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16.03.01 - Eligibility for Health Care Assistance for Families and Children

IDAPA 16
TITLE 03
CHAPTER 01

16.03.01 - ELIGIBILITY FOR HEALTH CARE ASSISTANCE FOR FAMILIES AND CHILDREN

000. LEGAL AUTHORITY.
In accordance with Sections 56-202, 56-203, 56-209, 56-239, 56-250, 56-253, 56-255, 56-256 and 56-257, Idaho Code, the Idaho Legislature has authorized the Department of Health and Welfare to adopt and enforce rules for the administration of Title XIX of the Social Security Act (Medicaid), and Title XXI of the Social Security Act. (1-1-14)T

001. TITLE AND SCOPE.

01. Title. These rules will be cited as IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children." (1-1-14)T

02. Scope. These rules provide standards for issuing coverage for Title XIX and Title XXI of the Social Security Act. (1-1-14)T

002. WRITTEN INTERPRETATIONS.
In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency has written statements that pertain to the interpretation of the rules of this chapter, or to the documentation of compliance with the rules of this chapter. The document is available for public inspection and copying at cost at the Department of Health and Welfare, 450 West State Street, P.O. Box 83720, Boise, Idaho, 83720-0036 or at any of the Department's Regional Offices. (1-1-14)T

003. ADMINISTRATIVE APPEALS.
All administrative appeals are governed by provisions of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." (1-1-14)T

004. INCORPORATION BY REFERENCE.
No documents have been incorporated by reference into these rules. (1-1-14)T

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- TELEPHONE NUMBER -- INTERNET WEBSITE.

01. Office Hours. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the state of Idaho. (1-1-14)T

02. Mailing Address. The mailing address for the business office is Idaho Department of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. (1-1-14)T

03. Street Address. The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. (1-1-14)T

04. Telephone. The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500. (1-1-14)T

05. Internet Website. The Department's internet website is http://www.healthandwelfare.idaho.gov. (1-1-14)T

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS.

01. Confidential Records. Any information about an individual covered by these rules and contained in the Department's records must comply with IDAPA 16.05.01, "Use and Disclosure of Department Records." (1-1-14)T

02. Public Records. The Department will comply with Sections 9-337 through 9-350, Idaho Code,

when requests for the examination and copying of public records are made. Unless otherwise exempted, all public records in the custody of the Department are subject to disclosure. (1-1-14)T

007. -- 009. (RESERVED)

010. DEFINITIONS (A THROUGH L).
For the purposes of this chapter, the following terms apply. (1-1-14)T

01. Advanced Payment of Premium Tax Credit. Payment of federal tax credits specified in 26 U.S.C. Part 36B (as added by section 1401 of the Affordable Care Act) which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an exchange in accordance with sections 1402 and 1412 of the Affordable Care Act. (1-1-14)T

02. Adult. Any individual who has passed the month of his nineteenth birthday. (1-1-14)T

03. Affordable Care Act. The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152). (1-1-14)T

04. Applicant. A person applying for public assistance from the Department, including individuals referred to the Department from a Health Insurance Exchange or Marketplace. (1-1-14)T

05. Application. An application for benefits including an Application for Assistance (AFA) or other application recognized by the Department, including referrals from a Health Insurance Exchange or Marketplace. (1-1-14)T

06. Application Date. The date the Application for Assistance (AFA) is received by the Department or by the Health Insurance Exchange or Marketplace electronically, telephonically, in person, or the date the application is postmarked, if mailed. (1-1-14)T

07. Caretaker Relative. A caretaker relative is a relative of a dependent child by full- or half-blood, adoption, or marriage with whom the child is living and who assumes primary responsibility for the child's care. A caretaker relative is one of the following: (1-1-14)T

a. A child's natural, adoptive, or step-parents; (1-1-14)T

b. A child's natural, adoptive, or step-grandparents; (1-1-14)T

c. A child's natural, adoptive, half- or step-siblings; (1-1-14)T

d. A child's natural, adoptive, half- or step-uncle, aunt, first cousin, nephew, niece; first cousin once removed; or (1-1-14)T

e. A current or former spouse of a qualified relative listed above. (1-1-14)T

08. Child. Any individual from birth through the end of the month of his nineteenth birthday. (1-1-14)T

09. Citizen. A person having status as a “national of the United States” defined in 8 U.S.C. 1101(a)(22) that includes both citizens of the United States and non-citizen nationals of the United States. (1-1-14)T

10. Cost-Sharing. A participant payment for a portion of Medicaid service costs such as deductibles, co-insurance, or co-payment amounts. (1-1-14)T

11. Creditable Health Insurance. Creditable health insurance is coverage that provides benefits for inpatient and outpatient hospital services and physicians' medical and surgical services. Creditable coverage excludes liability, limited scope dental, vision, specified disease, or other supplemental-type benefits. (1-1-14)T

12. **Department**. The Idaho Department of Health and Welfare. (1-1-14)T

13. **Disenrollment**. The end of an individual's participation in a Health Care Assistance program. (1-1-14)T

14. **Electronic Account**. An electronic file that includes all information collected and generated by the state regarding each individual's Health Care Assistance eligibility and enrollment, including all documentation required and information collected as part of an eligibility review, or during the course of an appeal. (1-1-14)T

