FINAL PROPOSED RULE # 26-P021

Final Proposed Filing - Coversheet

Instructions:

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

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

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

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

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

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

/s/ Dawn O'Toole _____ , on 10/07/26

(signature) (date)

Printed Name and Title:
Dawn O'Toole, Chief Operations Officer, 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 Standards (Part 2)
2. PROPOSED NUMBER ASSIGNED BY THE SECRETARY OF STATE
   26P021
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: Emily Belanger

   Agency: Agency of Human Services

   Mailing Address: 280 State Drive, NOB 1 South, Waterbury, Vermont 05671-1010

   Telephone: 802-760-0118 Fax: 802-241-0450

   E-Mail: emily.m.belanger@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: 5 Pilgrim Park, 1st Floor Suite 2, Waterbury VT 05671-1010

   Telephone: 802-241-0454 Fax: 802-241-0260

   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 and 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 rule amends part 1-3, 5 and 7 of the 8-part Health Benefits Eligibility and Enrollment (HBEE) rule. Parts 1,2,3,5 and 7 were last amended effective January 1, 2026. Substantive revisions include: newly requiring certain adult Medicaid applicants and enrollees demonstrate compliance with work and community engagement rules as a factor of eligibility; reducing the retroactive Medicaid coverage period from three months to one month for Adult coverage group enrollees and two months for all other enrollees; restricting non-citizen eligibility for both Medicaid and Qualified Health Plan premium tax credits and adding a new category of "eligible non-citizen" to clarify which individuals remain eligible; adjusting the renewal period from 12 to 6 months for Medicaid

enrollees in the Adult coverage group; shortening the annual open enrollment period from November 1st-January 15th to November 1st - December 28th. All of these substantive revisions are required by federal law.

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 federal and state 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:

Applicants and enrollees of Medicaid and Qualified Health Plans with financial assistance;

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

Health care providers;

Eligibility and enrollment assisters, including agents and brokers;

The Agency of Human Services including its departments;

The Vermont Department of Labor.

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

AHS anticipates that many of the proposed changes to HBEE carry an economic impact. Changes to eligibility criteria for certain non-citizens results in reduced enrollment in Medicaid and Qualified Health Plans. AHS anticipates that increased frequency of renewals for enrollees in the Medicaid Adult coverage group, as well as the introduction of new work and community engagement requirements, will reduce enrollment in Medicaid. The change to retroactive Medicaid periods represents a reduction in coverage for eligible

Medicaid enrollees. Overall, these changes may reduce total Medicaid enrollment, increase the number of uninsured people in Vermont, increase financial hardship on individuals and families impacted, and increase the burden of uncompensated care on healthcare providers and systems. The implementation and ongoing administration of these changes represent significant additional costs to the state. These costs have been quantified in a $5 million dollar project budget for implementation.

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: 8/14/2026

Time: 01:00 PM

Street Address: Agency of Human Services
Waterbury State Office Complex
Conference Room – Cherry A
280 State Drive
Waterbury, Vermont

Zip Code: 05671

URL for Virtual: Virtual Hearing-Phone or Microsoft Teams Call in (audio only) (802) 828-7667; Conference ID: 564 838 973#

https://teams.microsoft.com/meet/233297609116516?p=1eCIIA3r4n2nvslTbO

Date:

Time: AM

Street Address:

Zip Code:

URL for Virtual:

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

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

21. DEADLINE FOR COMMENT (NO EARLIER THAN 7 DAYS FOLLOWING LAST HEARING):
8/21/2026

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

Health Benefits Eligibility and Enrollment
HBEE
Medicaid
Vermont Health Connect
QHP
Exchange
Qualified Health Plan
Health Benefit

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

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

MEMORANDUM

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

From: Leslie Wisdom, Deputy Commissioner, Department of Vermont Health Access

Cc: Dawn O'Toole, Chief Operating Officer, Agency of Human Services
Megan Cannella, Committee Assistant, Legislative Committee on Administrative Rules
Louise Corliss, APA Coordinator, Secretary of State's Office

Date: October 9, 2026

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:

- 26P020 HBEE Part One – General Provisions and Definitions
- 26P021 HBEE Part Two – Eligibility Standards
- 26P022 HBEE Part Three – Nonfinancial Eligibility Requirements
- 26P023 HBEE Part Five – Financial Methodologies
- 26P024 HBEE Part Seven – Eligibility and Enrollment Procedures

Public comments were received on HBEE Part Two and HBEE Part Seven during the public comment period. No comments were received for the other parts.

HBEE Part Seven was amended in response to comments from Vermont Legal Aid, Inc. (VLA). Please see the State's Responsiveness Summary and Summary of Changes at the end of each rule package for the list of changes from the proposed 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 Seven. No changes were made from the proposed rule in HBEE Part One, Part Three, and Part Five.

If you have any questions, please contact Emily Belanger, Policy Analyst, at 802-760-0118.

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 19, 2026

Re: Summary of Changes from proposed to final proposed rule filing for Health Benefits Eligibility and Enrollment (HBEE) rules (GCR 26-051 through GCR 26-055)

In addition to the change being made in response to public comments (see responsiveness summary), additional changes are being made to align the rule with changes made in federal law since the filing of the proposed rule.

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 12.05 – To align more closely with federal law at 45 CFR 155.305(f)(4), replace "two consecutive years" with "a year" on the third line of text; delete "and for the previous year" on the fifth line of text.

PART SEVEN

Section 55.02 – To align more closely with federal law at 45 CFR 155.320(c)(3)(ix), add a new subsection (f).

Section 61.00(d) – To align more closely with federal law at 42 CFR 435.912(e), add "than the standards in paragraph (c) above" on the first line of text; add a new subparagraph (4).

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

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

JENNEY SAMUELSON
SECRETARY

TODD W. DALOZ
DEPUTY SECRETARY

STATE OF VERMONT
AGENCY OF HUMAN SERVICES

MEMORANDUM

TO: Sarah Copeland Hanzas, Secretary of State

FROM: Jenney Samuelson, Secretary, Agency of Human Services

DATE: June 29, 2026

SUBJECT: Signatory Authority for Purposes of Authorizing Administrative Rules

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I hereby designate Dawn O'Toole, Chief Operating Officer, Agency of Human Services 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 Procedures Act, 3. V.S.A § 801 et seq.

CC: Dawn O'Toole via Dawn.OToole@vermont.gov

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.

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1. TITLE OF RULE FILING:
   Health Benefits Eligibility and Enrollment Rule, Eligibility Standards (Part 2)
2. ADOPTING AGENCY:
   Agency of Human Services (AHS)
3. 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 # 25P025, effective 1/1/2026; Part 2 - Eligibility Standards, SOS #25P026, effective 1/1/2026; Part 3 - Nonfinancial Eligibility Requirements, SOS # 25P027,

effective 1/1/2026; Part 5 - Financial Methodologies, SOS # 25P029, effective 1/1/2026; Part 7 - Eligibility and Enrollment Procedures, SOS # 25P030, effective 1/1/2026.

Interagency Committee on Administrative Rules (ICAR) Minutes

Date/Time: June 8, 2026, 2:00 PM

Location: Virtually via Microsoft Teams

Members Present: Chair Nick Kramer, Heidi Moreau, Patrick Murphy, Earl Fechter, John Kessler, Russ McCracken, Stephen Brown

Members Absent: Jennifer Mojo

Minutes By: Chrissy Gilhuly

- 2:00 p.m. meeting called to order.
- Review and approval of minutes from the May 11, 2026 meeting.
- No additions/deletions to agenda. Agenda approved as drafted.
- No public comments made.
- Presentation of Proposed Rules with recommended changes on pages to follow.

1. Vermont Department of Labor (VDOL) – Workers' Compensation Medical Fee Schedule Rule 40
    a. Medical providers who care for injured workers covered by a workers' compensation policy are required to bill for their services using the Workers' Compensation Medical Fee Schedule. It is vital to the health of the workers' compensation system that such fees be sufficient to ensure the provision of services, without being so generous as to increase the cost of insurance coverage. The rule generally modestly raises reimbursement amounts, adds a more robust table of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes, and provides for annual indexing going forward using Centers for Medicare & Medicaid Services (CMS) "market basket" factors, capped at 3% annually.

2. Department of Fish and Wildlife (DFW) - 10 App. V.S.A. § 2, Report, Big Game (CVR 12-010-090)
    a. The proposed changes explicitly prohibit making false statements in the reporting of wild game taken, allow the Commissioner of Fish and Wildlife to pay a fee of at least one dollar per report to agents at authorized reporting stations, and make minor technical updates to the citations in the rule.

3. Department of Fish and Wildlife (DFW) - 10 App. V.S.A. § 2a. Big game; tagging (CVR 12-010-032)
    a. The proposed amendments are intended to clarify the big game tagging requirements regarding required tag information, requirements for individuals taking game on their own land, and tagging requirements for the transportation of animal parts. The proposed rule language requires that all big game carcasses are tagged with a tag that contains the name of the hunter and the applicable tag or permit number. This information is necessary for appropriate enforcement of license and permitting requirements.

