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4100 Medicaid Program (04/01/1999, 98-11F)

Medicaid is a federal-state program of financial help with the cost of medical care. Vermont began participating in the Medicaid program in 1967 to assist Vermont's eligible low-income individuals to gain access to needed medical services. The federal funds come through Title XIX of the Social Security Act. State funds are appropriated by the General Assembly. The department determines eligibility for Medicaid in Vermont.

Medicaid covers most, but not all, medically necessary medical care and services provided to eligible individuals (see rules 7200-7608 for covered services). In order to receive federal financial participation in program expenditures, the state must provide coverage to certain mandated categories of beneficiaries [42 U.S.C. § 1396a(a)(10)(A)] and offer specified categories of medical services [42 U.S.C. § 1396a(a)(10)]. At state option, additional categories of beneficiaries may be covered or services can be offered, for which federal financial participation is also available. Services are provided through fee-for-service and managed health care delivery systems as described in rule 7101. The Vermont program covers all mandated categories of beneficiaries. It also offers all mandatory services -- general hospital inpatient; outpatient hospital and rural health clinics; other laboratory and x-ray; nursing facility, EPSDT, and family planning services and supplies; physician's services and medical and surgical services of a dentist; home health services; and nurse-midwife and nurse practitioner services. Vermont includes certain, but not all, optional categories of beneficiaries. Vermont has also elected to cover certain, but not all, optional services for which federal financial participation is available.

Vermont is authorized to establish reasonable standards, consistent with the objectives of the Medicaid statute, for determining the extent of coverage in the optional categories (42 U. S. C. § 1396a(a)(17)) based on such criteria as medical necessity or utilization control (42 C. F. R. § 440.230(d)). In establishing such standards for coverage, Vermont must ensure that the amount, duration, and scope of coverage are reasonably sufficient to achieve the purpose of the service (42 C. F. R. § 440.230(b)). Vermont may not limit services based upon diagnosis, type of illness, or condition (42 C. F. R. § 440.230(c)).

In order to obtain federal financial participation in the Vermont program, a state plan must be filed with and approved by Health Care Financing Administration (HCFA) (42 U. S. C. § 1396a). Among other things, the plan describes the amount, duration, and scope of services included in the Vermont program. Vermont is also required to have a statewide management program to control utilization and appropriateness of Medicaid services, based on such criteria as medical necessity and the relative cost-effectiveness of covered services [42 U. S. C. § 1396a(a)(30)(A)].

The scope of coverage for children under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) provisions of Title XIX is different and more extensive than coverage for adults. The EPSDT provisions of Medicaid law specify that services that are optional for adults are mandatory covered services for all Medicaid-eligible children under age 21 when such services are determined necessary as a result of an EPSDT screen. Specifically, Vermont is required to provide

> ...such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of [1396d] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State [Medicaid] plan. 42 U. S. C. § 1396d(r) (5).

A further definition of the scope of EPSDT services is found in 42 C. F. R. § 1396d(a)(13) which requires states to provide

> other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, home, or other setting) recommended by a physician or other licensed

professional of the healing arts within the scope of their practice under State Law, for the maximum reduction of physical or mental disability and restoration of an individual to the best functional level.

Medicaid is provided to pregnant women, individuals age 20 or younger, parents or caretaker relatives of a dependent child, and aged, blind or disabled individuals, as long as the individual meets general and financial eligibility criteria and has, if required of him/her:

- assigned rights to any medical support and other payments for medical care;
- cooperated with the department in establishing paternity;
- enrolled in a group health plan if the department has determined this would be cost-effective; and
- declared, under penalty of perjury, that he/she is a citizen or national of the United States or a noncitizen qualified to participate in the Medicaid program (see sections on Citizenship).

Most individuals who are eligible for and receiving Supplemental Security Income (SSI/AABD) benefits or who meet the July 16, 1996, ANFC rules are eligible for Medicaid as long as they meet the above requirements, if applicable, and do not have a trust that places them over the resource maximum.

Irrevocable trusts are not counted in the SSI program or under the July 16, 1996, ANFC rules but must be counted in the Medicaid program (see section on Trusts).

Individuals receiving essential person grants and the essential persons for whom the state-funded AABD-EP benefits are paid are not automatically eligible and must meet all eligibility criteria before being granted Medicaid.

INTERPRETIVE MEMO

[X] Medicaid Rule Interpretation **[ ] Medicaid Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4101 **Date of this Memo** 06/06/1984 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: What is the effective date of new or changed rule?

ANSWER: For applicants: As of the date shown on the rule page; or, as of the transmittal date of the cover bulletin; whichever is later.

For recipients: At the time of the next eligibility review; or, at the time of the desk review specified in the cover bulletin.

4101 Purpose - Medicaid Program (04/01/1999, 98-11F)

Medicaid was established as a result of amendments in 1965 that added Title XIX to the Social Security Act. It is a program administered within a federal-state regulatory framework. The first statutory section of Title XIX, 42 U. S. C. § 1396, "Appropriation," states:

For the purpose of enabling each State, as far as practicable, under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and beneficiaries attain or retain the capability for independence and self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.

Vermonts State plan for medical assistance “must...include reasonable standards ...for determining eligibility for and the extent of medical assistance under the plan which are consistent with the objectives” of Title XIX. 42 U. S. C.§ 1396a(a)(17); Beal v. Doe, 432 U. S. 438, 444 (1977).

4102 Vermont Health Access Plan (04/01/1999, 98-11)

The Vermont Health Access Plan (VHAP) operates as a Research and Demonstration Project authorized under Section 1115(a) of the Social Security Act. This program permits federal financial participation in health benefit coverage to low-income, previously uninsured Vermont adults who do not meet the Medicaid eligibility rules and pharmacy benefits to low-income elderly or disabled adults who are eligible under the conditions of the waiver as approved by HCFA. Under the terms of the waiver, coverage under this program is not an entitlement in that the services covered are limited to those included in the approved waiver program. VHAP beneficiaries do not have the same scope of coverage as Medicaid beneficiaries as described in the state plan.

The department may, by rule, impose additional limitations on coverage of services or items for expansion populations included in the waiver for the effective and efficient administration of the program, consistent with state and federal law and waiver terms and conditions.

4103 VHAP Determination When Medicaid Closes (09/07/1996, 96-45F)

Individuals found no longer eligible for Medicaid shall have their financial eligibility under the rules of the Vermont Health Access Plan (VHAP) determined before Medicaid is closed. An individual who meets the financial eligibility criteria for VHAP shall be accepted in that program, subject to program enrollment caps and shall have 30 days in which to pay any required premium.

In areas where managed care is available, the individual shall be contacted by the benefits counselor and enrolled in a managed health care plan.

A delay in paying a required premium or in choosing a plan could result in a gap between the date when Medicaid coverage ends and the date when VHAP coverage begins.

Quality Control Review

4104 Quality Control Review (12/01/1997, 97-10)

The main reason for quality control review is to be sure that Medicaid rules are clear and consistently applied and that Medicaid applicants and recipients can understand and give correct information for the eligibility tests.

A random sample of active Medicaid recipients is chosen each month for a full field review of their Medicaid eligibility. Each eligibility factor must be verified with the recipient and collateral sources. If the recipient refuses to cooperate in completing a quality control review, his Medicaid benefits must be closed.

A similar sample of negative actions (denials, closures, benefit decreases) is also chosen each month. These reviews do not usually require a contact with the applicant or recipient, although the reviewer may sometimes need to check facts with him or her.

When the quality control review shows different facts about the person's situation, the department must schedule an eligibility review and take action to correct errors or review the effect of the changes.

4105 Beneficiary Fraud (12/01/1997, 97-10)

An individual who deliberately hides or omits information or gives false information to get, or help another person to get, benefits he or she would not otherwise be eligible for, may be prosecuted under Vermont law for recipient fraud. If convicted, the individual may be fined or imprisoned or both. The department may also take action to recover the value of benefits paid in error due to fraud.

When the department learns that fraud may have been committed, it will investigate the case with respect for confidentiality and legal rights of the recipient. If appropriate, the case will be referred to the State's Attorney or Attorney General for a decision on whether or not to prosecute.

4110 Eligibility and Enrollment Process (04/01/2005, 05-09)

The eligibility and enrollment process includes the steps an individual requesting health care assistance and the department must take to determine an individuals eligibility for and enrollment in health care assistance programs.

Eligible means the department has decided the individual meets all the eligibility criteria specific to the coverage group such as age, residency, and income level.

Enrolled means the department has received full payment of required premiums for the individual who has been determined to meet all eligibility criteria specific to the coverage group. Enrolled individuals are health care assistance beneficiaries. Coverage begins the first day of the month after receipt of any required premiums, unless retroactive coverage provisions apply as in rule 4122.

A. The person (or group) must:
    1. apply for health care assistance,
    2. give necessary facts about their (or their family's) situation for the eligibility tests, and
    3. pay any required premium by the due date.

B. The department must:
    1. accept all health care assistance applications and premium payments,
    2. compare the facts of the individual's situation to the health care assistance eligibility rules,
    3. make decisions on initial and continuing eligibility for health care assistance,
    4. notify the individual of its decisions, and
    5. keep records of decisions and the facts used to make them.

Rules and time limits for these steps are given in rules 4120–4154.

Premiums

4111 Premiums (04/01/2005, 05-09)

Certain health care assistance groups are required to pay a monthly premium as a condition of initial and continuing coverage. The amount of the premium depends on the net income of the assistance group on the most recent approved version of eligibility on the case record at the time the bill is generated, and for some coverage groups, the existence of other insurance that includes both hospital and physician coverage.

Failure to pay the full premium by the last day of the month shall result in disenrollment.

The premium payment system is described in rules 4160–4162.

4112 Authorized Representative (12/01/1980, 80-62)

The parent, guardian or other caretaker responsible for a minor child acts as the child's representative in the eligibility process.

When a person cannot act for himself, because of his physical or mental condition, one of the following people may act as his authorized representative in the eligibility process:

- A court appointed legal guardian or legal representative; or
- A relative, friend or other person who knows about or handles his affairs; or
- A person he names in a letter to the department to take his place when he cannot come for a necessary interview because of an unexpected emergency.

When a person dies before he can apply for retroactive Medicaid coverage, the administrator or executor of his estate, a surviving relative or other responsible person may act as his authorized representative.

Case Records

4113 Case Records (12/01/1980, 80-62)

The Department keeps a permanent written record of facts and actions concerning a person's (or group's) Medicaid eligibility for administrative and accountability purposes. Information about each person or group is kept in an individual case file in the district office responsible for the town where the person or group lives. Information necessary to assure prompt and correct payment of Medicaid benefits is also stored in computer files.

Information which identifies a person or group as a Medicaid applicant or recipient is only given out when it is necessary to furnish or pay for Medicaid services. A recipient may permit the Department to give information to another agency to help him get services from that agency.

Information about many applicants or recipients, which does not identify persons or groups by name or other individual characteristics, may be combined in the form of statistics or general descriptions for planning, research and program administration.

INTERPRETIVE MEMO

[X] Medicaid Rule Interpretation **[ ] Medicaid Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4120 **Date of this Memo** 10/17/1995 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: What do I do if an individual has been granted SSI and Medicaid and has received General Assistance (GA) in the three-month retroactive period?

ANSWER: Find the individual eligible for Medicaid in the retroactive period, without an application for retroactive benefits, if:

- the individual was granted SSI based on blindness or disability; and
- the individual was eligible for GA for other than catastrophic reasons at any time during the three months.

This action reduces the paperwork involved in sending the form 202A (Medicaid Request for Retroactive Assistance) when we already have information about the individual's circumstances. We can also cover medical expenses under the Medicaid program with the federal match rather than under the GA program which is 100 percent state funded.

QUESTION: What do I do if an individual has been granted SSI and Medicaid and has been enrolled in an ESD program within the three-month retroactive period?

ANSWER: Determine whether or not the individual is eligible for retroactive benefits using the income and resource information you have on file. An application for retroactive benefits is not required. If the individual is eligible, send a grant letter. If the individual is not eligible based on the information you have on file, send him/her the form 202A (Medicaid Request for Retroactive Assistance) form.

QUESTION: What do I do if an individual has been granted SSI and Medicaid and has not been enrolled in a n ESD program within the three-month retroactive period?

ANSWER: Send them the form 202A (Medicaid Request for Retroactive Assistance) and determine eligibility for Medicaid upon receipt of the form (see rule 4122). A notice of denial or a grant notice is required.