15. **Eligibility**. The determination of whether or not an individual is eligible for participation in a Health Care Assistance program. (1-1-14)T

16. **Enrollment**. The process of adding eligible individuals to a Health Care Assistance program. (1-1-14)T

17. **Extended Medicaid**. Extended Medicaid is four (4) additional months of medical assistance for a parent or relative caretaker who becomes ineligible for Title XIX Medicaid due to an increase in spousal support payments. (1-1-14)T

18. **Federal Poverty Guidelines (FPG)**. The federal poverty guidelines issued annually by the Department of Health and Human Services (HHS).The Federal Poverty Guidelines (FPG) are available on the U.S. Health and Human Services website at http://aspe.hhs.gov/poverty. (1-1-14)T

19. **Health Assessment**. Health Assessment is an examination performed by a primary care provider in order to determine the appropriate health plan for a Medicaid-eligible individual. (1-1-14)T

20. **Health Care Assistance (HCA)**. Health coverage, including Title XIX or Title XXl benefits granted by the Department for persons or families under the authority of Title 56, Chapter 2, Idaho Code, as well as private health insurance plans purchased with a Premium Tax Credit described in Subsection 010.01 of this rule. (1-1-14)T

21. **Health Insurance Exchange or Marketplace**. A resource where individuals, families, and small businesses can: (1-1-14)T

a. Learn about their health coverage options; (1-1-14)T

b. Compare health insurance plans based on costs, benefits, and other important features: (1-1-14)T

c. Choose a health coverage plan; and (1-1-14)T

d. Enroll in health coverage. (1-1-14)T

22. **Health Insurance Premium Program (HIPP)**. The Premium Assistance program in which Title XIX and Title XXI participants may participate. (1-1-14)T

23. **Health Plan**. A set of health services paid for by Idaho Medicaid, or health insurance coverage obtained through the Health Insurance Exchange or Marketplace. (1-1-14)T

24. **Health Questionnaire**. A tool used to assist Health and Welfare staff in determining the correct Health Plan for the Medicaid applicant. (1-1-14)T

25. **Internal Revenue Code**. The federal tax law used to determine eligibility under Title 26 U.S.C. for individual income and self-employment income. (1-1-14)T

26. **Internal Revenue Service (IRS)**. The U.S. government agency in charge of tax laws. These laws are used to determine income eligibility. The IRS website is at http://www.irs.gov. (1-1-14)T

27. Insurance Affordability Programs. Insurance affordability programs include Title XIX title XXI and all insurance programs available in the Health Insurance Exchange or Marketplace. (1-1-14)T

28. Lawfully Present. An individual who is a qualified non-citizen as described in Section 221 of these rules. (1-1-14)T

29. Lawfully Residing. An individual who is lawfully present in the United States and is a resident of the state in which they are applying for health care coverage. (1-1-14)T

011. DEFINITIONS (M THROUGH Z).
For the purposes of this chapter, the following terms apply. (1-1-14)T

01. MAGI-Based Income. Income calculated using the same financial methodologies used by the IRS to determine modified adjusted gross income for federal tax filers, with the exception that: (1-1-14)T

a. Educational income is excluded in Section 382 of these rules; (1-1-14)T

b. Indian monies excluded by federal law are not included in MAGI-based income; (1-1-14)T

c. Lump sum income is counted only in the month received in Section 384 of these rules; and (1-1-14)T

d. For Medicaid applicants, MAGI-based income is calculated based on income received in the month of application. (1-1-14)T

02. Medicaid. Idaho's Medical Assistance Program administered by the Department and funded with federal and state funds according to Title XIX of the Social Security Act that provides medical care for eligible individuals. (1-1-14)T

03. Modified Adjusted Gross Income (MAGI). Modified Adjusted Gross Income (MAGI), is Adjusted Gross Income as defined by the IRS, plus certain tax-exempt income. (1-1-14)T

04. Newborn Deemed Eligible. A child born to a woman who is eligible for and receiving medical assistance on the date of the child's birth, including during a month of retroactive eligibility for the mother. A child so born is eligible for Medicaid for the first year of his life. (1-1-14)T

05. Non-Citizen. Same as "alien" defined in Section 101(a)(3) of the Immigration and Nationality Act (INA) (8 U.S.C. 1101 (a)(3)), and includes any individual who is not a citizen or national of the United States. (1-1-14)T

06. Parent. For a household with a MAGI-based eligibility determination a parent can be: (1-1-14)T

a. Natural; (1-1-14)T

b. Biological; (1-1-14)T

c. Adoptive; or (1-1-14)T

d. Step-parent. (1-1-14)T

07. Participant. An individual who is eligible for, and enrolled in, a Health Care Assistance program. (1-1-14)T

08. Pregnant Woman Coverage. Medical assistance for a pregnant woman that is limited to pregnancy-related services for the period of the pregnancy and sixty (60) days after the pregnancy ends. (1-1-14)T

09. Premium. A regular, periodic charge or payment for health coverage. (1-1-14)T

10. Qualified Hospital. A qualified hospital has a Memorandum of Understanding (MOU) with the Department, participates as a provider under the Medicaid state plan, may assist individuals in completing and submitting applications for Health coverage, and has not been disqualified from doing presumptive eligibility determinations. (1-1-14)T

