 Eligibility renewal[153] (10/01/2021, GCR 20-004)

75.01 In general (10/01/2021, GCR 20-004)

(a) Renewal occurs annually. Eligibility of an individual in a health-benefits program or for enrollment in a QHP will be renewed on an annual basis.

(b) Updated income and family size information. In the case of an individual who requested an eligibility determination for a health-benefits program (i.e., health benefits other than enrollment in a QHP without APTC or CSR), AHS will request updated tax return information, if the individual has authorized the request of such tax return information, data regarding Social Security benefits, and data regarding income (as described in § 56.01) for use in the individual's eligibility renewal.

(c) Authorization of the release of tax data to support annual redetermination[154]

(1) AHS must have authorization from an individual in order to obtain updated tax return information described in paragraph (b) of this subsection for purposes of conducting an annual redetermination.

(2) AHS is authorized to obtain the updated tax return information described in paragraph (b) of this subsection for a period of no more than five years based on a single authorization, provided that:

(i) An individual may decline to authorize AHS to obtain updated tax return information; or

(ii) An individual may authorize AHS to obtain updated tax return information for fewer than five years; and

(iii) AHS must allow an individual to discontinue, change, or renew his or her authorization at any time.

75.02 Renewal procedures for QHP enrollment (10/01/2021, GCR 20-004)

(a) Procedures for annual renewals. AHS will conduct annual renewals of QHPs using procedures derived from 45 CFR § 155.335 and approved annually by HHS based on a showing by AHS that these procedures facilitate continued enrollment in coverage for which the individual remains eligible, provide clear information about the process to the individual (including regarding any action by the individual necessary to obtain the most accurate redetermination of eligibility), and provide adequate program integrity protections.

(b) AHS will publish the approved renewal procedures for QHP enrollment.

(c) Continuation of coverage. An individual who is enrolled in a QHP and whose QHP remains available will not be required to reapply or take other actions to renew coverage for the following year.

[153] 42 CFR § 435.916(a) and (b); 45 CFR § 155.335.

[154] 45 CFR § 155.335(k).

75.03 Renewal procedures for Medicaid (01/15/2017, GCR 16-100)

(a) Renewal on basis of available information

(1) A redetermination of eligibility for Medicaid will be made without requiring information from the individual if AHS is able to do so based on reliable information contained in the individual's account or other more current information available, including but not limited to information accessed through any data bases.

(2) If eligibility can be renewed based on such information, the individual will be notified:

(i) Of the eligibility determination, and basis; and

(ii) That the individual must inform AHS if any of the information contained in such notice is inaccurate, but that the individual is not required to sign and return such notice if all information provided on such notice is accurate.

(b) Eligibility renewal using pre-populated renewal form. If eligibility cannot be renewed in accordance with paragraph (a)(2) of this subsection, AHS will:

(1) Provide the individual with:

(i) A renewal form containing information available to AHS that is needed to renew eligibility;

(ii) At least 30 days from the date of the renewal form to respond and provide any necessary information through any of the modes of submission specified in § 52.02(b), and to sign the renewal form in a manner consistent with § 52.02(h);

(iii) Notice in a timely manner of the decision concerning the renewal of eligibility in accordance with the requirements specified in § 68.00;

(2) Verify any information provided by the individual in accordance with §§ 53.00 through 56.00;

(3) Reconsider in a timely manner the eligibility of an individual who is terminated for failure to submit the renewal form or necessary information, if the individual subsequently submits the renewal form within 90 days after the date of termination without requiring a new application;

(4) Not require an individual to complete an in-person interview as part of the renewal process; and

(5) Include in its renewal forms its toll-free customer service number and a request that individuals call if they need assistance.

(c) Medicaid continues for all individuals until they are found to be ineligible. When a Medicaid enrollee has done everything they were asked to do, Medicaid will not be closed even though a decision cannot be made within the required review frequency.[155]

[155] Former Medicaid Rule 4142.

76.00 Termination of QHP enrollment or coverage[156] (10/01/2021, GCR 20-004)

(a) General requirements. AHS will determine the form and manner in which enrollment in a QHP may be terminated.

(b) Termination events[157]

(1) Enrollee-initiated terminations

(i) An individual will be permitted to terminate their coverage or enrollment in a QHP, including as a result of the individual obtaining other MEC, with appropriate notice to AHS.