INTERPRETIVE MEMO

[X] Medicaid Rule Interpretation **[ ] Medicaid Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory policy with a later date.

Please file in your manual facing the page indicated below.

Facing Page 4120 **Date of this Memo** 10/18/1995 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: Rule 4121 states an individual who is "not now eligible for coverage may re-apply at any time." What do I do if:

- I denied an application because the individual had excess income; and
- I gave the individual the spend-down amount and the six-month spend-down period; and
- the individual reports a change in his/her circumstances and requests a recalculation of his/her eligibility?

ANSWER: Have the individual withdraw his/her old application and complete a new application. A new six-month spend-down period is calculated and may include up to a three calendar months prior to the month of the new application.

INTERPRETIVE MEMO

[X] Medicaid Rule Interpretation **[ ] Medicaid Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4120 **Date of this Memo** 04/14/1994 **Page** 1 of 1

This Memo: [X] **is New** [ ] **Replaces one dated** _____

QUESTION: Rule 4122 states that retroactive payments can be made for Medicare cost-sharing groups other than QMB's. If an individual is eligible for one or two of the months in the retroactive period but not all three months, may we grant for the months he/she is eligible for the benefit?

ANSWER: Yes.

Application

4120 Application (04/01/2005, 05-09)

Any individual who wants Medicaid must file a Medicaid application with the department except: An individual who has applied at a Social Security Office for supplemental security income.

If an individual granted SSI/AABD also wants retroactive Medicaid coverage before the start of the cash assistance grant, he/she must file a separate application for retroactive Medicaid coverage and be found eligible based on criteria other than receiving cash assistance.

Filing an application means taking or mailing a signed Medicaid application form to a department office, preferably the district office responsible for the town where the applicant lives. Department offices give Medicaid application forms to any individual who asks for one. Medicaid providers, referring agencies and other locations serving the public may also keep supplies of application forms.

An application form must be signed by individuals applying for Medicaid or by their authorized representative.

INTERPRETIVE MEMO

[X] Medicaid Rule Interpretation **[ ] Medicaid Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4121 **Date of this Memo** 10/18/1995 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: Rule 4121 states an individual who is "not now eligible for coverage may re-apply at any time." What do I do if:

- I denied an application because the individual had excess income; and
- I gave the individual the spend-down amount and the six-month spend-down period; and
- the individual reports a change in his/her circumstances and requests a recalculation of his/her eligibility?

ANSWER: Have the individual withdraw his/her old application and complete a new application. A new six-month spend-down period is calculated and may include up to a three calendar months prior to the month of the new application.

INTERPRETIVE MEMO

[X] Medicaid Rule Interpretation **[ ] Medicaid Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4121 **Date of this Memo** 04/14/1994 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: Rule 4122 states that retroactive payments can be made for Medicare cost-sharing groups other than QMB's. If an individual is eligible for one or two of the months in the retroactive period but not all three months, may we grant for the months he/she is eligible for the benefit?

ANSWER: Yes.

Reapplication and Reenrollment

4121 Reapplication and Reenrollment (04/01/2005, 05-09)

Any individual who has applied before for Medicaid and is not now eligible for coverage may reapply at any time.

To reapply, the individual (or group) must file a new up-to-date signed application form with the department. An authorized representative may act for the individual or group when needed.

When an individual has been disenrolled from coverage solely for non-payment of a premium, if the department receives and processes the payment on the next business day following the last day of the month the premium was due, the coverage group will be automatically reenrolled without a new application and without a break in benefits.

If the department receives and processes the payment after the first business day after the month the premium was due, but within the first month after closure, the coverage group will be automatically reenrolled for the next month with a one month break in coverage. Beneficiaries must submit a new application, however, if any change in a coverage group's circumstances affects its eligibility or a review of the case is scheduled for the current month or the following month.

Retroactive Application

4122 Retroactive Application (04/01/2005, 05-09)

Medicaid may be granted retroactively for up to three calendar months before the month of application provided all eligibility criteria were met during the retroactive period and any premiums required for those months have been received by the department. A woman is not eligible for the 60-day post-pregnancy period (i.e., when no other categorical criterion is met) if she was granted retroactively after her pregnancy has ended.

An authorized representative may apply for retroactive coverage on behalf of an individual who dies before he or she can apply for Medicaid.

Payments for Medicare cost sharing for individuals who are Qualified Medicare Beneficiaries (QMBs) and not otherwise eligible for Medicaid are first made in the month following the month QMB eligibility is determined. There is no retroactive QMB coverage.

Payments for Medicare cost sharing for the other Medicare cost-sharing groups can be paid for allowed Medicare costs incurred prior to the month of application provided all eligibility criteria were met during the three month retroactive period.

Date of Application

4123 Date of Application (02/01/1993, 93-2)

The date of application is the day on which a signed Medicaid application form is received in a Department office, or the day on which an application for Supplemental Security Income/Aid to the Aged, Blind or Disabled (SSI/AABD) is filed with a Social Security office.

The application date sets the time limits for making a decision on the application and the earliest date retroactive coverage may begin.

INTERPRETIVE MEMO

[X] Medicaid Rule Interpretation **[ ] Medicaid Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4124 **Date of this Memo** 05/03/1995 **Page** 1 of 3

This Memo: [ ] is New [X] Replaces one dated 08/01/1989

QUESTION: What if a family applies for Medicaid and we identify one or more members of the family who have a choice of having their eligibility determined using either the SSI-related rules or the ANFC-related rules. Is there any way to grant Medicaid to the family members with a choice and then exclude any portion of their income and resources used to determine their Medicaid eligibility in determining the financial eligibility of the rest of the family?

ANSWER: Yes. After receiving the family's Medicaid application, assist the family by identifying the possible groups which may be formed. Take into account the financial responsibility of spouses/parents and the medical expenses of each member of the family. The individuals with the choice must determine under which rules (SSI or ANFC) they want their Medicaid eligibility determined. Once that choice has been made, you may grant Medicaid to group members who are eligible, either immediately or after meeting a spend-down, under the rules chosen. Make sure the application (form 201) is signed by a member of this (first) group.

For any other family members who are not covered under the rules chosen but who wish to apply for Medicaid, make sure you have a separate, subsequent (i.e., with a later time and/or date) application (form 201) for Medicaid signed by an adult member of this (second) group. Note: if all members of this second group are dependent children, have the application signed by an adult family member. You may use the same Statement of Need (form 202) as long as the second application is received within 30 days of the receipt of the form 202.

Determine the Medicaid eligibility of the rest of the family after you have found the first group eligible and have granted them Medicaid. For this second eligibility determination you may exclude from consideration all of the income and resources of the individuals with a choice that were used in determining their eligibility for Medicaid.

Example: Mr. and Mrs. Jones and their 14-year-old son live in Barre. Mr. Jones is disabled and receives $640 from Social Security. Mrs. Jones has a part-time job and earns $400 a month. The son receives $125 a month from Social Security. Mr. Jones applies for Medicaid for the family, and you determine the family has resources under the resource maximum for 3 but countable income over the PIL for 3.

Since Mr. Jones is disabled, he has the choice of applying for Medicaid under the SSI rules. Note: Mrs. Jones and their son are ineligible for SSI-related Medicaid because they are not aged, blind or disabled. Mrs. Jones does have financial responsibility for her spouse, however, so her income and resources are counted. You determine he has countable resources under $3000 and countable income under

the SSI/AABD payment level for 2 using the rule 4281.1 and/or the SSI/AABD-related worksheet (form 203 B1) as follows:

Unearned Income	$ 640.00	
Disregard	— 20.00	
Allocation to Child	— 104.00	($229 — $125)
Net unearned =	$516.00	
Earned Income	$ 400.00	
Deduction	— 65.00	
	$335.00	
Net earned =	—167.50	(1/2)
	$167.50	
Countable Income	$ 516.00	unearned
	+ 167.00	earned
	$ 683.50	

You grant Medicaid to Mr. Jones.

Mrs. Jones will need to sign a separate, subsequent application for Medicaid for herself and their child. Since you have granted Medicaid to Mr. Jones you may now disregard his income of $640.00, which was used in determining his eligibility. Mrs. Jones and the child have resources under $3000. You determine their countable income using the ANFC-related rules as follows:

$125.00	Unearned Income	$400.00	Earned Income
+104.00	Allocation to Child	—90.00	Standard Employment Expense Deduction
$229.00		$310.00	
		—0.00	No Dependent Care Expenses

	Countable Income	$229.00	
		+310.00	
		$539.00	

Because their countable income does not exceed the PIL for 2, you grant Medicaid to Mrs. Jones and her son.

This example is based on PILs and allowable deductions in effect in April, 1995.

Choice of Category

4124 Choice of Category (02/01/1993, 93-2)

In order to be found eligible for Medicaid, an individual must meet one of the following requirements:

- be found eligible for Medicaid as determined by the Department 's application of SSI/AABD-related Medicaid rules (4200); or
- be found eligible for Medicaid as determined by the Department 's application of ANFC-related Medicaid rules (4300).

Any individual seeking Medicaid coverage has the right to select which of the two sets of rules listed above, he or she wishes to have applied to his or her eligibility determination. In order to assist applicants in making this decision, the Department is responsible for providing the following information:

A. the requirements specific to SSI/AABD-related Medicaid eligibility. In order to be SSI/AABD-related, an applicant must be either:

   1. 65 years of age or older, or
   2. blind, or
   3. disabled

B. the requirements specific to ANFC-related Medicaid eligibility. In order to be ANFC-related, an applicant must be:

   1. 20 years of age or younger, or
   2. a pregnant woman, or
   3. a parent or caretaker relative of a child who meets the Reach Up age criteria for a child and is deprived of parental care and support in accordance with the rules of the ANFC-related Medicaid program.

In some instances an applicant may meet the non-financial requirements applicable to both ANFC- and SSI/AABD-related Medicaid eligibility. In these cases, the Department is responsible for providing the following information regarding the financial requirements of both programs.

A. The SSI/AABD rules usually allow more extensive exclusions of income and resources. In addition, a larger portion of earned income may be disregarded than is allowed by the ANFC-related rules. If the applicant who meets the non-financial requirements of both programs is the only member of the family in need of Medicaid enrollment, it may be more advantageous for him or her to apply under the SSI/AABD-related rules than under the ANFC-related rules.

B. When an individual(s) who has a choice of category and other members of his/her family apply for Medicaid at the same time, the individual(s) having a choice of category may choose to apply on the basis of the rules of the program for which the rest of the family is not eligible. In this situation, the individual(s) with the choice must be included in the other family members' Medicaid group when determining their financial eligibility for Medicaid provided that the inclusion of the individual(s) having the choice of category is required by the rules of the program under which the other family members are applying and his/her inclusion does not result in prohibited deeming.

If one or more members of the family are already enrolled in Medicaid, the worker must determine if any change in the family's circumstances has occurred since the most recent eligibility determination which would require a redetermination of his/her (their) Medicaid eligibility. If circumstances relevant to his/her (their) Medicaid eligibility have changed the Medicaid eligibility of the members of the family who are

Choice of Category

already enrolled in Medicaid must be redetermined prior to completing the determination of Medicaid eligibility for those family members who are not currently enrolled in Medicaid. If circumstances relevant to Medicaid eligibility have not changed, no redetermination of Medicaid eligibility should be completed at this time.

When one or more family members are already enrolled in and remain eligible for Medicaid, the determination of the other family members' financial eligibility for Medicaid will exclude from consideration:

A. All of their (i.e. the Medicaid recipients' or recipient's) benefits which are based on financial need; and

B. Those portions of their (i.e. the Medicaid recipients' or recipient's) income used to determine their benefits with the following exception. The exclusion of income does not apply to individuals found eligible due to total countable income which does not exceed one of the special income tests but does exceed the applicable Protected Income Level; and

C. Resources owned solely or jointly by the Medicaid recipient(s) with the following exception. A resource cannot be excluded if it was an excluded resource for the family member(s) already enrolled in Medicaid solely because the joint-owner member(s) of the subsequent applicant group refused to make the resource accessible to the family member(s) already enrolled in Medicaid.

4130 Application Decisions (12/01/1980, 80-62F)

A decision must be made to grant or deny any Medicaid application filed with a Department Office.