11. Qualified Non-Citizen. Same as "qualified alien" defined at 8 U.S. C.164(b) and (c). (1-1-14)T

12. Reasonable Opportunity Period. A period of time allowed for an individual to provide requested proof of citizenship or identity. A reasonable opportunity period extends for ninety (90) days beginning on the 5th day after the notice requesting the proof has been mailed to the applicant. This period may be extended if the Department determines that the individual is making a "good faith" effort to obtain necessary documentation. (1-1-14)T

13. Sibling. For household with MAGI-based eligibility determination: Is a natural or biological, adopted, half- or step-sibling. (1-1-14)T

14. SSI. Supplemental Security Income. (1-1-14)T

15. SSN. Social Security Number. (1-1-14)T

16. State. The state of Idaho. (1-1-14)T

17. TAFI. Temporary Assistance for Families in Idaho. (1-1-14)T

18. TANF. Temporary Assistance to Needy Families. (1-1-14)T

19. Tax Dependent. A person, who is a related child, or other qualifying relative or person, according to federal IRS standards for whom another individual can claim a deduction for a personal exemption when filing a federal income tax for a taxable year. (1-1-14)T

20. Third Party. Includes a person, institution, corporation, public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of a medical assistance participant. (1-1-14)T

21. Title XIX. Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the States. This program pays for medical assistance for certain individuals and families with low income, and for some program types, limited resources. (1-1-14)T

22. Title XXI. Title XXI of the Social Security Act, known as the Children's Health Insurance Program (CHIP), is a federal and state partnership similar to Medicaid, that expands health insurance to targeted, low-income children. (1-1-14)T

23. Working Day. A calendar day when regular office hours are observed by the state of Idaho. Weekends and state holidays are not considered working days. (1-1-14)T

012. -- 099. (RESERVED)

APPLICATION REQUIREMENTS
(Sections 100 Through 199)

100. PARTICIPANT RIGHTS.
The participant has rights protected by federal and state laws and Department rules. The Department must inform participants of the following rights during the application process and eligibility reviews. (1-1-14)T

01. Right to Apply. Any person has the right to apply for any Health Care Assistance program.

Applications may be submitted by paper, electronically, fax, or telephonically. Application information must be in a form or format provided by the Department. (1-1-14)T

02. Right to Hearing. Any participant can request a hearing to contest a Department or Health Insurance Exchange or Marketplace decision under the provisions in IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Ruling." (1-1-14)T

03. Right to Request Reinstatement of Benefits. Any participant has the right to request reinstatement of benefits until a hearing decision is made if the request for the reinstatement is made before the effective date of the action taken on the notice of decision. Reinstatement pending a hearing decision is not provided in the case of an application denied because an individual did not provide citizenship or identity documentation during a reasonable opportunity period allowed by the Department. (1-1-14)T

04. Civil Rights. Participants have civil rights under the U.S. and Idaho Constitutions, the Social Security Act, Title IV of the Civil Rights Act of 1964, the Rehabilitation Act of 1973 contained in Title 29 of the U.S. Code, and all other relevant parts of federal and state laws. (1-1-14)T

101. -- 109. (RESERVED)

110. APPLICATION FOR HEALTH CARE ASSISTANCE.
The application must be complete and signed by the participant or authorized representative. By signing the application, the participant or authorized representative agrees, under penalty of perjury, that statements made on the application are truthful. (1-1-14)T

111. SIGNATURES.
An individual who is applying for benefits, receiving benefits, or providing additional information as required by this chapter, may do so with the depiction of the individual's name either handwritten, electronic, or recorded telephonically. Such signature serves as intention to execute or adopt the sound, symbol, or process for the purpose of signing the related record. (1-1-14)T

112. -- 119. (RESERVED)

120. COLLATERAL SOURCES.
A participant's signature on the application is his consent for the Department to contact collateral sources for verification of eligibility requirements. Collateral sources include available electronic data sources to verify eligibility requirements which may include: Homeland Security, IRS, Social Security, State and Federal wage verification systems, child support services, or other electronic sources available to the Department. (1-1-14)T

121. -- 129. (RESERVED)

130. APPLICATION TIME LIMITS.
Each application must be processed as close to real time as practicable, but not longer than forty-five (45) days, from the date of application, unless prevented by events beyond the Department's control. (1-1-14)T

131. -- 139. (RESERVED)

140. ELIGIBILITY EFFECTIVE DATES.
Title XIX and Title XXI coverage begins the first day of the application month. Coverage for a newborn is effective the date of birth if the mother was covered by Medicaid for the child's birth. (1-1-14)T

141. -- 149. (RESERVED)

150. RETROACTIVE MEDICAL ASSISTANCE ELIGIBILITY.
Title XIX and Title XXI can begin up to three (3) calendar months before the application month if the participant is eligible during the prior period. Coverage is provided if services that can be paid by Medicaid were received in the prior period. (1-1-14)T

151. -- 199. (RESERVED)

NON-FINANCIAL REQUIREMENTS
(Sections 200 Through 299)

200. NON-FINANCIAL CRITERIA FOR DETERMINING ELIGIBILITY.
Non-financial criteria are conditions of eligibility, other than income, that must be met before Health Care Assistance can be authorized. (1-1-14)T