4. Department of Fish and Wildlife (DFW) - 10 App. V.S.A. § 5. Bow and arrow and crossbow standards
    a. The proposed amendments continue to require the same arrowhead width and cutting edges but apply the standards to broadheads used with crossbows as well.

5. Department of Fish and Wildlife (DFW) - 10 App. V.S.A. § 12., Leashed tracking dogs (CVR 12-010-059)
    a. The proposed rule amendments make two changes to the existing leashed tracking dog rule. They amend the definition of "big game animal" to be consistent with the definition in 10 V.S.A. § 4001, to include all big game animals including moose. This will allow hunters to employ leashed tracking dogs to legally track dead or wounded moose. The proposed amendment also strikes language limiting tracking to big game seasons and the 24-hour period immediately following the season. This will allow for the use of tracking dogs to locate animals injured or killed outside the legal hunting seasons.

6. Agency of Human Services (AHS) - Health Benefits Eligibility and Enrollment Rule, General Provisions and Definitions (Part 1)
    a. This proposed rule amends part 1-3, 5 and 7 of the 8-part Health Benefits Eligibility and Enrollment (HBEE) rule. Parts 1,2,3,5 and 7 were last amended effective January 1, 2026. Substantive revisions include: newly requiring certain adult Medicaid applicants and enrollees demonstrate compliance with work and community engagement rules as a factor of eligibility; reducing the retroactive Medicaid coverage period from three months to one month for Adult coverage group enrollees and two months for all other enrollees; restricting non-citizen eligibility for both Medicaid and Qualified Health Plan premium tax credits and adding a new category of "eligible non-citizen" to clarify which individuals remain eligible; adjusting the renewal period from 12 to 6 months for Medicaid enrollees in the Adult coverage group; shortening the annual open enrollment period from November 1st-January 15th to November 1st - December 15th. All of these substantive revisions are required by federal law.

7. Agency of Human Services (AHS) - Health Benefits Eligibility and Enrollment Rule, Eligibility Standards (Part 2)

8. Agency of Human Services (AHS) - Health Benefits Eligibility and Enrollment Rule,Nonfinancial Eligibility Requirements (Part 3)

9. Agency of Human Services (AHS) - Health Benefits Eligibility and Enrollment Rule, Financial Methodologies (Part 5)

10. This proposed rule amends part 1-3, 5 and 7 of the 8- part Health Agency of Human Services (AHS) - Health Benefits Eligibility and Enrollment Rule, Eligibility-and-Enrollment Procedures (Part 7)

11. VOSHA Review Board - VOSHA Review Board Rules of Procedure
    a. These rules serve as a guide to the Review Board, its Clerk and Hearing Officers, and parties regarding the orderly transaction of its proceedings regarding contested VOSHA cases. There are two levels of review available to the parties through the Rules of Procedure. The first is through a hearing before a Hearing Officer. The second level is through a discretionary review by the Review Board, should a party (or the Review Board on its own motion) want to appeal the Hearing Officer's decision. There are two types of proceedings offered in the Rules: conventional and simplified. Simplified Proceedings offer employers (respondents) a less formal way to contest a citation (no answer needs to be filed and documents are exchanged freely without the use of discovery, generally). Rules regarding settlement and the parties' option of using Hearing Officers to mediate a settlement are covered in the Rules.

- Other business
  - Advice for completing APA forms – Approved forms for posting.
- Next scheduled meeting is July 13, 2026, at 2:00 p.m.
- 3:55 p.m. meeting adjourned.

To receive this information in an alternative format or for other accessibility requests, please contact:

Agency of Administration
ADM.Secretary@vermont.gov, 802-828-3322

DRAFT

Proposed Rule: Agency of Human Services (AHS) - Health Benefits Eligibility and Enrollment (HBEE) Rule, General Provisions and Definitions (Part 1-3, 5 and 7)

Presented By: Dani Fuoco

Motion made to accept ***all five parts*** of the HBEE rules by John Kessler, seconded by Stephen Brown, and passed unanimously, except for Heidi Moreau, who abstained, with the following recommendations:

1. **Economic Impact**
    a. #3: Typo in the word ineligible
    b. #8: Other – add positive impact if applicable
2. **Environmental Impact**
    a. #3: Repeat of answer to #2, adopting agency, instead of impact.

DRAFT

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.)

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.

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.)

Economic Impact Analysis

Instructions:

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

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

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

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1. TITLE OF RULE FILING:

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

2. ADOPTING AGENCY:

   Agency of Human Services (AHS)

3. CATEGORY OF AFFECTED PARTIES:

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

   Parties impacted:

   Applicants and enrollees of Medicaid and Qualified Health Plans with financial assistance;

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

Health care providers;

Eligibility and enrollment assisters, including agents and brokers;

The Agency of Human Services including its departments;

The Vermont Department of Labor.

Anticipated costs and benefits of this rule:

AHS anticipates that many of the proposed changes to HBEE carry an economic impact. As a result of restrictions to non-citizen Medicaid eligibility, less than 300 non-citizen enrollees, including certain asylees and refugees, will be disenrolled from Medicaid.

Changes to non-citizen eligibility for Advance Premium Tax Credits and Cost-Sharing Reductions will reduce the number of Qualified Health Plan (QHP) enrollees able to purchase a QHP with financial assistance. AHS anticipates that individuals who become ineligible for financial assistance will disenroll from Marketplace coverage. AHS expects less than 100 QHP enrollees to be impacted by these changes.

The introduction of new work and community engagement rules for the Medicaid Adult coverage group will impact a potential total of 49,000 adults- although AHS estimates that many of these adults are likely either already meeting this new requirement or will have an exemption from the work rules. These new rules will likely reduce the number of applicants who are found eligible for or who remain enrolled in Medicaid. Individuals who are found ineligble for Medicaid due to failure to meet work or community engagement rules are considered ineligible to enroll in QHPS with financial assistance. These changes are expected to increase the percentage of adults in Vermont without healthcare coverage.

The new work and community engagement rules necessitate new verification processes, associated with significant increases in administrative costs. Additional administrative costs are also associated with the introduction of more frequent eligibility renewal cycles for Adult coverage group enrollees. Both of these changes will decrease the percentage of Medicaid enrollees who are successfully renewed automatically, without requiring the enrollee to complete paperwork. AHS estimates that these changes will place many Adult coverage group enrollees at risk of disenrollment from Medicaid.

The reduced availability of retroactive Medicaid coverage, from 3 months to 2 months for most enrollees, and 1 month for Adult coverage group enrollees, reduces Medicaid coverage and shifts healthcare costs onto individuals and providers.

The cumulative anticipated impact of these changes is an overall reduced enrollment in Medicaid. This will result in reduced Medicaid spending. This will also likely increase the number of uninsured individuals in Vermont, creating financial hardship for those impacted and their families, and adding to the burden of uncompensated care throughout Vermont's healthcare systems.

AHS intends to implement these changes in a way that minimizes enrollment loss, but the implementation and ongoing administration of these changes represent significant costs to the state, including expenses related to staffing, contracts, and information technology (IT) updates necessary to comply with these new federal requirements. These costs have been quantified in a $5 million dollar project budget for implementation. AHS has received one-time Federal grants in the amounts of ~$2 million and ~$200,000. These funds are available for certain updates necessary to implement these changes.

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 benenfits programs.

Environmental Impact Analysis

Instructions:

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

Examples of Environmental Impacts include but are not limited to:

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

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1. TITLE OF RULE FILING:

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

2. ADOPTING AGENCY:

   Agency of Human Services (AHS)

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

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 anticipated.

5. LAND: *EXPLAIN HOW THE RULE IMPACTS LAND (E.G. IMPACTS ON FORESTRY, AGRICULTURE ETC.):*
   No impact anticipated.

6. RECREATION: *EXPLAIN HOW THE RULE IMPACTS RECREATION IN THE STATE:*
   No impact anticipated.
7. CLIMATE: *EXPLAIN HOW THE RULE IMPACTS THE CLIMATE IN THE STATE:*
   No impact anticipated.
8. OTHER: *EXPLAIN HOW THE RULE IMPACT OTHER ASPECTS OF VERMONT'S ENVIRONMENT:*
   No impact anticipated.
9. SUFFICIENCY: *DESCRIBE HOW THE ANALYSIS WAS CONDUCTED, IDENTIFYING RELEVANT INTERNAL AND/OR EXTERNAL SOURCES OF INFORMATION USED.*
   Not applicable.

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 Standards (Part 2)

2. ADOPTING AGENCY:

   Agency of Human Services (AHS)

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

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

   The proposed rule was posted on the AHS website for public comment, and a public hearing was held on August 14, 2026. No one attended the hearing. When the rule is filed with the Office of the Secretary of State, AHS provides notice and access to the rule, through the Global Commitment Register, to all persons who subscribe to the Global Commitment Register.