Medicaid is granted when a person's situation passes all necessary eligibility tests. When a family group applies together, some members may pass the tests and be granted Medicaid while other members do not and must be denied. A Medicaid grant begins on the first day that all eligibility tests are passed. This may be the first of a month during which all the tests are passed at any time during that month, except when an income spend-down test is necessary (see rule 4441).

Medicaid is denied when a person's situation does not pass any one or more of the eligibility tests. A Medicaid denial takes effect on the day the decision is made.

An application decision may grant Medicaid for part of the period applied for and deny it for another part (such as the retroactive period) because the person did not pass all the tests for the full time.

When an applicant fails to do his part, an application may be denied if a decision cannot be made within the time limit, for example:

An applicant fails to give necessary information or proofs asked for or takes longer than expected without explaining the delay; or

An applicant fails to have necessary medical examinations asked for.

When an applicant has done everything he was asked to do, the application will not be denied even though a decision cannot be made before the time limit.

Decision Time Limits

4131 Decision Time Limits (04/01/1990, 90-1)

A decision on a Medicaid application must be made as soon as possible, but no later than:

- 90 days after the application date, if the application is based on a person's disability; or
- 30 days after the application date for any other Medicaid application.

The decision is not completed until a written notice of the decision has been given or mailed to the applicant.

Decisions may take longer in unusual situations, such as:

- An examining physician delays sending a necessary report; or
- An unexpected emergency or administrative problem beyond Department control delays action on applications.

Application Forms

4132 Application Forms (07/01/1993, 93-19F)

An applicant's signed application form(s) is the main source of information used to make a decision on the applicant's application.

The application form(s) provides the applicant's written record of the facts about his/her situation as related to Medicaid eligibility tests. A relative, friend or other interested person may help the applicant to fill out the statement. If the applicant has no one to help, he/she may ask for help at a Department Office.

The applicant, or his/her authorized representative (rule 4112,Authorized Representative), who signs the form(s) is held responsible for the truth of the information on the form. When no interview is necessary, the Department will make the application decision from the information on the form(s) and any necessary proofs. It may be necessary to write or telephone the applicant for more information or explanation of entries on the form(s).

Interview

4133 Interview (07/01/1993, 93-19F)

An interview is a face-to-face meeting between the applicant, or his/her authorized representative (see Authorized Representative), and a Department employee to review the applicant's application form(s) and resolve any problems or questions about the applicant's situation in relation to the Medicaid eligibility tests.

An interview must be held when:

- The Medicaid application includes a patient living in a long-term care living arrangement unless it is clear that no additional information will be gained from an interview (see below); or
- The application form(s) does not give enough clear and consistent information about the applicant's situation to make a decision on his/her application.

An interview may be desirable, but not necessary, to work out complex eligibility test problems, or to help an applicant who has trouble understanding eligibility rules or in giving written information.

Interviews are private. One representative chosen by the applicant may be present to help explain the applicant's situation. Interviews are held at the District Office or at the long-term care facility where the applicant is living. An interview at home, or some other location convenient for both, may be arranged if unusual health or transportation problems make an office visit impossible for the applicant or his/her representative.

A face-to-face interview is not required if no additional information will be gained. If the client is unable to respond to questions, consider a telephone interview with the individual(s) acting on behalf of the client to obtain additional information.

4134 Social Security Numbers (01/01/2007, 06-48)

The Department will notify applicants or recipients that Social Security numbers will be used in the administration of the Medicaid program.

Refusal to furnish a Social Security number, refusal to verify a Social Security number, or refusal to apply for a Social Security number for any applicant or recipient shall make that individual ineligible for assistance. However, refusal to furnish a Social Security number shall not affect eligibility if the individual is a member of a religious organization that objects to this practice.

The Department will advise applicants how to apply for Social Security numbers and will not delay, deny or discontinue assistance during the issuance and verification of such numbers.

INTERPRETIVE MEMO

[X] Medicaid Rule Interpretation **[ ] Medicaid Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4135 **Date of this Memo** 01/01/2007 **Page** 1 of 1

This Memo: [ ] is New [X] Replaces one dated 11/13/1995

Required verification

Written proof is required of:

- alien status
- citizenship and identification
- blindness or disability if individual is not receiving social security disability insurance benefits (SSDI) or Supplemental Security Income (SSI) on the basis of disability

Additional information should be verified, if questionable.

All other information is obtained through tape matches with other agencies, such as the Social Security Administration, the Internal Revenue Service, and the Department of Labor.

If written proof is required for other state programs but is not required for health care, district offices should process the health care eligibility on the basis of self-declaration.

INTERPRETIVE MEMO

[X] Medicaid Rule Interpretation **[ ] Medicaid Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4135 Date of this Memo 10/17/1995 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

QUESTION: Is there ever a time when we may find individuals eligible for Medicaid even though they refuse to provide their social security numbers (SSN)?

ANSWER: Yes. You may grant Medicaid to an otherwise eligible individual if the applicant/recipient is a member of a religious organization that objects to furnishing a social security number (SSN). Obtain a permanent number to use instead of the SSN by calling Catherine Mears at 241-1560 in the Office of Child Support. Catherine is the parent locator for Vermont and maintains the (only) list of persons assigned permanent alternate numbers. She will need the full name of our client for her files.

QUESTION: Is there ever a time when we may grant Medicaid to an individual who is not eligible for a Social Security number (SSN)?

ANSWER: Yes. You may grant Medicaid to an illegal alien to cover an emergency medical condition (rules 4216 and 4330) even though he/she is not eligible for a SSN. Assign a temporary number for this individual.

Verification

4135 Verification (07/01/2008, 08-38)

Verification means proof of an applicant's statements by written records or documents shown to the Department's employee or agent, or by statements of another person who adds to or supports the applicant's statements.

Proof of the following is required:

A. All applicants' and recipients' Social Security numbers. Verification of application for such numbers is an acceptable substitute until such time as the Social Security numbers are received and verified; and

B. A medical decision, based on professional examination and judgment, on blindness, disability or incapacity; and

C. All countable income;

D. All resources, when the total is within $200 of the resource maximum; and

E. Proof of citizenship or alienage status and identity (rule 4171).

Proof may also be necessary when the statement form and interview, if one is held, do not give enough clear and consistent information to make a decision on any other eligibility test.

Proof documents are returned to the applicant as soon as necessary after information is recorded. Proof documents may be brought to the interview if one is held. Added proofs asked for after review of the applicant's statement may be sent or brought to the office.

When an applicant refuses to give necessary proofs, the application may be denied.

Collateral Sources

4136 Collateral Sources (10/01/1986, 86-12)

Contact with sources other than the applicant may be made concerning his eligibility for aid or benefits. These contacts are limited to interviews, telephone calls, or correspondence necessary to obtain information required to make a decision on eligibility. Information requested from collateral sources is limited to the specific eligibility factors in question.

Common collateral sources are relatives, landlords, employers, town officials, Town Service Officers, public records, doctors, medical facilities, etc. Other agencies which have worked with the client are generally the best source of collateral information.

When information given by the client is either insufficient or questionable, contact with a collateral source may be made without the client's consent. Information requested from collateral sources is limited to eligibility requirements.

INTERPRETIVE MEMO

[X] Medicaid Rule Interpretation **[ ] Medicaid Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4137 **Date of this Memo** 03/19/1996 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: Is an individual eligible for Medicare Part B coverage required to apply for it?

ANSWER: No. Individuals are not required to apply for Medicare Part B as a condition of eligibility for Medicaid.

Potential Unearned Income

4137 Potential Unearned Income (12/01/1994, 94-42)

As a condition of eligibility, the Department requires an applicant or recipient to take all necessary steps to obtain any annuities, pensions, retirement, or disability benefits to which he or she may be entitled, unless he or she can show good cause for not doing so. Annuities, pensions, retirement and disability benefits include, but are not limited to, veterans' compensation and pensions, Old-Age, Survivors, and Disability Insurance (OASDI) benefits, railroad retirement benefits, and unemployment compensation. Application for these benefits, when appropriate, must be verified prior to granting or continuing Medicaid.

Individuals are not required to apply for cash assistance programs such as SSI/AABD or Reach Up as a condition of eligibility for Medicaid.

INTERPRETIVE MEMO

[X] Medicaid Rule Interpretation **[ ] Medicaid Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4138 **Date of this Memo** 12/30/1992 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: I understand there is an expansion of the requirement to "...cooperate with the Department in obtaining such third party payments..."

ANSWER: This is correct. Individuals who are eligible to enroll in a group health plan that the Department determines is likely to be cost effective, must enroll in the group health plan to obtain or maintain their Medicaid eligibility.

The premiums are paid by the Medicaid program.

The fact that an individual is enrolled in a group health plan does not change the individual's coverage under Medicaid. If services covered by Medicaid are not part of the services covered by an eligible individual's group health plan, the individual may obtain those services from participating Medicaid providers. These services are reimbursed at the State Medicaid rate.

Individuals meet this "condition of eligibility" when they sign the form 202, Statement of Need, but a verbal explanation of the above information and this requirement should be given to individuals who are eligible for a group health care plan. The Office of Vermont Health Access (OVHA) will make the determination as to cost effectiveness and notify the individual if he/she must enroll (or remain enrolled) in the group health care plan. OVHA will notify you if any individual refuses to cooperate with this requirement. Eligibility for Medicaid ends for any individual who refuses to cooperate.

INTERPRETIVE MEMO

[X] Medicaid Rule Interpretation **[ ] Medicaid Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4138 **Date of this Memo** 09/15/1988 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: If a Medicaid applicant or recipient is also applying for Reach Up and has refused to cooperate with the Department in the pursuit of child support, does this affect his/her eligibility for Medicaid?

ANSWER: No. Pursuit of child support for maintenance is not a requirement for Medicaid eligibility. The signing of the form 202, which contains an assignment to the Department of all rights to medical support and to third party payments for medical care, is the "assignment of rights" referred to in this rule as a condition of eligibility for Medicaid. The only circumstance in which an individual who has signed the form 202 might later lose his/her eligibility for Medicaid would be if the Department requires further action on the part of the recipient in order to pursue third party coverage and the client refuses to cooperate (rule 4138.1) without good cause (rule 4138.2)

You may accept the signing of the form 202 as meeting the requirement to assign rights unless one of the following occurs:

A. You are notified by OVHA's Third Party Liability Unit that the client has refused to provide information or otherwise cooperate in obtaining information necessary to pursue a third party claim; or

B. You are notified by the Child Support Division that it attempted to pursue acquisition of some form of third party medical coverage for the children, including the establishment of paternity necessary to pursue such third party medical coverage, and the client refused to cooperate.

If you of the above situations occurs, you must review the situation with the client no later than at the time of the next regular review and make sure the client understands that failure to cooperate without good cause will result in the loss of Medicaid. If the client still refuses to cooperate and you determine he/she does not have good cause for the refusal, you must close Medicaid for that individual.

QUESTION: If a Medicaid applicant or recipient is not applying for Reach Up, is there a requirement to complete a Support Enforcement Referral (form 137)?

ANSWER: There is no requirement to complete the form 137 unless the worker has been specifically requested by the Child Support Division to obtain this information about the Medicaid group.

4138 Other Potential Income (02/01/2003, 02-33)

As a condition of initial and continuing eligibility, all Medicaid applicants and beneficiaries must meet the requirements related to the pursuit of medical support, third-party payments and the requirement to enroll or remain enrolled in a group health insurance plan, as detailed in rules 4138.1-4138.4.

4138.1 Assignment of Rights to Payments (02/01/2003, 02-33)

Medicaid applicants and beneficiaries with the legal authority to do so must assign their rights to medical support and third-party payments for medical care to the department, with the exceptions noted below. If they have the legal authority to do so, they must also assign the rights of any other Medicaid applicants and beneficiaries to such support and payments to the department.

No assignment is required for Medicare payments or cash payments from the Department of Veterans Affairs for aid and attendance.

4138.2 Cooperation in Obtaining Payments (02/01/2003, 02-33)

Medicaid applicants and beneficiaries must cooperate with the department in obtaining medical support and third-party payments for medical care unless the department has granted them a good cause waiver for not cooperating (rule 4138.3). To meet this requirement, the department may require an individual to:

A. provide information or evidence relevant and essential to obtain such support or payments;

B. appear as a witness in court or at another proceeding;

C. provide information or attest to lack of information under penalty of perjury; or

D. take any other reasonable steps necessary for establishing parentage or securing medical support or third-party payments.