201. -- 209. (RESERVED)

210. RESIDENCY.
The participant must live in Idaho and have no immediate intention of leaving, including an individual who has entered the state to look for work, or who has no permanent, fixed address. (1-1-14)T

211. -- 219. (RESERVED)

220. U.S. CITIZENSHIP VERIFICATION.

01. Citizenship Verified. Citizenship must be verified through electronic means when available. If an electronic verification is not immediately obtainable, the Department may request documentation from the applicant. The Department will not deny the application for Health Coverage until the applicant has had a reasonable opportunity period to obtain and provide the necessary proof of U. S. citizenship. (1-1-14)T

02. Benefits During Reasonable Opportunity Period. Benefits are provided during the reasonable opportunity period that is provided to allow the applicant time to obtain and provide documentation to verify U.S. citizenship. No overpayment exists for the reasonable opportunity period if the applicant does not provide necessary documentation during the reasonable opportunity period so that the application results in denial. (1-1-14)T

221. U.S. CITIZENSHIP AND QUALIFIED NON-CITIZEN REQUIREMENTS.
To be eligible, an individual must be a lawfully present member of one (1) of the following groups: (1-1-14)T

01. U.S. Citizen. A U.S. Citizen or a "national of the United States." (1-1-14)T

02. Child Born Outside the U.S. A child born outside the U.S., as defined in Public Law 106-395, is considered a citizen if all of the following conditions are met: (1-1-14)T

a. At least one (1) parent is a U.S. Citizen. The parent can be a citizen by birth or naturalization. This includes an adoptive parent; (1-1-14)T

b. The child is residing permanently in the U.S. in the legal and physical custody of a parent who is a U.S. Citizen; (1-1-14)T

c. The child is under eighteen (18) years of age; (1-1-14)T

d. The child is a lawful permanent resident; and (1-1-14)T

e. If the child is an adoptive child, the child was residing in the U.S. at the time the parent was naturalized and was in the legal and physical custody of the adoptive parent. (1-1-14)T

03. Full-Time Active Duty U.S. Armed Forces Member. A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) who is currently on full-time active duty with the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy or U.S. Coast Guard, or a spouse or unmarried dependent child of the U.S. Armed Forces member. (1-1-14)T

04. Veteran of the U.S. Armed Forces. A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c)

who was honorably discharged from the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy, or U.S. Coast Guard for a reason other than their citizenship status, or a spouse, including a surviving spouse who has not remarried, or an unmarried dependent child of the veteran. (1-1-14)T

05. Non-Citizen Entering the U.S. Before August 22, 1996. A non-citizen who entered the U.S. before August 22, 1996, who is currently a qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c), who remained continuously present in the U.S. until he became a qualified non-citizen. (1-1-14)T

06. Non-Citizen Entering On or After August 22, 1996. A non-citizen who entered the U.S. on or after August 22, 1996, and who is: (1-1-14)T

a. A refugee admitted into the U.S. under 8 U.S.C. 1157, and can be eligible for seven (7) years from the date of entry; (1-1-14)T

b. An asylee granted asylum into the U.S. under 8 U.S.C. 1158, and can be eligible for seven (7) years from the date asylee status is assigned; (1-1-14)T

c. An individual whose deportation or removal from the U.S. has been withheld under 8 U.S.C. 1253 or 1231(b)(3) as amended by Section 305(a) of Division C of Public Law 104-208, and can be eligible for seven (7) years from the date deportation or removal was withheld; (1-1-14)T

d. An Amerasian immigrant admitted into the U.S. under 8 U.S.C. 1612(b)(2)(A)(i)(V), and can be eligible for seven (7) years from the date of entry; or (1-1-14)T

e. A Cuban or Haitian entrant to the U.S. under Section 501(e) of the Refugee Assistance Act under Section 501(e) of P.L. 96-422 (1980), and can be eligible for seven (7) years from the date of entry. (1-1-14)T

07. Qualified Non-Citizen Entering On or After August 22, 1996. A qualified non-citizen under 8 U.S.C. 1641(b) or (c), who entered the U.S. on or after August 22, 1996, and who has held a qualified non-citizen status for at least five (5) years. (1-1-14)T

08. American Indian Born in Canada. An American Indian born in Canada, under 8 U.S.C. 1359. (1-1-14)T

09. American Indian Born Outside the U.S. An American Indian born outside of the U.S., who is a member of a U.S. federally recognized tribe under 25 U.S.C. 450 b(e). (1-1-14)T

10. Qualified Non-Citizen Child Receiving Federal Foster Care. A qualified non-citizen child as defined in 8 U.S.C. 1641(b) or (c), and receiving federal foster care assistance. (1-1-14)T

11. Victim of Severe Form of Trafficking. A victim of a severe form of trafficking in persons, as defined in 22 U.S.C. 7102(13); who meets one (1) of the following: (1-1-14)T

a. Is under the age of eighteen (18) years; or (1-1-14)T

b. Is certified by the U.S. Department of Health and Human Services as willing to assist in the investigation and prosecution of a severe form of trafficking in persons; and (1-1-14)T

i. Has made a bona fide application for a temporary visa under 8 U.S.C. 1104(a)(15)(T), which has not been denied; or (1-1-14)T

ii. Is remaining in the U.S. to assist the U.S. Attorney General in the prosecution of traffickers in persons. (1-1-14)T