   The public comment period ended August 21, 2026. Comments were received from Vermont Legal Aid on Part 2 and Part 7 of the HBEE rule. Part 7 has been amended in response to comments since the proposed filing. The

comments received and responsiveness summary are included with this filing.

Part 2 and Part 7 have also been amended since the proposed filing to bring the rule into alignment with recently issued federal regulations. These changes are included in the Global Commitment Register Notice as well as the Summary of Changes memo attached to this filing. There are no changes to Parts 1, 3, and 5 since the proposed filing.

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

Exchange Advisory Committee;

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

Eligibility and enrollment assisters, including agents and brokers;

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

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Part Two
Eligibility Standards

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

6.00 Medicaid – in general (01/01/2025, GCR 24-075)

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

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

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

(2) Vermont residency (§ 21.00);

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

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

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

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

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

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

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

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

7.00 Medicaid for children and adults (MCA) (01/01/2027~~01/01/2026~~, GCR 26-0522~~5-051~~)

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

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

7.02 Nonfinancial criteria (01/01/2025, GCR 24-075)

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

(a) Social Security number (§ 16.00);

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

(c) Residency (§ 21.00)[2];

(d) Living arrangements (§ 20.00); and

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

7.03 Categorical and financial criteria (01/01/2027~~01/01/2026~~, GCR 26-052~~25-051~~)

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

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

(2) Pregnant woman[5]

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

(ii) Retroactive eligibility:

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

[1] 42 CFR § 435.406.

[2] 42 CFR § 435.403.

[3] 42 CFR § 435.610.

[4] 42 CFR § 435.110.

[5] 42 CFR § 435.116.

(iii) Continuous eligibility:

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

(A) The woman requests voluntary termination;

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

(C) The woman dies; or

(D) AHS determines that eligibility was determined incorrectly at the most recent determination or redetermination of eligibility because of agency error or fraud, abuse, or perjury attributed to the woman.[6]

This provision applies to a medically-needy pregnant woman as follows: If the woman meets her spenddown while pregnant, her eligibility continues during the remainder of her pregnancy and post partum period. The woman does not have to meet a spenddown again until the end of her post partum period.

(3) Child[7]

(i) An individual, who is under the age of 19[8], with a MAGI-based household income, as defined in § 28.03, that is at or below 312 percent of the FPL for the applicable family size.

(ii) Continuous eligibility for children effective January 1, 2024[9]:

(A) This provision implements section 1902(e)(12) of the Social Security Act.

(B) The length of the continuous eligibility period is 12 months.

(C) The continuous eligibility period begins on the effective date of the individual's initial eligibility or most recent renewal or most recent redetermination if the redetermination results in the reestablishment of the annual renewal date pursuant to § 73.03.

(D) An individual's eligibility may not be terminated during a continuous eligibility period, regardless of any changes in circumstances, unless:

(I) The individual attains the age of 19;

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

[7] 42 CFR § 435.118.

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

[9] 42 CFR § 435.926.

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

(III) The individual or the individual's representative requests a voluntary termination of eligibility;

(IV) AHS determines that eligibility was erroneously granted at the most recent determination, redetermination or renewal of eligibility because of agency error or fraud, abuse or perjury attributed to the individual or the individual's representative; or

(V) The individual dies.

This provision also applies to children who are under the age of 19 and eligible for Medicaid under MABD categorically-needy coverage groups.[10] This provision does not apply to medically-needy children, children in a period of presumptive eligibility who have not yet received an eligibility determination on a regular Medicaid application, or children eligible for Medicaid on the basis of Transitional Medical Assistance.

(iii) Continuous eligibility for a hospitalized child[11]:

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

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

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

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

(4) [Reserved]

(5) Adult[12]

(i) ~~Effective January 1, 2014, a~~An individual who:

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

(B) Is not pregnant;

(C) Is not entitled to or enrolled in Medicare under parts A or B of Title XVIII of the Act;[13]

[10] See, § 8.03(d)(2).

[11] 42 CFR § 435.172.

[12] 42 CFR § 435.119.

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

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

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

~~(E)~~(F) Demonstrates community engagement in compliance with requirements described in federal law[14] and pursuant to processes developed by AHS as detailed in related procedural documentation[15].[16]

(ii) Coverage for children under 21:[17]

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

(6) Families with Medicaid eligibility extended because of increased earnings; Transitional Medical Assistance under § 1925 of the Social Security Act[18]

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

(ii) Initial 12-month extension. For a parent or caretaker relative to remain eligible for the initial 12-month extension, they must continue to have a dependent child, as defined in § 3.00, living with them. Parents, caretaker relatives, and children eligible for TMA must continue to reside in

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version.

[14] Pub. L. No. 119-21, § 71119 (2025).

[15] For AHS's procedural documentation on community engagement (also referred to as work requirements), see the Department of Vermont Health Access website.

[16] An individual that fails to demonstrate community engagement is still deemed to be eligible for minimum essential coverage (MEC) if they would have been eligible for Medicaid but for that failure. For more information on MEC, see § 23.00.

[17] 42 CFR § 435.119(c).

[18] §§ 408(a)(11)(A), 1902(e)(1), 1925, and 1931(c)(2) of the Social Security Act.

Vermont.

(7) Families with Medicaid eligibility extended because of increased collection of spousal support[19]

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

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

(8) Medically Needy

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

(ii) Income eligibility.[20] For purposes of determining medically-needy eligibility under this sub clause, AHS applies the MAGI-based methodologies defined in § 28.03 subject to the requirements of § 28.04.

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

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

(9) Coverage of long-term care services and supports.[21] For an individual eligible for MCA who seeks Medicaid coverage of long-term care services and supports under MCA, AHS will apply the following rules in determining the individual's eligibility for such coverage:

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

(ii) Income and resource transfers under § 25.00.

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

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[19] 42 CFR § 435.115; §§ 408(a)(11)(B) and 1931(c)(1) of the Social Security Act.

[20] 42 CFR § 435.831.

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

8.00 Medicaid for the aged, blind, and disabled (MABD) (01/01/2027~~01/01/2026~~, GCR 26-052~~25-051~~)

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

An individual is eligible for MABD if they meet the nonfinancial, categorical, and financial criteria outlined in this section.[22]

8.02 Nonfinancial criteria (01/01/2025, GCR 24-075)

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

(a) Social Security number (§ 16.00);

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

(c) Residency (§ 21.00);

(d) Living arrangements (§ 20.00); and

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

8.03 Categorical relationship to SSI (01/01/2024, GCR 23-083)

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

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

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

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

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

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

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

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

(d) Definition: blind or disabled child; continuous eligibility for children.

(1) Definition. A blind or disabled child is defined as a blind or disabled individual who is either single or not

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

the head of a household; and

(i) Under age 18, or

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

(2) Continuous eligibility for children. The continuous eligibility for children provision at § 7.03(a)(3)(ii) applies to individuals, who are under age 19, eligible for Medicaid under the MABD categorically-needy coverage groups.

See, also, § 29.02(a)(1).

8.04 Determination of blindness or disability (01/01/2026, GCR 25-051)

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

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

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

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

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

(4) An individual who has been found "not disabled" by SSA, has filed a timely appeal with SSA, and a final determination has not been made by SSA. See, also, §§ 82.00(e) and (f).

(5) An individual who claims that:

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

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

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

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

(6) An individual who claims that:

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

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

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

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

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

8.05 The categorically-needy coverage groups (01/01/2026, GCR 25-051)

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

(a) Individual enrolled in SSI/AABD[23]

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

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

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

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

(b) Individual who is SSI-eligible

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

(i) Have not applied for SSI/AABD[24]; or

(ii) Do not meet SSI/AABD requirements not applicable to Medicaid (e.g., participation in vocational rehabilitation or a substance abuse treatment program)[25].

(2) An individual in this group must:

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

[23] 42 CFR § 435.120.

[24] 42 CFR § 435.210.

[25] 42 CFR § 435.122.

at or below the SSI/AABD payment level for the individual's Medicaid group (as defined in § 29.04);

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

(iii) Meet the MABD nonfinancial criteria.

(c) Individual eligible for SSI but for earnings[26] (Section 1619(b) of the Social Security Act)

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

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

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

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

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

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

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

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

(B) After disregarding the working disabled person's earnings, Social Security Disability Insurance benefits (SSDI) including, if applicable, Social Security retirement benefits automatically converted from SSDI[27], and any veterans' disability benefits, and, if married, all income of the working disabled person's spouse[28], has MABD income that is:

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

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

(ii) Has resources at the time of enrollment in the group that do not exceed $10,000.00[29] for a single

[26] 42 CFR § 435.120(c).

[27] 33 VSA § 1902(b).

[28] 33 VSA § 1902(b).

[29] 33 VSA § 1902(b).

individual and $15,000.00[30] for a couple (see § 29.08(i)(8) for resource exclusion after enrollment).