(ii) An individual will be provided an opportunity at the time of plan selection to choose to remain enrolled in a QHP if they become eligible for other MEC and the individual does not request termination in accordance with paragraph (b)(1)(i) of this section. If an individual does not choose to remain enrolled in a QHP in such a situation, AHS will initiate termination of their enrollment upon completion of the redetermination process specified in § 73.00.

(iii) AHS will establish a process to permit individuals, including enrollees' authorized representatives, to report the death of an enrollee for purposes of initiating termination of the enrollee's enrollment. AHS may require the reporting party to submit documentation of the death.

(iv) AHS will permit an enrollee to retroactively terminate or cancel their coverage or enrollment in a QHP in the following circumstances:

(A) The enrollee demonstrates to AHS that they attempted to terminate their coverage or enrollment in a QHP and experienced a technical error that did not allow the enrollee to terminate their coverage or enrollment through VHC, and requests retroactive termination within 60 days after they discovered the technical error.

(B) The enrollee demonstrates to AHS that their enrollment in a QHP through VHC was unintentional, inadvertent, or erroneous and was the result of the error or misconduct of an officer, employee, or agent of AHS or HHS, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities. Such enrollee must request cancellation within 60 days of discovering the unintentional, inadvertent or erroneous enrollment. For purposes of this paragraph, misconduct includes the failure to comply with applicable standards under this rule or other applicable federal or state laws, as determined by AHS.

(C) The enrollee demonstrates to AHS that they were enrolled in a QHP without their knowledge or consent by any third party, including third parties who have no connection with AHS, and requests cancellation within 60 days of discovering of the enrollment.

(2) AHS or issuer-initiated termination. AHS may initiate termination of an individual's enrollment in a QHP, and must permit a QHP issuer to terminate such coverage or enrollment, in the following circumstances:

[156] 45 CFR § 155.430.

[157] 45 CFR § 155.430(b).

(i) The individual is no longer eligible for coverage in a QHP;

(ii) Non-payment of premiums for coverage of the individual, and

(A) The 3-month grace period required for individuals who when first failing to timely pay premiums are receiving APTC[158] has been exhausted; or

(B) Any other grace period not described in paragraph (b)(2)(ii)(A) of this section has been exhausted;

(iii) The individual's coverage is rescinded;

(iv) The QHP terminates or is decertified;

(v) The individual changes from one QHP to another during an AOEP or SEP in accordance with § 71.02 or § 71.03; or

(vi) The enrollee was enrolled in a QHP without their knowledge or consent by a third party, including a third party with no connection with AHS.

(c) Termination of coverage or enrollment tracking and approval.[159] AHS will:

(1) Establish mandatory procedures for QHP issuers to maintain records of termination of enrollment;

(2) Send termination information to the QHP issuer and HHS, promptly and without undue delay, at such time and in such manner as HHS may specify;

(3) Require QHP issuers to make reasonable accommodations for all individuals with disabilities (as defined by the ADA) before terminating enrollment of such individuals; and

(4) Retain records in order to facilitate audit functions.

(d) Effective dates for termination of coverage or enrollment[160]

(1) For purposes of this section:

(i) Reasonable notice is defined as at least fourteen days from the requested effective date of termination; and

(ii) Changes in eligibility for APTC and CSR, including terminations, must adhere to the effective dates specified in § 73.06.

(2) In the case of a termination in accordance with paragraph (b)(1) of this section, the last day of enrollment

[158] 45 CFR §§ 156.270(d) and (g).

[159] 45 CFR § 155.430(c).

[160] 45 CFR § 155.430(d).

is the last day of the month during which the termination is requested by the individual, unless the individual requests a different termination date. If an individual requests a different termination date, the last day of enrollment is:

(i) The termination date specified by the individual, if the individual provides reasonable notice.

(ii) If the individual does not provide reasonable notice, fourteen days after the termination is requested by the individual.

(iii) If the individual is newly eligible for Medicaid or other MEC, and the individual so requests, the last day of the month prior to the month during which the termination is requested by the individual, subject to the determination of the individual's QHP issuer.

(3) In the case of a termination in accordance with paragraph (b)(2)(i) of this section, the last day of enrollment is the last day of eligibility, as described in § 73.06, unless the individual requests an earlier termination effective date per paragraph (b)(1)(i) of this section.

(4) In the case of a termination in accordance with paragraph (b)(2)(ii)(A) of this section, the last day of enrollment will be the last day of the first month of the 3-month grace period.

(5) In the case of a termination in accordance with paragraph (b)(2)(ii)(B) of this section, the last day of enrollment should be consistent with existing State laws regarding grace periods.