12. Afghan Special Immigrant. An Afghan special immigrant, as defined in Public Law 110-161, who has special immigration status after December 26, 2007. (1-1-14)T

13. Iraqi Special Immigrant. An Iraqi special immigrant, as defined in Public Law 110-181, who has special immigration status after January 28, 2008. (1-1-14)T

14. Employment Authorized Alien. An alien granted an employment authorization document (EAD), as defined in 8 CFR Part 274a.12(c). (1-1-14)T

15. Individuals not Meeting the Citizenship or Qualified Non-Citizen Requirements. An individual who does not meet the citizenship or qualified non-citizen requirements in Subsections 221.01 through 221.14 of this rule, may be eligible for emergency medical services if he meets all other conditions of eligibility. (1-1-14)T

222. U.S. CITIZENSHIP AND IDENTITY VERIFICATION REQUIREMENTS.
Any individual who participates in a Title XIX Medicaid or Title XXI CHIP funded program must provide proof of U.S. citizenship and identity unless he has otherwise met the requirements under Section 226 of these rules. (1-1-14)T

01. Electronic Verification. Electronic interfaces initiated by the Department with agencies that maintain citizenship and identity information are the primary sources of verification of U.S. Citizenship and Identity. (1-1-14)T

02. Documents. When verification is not available through an electronic interface, the individual must provide the Department with the most reliable document that is available. Documents can be: (1-1-14)T

a. Originals; (1-1-14)T

b. Photocopies; (1-1-14)T

c. Facsimiles; (1-1-14)T

d. Scanned; or (1-1-14)T

e. Other type of copy of a document. (1-1-14)T

03. Accepted Documentation. Other forms of documentation are accepted to the same extent as an original document, unless information on the submitted document is: (1-1-14)T

a. Inconsistent with other information available to the Department; or (1-1-14)T

b. The Department has good cause to question the validity of the document or the information on it. (1-1-14)T

04. Submission of Documents. The Department accepts documents that are submitted: (1-1-14)T

a. In person; (1-1-14)T

b. By mail or parcel service; (1-1-14)T

c. Through an electronic submission; or (1-1-14)T

d. Through a guardian or authorized representative. (1-1-14)T

223. DOCUMENTATION OF U.S. CITIZENSHIP.

01. Documents Accepted as Stand-Alone Proof of U.S. Citizenship and Identity. The following documents are accepted as proof of both U.S. citizenship and identity: (1-1-14)T

a. A U.S. passport or a U.S. passport card, without regard to expiration date as long as the passport or

passport card was issued without limitation; (1-1-14)T

b. A Certificate of Naturalization; (1-1-14)T

c. A Certificate of U.S. Citizenship. (1-1-14)T

d. Documented evidence, issued by a federally recognized Indian tribe, including tribes with an international border that identifies: (1-1-14)T

i. The federally recognized Indian Tribe issuing the document; (1-1-14)T

ii. The individual by name; (1-1-14)T

iii. Confirms the individual's membership; and (1-1-14)T

iv. Enrollment or affiliation with the Tribe. (1-1-14)T

f. Verification of U.S. citizenship by a federal agency or another state on or after July 1, 2006, no further documentation of U.S. citizenship or identity is required. (1-1-14)T

02. Documents Accepted as Evidence of U.S. Citizenship. The following documents are accepted as proof of U.S. citizenship if documented proof in Subsection 223.01 of this rule is not available. These documents are not proof of identity and must be used in combination with a least one (1) document listed in Subsection 223.03 or Section 224 of these rules to establish both citizenship and identity. (1-1-14)T

a. A U.S. birth certificate that shows the individual was born in one (1) of the following: (1-1-14)T

i. United States' fifty (50) states; (1-1-14)T

ii. District of Columbia; (1-1-14)T

iii. Puerto Rico, on or after January 13, 1941; (1-1-14)T

iv. Guam; (1-1-14)T

v. U.S. Virgin Islands, on or after January 17, 1917; (1-1-14)T

vi. America Samoa; (1-1-14)T

vii. Swain's Island; (1-1-14)T

viii. Northern Mariana Islands, after November 4, 1986; or (1-1-14)T

b. A cross match with a state's vital statistics agency that documents birth records. (1-1-14)T

c. A certification of report of birth issued by the Department of State, Forms DS-1350 or FS-545; (1-1-14)T

d. A report of birth abroad of a U.S. Citizen, Form FS 240; (1-1-14)T

e. A U.S. Citizen I.D. card, DHS Form I-197; (1-1-14)T

f. A Northern Mariana Identification Card; (1-1-14)T

g. A final adoption decree showing the child's name and U.S. place of birth, or if the adoption is not final, a statement from the state-approved adoption agency that shows the child's name and U.S. place of birth; (1-1-14)T

h. Evidence of U.S. Civil Service employment before June 1, 1976; (1-1-14)T

i. An official U.S. Military record showing a U.S. place of birth; (1-1-14)T

j. Certification of birth abroad, Form FS-545; (1-1-14)T

k. Verification with the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) database; (1-1-14)T