The department shall exempt an unmarried pregnant woman with income under 200 percent of the federal poverty level from the requirement to cooperate in establishing paternity or obtaining medical support and payments from, or derived from, the father of the child she expects to deliver or from the father of any of her children born out-of-wedlock. She shall remain exempt through the end of the calendar month in which the 60-day period beginning with the date of her delivery ends.

4138.3 Good Cause for Noncooperation (02/01/2003, 02-33)

Medicaid applicants and beneficiaries may request a waiver of the cooperation requirement from the department. Those to whom the department has granted a good cause waiver for noncooperation are eligible for Medicaid, provided that all other program requirements are met. The department shall grant such waivers when either of the following circumstances has been substantiated to the departments satisfaction:

A. Compliance with the cooperation requirement is reasonably anticipated to result in physical or emotional harm to the individual responsible for cooperating or the person for whom medical support or third-party payments are sought. Emotional harm means an emotional impairment that substantially affects an individuals functioning.

B. Compliance with the cooperation requirement would entail pursuit of medical support for a child:

1. conceived as a result of incest or rape from the father of that child;

2. for whom adoption proceedings are pending; or

3. for whom adoptive placement is under active consideration.

Individuals requesting waivers of the cooperation requirement bear the primary responsibility for providing the documentation the department deems necessary to substantiate their claims of good cause. The department shall consider an individual who has requested a good cause waiver and submitted the required documentation to be eligible for Medicaid while a decision on the request is pending.

4138.4 Enrollment in a Health Insurance Plan (02/01/2003, 02-33)

The department may require a Medicaid applicant or beneficiary to enroll or remain enrolled in a group health insurance plan for which the department pays the premiums. See rule 7108. Payment of group health insurance premiums shall be made only under the conditions specified in this section and in rule 7108.1 and remain entirely at the departments discretion. Such payment of premiums shall not be considered an entitlement for any individual.

As a condition of continuing eligibility, the department may require beneficiaries to remain enrolled in individual health insurance plans, provided that they are enrolled in plans for which the department has been paying the premiums on a continuous basis since July 2000.

For the purposes of this section and rule 7108.1, a group health insurance plan is a plan that meets the definition of a group health insurance plan specified in 8 V. S. A. §4079. An individual health insurance plan is a plan that does not meet that definition.

Eligibility Review

4140 Eligibility Review (12/01/1980, 80-62)

Once granted, Medicaid coverage continues until a decision is made to end it because the person (or group) no longer passes all the eligibility tests or the recipient chooses not to continue Medicaid coverage although still eligible. Eligibility must be reviewed to take into account any changes in the facts of the recipient's situation from the facts on which the grant decision was based.

Each Medicaid recipient is responsible for reporting to the Department any change in his situation that is related to the Medicaid eligibility tests (such as changes in income, resources, disability, living arrangement, Medicaid group membership, etc.). He must report any change within ten days after he learns of it.

Every recipient's Medicaid eligibility must be reviewed in full every so often, whether or not his situation changes. The frequency of full reviews depends on how likely the recipient's situation is to change.

Eligibility reviews are carried out under the same rules as initial eligibility investigations (see rules 4132–4135). New up-to-date forms must be filed and proofs given. Interviews are not, however, required, but may be used to clear up incomplete or inconsistent information. Collateral sources may also be used, as needed.

The Department reminds recipients when eligibility must be reviewed by sending necessary forms and directions far enough ahead to complete the review within the time limit. If the recipient fails to do his part, Medicaid coverage may be ended.

INTERPRETIVE MEMO

[X] Medicaid Rule Interpretation **[ ] Medicaid Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4141 Date of this Memo 05/01/2007 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

UPDATE:
Medicaid for Working People with Disabilities

Individuals found eligible for Medicaid for Working People with Disabilities must have a full eligibility review within 12 months after the initial eligibility date or the date of last full eligibility review.

Medicaid through the Reach Up programs

Individuals receiving Medicaid through Reach Up do not have a Medicaid review during their Reach Up eligibility period.

Review Frequency

4141 Review Frequency (07/01/2001, 01-16)

Individuals receiving cash assistance through Supplemental Security Income/Aid to the Aged, Blind or Disabled (SSI/AABD) or state Aid to the Aged, Blind or Disabled (AABD) do not need a separate Medicaid eligibility review by the department. Their Medicaid eligibility is reviewed by the Social Security Administration at the same time as their cash assistance eligibility.

When a recipient's situation is known to change frequently, schedule more frequent reviews. If the Medicaid group meets more than one of the following criteria, schedule a review at the earliest required time.

A. A full eligibility review must be completed within 12 months after the initial eligibility date, or the date of last full eligibility review, for:

1. individuals whose Medicaid group has stable countable income under one of the following levels applicable to their Medicaid eligibility determination: the Reach Up payment level in effect as of July 16, 1996, the SSI/AABD payment level, or the protected income level (PIL);

2. individuals living in long-term care whose gross income does not exceed the Institutional Income Standard or whose monthly cost of long-term care exceeds their monthly spend-down requirement;

3. children whose Medicaid group has stable countable income under one of the special income levels and who will not become ineligible for the special income level due to age in the 12-month period;

4. children living in Vermont for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under title IV-E of the Social Security Act;

5. children committed by a Vermont court to the care and custody of Social and Rehabilitation Services; and

6. women determined eligible for the breast and cervical cancer treatment group.

B. A full eligibility review must be completed within six months after the initial eligibility date, or the date of last full eligibility review, for:

1. individuals voluntarily placed in the care of the Family Services Division (FSD), and

2. individuals living in long-term care who have gross income over the Institutional Income Standard, have excess income over the cost of long-term care, and must spend-down this excess income on other medical expenses. A review of income eligibility must be completed every month.

3. persons determined eligible as working disabled.

C. A full eligibility review must be completed by the end of the six-month accounting period for:

1. individuals living in the community who were not eligible for Medicaid until their Medicaid group incurred medical expenses equal to their spend-down amount (i.e., the group met their six-month spend-down requirement).

D. A full eligibility review must be completed (at the stated time) for:

1. an individual granted Medicaid because he/she meets the Reach Up age criteria whose eligibility based on age is ending (review month is the month prior to the month of the child's birthday),

Review Frequency

2. a woman granted Medicaid because she was pregnant whose Medicaid eligibility under that provision is ending (review month is the month in which the 60th day, beginning with the last day of the pregnancy, falls),

3. a child who has been granted Medicaid based on the special income level whose eligibility for the special income level is ending (review month is the month prior to the month of the child's birthday),

4. a family found eligible for the 12-month (or 36-month) transitional Medicaid extension whose eligibility under this coverage provision is ending must be redetermined (before Medicaid is terminated), and

5. individuals who lose SSI/AABD for a reason other than a final determination by the Social Security Administration that the individual is no longer blind or disabled. Medicaid is reviewed when cash benefits under SSI/AABD are ended and before Medicaid is terminated.

Review Decisions

4142 Review Decisions (12/01/1994, 94-42)

A decision must be made to continue or close Medicaid coverage. Medicaid continues for all individuals until they are found to be ineligible.

Medicaid is continued when an individual continues to pass all necessary eligibility tests. When a family's eligibility is reviewed, some members may pass the tests and have coverage continued while others no longer pass the tests and must be closed. The patient share payment may change for a recipient living in long-term care due to changes in the recipient's circumstances. Changes in the patient share payment take effect on the first of the month after the recipient has been notified of the change.

Medicaid is closed when an individual no longer passes any one or more of the eligibility tests. The last day of coverage is the last day of the "eleven (11) day notice period" or the date of decision if an eleven (11) day notice is not required. (see Notice of Decision at rule 4150).

When a recipient fails to do his or her part in the eligibility review, his or her Medicaid coverage may be closed, for example:

- The recipient fails to give necessary information or proofs asked for, or takes longer than expected without explaining the delay; or
- The recipient fails to obtain required medical examinations.

When a recipient has done everything he or she was asked to do, Medicaid will not be closed even though a decision cannot be made within the required review frequency.

INTERPRETIVE MEMO

[X] Medicaid Rule Interpretation **[ ] Medicaid Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4150 **Date of this Memo** 10/27/1994 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: I understand there has been a change in when a notice of decision must be mailed.

ANSWER: Yes. The notice of decision must be mailed at least eleven (11) days before the closure or change will take effect. This will provide the beneficiary with a full 10 day notice period before the closure or change will take effect when such a period is required. The last day of the 10-day notice period is the last day of coverage. There is no change to the list of exceptions to the 10 day notice period requirement.

4150 Notice of Decision and Appeal (07/01/1992, 92-1)

Each Medicaid applicant/recipient must be given written notice of the decision on his or her application or review of eligibility. A group notice must include notice of the decisions about each member of the group.

A. All notice letters must contain:

1. A statement of what action the Department intends to take;
2. When it intends to take the action;
3. The reasons for the intended action;
4. The policy citation(s) that supports the action;
5. An explanation of the individual's right to appeal the decision and the circumstances under which a hearing will be granted; and

   NOTE: The Department need not grant a hearing if the sole issue is a Federal or State law requiring an automatic change adversely affecting some or all recipients.

6. An explanation of the circumstances under which Medicaid is continued if a hearing is requested.

B. When an eligibility review decision will end or reduce the amount of Medicaid coverage an individual has been receiving, the notice of decision must be mailed at least eleven (11) days before the closure or change will take effect, except when:

1. The Department has facts confirming the death of a Medicaid recipient;
2. The Department has facts confirming that the recipient has been granted Medicaid in another State;
3. The recipient has been admitted or committed to an institution where he or she is ineligible for further services;
4. The Department receives a clear written statement signed by a recipient that:
   a. He or she no longer wishes services; or
   b. Gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information;
5. The recipient's whereabouts are unknown and the post office returns agency mail directed to him or her indicating no forwarding address; or
6. A change in the level of medical care is prescribed by the recipient's physician.

Right to Appeal

4151 Right to Appeal (07/01/2007, 06-05)

Any Medicaid applicant or beneficiary has a right to appeal any decision about his or her Medicaid eligibility or amount of coverage, and to request a fair hearing before the Human Services Board (rule 4154) with the following exception: An applicant for or recipient of Supplemental Security Income (SSI/AABD) benefits who is denied SSI/AABD benefits or has his/her SSI/AABD benefits terminated because the Social Security Administration (SSA) or its agent found him/her to be not disabled, may not appeal the Medicaid denial or termination that results from this action by the SSA or its agent to the Human Services Board (see Disability Determination Appeal below).

NOTE

An applicant or beneficiary found to be not disabled by the SSA prior to 4/1/90 may appeal the resulting denial or termination to the Human Services Board as long as the appeal is filed within ninety (90) days of the date the notice of denial or termination was mailed. A person may also appeal if he or she thinks the Department is taking too long to make a decision. The right to appeal and procedures for making an appeal must be explained in Department forms and publications used by Medicaid applicants and beneficiaries and by Department employees during eligibility determination and review contacts.

Regarding eligibility issues, complaints or misunderstandings about decisions may be discussed with the employee who made the decision or his or her supervisor. If this review does not satisfy the applicant or beneficiary, he or she still has the right to request a fair hearing. A request for a fair hearing must be made within ninety (90) days of the date the notice of the decision being appealed was mailed. A request for a hearing is defined as a clear expression, oral or written, that the Medicaid applicant or beneficiary wishes to appeal a decision or that he/she wants an opportunity to present his/her case to a higher authority.

Regarding issues of coverage, a beneficiary may utilize the internal Managed Care Organization (MCO) appeal process (rule 7110.2) while a fair hearing is pending or before a fair hearing is requested (rule 7110.3). Fair hearings or MCO appeals must be filed within 90 days of the date the notice of action was mailed by the MCO, or if no mailing, within 90 days after the action occurred. A request for a fair hearing challenging an MCO appeal decision must be made within ninety (90) days of the date the original notice of the MCO decision being appealed was made, or within thirty (30) days of the date the notice of the MCO decision being appealed was mailed.

Medicaid beneficiaries also have the right to file grievances using the provisions of the Global Commitment for Health 1115 waiver internal grievance process. Beneficiaries (or duly appointed representatives) may file grievances orally or in writing. The grievance provisions are found at rule 7110.5.

4152 Disability Determination Appeal (07/01/2007, 06-05)

A. Social Security Administration (SSA) Disability Decision - except when the Department has made the disability determination (see below),

1. a final SSA disability determination is binding on the Department for 12 months or, if earlier, until the determination is changed by SSA and may not be appealed through the Department's appeal process. However, when an individual who has been found "not disabled" by the SSA meets the requirements specified in rule 4215, he or she, though not entitled to an appeal of the SSA determination through the Department's appeal process, is entitled to a separate state determination of disability for the purposes of determining his or her eligibility for Medicaid.