(6) In the case of a termination in accordance with paragraph (b)(2)(v) of this section, the last day of coverage in an individual's prior QHP is the day before the effective date of coverage in their new QHP, including any retroactive enrollments.

(7) In the case of termination due to death, the last day of enrollment is the date of death.

(8) In cases of retroactive termination dates, AHS will ensure that appropriate actions are taken to make necessary adjustments to APTC, CSR, premiums and claims.

(9) In case of a retroactive termination in accordance with paragraph (b)(1)(iv)(A) of this section, the termination date will be no sooner than 14 days after the date that the enrollee can demonstrate they contacted AHS to terminate their coverage or enrollment through VHC, unless the issuer agrees to an earlier effective date as set forth in paragraph (d)(2)(iii) of this section.

(10) In case of a retroactive cancellation or termination in accordance with paragraph (b)(1)(iv)(B) or (C) of this section, the cancellation date or termination date will be the original coverage effective date or a later date, as determined appropriate by AHS, based on the circumstances of the cancellation or termination.

(11) In the case of cancellation in accordance with paragraph (b)(2)(vi) of this section, AHS may cancel the enrollee's enrollment upon its determination that the enrollment was performed without the enrollee's knowledge or consent and following reasonable notice to the enrollee (where possible). The termination date will be the original coverage effective date.

(12) In the case of retroactive cancellations or terminations in accordance with paragraphs (b)(1)(iv)(A), (B)

and (C) of this section, such terminations or cancellations for the preceding coverage year must be initiated within a timeframe established by AHS based on a balance of operational needs and consumer protection. This timeframe will not apply to cases adjudicated through the appeals process.

(e) Termination, cancellation, reinstatement defined

(1) *Termination.* A termination is an action taken after a coverage effective date that ends an enrollee's enrollment through VHC for a date after the original coverage effective date, resulting in a period during which the individual was enrolled in coverage through VHC.

(2) *Cancellation.* A cancellation is specific type of termination action that ends a qualified individual's enrollment on the date such enrollment became effective resulting in enrollment never having been effective.

(3) *Reinstatement.* A reinstatement is a correction of an erroneous termination or cancellation action and results in restoration of an enrollment with no break in coverage.

77.00 Administration of APTC and CSR[161] (10/01/2021, GCR 20-004)

(a) Requirement to provide information to enable APTC and CSR.[162] In the event that a tax filer is determined eligible for APTC and the Vermont Premium Reduction, if applicable, or an individual is eligible for federal or state CSR, or that such eligibility for such programs has changed, AHS will, simultaneously:

(1) Transmit eligibility and enrollment information to HHS necessary to enable HHS to begin, end, or change APTC or federal CSR; and

(2) Notify and transmit information necessary to enable the issuer of the QHP to implement, discontinue the implementation, or modify the level of APTC, the Vermont Premium Reduction or federal or state CSR, as applicable, including:

(i) The dollar amount of the advance payment including the Vermont Premium Reduction; and

(ii) The CSR eligibility category.

(b) Requirement to provide information related to employer responsibility[163]

(1) AHS will transmit the individual's name and tax filer identification number to HHS in the event that it determines that an individual is eligible for APTC or CSR based in part on a finding that an individual's employer:

[161] 45 CFR § 155.340.

[162] 45 CFR § 155.340(a).

[163] 45 CFR § 155.340(b).

(i) Does not provide MEC;

(ii) Provides MEC that is unaffordable, within the standard of § 23.02; or

(iii) Provides MEC that does not meet the minimum value requirement specified in § 23.03.

(2) If an individual for whom APTC are made or who is receiving CSR notifies AHS that they have changed employers, AHS must transmit the individual's name and tax filer identification number to HHS.

(3) In the event that an individual for whom APTC are made or who is receiving CSR terminates coverage from a QHP during a benefit year:

(i) AHS will transmit the individual's name and tax filer identification number, and the effective date of coverage termination, to HHS, which will transmit it to the Secretary of the Treasury; and

(ii) AHS may transmit the individual's name and the effective date of the termination of coverage to their employer.

(c) Requirement to provide information related to reconciliation of APTC.[164] AHS will comply with the requirements of § 78.00 regarding reporting to the IRS and to tax filers.

(d) Timeliness standard.[165] All information required in accordance with paragraphs (a) and (b) of this section will be transmitted promptly and without undue delay.