l. Evidence of meeting the automatic criteria for U.S. citizenship outlined in the Child Citizenship Act of 2000; (1-1-14)T

m. Medical records from a hospital, clinic, or doctor, admission papers from nursing facility, skilled care facility, or other institution that indicates a U.S. place of birth: (1-1-14)T

n. Life, health, or other insurance record that indicates a U.S. place of birth. (1-1-14)T

o. Officially recorded religious record that indicates a U.S. place of birth; (1-1-14)T

p. School records, including pre-school, Head Start, and daycare that shows the child's name and indicates a U.S. place of birth; (1-1-14)T

q. Federal or state census record that shows U.S. Citizenship or indicates a U.S. place of birth; or (1-1-14)T

r. When an applicant has none of the documents listed in Subsections 223.02.a. through q. of this rule, an affidavit signed by another individual under the penalty of perjury who can reasonably attest to the applicant's citizenship, and that contains the applicant's name, and indicates the date and U.S. place of birth, may be submitted. The affidavit does not need to be notarized. (1-1-14)T

03. Documents Accepted for Evidence of Identity. The following documents are accepted as proof of identity provided the document has a photograph or other identifying information that includes name, age, sex, race, height, weight, eye color, or address. (1-1-14)T

a. A driver's license issued by a state or territory. A driver's license issued by a Canadian government authority is not a valid indicator of identity in the U.S. and cannot be used as evidence of identity. (1-1-14)T

b. An identity card issued by federal, state, or local government; (1-1-14)T

c. School identification card; (1-1-14)T

d. U.S. Military card or draft record; (1-1-14)T

e. Military dependent's identification card; (1-1-14)T

f. U. S. Coast Guard Merchant Mariner card; or (1-1-14)T

g. A finding of identity from a federal or state governmental agency, when the agency has verified and certified the identity of the individual, including public assistance, law enforcement, internal revenue or tax bureau, or corrections agency; (1-1-14)T

h. A finding of identity from another state benefits agency or program provided that it obtained verification of identity as a criterion of participation; (1-1-14)T

i. Two (2) documents containing consistent information that corroborates the applicant's identity including: employer identification cards, high school or high school equivalency diplomas, college diplomas,

marriage certificates, divorce decrees, property deeds or titles; (1-1-14)T

j. Identity affidavits are acceptable evidence of identity for individuals living in a residential care facility. (1-1-14)T

k. When an applicant has none of the specified findings or documents listed in Subsections 223.03.a. through j. of this rule, the applicant may submit an affidavit signed by another individual under the penalty of perjury who can reasonably attest to the applicant's identity. The affidavit must contains the applicant's name, and identifying information to establish identity. The affidavit does not need to be notarized. (1-1-14)T

224. IDENTITY RULES FOR CHILDREN.
The following additional sources of documentation of identity for children under nineteen (19) years of age may be used: (1-1-14)T

01. School Records. School records may be used to establish identity, including nursery or day care records. (1-1-14)T

02. Medical Records. Clinic, hospital, or doctor records may be used to establish identity. (1-1-14)T

225. ELIGIBILITY FOR APPLICANTS WHO DO NOT PROVIDE U.S. CITIZENSHIP AND IDENTITY DOCUMENTATION.

01. U.S. Citizenship and Identity not Verified. When the Department is unable to obtain verification of U.S. citizenship and identity through electronic means, or the applicant is unable to provide documentation at the time of application, the applicant will have a reasonable opportunity period of ninety (90) days to provide proof of U.S. citizenship and identity. (1-1-14)T

02. Notice Mailed. The reasonable opportunity period of ninety (90) days to provide needed documentation for proof of U.S. citizenship and identity begins five (5) days after the date the notice requesting the proof of documentation is mailed. (1-1-14)T

03. Medicaid Benefits. If the applicant meets all other eligibility requirements, Medicaid benefits will be approved pending verification of U.S. citizenship and identity. Medicaid benefits will be denied if the applicant refuses to obtain documentation. (1-1-14)T

226. INDIVIDUALS CONSIDERED AS MEETING THE U.S. CITIZENSHIP AND IDENTITY DOCUMENTATION REQUIREMENTS.
The individuals listed in Subsections 226.01 through 226.06 of this rule are considered to have met the U.S. citizenship and identity requirements and are not required to provide further documentation. (1-1-14)T

01. Supplemental Security Income (SSI) Recipients. (1-1-14)T

02. Social Security Disability Income (SSDI) Recipients. (1-1-14)T

03. Individuals Entitled or Enrolled in Medicare by SSA. Individuals determined by the SSA to be entitled or enrolled in any part of Medicare. (1-1-14)T

04. Adoptive or Foster Care Children Receiving Assistance. Adoptive or foster care children receiving under Title IV-B or Title IV-E of the Social Security Act. (1-1-14)T

05. Individuals Deemed Eligible for Medicaid. A waived newborn under Section 530 of these rules. (1-1-14)T

06. Individuals Whose Records Match Records of the SSA. Confirmed records of SSA that match and include: (1-1-14)T

a. Name; (1-1-14)T

b. Social Security Number; and (1-1-14)T

c. Declaration of U.S. Citizenship. (1-1-14)T

227. ASSISTANCE IN OBTAINING DOCUMENTATION.
The Department will provide assistance to individuals who need assistance in securing satisfactory documentary evidence of U.S. citizenship. (1-1-14)T