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

(i) Federal Insurance Contributions Act tax payments;

(ii) Self-employment Contributions Act tax payments or reported self-employment income from the individual's most recent Federal Income Tax Return and relevant schedules. For an individual who has been self-employed for less than a year, AHS may accept as documentation of the individual's self-employment business records showing income and expenses for the relevant period; or

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

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

(e) Child under 18 who lost SSI because of August 1996 change in definition of disability. An individual under the age of 18 who lost their SSI or SSI/AABD eligibility because of the more restrictive definition of disability enacted in August 1996 but who continues to meet all other MABD criteria until their 18th birthday.[31] The definition of disability for this group is the definition of childhood disability in effect prior to the 1996 revised definition.

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

(1) The individual is:

(i) A surviving spouse; or

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

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

(B) Remains single.

(2) The individual meets one of the following groups of criteria under the Act:[32]

[30] 33 VSA § 1902(b).

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

[32] Social Security Act §§ 1634(b)(1) and 1634(d); 42 USC §§ 1383c(b)(1) and 1383c(d).

(i) The individual:

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

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

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

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

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

(ii) The individual:

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

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

(C) Is at least age 50[33], but has not yet attained age 65; and

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

(3) An individual in this group must:

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

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

(iii) Meet the MABD nonfinancial criteria.

(g) Disabled adult child (DAC)[34]

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

(i) Is at least 18 years of age;

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

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

[34] Social Security Act § 1634(c).

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

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

(2) An individual in this group must:

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

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

(iii) Meet the MABD nonfinancial criteria.

(h) Individual eligible under the Pickle Amendment[35]

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

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

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

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

(2) An individual in this group must:

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

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

(iii) Meet the MABD nonfinancial criteria.

(i) Individual eligible for Medicaid in December 1973.[36] An individual who was eligible for Medicaid in December 1973 and meets at least one of the following criteria:

(1) An institutionalized individual who was eligible for Medicaid in December 1973, or any part of that month,

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

[36] 42 CFR §§ 435.131, 435.132 and 435.133.

as an inpatient of a medical institution or intermediate care facility that was participating in the Medicaid program and who, for each consecutive month after December 1973:

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

(ii) Continues to reside in the institution; and

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

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

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

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

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

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

(v) Meets the MABD nonfinancial criteria.

(3) An individual who was eligible for Medicaid in December 1973 as an essential spouse of an aged, blind, or disabled individual who was receiving cash assistance, if the following conditions are met:[37]

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

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

(j) Individual eligible for AABD in August 1972[38]

(1) An individual who meets the following conditions:

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

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

[38] 42 CFR § 435.134.

intermediate care facility; and

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

(2) An individual in this group must:

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

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

(iii) Meet the MABD nonfinancial criteria.

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

(1) [Reserved]

(2) Individual who would be eligible for cash assistance if they were not in a medical institution[39]

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

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

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

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

(3) Individual living in a medical institution eligible under a special income level.[40] An aged, blind or disabled individual who is living in a medical institution and who:

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

(ii) Has MABD income for the individual's financial responsibility group (as defined in § 29.03) that does not exceed 300 percent of the maximum SSI federal payment to an individual living independently in the community (institutional income standard (IIS));[41]

(iii) Has MABD resources for the individual's financial responsibility group that is at or below the

[39] 42 CFR § 435.211.

[40] 42 CFR § 435.236.

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

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

(iv) Meets the MABD non-financial criteria.

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

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

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

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

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

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

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

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

(6) Disabled child in home care (DCHC, Katie Beckett).[42] A disabled individual who:

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

(A) For purposes of § 8.05(k)(6):

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

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

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

(C) Level of care eligibility for DCHC may be reviewed by AHS annually, unless it is determined that the frequency of reviews should be altered due to the unique circumstances of the individual, or

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

when there is a change in health or functional status of the individual.

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

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

(iv) Is age 18 or younger;

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

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

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

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

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

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

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

8.06 Medically-needy coverage group (01/01/2024, GCR 23-083)

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

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

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

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

8.07 Medicare savings programs (01/01/2027~~01/01/2026~~, GCR 26-052~~25-051~~)

(a) In general

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

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

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

(4) For purposes of determining income eligibility for these coverage groups, an individual's family size is as follows:

(i) Effective April 1, 2026, an individual's family size includes the individual, their spouse who is living in the same household, if any, and anyone who is related to the individual by blood, adoption or marriage if they are living in the same household and are dependent on the individual or the individual's spouse for at least one-half of their financial support.[43]

(ii) Through March 31, 2026, an individual's family size is the same as the individual's Medicaid group (as defined in § 29.04) for purposes of MABD eligibility.

(b) Coverage groups

(1) Qualified Medicare Beneficiaries (QMB)[44]

(i) An individual is eligible for Medicaid payment of their Medicare Part A and Part B premiums, deductibles, and coinsurance, or coverage of premiums and cost sharing related to enrollment in Medicare Part B for coverage of immunosuppressive drugs, if the individual is a member of a Medicaid group (as defined in § 29.04) with MABD income at or below 150 percent of the FPL for their applicable family size as defined in subparagraph (a)(4) above; and

(A) Entitled to Medicare Part A with or without a premium (but not entitled solely because they are eligible to enroll under § 1818A of the Act, which provides that certain working disabled individuals may enroll for premium Part A) for purposes of Medicaid payment of their Medicare Part A and Part B premiums, deductibles, and coinsurance as described in (i) above; or

(B) Enrolled under Medicare Part B for coverage of immunosuppressive drugs for purposes of coverage of premiums and cost sharing related to enrollment in Medicare Part B for coverage of immunosuppressive drugs as described in (i) above.

(ii) There is no resource test for this group and any dividend or interest income earned on resources

[43] 42 CFR § 435.601(e).

[44] 42 CFR § 435.123.

is disregarded.

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

(iv) Retroactive eligibility is not available.

(v) *Special income disregard for an individual who is receiving a monthly insurance benefit under Title II of the Social Security Act.* If an individual receives a Title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit payable as a result of a Title II cost-of-living adjustment (COLA) is not counted as income until the beginning of the second month following the month of publication of the revised annual FPL. For individuals who have Title II income, the new poverty levels are effective beginning with the month after the last month for which COLAs are disregarded. For individuals without Title II income, the new poverty levels are effective no later than the date of publication in the Federal Register.[45]

(2) [Reserved]

(3) Qualified Individuals (QI-1)[46]

(i) An individual is eligible for Medicaid payment of their Medicare Part B premiums if the individual is entitled to Medicare Part A, or coverage of the Part B premium related to enrollment in Medicare Part B for coverage of immunosuppressive drugs if the individual is enrolled under Medicare Part B for coverage of immunosuppressive drugs, if the individual:

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

(B) Is a member of a Medicaid group (as defined in § 29.04) with MABD income that is greater than 150 percent but less than 202 percent of the FPL for their applicable family size as defined in subparagraph (a)(4) above; and

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

(ii) There is no resource test for this group and any dividend or interest income earned on resources is disregarded.

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

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

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

[46] 42 CFR § 435.125.

(A) The individual met all QI-1 eligibility criteria in the retroactive period defined in § 70.01(b); and

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

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

(4) Qualified Disabled and Working Individuals (QDWI)

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

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

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

(C) Is a member of a Medicaid group (as defined in § 29.04) with MABD income at or below 200 percent of the FPL for their applicable family size as defined in subparagraph (a)(4) above;

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

(E) Is not otherwise eligible for Medicaid.

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

(iii) Benefits for a retroactive period, as defined in § 70.01(b), ~~of up to three months prior to that effective date~~ may be granted, provided that the individual meets all eligibility criteria during the retroactive period.

9.00 Special Medicaid groups (01/01/2025, GCR 24-075)

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

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

9.02 Nonfinancial criteria (01/01/2025, GCR 24-075)

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

(a) Social Security number (§ 16.00);

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

(c) Residency (§ 21.00);

[47] CMS State Medicaid Manual, § 3492.

(d) Living arrangements (§ 20.00); and

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

9.03 Categorical and financial criteria (01/01/2024, GCR 23-083)

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

(b) Deemed newborn[48]

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

(2) Eligibility

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

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

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

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

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

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

(3) Medicaid identification number

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

[48] 42 CFR § 435.117.

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

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

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

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

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

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

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

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

(d) Special needs adoption[51]

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

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

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

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

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

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

[50] 42 CFR § 435.145.

[51] 42 CFR § 435.227.

(e) Former foster child[52]

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

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

(i) Is under age 26; and

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

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

(B) Was in foster care under the responsibility of Vermont and enrolled in Medicaid under the state's Medicaid State plan or 1115 demonstration upon attaining age 18; or

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

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

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

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

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

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

(2) Eligibility

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

(A) Is under age 65;

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

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

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

[53] 42 CFR § 435.213; CMS SHO Letter (January 4, 2001).

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

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

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

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

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

(iii) Medicaid eligibility for an individual in this group begins following the screening and diagnosis and continues as long as a treating health professional verifies the individual is in need of cancer treatment services.

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

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

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

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

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

(g) Family planning services[55]

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

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

screening or diagnostic service.