2. the Department must refer all applicants who do not meet the requirements specified in rule 4215 for a separate state determination of disability and who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability, to SSA for reconsideration or reopening of the determination.

B. Department Disability Decision - if the state's disability determination agent has made a Medicaid disability determination under the circumstances specified in Determination of Disability or Blindness, the decision may be appealed to the Human Services Board.

Continued Benefits Pending Appeal

4153 Continued Benefits Pending Appeal (07/01/2007, 06-05)

When beneficiaries appeal a decision to end or reduce Medicaid coverage, they have the right, under certain conditions, to have benefits continue without change until the appeal is decided or the fair hearing is resolved provided the beneficiary requests an appeal or fair hearing before the effective date of the adverse action and has paid in full any required premiums (see rule 7110). If the last day before the adverse action date is on a weekend or holiday, the beneficiary has until the end of the first subsequent working day to request the appeal or fair hearing. Beneficiaries appealing the amount of their premiums shall pay at the billed amount in order for coverage to continue until the dispute is resolved. Beneficiaries who are successful on an appeal concerning the amount of their premium will be reimbursed by the Department for any premium amounts overpaid.

Continuation of benefits without change does not apply when the appeal or fair hearing is based solely on a reduction or elimination of a benefit required by federal or state law affecting some or all beneficiaries, or when the decision does not require the minimum advance notice (see Notice of Decision at rule 4150).

Beneficiaries may waive their right to continued benefits. If they do so and are successful on an appeal, benefits will be paid retroactively.

The OVHA may recover from the beneficiary the value of any continued benefits paid during the appeal and fair hearing period when the beneficiary withdraws the appeal or fair hearing before the relevant Managed Care Organization (MCO) or fair hearing decision is made, or following a final disposition of the matter in favor of the MCO. Beneficiary liability will occur only if an MCO appeal, fair hearing decision, Secretary's reversal and/or judicial opinion upholds the adverse determination, and the MCO also determines that the beneficiary should be held liable for service costs.

When SSI/AABD beneficiaries are determined "not disabled" by the Social Security Administration (SSA) and appeal this determination, their Medicaid coverage continues as long as their SSI/AABD benefits are continued (or could have been continued but the client chose not to receive them during the appeal period) pending a SSA decision on the appeal. When eligibility for SSI/AABD benefits is terminated following a determination of "not disabled", Medicaid coverage ends unless they apply and are found eligible for Medicaid on the basis of a categorical factor other than disability.

When Medicaid beneficiaries apply for SSI/AABD and are determined "not disabled" by the Social Security Administration (SSA) and file a timely appeal of this determination with the SSA, their Medicaid coverage continues until a final decision is made on the appeal provided the SSA's determination of "not disabled" is the only basis on which they might be found ineligible for Medicaid. If they continue to appeal unfavorable decisions by SSA, the "final decision" is made by the SSA Appeals Council.

Managed Care Organization Appeal and Fair Hearing

4154 Managed Care Organization Appeal and Fair Hearing (07/01/2007, 06-05)

Medicaid coverage appeals are processed in accordance with applicable Managed Care Organization (MCO) Appeals Rules, at rule 7110.2, and fair hearing rules, as promulgated separately by the Human Services Board pursuant to 3 V. S. A. § 3091 (d). A copy of the Human Services Board fair hearing rules is in the All Programs Procedures Manual.

Payment System

4160 Payment System (04/01/2005, 05-09)

The Vermont legislature instituted a premium-based payment system for most health care assistance programs with the 2004 Appropriations Act, Act 66 of 2003. This legislation also unified the method of billing and the premium collection system for all coverage groups.

Cost Sharing

4161 Cost Sharing (08/01/2012, 12-08)

A. Definitions

1. "Medical incapacity" means a serious physical or mental infirmity to the health of the adult beneficiary or beneficiaries responsible for paying the premium that prevented the adult beneficiary or beneficiaries from paying the premium timely, as verified in a physician's certificate furnished to the department. Notice by telephone or otherwise by the physician that such certificate will be forthcoming will have the effect of receipt, providing the certificate is in fact received within seven days.

2. "Physician's certificate" means a written statement on a form supplied by the department signed by a duly licensed physician certifying that an adult beneficiary suffered from medical incapacity that prevented the beneficiary from paying the premium timely. If the medical incapacity is expected to continue or recur, the department will encourage beneficiaries to designate an authorized representative to receive and pay future bills for as long as the anticipated duration of the condition.

3. "Premium" means a nonrefundable charge as a condition of initial and ongoing enrollment received in full by the department from applicants.

4. "Received" or "received and processed" means the department has posted the full premium payment and logged the transaction on the applicable case record on the departments computer system, thereby ensuring the information is available to authorized staff.

B. Premium

This section describes the general premium rules and process. Additional rules applicable to the specific coverage groups subject to these premium rules vary, and are described in the following sections: Dr. Dynasaur (4312.6 and 4312.7), VHAP (5300), VHAP-Pharmacy (5500), and VScript (5600).

1. Coverage always begins on the first day of a month and only after the full premium has been received. Beneficiaries must pay the full monthly premium before coverage will begin, even if the department finds them eligible in all other respects before the first day of the next month. Coverage will not begin in the first day of a month after the full premium has been received, if the individual has not yet enrolled in Catamount Health. Applicants for Dr. Dynasaur may also be granted coverage during the months of application and billing provided all eligibility criteria were met during those months and the department has received and processed any premiums required for those months. They may also be granted retroactive coverage provided the requirements specified in rule 4122 are met.

2. The departments premium billing cycle is designed to make it as easy as possible for beneficiaries to maintain their monthly premium payments and avoid loss of coverage. The departments automated premium collection and distribution system manages the receipt and processing on the day of receipt of premiums if paid according to the billing directions.

The department will:

a. send premium bills at least 25 days before the last day of the month, which is the date that coverage will end if the department does not receive the payment;

b. mail beneficiaries a notice of impending closure at least 11 days before coverage ends for nonpayment of a premium;

c. reinstate coverage without a break in benefits if the department receives the payment by the last day of the month, or the first business day following the last day of the month in which the due date falls.

When households with more than one coverage group make a partial payment of a bill that includes more than one premium, the payment will be applied as payment of one or more premiums in full rather than as a partial payment of all of the billed premiums. Beneficiaries who want to choose which premium to pay must call the Member Services number on the bill to record that designation on the case record.

In the event the beneficiary has not made the designation, the department will apply the partial payment to the following coverage groups in the following order: (1) Dr. Dynasaur; (2) VHAP; (3) VHAP-Pharmacy (or VPharm 1); (4) VScript (or VPharm 2 or 3); and (5) Catamount Health Assistance Program. If there is more than one beneficiary in the same coverage group with the same premium amount, the department will apply the partial payment to the first beneficiary listed on the bill.

In the event of an overpayment, the department will retain and reflect it as a credit on the next premium bill. When coverage ends, to expedite a possible reinstatement if requested, the department will wait 30 days before reimbursing a beneficiary any credit remaining on the account. If coverage remains closed for 30 days, DCF will issue a refund within 10 business days thereafter. If it will be a financial hardship to apply an overpayment in this way, beneficiaries may request that the department reimburse the overpayment within 30 days.

3. The department will automatically reimburse a beneficiary the amount of a premium within 30 days from when coverage terminates before the month the premium pays for because the beneficiary:

a. moves out of state;

b. moves from a premium-based coverage group to a non-premium-based group;

c. becomes ineligible because of an increase of income; or

d. dies.

In addition to premiums, health care beneficiaries may also be responsible for copayments for some services, which are described below.

4. Precedence. If there is a conflict between provisions in this rule and any other health-care rule, the provisions in this rule shall take precedence.

5. Special Dr. Dynasaur premium rules

a. Definitions.

i. Billed month. The month that follows the coverage month and is associated with the department's most recent regular billing.

ii. Cancel.Determine that an individual no longer meets all of a health-care program's qualifications.

iii. Close. Cancel eligibility and disenroll from coverage.

iv. Coverage. The scope of benefits provided to an individual who is enrolled in a health-care program.

(A) Nonpremium-based coverage. Any coverage that is provided without a premium charge.

(B) Premium-based coverage. Any coverage that is provided with a premium charge.

v. Coverage month. The current month in which an enrolled individual is entitled to receive coverage. In the case of premium-based coverage, to be a coverage month, the full premium must have been received.

vi. Dr. Dynasaur For the purposes of this rule, Dr. Dynasaur includes children in the group defined in rule 4312.6 and pregnant women in the group defined in rule 4312.7.

vii. Eligible. Status of an individual that meets all of a health-care program's qualifications.

viii. Enroll. Begin to provide coverage to an eligible individual.

ix. Grace month. A billed month in which coverage continues but for which the full premium has not been received.

x. Health-care adverse-action approval deadline. Including the last day of the month, the twelfth day prior to the end of a month. However, if that day falls on a weekend or holiday, the health-care adverse-action approval deadline is the preceding business day. The health-care adverse-action approval deadline is the last day in a month that an action that negatively affects eligibility, enrollment, or benefits can be processed in the department's eligibility system if that action is to take effect by the first day in the following month. The purpose of this deadline is to ensure timely notification of the health-care adverse-action approval deadline.

xi. Reenroll. Restore a reinstated individual's enrollment.

xii. Reinstate. Restore an individual's eligibility after cancellation.

b. Basic rule. Except as otherwise provided in this paragraph, all of the department's premium billing and collection rules apply to individuals who are eligible for Dr. Dynasaur.

c. Dr. Dynasaur premium grace period. An individual who does not pay a monthly premium by the premium due date for the billed month shall have a one-month grace period to pay the premium before closure. The billed month becomes the grace month.

d. Dr. Dynasaur premium grace period notices.

i. If the department does not receive a full premium payment before the premium due date, it will send a closure notice, advising that coverage will end at the end of the grace month.

ii. If the department does not receive a full premium payment before the fifth business day of the grace month, it will send a notice, advising that the individual is in grace status. The notice will advise that coverage will end at the end of the grace month.

iii. At least 11 days before the end of the grace month, the department will mail a final closure notice, advising that coverage will end at the end of the grace month.

iv. In addition to the above, the Dr. Dynasaur premium grace-period notices will:

(A) Advise of the Dr. Dynasaur closure protection, as provided in subparagraph 5(e) of this section; and

(B) Otherwise comply with the notice requirements set forth in Medicaid Rule 4150.

e. Dr. Dynasaur closure protection. Prior to closure, an individual who has received a nonpayment closure notice may contact the department to show that, due to changed household circumstances, the individual is eligible for nonpremium-based coverage or a lower premium amount.

i. If the showing indicates that the individual is eligible for nonpremium-based coverage, the department will reinstate and reenroll the individual and waive the past-due premium.

ii. If the showing indicates that the individual is eligible for premium-based coverage, but at a lower premium amount, the department will adjust any outstanding premium amounts due. Reinstatement and reenrollment will proceed as provided for in subparagraph f of this paragraph.

f. Reinstatement and reenrollment.

i. Except as specified in subparagraph ii. below, the department will reinstate an individual whom it closed for premium nonpayment under the following circumstances:

(A) Without break in coverage.

(1) If the department receives a full premium payment for the grace month on or before the first business day of the month following the grace month:

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

(2) The individual will be reinstated; and

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

(2) If the payment is not enough to cover the premium due for the grace month and the following month, the following month becomes a new grace month.

(B) With break in coverage

(1) If the department receives a full premium payment for the grace month after the first business day in the month following the grace month, but before the end of that month:

- The payment will first be applied to cover the premium due for the grace month;

- The individual will be reinstated; and
- The individual will be conditionally-approved for reenrollment, pending receipt of the full premium due for at least one new month of coverage.

If the department receives such a payment before the monthly bills are created in the first month following the grace month, the individual will be reenrolled for coverage on the first day of the second month following the grace month.

If the department receives such a payment after the monthly bills are created in the first month following the grace month, but before the health-care adverse-action approval deadline of the second month following the grace month, the individual will be reenrolled for coverage on the first day of the third month following the grace month.

If the department does not receive such a payment by the health-care adverse-action approval deadline of the second month following the grace month, the individual is cancelled. However, if the department subsequently receives such a payment before the end of that month, the department will reinstate and reenroll the individual for coverage on the first day of the third month following the grace month.