228. VERIFICATION OF CITIZENSHIP AND IDENTITY ONE TIME.
Once an individual's U.S. citizenship and identity have been verified, whether through an electronic data match or by provided documentation, changes in eligibility will not require an individual to provide the verification again. If later verification, documentation, or information provides the Department with good cause to question the validity of the individual's U.S. citizenship or identity, the individual may be requested to provide further verification. (1-1-14)T

229. -- 239. (RESERVED)

240. INDIVIDUALS WHO DO NOT MEET THE CITIZENSHIP OR QUALIFIED NON-CITIZEN REQUIREMENTS.

01. Non-Citizen. An individual who does not meet the citizen or qualified non-citizen requirements may be eligible for emergency medical services if he meets all other conditions of eligibility for a Title XIX or Title XXI program. (1-1-14)T

02. Limited Eligibility. Eligibility for emergency medical assistance under the Title XIX or Title XXI programs is limited to the dates of the emergency condition. (1-1-14)T

241. -- 249. (RESERVED)

250. EMERGENCY MEDICAL CONDITION.
An individual who meets eligibility criteria for a category of assistance but does not meet U.S. citizenship requirements or eligible non-citizen requirements may receive medical assistance under a Title XIX or Title XXI coverage group as follows: (1-1-14)T

01. Emergency Medical Conditions. An individual not meeting the U.S. citizenship requirement may receive medical services necessary to treat an emergency medical condition, including labor and delivery. Emergency medical conditions have acute symptoms of severity, including severe pain. (1-1-14)T

02. Determination of Emergency Medical Conditions. The Department determines if a condition meets criteria of an emergency medical condition. (1-1-14)T

03. Limitation on Medical Assistance. Medical assistance is limited to the period of time established for the emergency medical condition. (1-1-14)T

04. Documentation Waived. For undocumented individuals with emergency medical conditions, the Social Security Number (SSN) requirement is waived because an SSN cannot be issued. Individuals must be otherwise eligible for Title XIX or XXI. (1-1-14)T

251. SPONSOR DEEMING.
Income of a legal non-citizen's sponsor and the sponsor's spouse are counted in determining eligibility. (1-1-14)T

252. SPONSOR RESPONSIBILITY.
Section 213 of the Immigration and Naturalization Act requires that a sponsor signing Form I-864, Affidavit of Support, reimburse the Department for Health Care Assistance benefits paid for a sponsored, qualified non-citizen. (1-1-14)T

253. -- 269. (RESERVED)

270. SOCIAL SECURITY NUMBER (SSN) REQUIREMENT.

01. SSN Required. An applicant must provide his social security number (SSN), or proof he has applied for an SSN, to the Department before approval of eligibility. If the applicant has more than one (1) SSN, all numbers must be provided. (1-1-14)T

a. The SSN must be verified by the Social Security Administration (SSA) electronically. When an SSN is unverified, the applicant is not eligible for Health Care Assistance. (1-1-14)T

b. The Department must notify the applicant in writing if eligibility is being denied or lost for failure to meet the SSN requirement. (1-1-14)T

02. Application for SSN. The applicant must apply for an SSN, or a duplicate SSN when he cannot provide his SSN to the Department. If the SSN has been applied for, but not issued by the SSA, the Department can not deny, delay, or stop benefits. The Department will help an applicant with required documentation when the applicant applies for an SSN. (1-1-14)T

03. Failure to Apply for SSN. The applicant may be granted good cause for failure to apply for an SSN if they have a well-established religious objection to applying for an SSN. A well-established religious objection means the applicant: (1-1-14)T

a. Is a member of a recognized religious sect or division of the sect; and (1-1-14)T

b. Adheres to the tenets or teachings of the sect, or division of the sect, and for that reason is conscientiously opposed to applying for or using a national identification number. (1-1-14)T

04. SSN Requirement Waived. An applicant may have the SSN requirement waived when he is: (1-1-14)T

a. Only eligible for emergency medical services as described in Section 250 of these rules; or (1-1-14)T

b. A newborn deemed eligible child as described in Section 530 of these rules. (1-1-14)T

271. -- 279. (RESERVED)

280. GROUP HEALTH PLAN ENROLLMENT.
Title XIX and Title XXI participants must apply for and enroll in a cost-effective group health plan if one is available. A cost-effective health plan is one which has premiums and co-payments at a lower cost than Medicaid would pay for full medical services. Medicaid will pay premiums and other co-payments for plans the Department finds cost-effective. (1-1-14)T

281. -- 289. (RESERVED)

290. ASSIGNMENT OF RIGHTS TO MEDICAL SUPPORT AND THIRD PARTY LIABILITY.
By operation of Sections 56-203B and 56-209b(3), Idaho Code, medical support rights are assigned to the Department by signature on the application for assistance. The participant must cooperate to secure medical support from any liable third party. The cooperation requirement may be waived if the participant has good cause for not cooperating. (1-1-14)T

291. MEDICAL SUPPORT COOPERATION.
A Medicaid participant responsible for assigning their rights to medical support must cooperate to identify and locate the noncustodial parent, establish paternity, and establish, modify, and enforce a medical support order. (1-1-14)T