[55] 42 CFR § 435.214.

(i) Is not pregnant; and

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

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

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

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

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

10.00 Pharmacy benefits (01/01/2027~~01/15/2017~~, GCR 26-052~~16-095~~)

10.01 VPharm program (01/01/2027~~01/15/2017~~, GCR 26-052~~16-095~~)

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

10.02 Healthy Vermonters ~~P~~program (HVP) (01/01/2027~~01/15/2017~~, GCR 26-052~~16-095~~)

See, ~~The~~ Healthy Vermonters ~~Program (HVP) rules located in~~ Rule 5700 *et seq*. ~~will remain in effect.~~

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

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

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

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

The individual must meet all of the following nonfinancial criteria:

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

(b) Incarceration (§ 19.00); and

(c) Residency (§ 21.00).

[56] 45 CFR § 155.305(a).

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

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

12.00 Advance payments of the premium tax credit (APTC) (01/01/2027~~01/01/2026~~, GCR 26-052~~25-051~~)

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

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

12.02 Nonfinancial criteria[58] (01/01/2027~~01/01/2026~~, GCR 26-052~~25-051~~)

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

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

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

~~(b)~~(c) Is a U.S. citizen, U.S. national, or an eligible non-citizen as defined in § 17.01(i).

12.03 Applicable tax filer[59] (01/01/2027~~01/01/2026~~, GCR 26-052~~25-051~~)

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

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

(b) Married tax filers must file joint return

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

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[57] 45 CFR § 155.305(b).

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

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

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

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

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

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

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

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

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

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

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

(e) [Reserved]

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

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

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

[61] 26 CFR § 1.36B-2(b)(6).

year;

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

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

(4) The tax filer would be an applicable tax filer if the tax filer's household income for the benefit year was at least 100 but not more than 400 percent of the FPL for the tax filer's family size.

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

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

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

12.05 Compliance with filing requirement[63] (01/01/2027~~01/01/2026~~, GCR 26-052~~25-051~~)

AHS may not determine a tax filer eligible for APTC if HHS notifies AHS as part of the process described in §§ 56.03 through 56.08 that APTC payments were made on behalf of either the tax filer or spouse, if the tax filer is a married couple, for a ~~two consecutive~~ year~~s~~ for which tax data would be utilized for verification of household income and family size in accordance with § 56.01(a), and the tax filer or their spouse did not comply with the requirement to file an income tax return for that year ~~and for the previous year~~ as required by 26 USC § 6011, 6012, and in 26 CFR chapter I, and reconcile APTC for that period.

AHS will send a notice to the tax filer or the individual which informs the tax filer or the individual that they may be at risk of being determined ineligible for APTC.

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

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

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

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

(c) Is expected to have household income, as defined in § 28.05(c), that does not exceed 300 percent of the FPL

[62] 45 CFR § 155.305(f)(3).

[63] 45 CFR § 155.305(f)(4).

for the benefit year for which coverage is requested.

13.00 Cost-sharing reductions (CSR) (01/01/2027~~01/15/2017~~, GCR 26-052~~16-095~~)

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

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

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

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

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

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

13.02 Eligibility categories[65] (01/01/2027~~01/15/2017~~, GCR 26-052~~16-095~~)

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

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

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

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

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

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

Income as a Percent of Federal Poverty Level	Tier	Actuarial Value of Plan with Federal and State CSR

[64] 45 CFR § 155.305(g).

[65] 45 CFR § 155.305(g)(2).

Not more than 150%	I	94%
More than 150% but not more than 200%	II	87%
More than 200% but not more than 250%	III	77%
More than 250% but not more than 300%	IV	73%

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

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

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

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

(c) § 13.02(d);

(d) § 13.02(c);

(e) § 13.02(b);

(f) § 13.02(a);

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

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

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

[66] 45 CFR § 155.305(g)(3).

[67] 45 CFR § 155.305(h).

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

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

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

[68] 45 CFR § 156.155.

VERMONT LEGAL AID

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August 20, 2026

Agency of Human Services
Medicaid Policy Unit
280 State Drive, Center Building
Waterbury, VT 05671-1000

Re: GCR 26-051 to 26-055 PROPOSED Health Benefits Eligibility and Enrollment (HBEE) Rules Update

Dear Medicaid Policy Unit,

Thank you for the opportunity to comment on the proposed changes in GCR 26-051 through 26-055. The Office of the Health Care Advocate (HCA) helps Vermonters navigate the complex healthcare landscape, which includes Vermont's Medicaid programs.

The HCA reviewed the Center for Medicare and Medicaid Services' Interim Final Rule on community engagement requirements against the Dept. of VT Health Access' proposed updates to the Health Benefits Eligibility & Enrollment (HBEE) rules. We submit the following for your consideration:

GCR 26-052: HBEE Part 2 – Eligibility Standards

Section 8.07 Medicare savings programs

> **Comment:** For housekeeping purposes, we suggest eliminating the now outdated references to past definitions of family size for the Medicare Savings Program. Specifically:

8.07(a)(4)(i) ~~Effective April 1, 2026, a~~An individual's family size includes the individual, their spouse who is living in the same household, if any, and anyone who is related to the individual by blood, adoption or marriage if they are living in the same household and are dependent on the individual or the individual's spouse for at least one-half of their financial support.43

~~(ii) Through March 31, 2026, an individual's family size is the same as the individual's Medicaid group (as defined in § 29.04) for purposes of MABD eligibility~~

GCR 26-055: HBEE Part 7 – Eligibility-and-Enrollment Procedures

Rule 70.01(b) Retroactive Eligibility

Comment: We suggest clarifying the proposed language to clearly indicate that enrollees are eligible for up to two months of retro coverage:

70.01(b)(1)(ii) For all other Medicaid eligible individuals, the retroactive period is ~~the second month~~ up to two months before the month the individual's application is received by AHS.

Section 71.02(e) AEOP & 71.02(f) Coverage effective dates during the AOEP

Comment: Currently, the annual Open Enrollment Period (AOEP) runs from November 1 to January 15. The draft language in HBEE 71.02(2) proposes shortening the period from November 1 to December 15 annually.

The HCA opposes shortening the AEOP. Vermont consumers face myriad complex choices as they consider what they can afford to pay for health care. Consumers need as much time as possible to weigh their decisions. When enhanced Advance Premium Tax Credits ended in 2026, many Vermont households left the marketplace or purchased a less expensive plan. Households need time to determine what makes sense for them. We hope that Vermonters will weigh their options carefully this OEP.

Data collected by the Department of VT Health Access (DVHA) in past years has shown that many consumers enroll or make plan changes between December 15 and January 15. We believe that a narrower open enrollment

period will lead to fewer Vermonters enrolling in health insurance. Many states have preserved their longer open enrollment period for 2027, and Vermont should do the same.

Thank you for your consideration of these comments. Please feel free to reach out to our office with any questions.

Sincerely,

/s/ Marjorie Stinchcombe
Helpline Director
Office of the Healthcare Advocate

/s/ Mike Fisher
Chief Health Care Advocate
Office of the Healthcare Advocate

/s/ Emma Zavez
Consumer Research & Health Policy Analyst
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Jenney Samuelson, *Secretary*
[phone] 802-241-0440
[fax] 802-241-0450

Date: October 19, 2026

Re: Response to comments received from the public for the Health Benefits Eligibility & Enrollment (HBEE) Rule Update (Proposed GCR 26-051 to 26-055)

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

Comments by Rule Sections

PART TWO

Section 8.07 Medicare savings programs

Comment from Vermont Legal Aid (VLA):

VLA states, "For housekeeping purposes, we suggest eliminating the now outdated references to past definitions of family size for the Medicare Savings Program. Specifically:

8.07(a)(4)(i) ~~Effective April 1, 2026, a~~An individual's family size includes the individual, their spouse who is living in the same household, if any, and anyone who is related to the individual by blood, adoption or marriage if they are living in the same household and are dependent on the individual or the individual's spouse for at least one-half of their financial support.43

(ii) Through March 31, 2026, an individual's family size is the same as the individual's Medicaid group (as defined in § 29.04) for purposes of MABD eligibility.

Response:

The agency appreciates the commenter's suggestion and thinks that it is an important obligation of the agency to eliminate outdated references as part of maintaining clear, accurate, and understandable rules. The agency does plan to revise this provision but will delay doing so until future rulemaking. The agency thinks it is helpful for now to maintain visibility in the rule of this recent transitional date. In addition to it serving as general awareness of the recent transition, maintaining the current text may also be beneficial for a while for appeal or audit purposes.

PART SEVEN

Section 70.01(b) Retroactive eligibility

Comment from VLA:

VLA states, "We suggest clarifying the proposed language to clearly indicate that enrollees are eligible for up to two months of retro coverage:

70.01(b)(1)(ii) For all other Medicaid eligible individuals, the retroactive period is ~~the second month~~ up to two months before the month the individual's application is received by AHS."