(2) If the department does not receive a full premium payment for the grace month before the end of the month following the grace month, the individual must reapply.

(3) If the department receives the full premium payment for the grace month, but subsequently cancels the reinstatement because it does not timely receive a premium payment for the full premium due for at least one new month of coverage, the department will again reinstate the individual if it subsequently receives such payment before the end of the month following the cancellation month. The individual will be reenrolled as follows:

- If the department receives such a payment and approves the reinstatement before the monthly bills are created in the first month following cancellation, the individual will be reenrolled for coverage on the first day of the second month following cancellation.
- If the department receives such a payment or approves the reinstatement after the monthly bills are created in the first month following the cancellation, but before the end of the month following the cancellation month, the individual will be reenrolled for coverage on the first day of the third month following the cancellation month.

(4) If the department does not receive the full premium due for at least one new month of coverage before the end of the first month following the cancellation month, the individual must reapply.

(5) An individual who is reinstated and reenrolled under this subparagraph 5(f)(i)(2) may secure coverage for any or all of the months between the

grace month and the reenrollment month by paying the full premiums due for that month or those months.

ii. Exception. Individuals will not be reinstated or reenrolled without submitting a new application if a review of the case is scheduled for the reinstatement month or the following month.

g. Partial payments. Partial payments will be applied to the premium owed for the grace month. However, the department must receive the full amount owed for the grace month before eligibility will be reinstated.

6. Households with outstanding grace-period premium balances. When any individual in a household applies for any health-care program and the household has an outstanding premium balance due to an unpaid grace period, the department will only enroll the individual if:

a. Past due premiums and the first premium of the new coverage period are paid in full, or

b. All members of the household are eligible for nonpremium-based coverage.

7. Waiver of past-due premiums. The department will waiver outstanding grace-period premium balances that are older than 12 months.

8. Payment priority. The department will always apply payments first, to satisfy any past-due premium balances.

C. Copayments

Copayments from some beneficiaries are required for certain services. Copayments will be deducted from the Medicaid payment for each service subject to copayment. Section 1916(c) of the Social Security Act requires that "no provider participating under the State (Medicaid) plan may deny care of services to an individual eligible for (Medicaid) . . . on account of such individual's inability to pay (the copayment)." This subsection further provides, however, that these requirements "shall not extinguish the liability of the individual to whom the care or services were furnished for the payment of (the copayment)."

1. Copayments are never required from beneficiaries who are:

a. long-term care beneficiaries; or

b. Medicaid beneficiaries under age 21; or

c. pregnant or in the 60-day post-pregnancy period.

2. Copayments are required for these services:

a. $3 per day per hospital for hospital outpatient services unless the individual is also covered by Medicare. An individual covered by Medicare has no copayment requirement for outpatient services.

b. Prescriptions and durable medical equipment/supplies for recipients age 21 and older as follows:

i. $1.00 for each prescription, original or refill, or durable medical equipment/supplies having a usual and customary charge of less than $30.

ii. $2.00 for each prescription, original or refill, or durable medical equipment/supplies having a usual and customary charge of $30 but less than $50.

iii. $3.00 for each prescription, original or refill, or durable medical equipment/supplies having a usual and customary charge of $50.00 or more.

c. $3.00 per date of service per provider for dental services for recipients age 21 and older.

3. No copayments are required for the following services:

a. Services reimbursed by the Department of Developmental and Mental Health Services.

b. Emergency hospital services.

c. Home Health, Hospice, and Home and Community Based Services for the Elderly and Disabled.

d. Services provided by other licensed practitioners including:

i. Podiatry

ii. Audiology

iii. Psychological

iv. Optometric and Optician

v. Nurse practitioner

e. Services provided by rural health clinics and federally qualified health care facilities.

f. Independent laboratory.

g. X-ray interpretations performed by a physician who has no direct contact with the beneficiary.

h. Transportation including ambulance.

i. Medical supplies.

j. Durable Medical Equipment (DME) purchases and rental and nursing services.

k. Oxygen and respiratory equipment and supplies.

l. Family planning services.

4. The department is not responsible for copayments a provider may collect in error or a beneficiary makes on a service that is not paid for by Medicaid.

Obligation of the Department

4162 Obligation of the Department (12/01/2003, 03-17)

The department will assure that mechanisms exist for the payment of reimbursable expenses.

Eligibility Expenses

4163 Eligibility Expenses (12/01/2003, 03-17)

The department will pay the reasonable charge for any professional examination and report necessary to make a decision, or appeal a decision, on medical factors of blindness, disability or incapacity.

To receive payment, the examiner must submit the required report and an itemized bill for services necessary to complete the report.

INTERPRETIVE MEMO

[X] Medicaid Rule Interpretation **[ ] Medicaid Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4170 **Date of this Memo** 04/01/2009 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

The following individuals are permanently exempt from the citizenship and identity requirement:

A. Social Security Disability Insurance (SSDI) recipients

B. Children in foster care

C. Children receiving title IV-E adoption assistance. (Note: not all children receiving adoption assistance do so under title IV-E)

D. SCHIP children — uninsured children with household income >225 and ≤ 300% FPL

E. Children born in the U.S. on or after 4/1/09 if the child's mother is on one of the department's health care programs at the time of birth.

Beneficiary Identification

4164 Beneficiary Identification (04/01/1994, 94-2F)

The Department must give each recipient a permanent identification document which can be used by a provider to determine eligibility for Medicaid at the time of service. Documents, including temporary identification as a Medicaid recipient, will be mailed to new recipients as soon as possible after Medicaid is granted. Temporary identification will also be given to the individual by the District Office when services are needed immediately.

Information the provider needs to claim payment from other available resources, such as health insurance, and to prepare his/her Medicaid claim, and information about restrictions, if any, imposed on the recipient's use of Medicaid Services due to utilization abuse (see also rule 7107) are provided when eligibility is confirmed by the provider.

Additional prior authorization to claim Medicaid payment may be required for certain types of Medicaid services, such as long-term care. (See also rules 7201–7203).

Citizenship

4170 Citizenship (05/01/2010, 10-02)

A. As a condition of eligibility for Medicaid an individual must be:

1. A citizen or national of the United States (rule 4171), or

2. A qualified alien (rule 4172).

B. Exceptions: Certain qualified aliens are barred from Medicaid for five years. (rule 4173).

C. Qualified aliens affected by the five-year bar and non-qualified aliens may be eligible for emergency services and/or emergency labor and delivery services. (rule 4177).

D. Except as provided in paragraph (E) of this section, Medicaid applicants and beneficiaries must:

1. Sign a declaration that the individual is a citizen or national of the United States (rule 4171) or a qualified alien (rule 4172), and

2. Provide documentation of citizenship or immigration status and identity (rules 4171.1 and 4171.2).

E. The following individuals are not required to document citizenship and identity as a condition of receipt of Medicaid benefits:

1. Those who have received either Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), or Medicare.

2. Children in IV-E foster care.

3. Children receiving Title IV-E adoption assistance.

4. Children born in the United States on or after April 1, 2009 when the child's mother is covered by state administered health care assistance under Title XIX or XXI, other than premium assistance, at the time of birth.

F. For purposes of the citizenship requirement, an individual is:

1. A health care applicant or beneficiary or

2. An individual receiving any services under a section 1115 demonstration waiver (*e.g.,* Global Commitment, Choices for Care).

U.S. Citizen

4171 U.S. Citizen (01/01/2007, 06-48)

A. A "U.S. citizen" is:

1. An individual born in the 50 states, the District of Columbia, Puerto Rico, Guam, Virgin Islands, and the Northern Mariana Islands (except for individuals born to foreign diplomats);
2. A naturalized citizen; or
3. An individual who otherwise qualifies for U.S. citizenship under §301 of the Immigration and Nationality Act (INA), 8 U.S. C. 1401.

B. A "national of the United States" is an individual who:

1. is a U.S. citizen or
2. Though not a citizen, owes permanent allegiance to the United States.

    a. As a practical matter, non-citizen nationals include individuals born in American Samoa or Swains Island. For purposes of determining Medicaid eligibility, including verification requirements, citizens and non-citizen nationals of the United States are treated the same.

4171.1 Notice of Verification Requirement (01/01/2007, 06-48)

The state may undertake to document citizenship or identity through one or more data-system cross matches that may be available for such purposes. If the state obtains the needed documentation, the individual need not provide additional proof in this regard. However, if the state does not secure such documentation, it will notify the individual as to the extent of the requirement that remains outstanding. The individual will then be responsible for securing acceptable documentation (rule 4171.2) and providing it to the department.

4171.2 Citizenship and Identity Documentation (05/01/2010, 10-02)

A. Available Evidence

Evidence is "available" if it exists and can be obtained within the period of time specified in paragraph (B) of this section.

B. Time Requirements

1. An individual shall be notified of the need to submit evidence of citizenship and identity. The initial notice shall afford a period of 10 days for compliance. If the individual does not submit the needed documentation within the time period prescribed in the initial notice, the individual shall receive a second notice, affording an additional 10 days to comply.
2. The time limit may be extended for periods of up to 90 days upon a showing that the individual has in good faith, tried to secure the documentation, but has been unable to do so within the prescribed period of time.

C. Primary Evidence of Citizenship and Identity

1. The following evidence will be accepted as satisfactory documentary evidence of both identity and citizenship:

a. A U.S. Passport

The Department of State issues this. A U.S. passport need not be currently valid to be accepted as evidence of U.S. citizenship, as long as it was originally issued without limitation. However, a passport that was issued with limitation and is not currently valid may be used as proof of identity.

i. U.S. passports issued after 1980 show only one person. However, spouses and children were sometimes included on one passport through 1980. Consequently, the citizenship and identity of the included person can be established when one of these passports is presented.

b. A Certificate of Naturalization (DHS Forms N-550 or N-570)

Department of Homeland Security issues this.

c. A Certificate of U.S. Citizenship (DHS Forms N-560 or N-561)

Department of Homeland Security issues certificates of citizenship to individuals who derive citizenship through a parent.

d. An Indian Tribe Document

A document issued by a federally recognized Indian tribe evidencing membership or enrollment, or affiliation with, such tribe (such as a tribal enrollment card or certificate of Indian blood.) The Secretary of Health and Human Services will issue regulations concerning tribes located in states with international borders whose members include individuals who are not citizens of the United States. The regulations will authorize the presentation of such other forms of identification that the Secretary determines to be satisfactory evidence of citizenship or nationality.

2. Individuals born outside the U.S. who were not citizens at birth must submit primary evidence of U.S. citizenship and identity. However, children born outside the United States and adopted by U.S. citizens may establish citizenship using the process established by the Child Citizenship Act of 2000 (Pub. L. 106-395, enacted on October 30, 2000). (rule 4171(c)).

a. Many foreign-born adopted children acquire U.S. citizenship as soon as they enter the United States. They do not need to formally apply (though they are entitled to a certificate of citizenship); they become citizens automatically.

b. Other foreign-born adopted children may need to wait until they have satisfied certain criteria before they automatically acquire citizenship. Still others (those living abroad) may need to formally apply to "naturalize."

c. Orphans adopted by a U.S. citizen parent are citizens once their adoption is final and they have lawfully entered the United States as permanent residents. Children who did not immigrate as orphans, but who were adopted by a U.S. citizen parent and obtained lawful permanent resident status also automatically acquire citizenship (so long as they meet all the criteria prior to their 18th birthday).

d. Foreign children who are adopted by U.S. citizens who reside overseas are also entitled to citizenship, but under slightly different criteria. Such children may file

for naturalization during a legal, temporary visit to the U.S. so long as they are under 18 and their parents or grandparents meet certain other eligibility criteria.