(e) Allocation of APTC and the Vermont Premium Reduction among policies.[166] If one or more advance payments of the premium tax credit, including the Vermont Premium Reduction, if applicable, are to be made on behalf of a tax filer (or two tax filers covered by the same plan(s)), and individuals in the tax filers' households are enrolled in more than one QHP or stand-alone dental plan, then that portion of the APTC, including the Vermont Premium Reduction, that is less than or equal to the aggregate monthly premiums, as defined in § 60.05, for the QHP policies properly allocated to essential health benefits must be allocated among the QHP policies based on the number of enrollees covered under the QHP.

(f) If either or both APTC and the Vermont Premium Reduction are received for a partial coverage month consistent with § 73.06, APTC and the Vermont Premium Reduction amounts are prorated by the number of days of coverage in the month.[167]

[164] 45 CFR § 155.340(c).

[165] 45 CFR § 155.340(d).

[166] 45 CFR § 155.340(e).

[167] See, also, 45 CFR § 155.240(e).

78.00 Information reporting by AHS[168] (01/15/2017, GCR 16-100)

(a) Information required to be reported[169]

(1) *Information reported annually.*

AHS will report to the IRS the following information for each QHP:

(i) The name, address and taxpayer identification number (TIN), or date of birth if a TIN is not available, of the tax filer or responsible adult (an individual on behalf of whom APTC is not paid);

(ii) The name and TIN, or date of birth if a TIN is not available, of a tax filer's spouse;

(iii) The amount of advance credit payments paid for coverage under the plan each month;

(iv) For plans for which advance credit payments are made, the premium (excluding the premium allocated to benefits in excess of essential health benefits) for the ABP for purposes of computing advance credit payments;

(v) For plans for which advance credit payments are not made, the premium (excluding the premium allocated to benefits in excess of essential health benefits) for the ABP that would apply to all individuals enrolled in the QHP if advance credit payments were made for the coverage;

(vi) The name and TIN, or date of birth if a TIN is not available, and dates of coverage for each individual covered under the plan;

(vii) The coverage start and end dates of the QHP;

(viii) The monthly premium for the plan in which the individuals enroll, excluding the premium allocated to benefits in excess of essential health benefits:

(ix) The name of the QHP issuer;

(x) The AHS-assigned policy identification number;

(xi) AHS's unique identifier; and

(xii) Any other information required in published guidance.

(2) *Information reported monthly.*

For each calendar month, AHS will report to the IRS for each QHP, the information described in (1) above and the following information:

[168] 26 CFR § 1.36B-5.

[169] 26 CFR § 1.36B-5(c).

(i) For plans for which advance credits are made:

(A) The names, TINs, or dates of birth if no TIN is available, of the individuals enrolled in the QHP who are expected to be the tax filer's dependent; and

(B) Information on employment (to the extent this information is provided to AHS) consisting of:

(I) The name, address and employer identification number (EIN) of each employer of the tax filer, the tax filer's spouse, and each individual covered by the plan; and

(II) An indication of whether an employer offered affordable minimum essential coverage that provided minimum value, and, if so, the amount of the employee's required contribution for self-only coverage;

(ii) The unique identifying number AHS uses to report data that enables the IRS to associate the data with the proper account from month to month;

(iii) The issuer's EIN; and

(iv) Any other information specified in published guidance.

(b) Time for reporting. AHS will submit the annual report required under § 78.00(a)(1) on or before January 31 of the year following the calendar year of coverage. AHS will submit the monthly reports required under § 78.00(a)(2) as required by federal law.

(c) Annual statement to be furnished to individuals. On or before January 31 of the year following the calendar year of coverage, AHS will furnish to each tax filer or responsible adult a written statement showing the name and address of the recipient and the information described in (a)(1) of this section.

(d) Manner of reporting. AHS will comply with all guidance published by the Commissioner of the IRS[170] for the manner of reporting under this section.

79.00 [Reserved] (01/15/2017, GCR 16-100)

[170] See § 601.601(d)(2) of chapter one of the Code.

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:	22P018
Title:	Health Benefits Eligibility and Enrollment Rule, Eligibility-and-Enrollment Procedures (Part 7).
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:	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.
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
Address: 280 State Drive, Center Building
City: Waterbury
State: VT
Zip: 05671
Telephone: 802-585-4265
Fax: 802-241-0450
Email: danielle.fuoco@vermont.gov
SEND A COMMENT

Website Address: https://humanservices.vermont.gov/rules-policies/health-care-rules
VIEW WEBSITE

Information for Secondary Contact

SECONDARY CONTACT PERSON - A SPECIFIC PERSON FROM WHOM 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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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 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.