Response:

The agency appreciates the commenter's suggestion and thinks that its proposed language could also convey the intent of this rule provision. However, the current language more closely aligns with the language used by the Centers for Medicare & Medicaid Services (CMS) in its regulation on retroactive eligibility at 42 CFR 435.915. The agency thinks it is helpful to align the text in its rules with the text in federal regulations where it can and when appropriate. Accordingly, the agency will maintain its current text.

Section 71.02(e) AEOP

Section 71.02(f) Coverage effective dates during the AOEP

Comment from VLA:

VLA states, "Currently, the annual Open Enrollment Period (AOEP) runs from November 1 to January 15. The draft language in HBEE 71.02(2) proposes shortening the period from November 1 to December 15 annually.

The HCA opposes shortening the AEOP. Vermont consumers face myriad complex choices as they consider what they can afford to pay for health care. Consumers need as much time as possible to weigh their decisions. When enhanced Advance Premium Tax Credits ended in 2026, many Vermont households left the marketplace or purchased a less expensive plan. Households need time to determine what makes sense for them. We hope that Vermonters will weigh their options carefully this OEP.

Data collected by the Department of VT Health Access (DVHA) in past years has shown that many consumers enroll or make plan changes between December 15 and January 15. We believe that a narrower open enrollment period will lead to fewer Vermonters enrolling in health insurance. Many states have preserved their longer open enrollment period for 2027, and Vermont should do the same."

Response:

Thank you for this comment. The agency has extended the annual Open Enrollment Period (AOEP) so that open enrollment runs November 1 through December 28. While the agency now has flexibility from the federal government to extend past the original planned December 15 end of AOEP, the agency is not able this year to extend the AOEP beyond January 1, 2027. Vermont has HR1 systems considerations at play this year that impact its decision to close AOEP on 12/28: a late December systems deployment of HR1 Medicaid changes (Medicaid work requirements and 6-month renewals for the new adult group) and required HR1 qualified health plan immigration eligibility rules changes. Extending AOEP into calendar year 2027 for the 2027 plan year is not possible operationally due to the systems changes that are being implemented at the end of December 2026 for the required HR1 Medicaid and qualified health plan changes.

The agency is amending section 71.02(e) to reflect that the AOEP runs from November 1 through December 28th. The agency is making conforming amendments in 71.02(f), which describes the effective dates of enrollment following plan selection during the AOEP.

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Part Two
Eligibility Standards

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

6.00 Medicaid – in general (01/01/2025, GCR 24-075)

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

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

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

(2) Vermont residency (§ 21.00);

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

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

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

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

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

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

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

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

7.00 Medicaid for children and adults (MCA) (01/01/2027, GCR 26-052)

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

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

7.02 Nonfinancial criteria (01/01/2025, GCR 24-075)

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

(a) Social Security number (§ 16.00);

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

(c) Residency (§ 21.00)[2];

(d) Living arrangements (§ 20.00); and

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

7.03 Categorical and financial criteria (01/01/2027, GCR 26-052)

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

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

(2) Pregnant woman[5]

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

(ii) Retroactive eligibility:

A woman may be retroactively granted Medicaid eligibility under this coverage group if she was pregnant during the retroactive period defined in § 70.01(b) and met all eligibility criteria.

(iii) Continuous eligibility:

An eligible pregnant woman who would lose eligibility because of a change in circumstances, including a change in household income, household composition or categorical eligibility, is

[1] 42 CFR § 435.406.

[2] 42 CFR § 435.403.

[3] 42 CFR § 435.610.

[4] 42 CFR § 435.110.

[5] 42 CFR § 435.116.

deemed to continue to be eligible throughout the pregnancy and the post partum period without regard to a change in circumstances unless:

(A) The woman requests voluntary termination;

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

(C) The woman dies; or

(D) AHS determines that eligibility was determined incorrectly at the most recent determination or redetermination of eligibility because of agency error or fraud, abuse, or perjury attributed to the woman.[6]

This provision applies to a medically-needy pregnant woman as follows: If the woman meets her spenddown while pregnant, her eligibility continues during the remainder of her pregnancy and post partum period. The woman does not have to meet a spenddown again until the end of her post partum period.

(3) Child[7]

(i) An individual, who is under the age of 19[8], with a MAGI-based household income, as defined in § 28.03, that is at or below 312 percent of the FPL for the applicable family size.

(ii) Continuous eligibility for children effective January 1, 2024[9]:

(A) This provision implements section 1902(e)(12) of the Social Security Act.

(B) The length of the continuous eligibility period is 12 months.

(C) The continuous eligibility period begins on the effective date of the individual's initial eligibility or most recent renewal or most recent redetermination if the redetermination results in the reestablishment of the annual renewal date pursuant to § 73.03.

(D) An individual's eligibility may not be terminated during a continuous eligibility period, regardless of any changes in circumstances, unless:

(I) The individual attains the age of 19;

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

(III) The individual or the individual's representative requests a voluntary termination of

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

[7] 42 CFR § 435.118.

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

[9] 42 CFR § 435.926.

eligibility;

(IV) AHS determines that eligibility was erroneously granted at the most recent determination, redetermination or renewal of eligibility because of agency error or fraud, abuse or perjury attributed to the individual or the individual's representative; or

(V) The individual dies.

This provision also applies to children who are under the age of 19 and eligible for Medicaid under MABD categorically-needy coverage groups.[10] This provision does not apply to medically-needy children, children in a period of presumptive eligibility who have not yet received an eligibility determination on a regular Medicaid application, or children eligible for Medicaid on the basis of Transitional Medical Assistance.

(iii) Continuous eligibility for a hospitalized child[11]:

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

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

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

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

(4) [Reserved]

(5) Adult[12]

(i) An individual who:

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

(B) Is not pregnant;

(C) Is not entitled to or enrolled in Medicare under parts A or B of Title XVIII of the Act;[13]

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

[10] See, § 8.03(d)(2).

[11] 42 CFR § 435.172.

[12] 42 CFR § 435.119.

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

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

(F) Demonstrates community engagement in compliance with requirements described in federal law[14] and pursuant to processes developed by AHS as detailed in related procedural documentation[15].[16]

(ii) Coverage for children under 21:[17]

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

(6) Families with Medicaid eligibility extended because of increased earnings; Transitional Medical Assistance under § 1925 of the Social Security Act[18]

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

(ii) Initial 12-month extension. For a parent or caretaker relative to remain eligible for the initial 12-month extension, they must continue to have a dependent child, as defined in § 3.00, living with them. Parents, caretaker relatives, and children eligible for TMA must continue to reside in Vermont.

[14] Pub. L. No. 119-21, § 71119 (2025).

[15] For AHS's procedural documentation on community engagement (also referred to as work requirements), see the Department of Vermont Health Access website.

[16] An individual that fails to demonstrate community engagement is still deemed to be eligible for minimum essential coverage (MEC) if they would have been eligible for Medicaid but for that failure. For more information on MEC, see § 23.00.

[17] 42 CFR § 435.119(c).

[18] §§ 408(a)(11)(A), 1902(e)(1), 1925, and 1931(c)(2) of the Social Security Act.

(7) Families with Medicaid eligibility extended because of increased collection of spousal support[19]

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

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

(8) Medically Needy

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

(ii) Income eligibility.[20] For purposes of determining medically-needy eligibility under this sub clause, AHS applies the MAGI-based methodologies defined in § 28.03 subject to the requirements of § 28.04.

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

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

(9) Coverage of long-term care services and supports.[21] For an individual eligible for MCA who seeks Medicaid coverage of long-term care services and supports under MCA, AHS will apply the following rules in determining the individual's eligibility for such coverage:

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

(ii) Income and resource transfers under § 25.00.

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

[19] 42 CFR § 435.115; §§ 408(a)(11)(B) and 1931(c)(1) of the Social Security Act.

[20] 42 CFR § 435.831.

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

8.00 Medicaid for the aged, blind, and disabled (MABD) (01/01/2027, GCR 26-052)

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

An individual is eligible for MABD if they meet the nonfinancial, categorical, and financial criteria outlined in this section.[22]

8.02 Nonfinancial criteria (01/01/2025, GCR 24-075)

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

(a) Social Security number (§ 16.00);

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

(c) Residency (§ 21.00);

(d) Living arrangements (§ 20.00); and

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

8.03 Categorical relationship to SSI (01/01/2024, GCR 23-083)

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

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

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

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

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

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

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

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

(d) Definition: blind or disabled child; continuous eligibility for children.

(1) Definition. A blind or disabled child is defined as a blind or disabled individual who is either single or not

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

the head of a household; and

(i) Under age 18, or

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

(2) Continuous eligibility for children. The continuous eligibility for children provision at § 7.03(a)(3)(ii) applies to individuals, who are under age 19, eligible for Medicaid under the MABD categorically-needy coverage groups.

See, also, § 29.02(a)(1).

8.04 Determination of blindness or disability (01/01/2026, GCR 25-051)

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

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

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

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

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

(4) An individual who has been found “not disabled” by SSA, has filed a timely appeal with SSA, and a final determination has not been made by SSA. See, also, §§ 82.00(e) and (f).