D. Secondary Evidence of Citizenship

If primary evidence from the list in paragraph (C) of this section is unavailable and the person claims a U.S. place of birth, the person should provide satisfactory documentary evidence from paragraph (G) of this section to establish identity, and satisfactory documentary evidence of citizenship from the list below:

1. A U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam (on or after April 10, 1899), the Virgin Islands of the U.S. (on or after January 17, 1917), American Samoa, Swains Island, or the Northern Mariana Islands (after November 4, 1986 (NMI local time)). The birth record document may be issued by the state, commonwealth, territory or local jurisdiction. It must have been issued before the person was 5 years of age. An amended birth record document that is amended after 5 years of age is considered fourth level evidence of citizenship. If the document shows the individual was born in Puerto Rico, Guam, the Virgin Islands of the U.S., or the Northern Mariana Islands before these areas became part of the U.S., the individual may be a collectively naturalized citizen. Collective naturalization occurred on the dates listed for each of the Territories. The following will establish U.S. citizenship for collectively naturalized individuals:

    a. Puerto Rico:

        i. Evidence of birth in Puerto Rico on or after April 11, 1899 and the persons statement that he or she was residing in the U.S., a U.S. possession or Puerto Rico on January 13, 1941; or

        ii. Evidence that the person was a Puerto Rican citizen and the persons statement that he or she was residing in Puerto Rico on March 1, 1917 and that he or she did not take an oath of allegiance to Spain.

    b. U.S. Virgin Islands:

        i. Evidence of birth in the U.S. Virgin Islands, and the persons statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927; or

        ii. The persons statement indicating residence in the U.S. Virgin Islands as a Danish citizen on January 17, 1917 and residence in the U.S., a U.S. possession, or the U.S. Virgin Islands on February 25, 1927, and that the person did not make a declaration to maintain Danish citizenship; or

        iii. Evidence of birth in the U.S. Virgin Islands and the persons statement indicating residence in the U.S., a U.S. possession, or Territory or the Canal Zone on June 28, 1932.

            (A) Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI)):

                (1) Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. Territory or possession on November 3, 1986 (NMI local time) and the persons statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or

(2) Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration prior to January 1, 1975 and the persons statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or

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

2. A Certification of Report of Birth (DS-1350)

   The Department of State issues a DS-1350 to U.S. citizens in the U.S. who were born outside the U.S. and acquired U.S. citizenship at birth, based on the information shown on the FS-240. When the birth was recorded as a Consular Report of Birth (FS-240), certified copies of the Certification of Report of Birth Abroad (DS-1350) can be issued by the Department of State in Washington, D. C. The DS-1350 contains the same information as that on the current version of Consular Report of Birth FS-240. The DS-1350 is not issued outside the U.S.

3. A Report of Birth Abroad of a U.S. Citizen (Form FS-240)

   The Department of State consular office prepares and issues this. A Consular Report of Birth can be prepared only at an American consular office overseas while the child is under the age of 18. Children born outside the U.S. to U.S. military personnel usually have one of these.

4. A Certification of Birth Issued by the Department of State (Form FS-545 or DS-1350)

   Before November 1, 1990, Department of State consulates also issued Form FS-545 along with the prior version of the FS-240. In 1990, U.S. consulates ceased to issue Form FS-545. Treat an FS-545 the same as the DS-1350.

5. A U.S. Citizen I. D. Card

   (This form was issued as Form I-197 until the 1980s by INS. Although no longer issued, holders of this document may still use it consistent with the provisions of section 1903(x) of the Act. Note that section 1903(x) of the Act incorrectly refers to the same document as an I-97). INS issued the I-179 from 1960 until 1973. It revised the form and renumbered it as Form I- 197. INS issued the I-197 from 1973 until April 7, 1983. INS issued Form I-179 and I-197 to naturalized U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossings. Although neither form is currently issued, either form that was previously issued is still valid.

6. A Northern Mariana Identification Card (I-873)

   (Issued by the DHS to a collectively naturalized citizen of the United States who was born in the Northern Mariana Islands before November 4, 1986.) The former Immigration and Naturalization Service (INS) issued the I-873 to a collectively naturalized citizen of the U.S. who was born in the NMI before November 4, 1986. The card is no longer issued, but those previously issued are still valid.

7. An American Indian Card (I-872) issued by the Department of Homeland Security with the classification code “KIC.” (Issued by DHS to identify U.S. citizen members of the

Texas Band of Kickapoos living near the United States/Mexican border.) DHS issues this card to identify a member of the Texas Band of Kickapoos living near the U.S./Mexican border. A classification code "KIC" and a statement on the back denote U.S. citizenship.

8. A final adoption decree showing the child's name and U.S. place of birth

   The adoption decree must show the childs name and U.S. place of birth. In situations where an adoption is not finalized and the state in which the child was born will not release a birth certificate prior to final adoption, a statement from a state-approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.

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

   The document must show employment by the U.S. government before June 1, 1976. Individuals employed by the U.S. Civil Service prior to June 1, 1976 had to be U.S. citizens.

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

    The document must show a U.S. place of birth (for example a DD-214 or similar official document showing a U.S. place of birth.)

E. Third-Level Evidence of Citizenship

If evidence from the lists in paragraphs (C) and (D) of this section is unavailable and the person claims a U.S. place of birth, the person should provide satisfactory documentary evidence from paragraph (G) of this section to establish identity, and satisfactory documentary evidence of citizenship from the list below:

1. Extract of a hospital record on hospital letterhead, indicating a U.S. place of birth

   The record must have been established at the time of the persons birth and created 5 years before the initial application date. (For children under 16 the document must have been created near the time of birth or 5 years before the date of application.) A souvenir "birth certificate" issued by a hospital does not satisfy this requirement.

2. Life, health, or other insurance record showing a U.S. place of birth

   The record must have been created at least 5 years before the initial application date.

F. Fourth-Level Evidence of Citizenship

If evidence from the lists in paragraphs (C), (D), and (E) of this section is unavailable and the person claims a U.S. place of birth, the person should provide satisfactory documentary evidence from paragraph (G) of this section to establish identity, and satisfactory documentary evidence of citizenship from the list below:

1. Federal or state census record showing U.S. citizenship or a U.S. place of birth

   The census record must also show the applicants age.

   a. Census records from 1900 through 1950 contain certain citizenship information. To secure this information, complete a Form BC-600, Application for Search of Census Records for Proof of Age. Add in the remarks portion "U.S. citizenship data requested." Also add that the purpose is for Medicaid eligibility. This form requires a fee.

2. One of the following documents that show a U.S. place of birth and was created at least 5 years before the application for Medicaid:

   a. Seneca Indian tribal census record.

   b. Bureau of Indian Affairs tribal census records of the Navajo Indians.

   c. U.S. State Vital Statistics official notification of birth registration.

   d. An amended U.S. public birth record that is amended more than 5 years after the person's birth.

   e. Statement signed by the physician or midwife who was in attendance at the time of birth.

3. Institutional admission papers from a nursing facility, skilled care facility or other institution, showing a U.S. place of birth.

4. Medical (clinic, doctor, or hospital) record showing a U.S. place of birth

   The record must have been created at least 5 years before the initial application date. (For children under 16 the document must have been created near the time of birth or 5 years before the date of application.) An immunization record is not considered a medical record for purposes of establishing U.S. citizenship.

5. Written Declarations of Citizenship

   Declarations should only be used in rare circumstances. If the documentation requirement needs to be met through declarations, the following rules apply:

   a. There must be at least two declarations by two people who have personal knowledge of the event(s) establishing the individuals claim of citizenship (the two declarations could be combined in a joint declaration).

   b. At least one of the people making the declaration cannot be related to the applicant or beneficiary. Neither of the two individuals can be the applicant or beneficiary.

   c. In order for the declarations to be acceptable, the people making them must be able to provide proof of their own citizenship and identity.

   d. If the people making the declarations have information that explains why documentary evidence establishing the individuals claim or citizenship does not exist or cannot be readily obtained, the declaration should contain this information as well.

   e. The applicant or beneficiary or other knowledgeable person (guardian or representative) must also provide a declaration explaining why the evidence does not exist or cannot be obtained.

   f. The declarations must be signed under penalty of perjury.

G. Evidence of Identity

U.S. Citizen

1. The following documents may be accepted as proof of identity and must be submitted when the person uses as proof of citizenship, a document listed in paragraphs (D) through (E) of this section. (A separate document proving identity need not be submitted when the person submits primary documentary evidence of citizenship and identity (rule 4171.2(c)).

   a. A drivers license issued by a state or territory

      i. The license must either have a photograph of the individual or other identifying information such as name, age, sex, race, height, weight, or eye color.

      ii. Individuals may not rely upon a Canadian drivers license, as the Centers for Medicare and Medicaid Services does not view this as a reliable form of identification.

   b. School identification card

      The card must have a photograph of the individual.

   c. U.S. military card or draft record.

   d. Identification card issued by the federal, state, or local government

      The card must have the same information that is required for drivers licenses.

   e. Military dependents identification card.

   f. Native American tribal document.

   g. U.S. Coast Guard Merchant Mariner card.

   h. Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native Tribal document

      The document must have a photograph or other personal identifying information relating to the individual.

2. Individuals may not rely upon a voters registration card, as CMS does not view this as a reliable form of identification.

H. Special Identity Rules for Children

For children under 16, if none of the documents in paragraph (G) are available, a Declaration of Identity (form 201ID) may be used to prove the identity of the child. A Declaration of Identity is only acceptable if it is signed under penalty of perjury by a parent or guardian stating the date and place of the birth of the child and cannot be used if declarations were used to establish citizenship.

I. Documentary Evidence

1. All documents must be either originals or copies certified by the issuing agency. Copies or notarized copies may not be accepted.

2. Copies of citizenship and identification documents shall be maintained in the case record or electronic data base.

3. Individuals may submit documentary evidence without appearing in person at a Medicaid office. Documents may be tendered in person, by mail, or by a guardian or authorized representative.

4. Presentation of documentary evidence of citizenship is a one-time activity; once a person's citizenship is documented and recorded in a state database, subsequent changes in eligibility should not require repeating the documentation of citizenship unless later evidence raises a question of the persons citizenship.

J. Assistance

ESD shall assist individuals to secure satisfactory documentary evidence of citizenship and identity when, because of incapacity of mind or body, the individual would be unable to comply with the requirement to present satisfactory documentary evidence of citizenship or identity in a timely manner and the individual lacks a representative to assist him or her.

INTERPRETIVE MEMO

[X] Medicaid Rule Interpretation **[ ] Medicaid Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4172 Date of this Memo 03/03/2010 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

Cuban & Haitian Entrants

There are three general categories of individuals who are considered "Cuban and Haitian entrants."

A **Haitian national** meets the definition of "Cuban and Haitian entrant" if he or she: (1) was granted parole status as a Cuban/Haitian entrant (Status Pending) on or after April 21, 1980 or **has been paroled into the United States** on or after October 10, 1980; or

(2) is the **subject of removal, deportation or exclusion proceedings** under the Immigration and Nationality Act and with respect to whom a final, nonappealable, and legally enforceable order of removal, deportation or exclusion has not been entered; or

(3) has **an application for asylum pending** with the Department of Homeland Security and with respect to whom a final, nonappealable, and legally enforceable order of removal, deportation or exclusion has not been entered.

Documentation

In order to access ORR-funded benefits and services, a Haitian national must provide acceptable documentation showing that he or she meets the definition of "Cuban and Haitian entrant." The following list includes documents that provide proof of status.

A national of Cuba or Haiti who was granted parole status as a Cuban/Haitian entrant (Status Pending) on or after April 21, 1980 or has been paroled into the United States on or after October 10, 1980 , regardless of the status of the individual at the time assistance or services are provided:

Documents/Codes	Comments
An I-94 Arrival/departure card with a stamp showing parole into the U.S. on or after April 21, 1980	I-94 may refer to §212(d)(5). I-94 may refer to humanitarian or public interest parole. I-94 may be expired.
An I-94 Arrival/departure card with a stamp showing parole at any time as a "Cuban/Haitian Entrant (Status Pending)"	I-94 may refer to §212(d)(5). I-94 may be expired
CH6 adjustment code on the I-551	Even after a Cuban/Haitian Entrant (Status Pending) becomes a permanent resident, he/she technically retains the status Cuban/Haitian Entrant (Status Pending). I-551 may be expired.
A Cuban or Haitian passport with a §212(d)(5) stamp dated after October 10, 1980.	Passport may be expired

INTERPRETIVE MEMO

[X] Medicaid Rule Interpretation **[ ] Medicaid Procedure Interpretation**

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Reference 4172 Date of this Memo 03/03/2010 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

Haitians Granted Humanitarian Parole Status

Haitians granted Humanitarian Parole status because of the earthquake are qualified aliens exempt from the 5-year waiting period, and if otherwise eligible, may receive Medicaid. As always, we must see a copy of their immigration paperwork and confirm their status through SAVES.