(5) An individual who claims that:

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

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

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

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

(6) An individual who claims that:

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

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

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

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

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

8.05 The categorically-needy coverage groups (01/01/2026, GCR 25-051)

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

(a) Individual enrolled in SSI/AABD[23]

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

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

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

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

(b) Individual who is SSI-eligible

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

(i) Have not applied for SSI/AABD[24]; or

(ii) Do not meet SSI/AABD requirements not applicable to Medicaid (e.g., participation in vocational rehabilitation or a substance abuse treatment program)[25].

(2) An individual in this group must:

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

[23] 42 CFR § 435.120.

[24] 42 CFR § 435.210.

[25] 42 CFR § 435.122.

at or below the SSI/AABD payment level for the individual's Medicaid group (as defined in § 29.04);

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

(iii) Meet the MABD nonfinancial criteria.

(c) Individual eligible for SSI but for earnings[26] (Section 1619(b) of the Social Security Act)

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

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

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

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

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

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

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

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

(B) After disregarding the working disabled person's earnings, Social Security Disability Insurance benefits (SSDI) including, if applicable, Social Security retirement benefits automatically converted from SSDI[27], and any veterans' disability benefits, and, if married, all income of the working disabled person's spouse[28], has MABD income that is:

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

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

(ii) Has resources at the time of enrollment in the group that do not exceed $10,000.00[29] for a single

[26] 42 CFR § 435.120(c).

[27] 33 VSA § 1902(b).

[28] 33 VSA § 1902(b).

[29] 33 VSA § 1902(b).

individual and $15,000.00[30] for a couple (see § 29.08(i)(8) for resource exclusion after enrollment).

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

(i) Federal Insurance Contributions Act tax payments;

(ii) Self-employment Contributions Act tax payments or reported self-employment income from the individual's most recent Federal Income Tax Return and relevant schedules. For an individual who has been self-employed for less than a year, AHS may accept as documentation of the individual's self-employment business records showing income and expenses for the relevant period; or

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

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

(e) Child under 18 who lost SSI because of August 1996 change in definition of disability. An individual under the age of 18 who lost their SSI or SSI/AABD eligibility because of the more restrictive definition of disability enacted in August 1996 but who continues to meet all other MABD criteria until their 18th birthday.[31] The definition of disability for this group is the definition of childhood disability in effect prior to the 1996 revised definition.

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

(1) The individual is:

(i) A surviving spouse; or

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

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

(B) Remains single.

(2) The individual meets one of the following groups of criteria under the Act:[32]

[30] 33 VSA § 1902(b).

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

[32] Social Security Act §§ 1634(b)(1) and 1634(d); 42 USC §§ 1383c(b)(1) and 1383c(d).

(i) The individual:

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

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

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

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

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

(ii) The individual:

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

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

(C) Is at least age 50[33], but has not yet attained age 65; and

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

(3) An individual in this group must:

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

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

(iii) Meet the MABD nonfinancial criteria.

(g) Disabled adult child (DAC)[34]

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

(i) Is at least 18 years of age;

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

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

[34] Social Security Act § 1634(c).

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

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

(2) An individual in this group must:

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

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

(iii) Meet the MABD nonfinancial criteria.

(h) Individual eligible under the Pickle Amendment[35]

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

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

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

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

(2) An individual in this group must:

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

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

(iii) Meet the MABD nonfinancial criteria.

(i) Individual eligible for Medicaid in December 1973.[36] An individual who was eligible for Medicaid in December 1973 and meets at least one of the following criteria:

(1) An institutionalized individual who was eligible for Medicaid in December 1973, or any part of that month,

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

[36] 42 CFR §§ 435.131, 435.132 and 435.133.

as an inpatient of a medical institution or intermediate care facility that was participating in the Medicaid program and who, for each consecutive month after December 1973:

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

(ii) Continues to reside in the institution; and

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

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

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

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

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

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

(v) Meets the MABD nonfinancial criteria.

(3) An individual who was eligible for Medicaid in December 1973 as an essential spouse of an aged, blind, or disabled individual who was receiving cash assistance, if the following conditions are met:[37]

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

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

(j) Individual eligible for AABD in August 1972[38]

(1) An individual who meets the following conditions:

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

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

[38] 42 CFR § 435.134.

intermediate care facility; and

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

(2) An individual in this group must:

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

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

(iii) Meet the MABD nonfinancial criteria.

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

(1) [Reserved]

(2) Individual who would be eligible for cash assistance if they were not in a medical institution[39]

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

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

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

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

(3) Individual living in a medical institution eligible under a special income level.[40] An aged, blind or disabled individual who is living in a medical institution and who:

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

(ii) Has MABD income for the individual's financial responsibility group (as defined in § 29.03) that does not exceed 300 percent of the maximum SSI federal payment to an individual living independently in the community (institutional income standard (IIS));[41]

(iii) Has MABD resources for the individual's financial responsibility group that is at or below the

[39] 42 CFR § 435.211.

[40] 42 CFR § 435.236.

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

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

(iv) Meets the MABD non-financial criteria.

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

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

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

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

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

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

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

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

(6) Disabled child in home care (DCHC, Katie Beckett).[42] A disabled individual who:

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

(A) For purposes of § 8.05(k)(6):

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

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

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

(C) Level of care eligibility for DCHC may be reviewed by AHS annually, unless it is determined that the frequency of reviews should be altered due to the unique circumstances of the individual, or

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

when there is a change in health or functional status of the individual.

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

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

(iv) Is age 18 or younger;

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

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

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

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

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

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

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

8.06 Medically-needy coverage group (01/01/2024, GCR 23-083)

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

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

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

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

8.07 Medicare savings programs (01/01/2027, GCR 26-052)

(a) In general

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

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

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

(4) For purposes of determining income eligibility for these coverage groups, an individual's family size is as follows:

(i) Effective April 1, 2026, an individual's family size includes the individual, their spouse who is living in the same household, if any, and anyone who is related to the individual by blood, adoption or marriage if they are living in the same household and are dependent on the individual or the individual's spouse for at least one-half of their financial support.[43]

(ii) Through March 31, 2026, an individual's family size is the same as the individual's Medicaid group (as defined in § 29.04) for purposes of MABD eligibility.

(b) Coverage groups

(1) Qualified Medicare Beneficiaries (QMB)[44]

(i) An individual is eligible for Medicaid payment of their Medicare Part A and Part B premiums, deductibles, and coinsurance, or coverage of premiums and cost sharing related to enrollment in Medicare Part B for coverage of immunosuppressive drugs, if the individual is a member of a Medicaid group (as defined in § 29.04) with MABD income at or below 150 percent of the FPL for their applicable family size as defined in subparagraph (a)(4) above; and

(A) Entitled to Medicare Part A with or without a premium (but not entitled solely because they are eligible to enroll under § 1818A of the Act, which provides that certain working disabled individuals may enroll for premium Part A) for purposes of Medicaid payment of their Medicare Part A and Part B premiums, deductibles, and coinsurance as described in (i) above; or

(B) Enrolled under Medicare Part B for coverage of immunosuppressive drugs for purposes of coverage of premiums and cost sharing related to enrollment in Medicare Part B for coverage of immunosuppressive drugs as described in (i) above.

(ii) There is no resource test for this group and any dividend or interest income earned on resources

[43] 42 CFR § 435.601(e).

[44] 42 CFR § 435.123.

is disregarded.

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

(iv) Retroactive eligibility is not available.

(v) *Special income disregard for an individual who is receiving a monthly insurance benefit under Title II of the Social Security Act.* If an individual receives a Title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit payable as a result of a Title II cost-of-living adjustment (COLA) is not counted as income until the beginning of the second month following the month of publication of the revised annual FPL. For individuals who have Title II income, the new poverty levels are effective beginning with the month after the last month for which COLAs are disregarded. For individuals without Title II income, the new poverty levels are effective no later than the date of publication in the Federal Register.[45]

(2) [Reserved]

(3) Qualified Individuals (QI-1)[46]

(i) An individual is eligible for Medicaid payment of their Medicare Part B premiums if the individual is entitled to Medicare Part A, or coverage of the Part B premium related to enrollment in Medicare Part B for coverage of immunosuppressive drugs if the individual is enrolled under Medicare Part B for coverage of immunosuppressive drugs, if the individual:

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

(B) Is a member of a Medicaid group (as defined in § 29.04) with MABD income that is greater than 150 percent but less than 202 percent of the FPL for their applicable family size as defined in subparagraph (a)(4) above; and

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

(ii) There is no resource test for this group and any dividend or interest income earned on resources is disregarded.

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

(iv) Retroactive eligibility applies if:

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

[46] 42 CFR § 435.125.

(A) The individual met all QI-1 eligibility criteria in the retroactive period defined in § 70.01(b); and

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

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

(4) Qualified Disabled and Working Individuals (QDWI)

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

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

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

(C) Is a member of a Medicaid group (as defined in § 29.04) with MABD income at or below 200 percent of the FPL for their applicable family size as defined in subparagraph (a)(4) above;

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

(E) Is not otherwise eligible for Medicaid.

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

(iii) Benefits for a retroactive period, as defined in § 70.01(b), may be granted, provided that the individual meets all eligibility criteria during the retroactive period.

9.00 Special Medicaid groups (01/01/2025, GCR 24-075)

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

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

9.02 Nonfinancial criteria (01/01/2025, GCR 24-075)

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

(a) Social Security number (§ 16.00);

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

(c) Residency (§ 21.00);

[47] CMS State Medicaid Manual, § 3492.

(d) Living arrangements (§ 20.00); and

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

9.03 Categorical and financial criteria (01/01/2024, GCR 23-083)

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

(b) Deemed newborn[48]

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

(2) Eligibility

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

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

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

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

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

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

(3) Medicaid identification number

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

[48] 42 CFR § 435.117.

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

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

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

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

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

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

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

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

(d) Special needs adoption[51]

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

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

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

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

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

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

[50] 42 CFR § 435.145.

[51] 42 CFR § 435.227.

(e) Former foster child[52]

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

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

(i) Is under age 26; and

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

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

(B) Was in foster care under the responsibility of Vermont and enrolled in Medicaid under the state's Medicaid State plan or 1115 demonstration upon attaining age 18; or

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

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

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

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

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

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

(2) Eligibility

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

(A) Is under age 65;

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

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

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

[53] 42 CFR § 435.213; CMS SHO Letter (January 4, 2001).

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

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

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

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

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

(iii) Medicaid eligibility for an individual in this group begins following the screening and diagnosis and continues as long as a treating health professional verifies the individual is in need of cancer treatment services.

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

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

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

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

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

(g) Family planning services[55]

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

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

screening or diagnostic service.

[55] 42 CFR § 435.214.

(i) Is not pregnant; and

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

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

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

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

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

10.00 Pharmacy benefits (01/01/2027, GCR 26-052)

10.01 VPharm program (01/01/2027, GCR 26-052)

See, VPharm Rule 5400 *et seq*.

10.02 Healthy Vermonters program (HVP) (01/01/2027, GCR 26-052)

See, Healthy Vermonters Rule 5700 *et seq*.

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

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

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

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

The individual must meet all of the following nonfinancial criteria:

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

(b) Incarceration (§ 19.00); and

(c) Residency (§ 21.00).

[56] 45 CFR § 155.305(a).

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

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

12.00 Advance payments of the premium tax credit (APTC) (01/01/2027, GCR 26-052)

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

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

12.02 Nonfinancial criteria[58] (01/01/2027, GCR 26-052)

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

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

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

(c) Is a U.S. citizen, U.S. national, or an eligible non-citizen as defined in § 17.01(i).

12.03 Applicable tax filer[59] (01/01/2027, GCR 26-052)

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

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

(b) Married tax filers must file joint return

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

(2) *Victims of domestic abuse and spousal abandonment:* Except as provided in (5) below, a married tax filer

[57] 45 CFR § 155.305(b).

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

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

will satisfy the joint filing requirement if the tax filer files a tax return using a filing status of married filing separately and:

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

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

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

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

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

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

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

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

(e) [Reserved]

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

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

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

[61] 26 CFR § 1.36B-2(b)(6).

year;

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

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

(4) The tax filer would be an applicable tax filer if the tax filer's household income for the benefit year was at least 100 but not more than 400 percent of the FPL for the tax filer's family size.

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

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

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

12.05 Compliance with filing requirement[63] (01/01/2027, GCR 26-052)

AHS may not determine a tax filer eligible for APTC if HHS notifies AHS as part of the process described in §§ 56.03 through 56.08 that APTC payments were made on behalf of either the tax filer or spouse, if the tax filer is a married couple, for a year for which tax data would be utilized for verification of household income and family size in accordance with § 56.01(a), and the tax filer or their spouse did not comply with the requirement to file an income tax return for that year as required by 26 USC § 6011, 6012, and in 26 CFR chapter I, and reconcile APTC for that period.

AHS will send a notice to the tax filer or the individual which informs the tax filer or the individual that they may be at risk of being determined ineligible for APTC.

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

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

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

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

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

[62] 45 CFR § 155.305(f)(3).

[63] 45 CFR § 155.305(f)(4).

13.00 Cost-sharing reductions (CSR) (01/01/2027, GCR 26-052)

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

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

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

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

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

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

13.02 Eligibility categories[65] (01/01/2027, GCR 26-052)

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

(a) An individual who is expected to have household income at least 100 but not more than 150 percent of the FPL for the benefit year for which coverage is requested;

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

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

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

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

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

[64] 45 CFR § 155.305(g).

[65] 45 CFR § 155.305(g)(2).

More than 200% but not more than 250%	III	77%
More than 250% but not more than 300%	IV	73%

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

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

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

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

(c) § 13.02(d);

(d) § 13.02(c);

(e) § 13.02(b);

(f) § 13.02(a);

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

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

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

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

[66] 45 CFR § 155.305(g)(3).

[67] 45 CFR § 155.305(h).

[68] 45 CFR § 156.155.

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

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

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FROM: APA Coordinator, VSARA **Date of Fax:** October 13, 2026

RE: The "Proposed State Rules " ad copy to run on **July 23, 2026**

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 proposed rule(s) you are interested in.

- Health Benefits Eligibility and Enrollment Rule, General Provisions and Definitions (Part 1).
  Vermont Proposed Rule: **26P020**
- Health Benefits Eligibility and Enrollment Rule, Eligibility Standards (Part 2).
  Vermont Proposed Rule: **26P021**
- Health Benefits Eligibility and Enrollment Rule, Nonfinancial Eligibility Requirements (Part 3).
  Vermont Proposed Rule: **26P022**
- Health Benefits Eligibility and Enrollment Rule, Financial Methodologies (Part 5).
  Vermont Proposed Rule: **26P023**
- Health Benefits Eligibility and Enrollment Rule, Eligibility-and-Enrollment Procedures (Part 7).
  Vermont Proposed Rule: **26P024**

AGENCY: Agency of Human Services

CONCISE SUMMARY: These proposed rules amend parts 1-3, 5 and 7 of the 8-part Health Benefits Eligibility and Enrollment (HBEE) rules. Parts 1,2,3,5 and 7 were last amended effective January 1, 2026. Substantive revisions include: newly requiring certain adult Medicaid applicants and enrollees demonstrate compliance with work and community engagement rules as a factor of eligibility; reducing the retroactive Medicaid coverage period from three months to one month for Adult coverage group enrollees and two months for all other enrollees; restricting non-citizen eligibility for both Medicaid and Qualified Health Plan premium tax credits and adding a new category of "eligible non-citizen" to clarify which individuals remain eligible; adjusting the renewal period from 12 to 6 months for Medicaid enrollees in the Adult coverage group; shortening the annual open enrollment period from November 1st-January 15th to November 1st - December 15th. All of these substantive revisions are required by federal law.

FOR FURTHER INFORMATION, CONTACT: Emily Belanger, Agency of Human Services 280 State Drive, NOB 1 South, Waterbury, VT 05671-1010 Tel: 802-760-0118 Fax: 802-241-0450 E-mail: emily.m.belanger@vermont.gov URL: https://humanservices.vermont.gov/rules-policies/health-care-rules.

FOR COPIES: Jessica Ploesser, Agency of Human Services, 5 Pilgrim Park, 1st Floor Suite 2, Waterbury, VT 05671-1010 Tel: 802-241-0454 Fax: 802-241-0260 E-mail: jessica.ploesser@vermont.gov.

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(802) 828-2863

MEMORANDUM OFFICE OF THE SECRETARY OF STATE

Primary Contact: Emily Belanger, Agency of Human Services 280 State Drive, NOB 1 South, Waterbury, VT 05671-1010 Tel: 802-760-0118 Fax: 802-241-0450 E-mail: emily.m.belanger@vermont.gov

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URL: https://humanservices.vermont.gov/rules-policies/health-care-rules

From: APA Coordinator, VSARA

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

Date 10/13/2026

We received Proposed Rule on 07/10/2026
Final Proposed Rule on 10/09/2026
Adopted Rule on
We have assigned the following rule number(s):
Proposed Rule Number: 26P021
Adopted Rule Number:
(Final Proposals are not assigned a new number; they retain the Proposed Rule Number.)

The following problems were taken care of by phone/should be taken care of immediately:

We cannot accept this filing until the following problems are taken care of:

The ad for this proposed rule appeared/will appear in newspapers of record on 07/23/2026 & / / .

This rule takes effect on
Adoption Deadline: 03/10/2027

Please note: The agency has requested a combined notice for 26P020, 26P021, 26P022, 26P023, and 26P024.

If you have any questions, please call me at 828-2863. OR
E-Mail me at: sos.statutoryfilings@vermont.gov

cc: Megan Cannella