Haitian orphans being adopted by U.S. parents who have had their adoption finalized in Haiti must also have their adoption finalized in the U.S. before it is officially recognized. If a Haitian child applies for health care and their adoption has only been finalized in Haiti, treat them as a HH of one. If the child's adoption has been finalized in the U.S. the adoptive parent's income will count when determining their eligibility.

4172 Qualified Alien (01/01/2007, 06-48)

A. A "qualified alien" is:

1. A lawful, permanent resident;

2. A refugee, including:

   a. Individuals admitted to the United States under § 207 of the Immigration and Nationality Act (INA);

   b. A Cuban or Haitian entrant, as defined in § 501(e)(2) of the Refugee Education Assistance Act of 1980;

   c. An Amerasian, admitted to the United States under § 584 of the Foreign Operations Export Financing, and Related Programs Appropriation Act, 1988 (as contained in § 101(e) of Public Law 100-202 and amended by the 9th proviso under Migration and Refugee Assistance in title II of the Foreign Operations Export Financing, and Related Programs Act, 1989, Public Law 100-461, as amended);

3. An asylee, as defined in § 208 of the INA;

4. An alien whose deportation has been withheld under:

   a. § 243(h) of the INA, as in effect prior to April 1, 1997 (the effective date of § 307 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA), division C of Public Law 104-208);

   b. § 241(b)(3) of the INA, as amended by section 305(a) of division C of Public Law 104-208;

5. An alien who has been granted parole for at least one year by the USCIS under § 212(d)(5) of the INA;

6. An alien who has been granted conditional entry under § 203(a)(7) of the INA;

7. A battered alien, as defined in rule 4172.1;

8. A victim of a severe form of trafficking, in accordance with § 107(b)(1) of the Trafficking Victims Protection Act of 2000; or

9. An American Indian, born outside the U.S. and who enters and re-enters and resides in the U.S. is, for Medicaid purposes such a person is, considered lawful permanent resident and, as such, a qualified alien. This includes:

   a. An American Indian who was born in Canada and who is of at least one-half American Indian blood. This does not include the non-citizen spouse or child of such an Indian or a non-citizen whose membership in an Indian tribe or family is created by adoption, unless such person is of at least 50% American Indian blood.

   b. An American Indian who is a member of a Federally-recognized Indian tribe, as defined in § 4(e) of the Indian Self-Determination and Education Assistance Act, 25 U.S. C. 450b(e). Abenaki is not a federally-recognized tribe.

Qualified Alien

4172.1 Battered Alien (01/01/2007, 06-48)

A. To qualify as a "battered alien" for purposes of establishing qualified alien status, the following conditions must be met:

1. The individual must be:

a. A victim of battering or cruelty by a spouse or a parent, or by a member of the spouse or parents family residing in the same household as the victim and the spouse or parent consented to, or acquiesced in the battery or cruelty; or

b. The parent of a child who has been such a victim, provided that the individual did not actively participate in the battery or cruelty; or

c. The child residing in the same household of such a victim.

2. The individual must no longer be residing in the same household as the perpetrator of the abuse or cruelty.

3. The battery or cruelty must have a substantial connection with the need for medical assistance.

4. The individual must have been approved for legal immigration status, or have a petition pending that makes a prima facie case for legal immigration status, under one of the following categories:

a. Permanent residence under the Violence Against Women Act (VAWA);

b. A pending or approved petition for legal permanent residence filed by a spouse or parent on USCIS Form I-130 or Form I-129f;

c. Suspension of deportation or cancellation of removal under VAWA.

4172.2 Immigration Status Documentation (01/01/2007, 06-48)

A. All non-citizen applicants for Medicaid must provide USCIS documents to establish immigration status, as specified below:

1. Lawful Permanent Resident:

a. USCIS Form I-551, or

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

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

2. Refugee:

a. USCIS Form I-94 endorsed to show entry as refugee under section 207 of INA and date of entry to the United States,

b. USCIS Form I-688B annotated “274a.12(a)(3)”

c. Form I-766 annotated ”A3”, or

d. Form I-571.

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

3. Asylee:

a. USCIS Form I-94 annotated with stamp showing grant of asylum under section 208 of the INA,

b. A grant letter from the Asylum Office of the USCIS,

c. Form I-688B annotated “274a.12(a)(5)”

d. Form I-766 annotated “A5” or

e. An order of the Immigration Judge granting asylum.

i. If a court order is presented, file a G-845 with the local USS district office attaching a copy of the document to verify that the order was not overturned on appeal.

4. American Indian born outside of the United States:

a. Documentation of LPR status (See I-313.1),

b. Birth or baptismal certificate issued on a reservation,

c. Membership card or other tribal records,

d. Letter from the Canadian Department of Indian Affairs,

e. School records, or

f. Contact with the tribe in question.

5. Alien granted parole for at least 1 year by the USCIS:

a. USCIS Form I-94 endorsed to show grant of parole under § 212 (d)(5) of the INA and a date showing granting of parole for at least 1 year.

6. Alien granted conditional entry under the immigration law in effect before April 1, 1980:

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

b. Forms I-688B annotated “274a.12 (a)(3),” or

c. Form I-766 annotated "A-3."

7. Alien who has had deportation withheld under § 243(h) of the INA:

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

   b. USCIS Forms I-688B annotated "247a.12(a)(10)" or

   c. Form I-766 annotated "A10."

INTERPRETIVE MEMO

[X] Medicaid Rule Interpretation **[ ] Medicaid Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4173 Date of this Memo 12/19/2009 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

Effective December 19, 2009, citizens and nationals of Iraq and Afghanistan with Special Immigrant status are eligible for benefits that are available to refugees. The five year bar no longer applies to these individuals.

4173 Five-Year Bar for Qualified Aliens (02/27/2012, 11-30)

A. Immigrants who enter the United States on or after August 22, 1996 as qualified aliens are not eligible to receive Medicaid for five years from the date they enter the country. If they are not qualified aliens when they enter, the five-year bar begins the date they become a qualified alien. The following qualified aliens are subject to the five-year bar:

1. Lawful permanent residents (LPRs);
2. Aliens granted parole for at least one year;
3. Aliens granted conditional entry (however, as a practical matter the five-year bar will never apply to such aliens, since, by definition, they entered the U.S. and obtained qualified alien status prior to August 22, 1996); and
4. Battered aliens.

B. The following qualified aliens are not subject to the five-year bar:

1. Refugees;
2. Asylees;
3. Cuban and Haitian Entrants;
4. Victims of a severe form of trafficking;
5. Aliens whose deportation is being withheld;
6. Qualified aliens who are (1) honorably discharged veterans, (2) on active duty in the U.S. military or (3) the spouse (including a surviving spouse who has not remarried) or unmarried dependent child of an honorably discharged veteran or individual on active duty in the U.S. Military;
7. Aliens admitted to the country as Amerasian immigrants;
8. Legal permanent residents who first entered the country under another exempt category (i.e., as a refugee, asylee, Cuban or Haitian entrant, trafficking victim, or alien whose deportation was being withheld) and who later converted to the LPR status.

C. The five-year bar does not apply to:

1. Immigrants who are applying for treatment of an emergency medical condition only;
2. Immigrants who entered the United States and became qualified aliens prior to August 22, 1996; and
3. Immigrants who entered prior to August 22, 1996 and remained "continuously present" in the United States until becoming a qualified alien on or after that date. Any single absence of more than 30 consecutive days or a combined total absence of 90 days before obtaining qualified alien status is considered to interrupt "continuous presence."
    a. Immigrants who do not meet "continuous presence" are subject to the five-year bar beginning from the date they become a qualified alien.
    b. Immigrants do not have to remain continuously present in the United States after obtaining qualified alien status.

4. Members of a Federally-recognized Indian tribe; and

5. American Indians born in Canada to whom Section 289 of the INA applies.

6. Children up to 21 years of age and women during pregnancy and the 60-day postpartum period, who are lawfully residing in the United States and are otherwise eligible for assistance. This exemption applies only to traditional Medicaid coverage groups, children in the group defined in rule 4312.6, and pregnant women in the group defined in rule 4312.7.

   A child or pregnant woman will be considered to be lawfully residing in the United States if he or she is:

   a. A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641) (see, Medicaid Rule 4172);

   b. An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;

   c. An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;

   d. An alien who belongs to one of the following classes:

      - Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);

      - Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;

      - Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);

      - Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;

      - Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;

      - Aliens currently in deferred action status; or

      - Aliens whose visa petition has been approved and who have a pending application for adjustment of status;

   e. A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;

   f. An alien who has been granted withholding of removal under the Convention Against Torture;

g. A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J)).

The state will verify that the child or pregnant woman is lawfully residing in the United States at the time of the individual's original eligibility determination and at the time of eligibility redetermination.

4173.1 Documentation of Entry Date (02/27/2012, 11-30)

A. The following are the documents that may be used to determine the five-year bar:

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

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

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

B. If a person presents a receipt indicating that he or she has applied to USCIS for a replacement document for one of the documents identified above, contact the USCIS to verify status by filing a G-845 with the local USCIS district office with a copy of the receipt. Contact the USCIS any time there is a reason to question the authenticity of a document presented or the information on the document is insufficient to determine whether alien status requirements are met.

4174 Non-Qualified Aliens (01/01/2007, 06-48)

Aliens who do not meet qualified alien status are considered non-qualified aliens. Non-qualified aliens who otherwise meet the Medicaid eligibility criteria of a categorical assistance program are eligible for the treatment of emergency medical conditions only. (rule 4177). These aliens do not have to make a declaration of immigration status. Immigration status does not have to be verified. Such aliens do have to provide their Social Security Number if one is available or apply for one if the person does not have one. Non-qualified aliens include illegal and undocumented aliens.

4174.1 Illegal Aliens (01/01/2007, 06-48)

These aliens were never legally admitted to the U.S. for any period of time, or were admitted for a limited time and did not leave the U.S. when the time expired. These individuals are not issued Social Security Numbers. Therefore, they do not have to provide one.

4174.2 Undocumented Aliens (01/01/2007, 06-48)

Aliens who do not have any type of Bureau of Citizenship and Immigration Services (BCIS) documentation are undocumented aliens.

4175 Ineligible Aliens and Non-Immigrants (01/01/2007, 06-48)

A. Some aliens may be lawfully admitted but only for a temporary or specified period of time as legal non-immigrants. These aliens are never qualified aliens. Because of the temporary nature of their admission status, they generally will be unable to establish residency and are not eligible for Medicaid. Thus, an alien in possession of a student visa, for example, is not a qualified alien for Medicaid purposes. In rare instances, an ineligible alien may be able to establish residency and meet all other Medicaid eligibility criteria of a categorical assistance program and therefore be eligible for treatment of emergency medical conditions only. (rule 4177).

B. Visitors, tourists, some workers and diplomats are also ineligible. These aliens would have the following types of documentation:

1. Form I-94 Arrival-Departure Record,
2. Form I-185 Canadian Border Crossing Card,
3. Form I-186 Mexican Border Crossing Card,
4. Form SW-434 Mexican Border Visitors Permit, or
5. Form I-95A Crewmans Landing Permit.

C. The following categories of individuals are ineligible aliens/non-immigrants and are not eligible for Medicaid:

1. Foreign government representatives on official business and their families and servants,
2. Visitors for business or pleasure, including exchange visitors,
3. Aliens in travel status while traveling directly through the U.S.,
4. Crewmen on shore leave,
5. Foreign students,
6. International organization representation personnel and their families and servants,
7. Temporary workers including agricultural contract workers, and
8. Members of foreign press, radio, film, or other information media and their families.

Confirmation of Immigration via SAVE

4176 Confirmation of Immigration via SAVE (01/01/2007, 06-48)

A qualified aliens immigration status must be confirmed through the Systematic Alien Verification for Entitlement (SAVE) Program, regardless of documentation presented by the alien.

4177 Emergency Medical Services (01/01/2007, 06-48)

A. Non-qualified aliens are eligible for the treatment of emergency medical conditions if all of the following conditions are met:

1. The individual has, after sudden onset, a medical condition–including emergency labor and delivery–manifesting itself by acute symptoms of sufficient severity–including severe pain–such that the absence of immediate medical attention could reasonably be expected to result in serious:

   a. jeopardy to the patients health;

   b. impairment of bodily functions; or

   c. dysfunction of any bodily organ or part.

2. Emergency Medical Services are not related to either an organ transplant procedure or routine prenatal or post-partum care.

3. The individual meets all eligibility requirements for SSI- or ANFC-related Medicaid except verification of alien status and, for illegal noncitizens, verification of a social security number.