01. Cooperation Defined. Cooperation includes providing all information to identify and locate the non-custodial parent, and identifying other liable third party payers. The participant must provide the first and last

name of the non-custodial parent. The participant must also provide at least two (2) of the following pieces of information about the non-custodial parent: (1-1-14)T

a. Birth date; (1-1-14)T

b. Social Security Number; (1-1-14)T

c. Current address; (1-1-14)T

d. Current phone number; (1-1-14)T

e. Current employer; (1-1-14)T

f. Make, model, and license number of any motor vehicle owned by the non-custodial parent; or (1-1-14)T

g. Names, phone numbers, and addresses of the parents of the non-custodial parent. (1-1-14)T

02. Good Cause Defined. The participant may claim good cause for failure to cooperate in securing medical support for a minor child. Good cause is limited to the following reasons: (1-1-14)T

a. There is proof the child was conceived as a result of incest or rape; (1-1-14)T

b. There is proof the child's non-custodial parent may inflict physical or emotional harm to the participant, the child, the custodial parent, or the caretaker relative; (1-1-14)T

c. A credible explanation is provided showing the participant cannot provide the minimum information regarding the non-custodial parent; or (1-1-14)T

d. A participant who has good cause for not cooperating as described in Subsection 291.03.b of this rule. (1-1-14)T

03. Conditions for Non-Denial of Medicaid. Medicaid cannot be denied for individuals who meet one (1) of the following conditions: (1-1-14)T

a. A child or unmarried minor child who cannot legally assign his rights to medical support; or (1-1-14)T

b. A pregnant woman whose income is at or below the federal poverty guideline, and who does not cooperate in establishing paternity and obtaining medical support from, or derived from, the father of the unborn child. (1-1-14)T

292. COOPERATION WITH HEALTHY CONNECTIONS PROGRAM.
Applicants must cooperate with Healthy Connections in establishing a primary care provider unless exempt under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." If a primary care provider is not chosen by the applicant, Healthy Connections will choose the primary care provider for the participant. (1-1-14)T

293. COST-SHARING REQUIREMENT.
Participants are required to pay a cost-sharing premium based on the level of the family's income described in IDAPA 16.03.18, "Medicaid Cost-Sharing." (1-1-14)T

294. -- 295. (RESERVED)

296. COOPERATION WITH THE QUALITY CONTROL PROCESS.
When the Department or federal government selects a case for review in the quality control process, the participant must cooperate in the review of the case. (1-1-14)T

297. -- 299. (RESERVED)

FINANCIAL REQUIREMENTS
(Sections 300 Through 344)

300. HOUSEHOLD COMPOSITION AND FINANCIAL RESPONSIBILITY.
Household composition and financial responsibility are divided into two categories: tax-filing and non-tax filing households. (1-1-14)T

01. Household Composition. The household composition includes: spouses, parents including stepparents, and all children including stepchildren and step siblings under age nineteen (19) who are living together, as members of the same household. (1-1-14)T

02. Financial Responsibility. (1-1-14)T

a. A tax-filing household is one whose individuals file taxes for themselves and their tax dependents. (1-1-14)T

b. A non-tax filing household is one whose individuals neither file a tax return nor are claimed as a tax dependent on someone else's tax return, also referred to as "non-filers." (1-1-14)T

301. TAX FILING HOUSEHOLD.

01. Taxpayers. For an individual filing a federal tax return for the taxable year in which an initial determination or redetermination of eligibility is made, and who is not claimed as a tax dependent by another taxpayer, the tax filing household consists of the taxpayer, the taxpayer's spouse, and the taxpayer's tax dependents. (1-1-14)T

02. Individuals Claimed as a Tax-Dependent. For an individual who is claimed as a tax dependent by another taxpayer, the tax filing household is the household of the taxpayer claiming such individual as a tax dependent, with the exception that tax dependents meeting any of the following criteria will be treated as non-filers described in Section 302 of these rules: (1-1-14)T

a. Individuals claimed as a tax dependent by an individual other than a spouse or custodial parent; (1-1-14)T

b. Individuals under age nineteen (19) living with both parents, if the parents are not married, or married filing separately; and (1-1-14)T

c. Individuals under age nineteen (19) claimed as a tax dependent by a parent residing outside of the applicant household. (1-1-14)T

03. Married Couples. For married couples living together, each spouse is included in the household of the other spouse, regardless of whether a joint federal tax return is filed, if one (1) spouse is claimed as a tax dependent by the other spouse, or if each filed separately. (1-1-14)T

302. NON-TAX FILING HOUSEHOLD.

01. Individuals Not Filing a Tax Return and Not Claimed as a Tax Dependent. For an individual who does not expect to file a federal tax return and is not claimed as a tax dependent by a tax filer, or meets one (1) of the exceptions in Subsections 301.02.a. through 301.02.c. of these rules, the household consists of the individual and, if living with the individual the following: (1-1-14)T

a. The individual's spouse; (1-1-14)T

b. The individual's natural, adopted, and stepchildren under age nineteen (19); or (1-1-14)T

c. In the case of individuals under age nineteen (19), the individual's natural, adopted, and step parents and natural, adoptive and step siblings under age nineteen (19). (1-1-14)T

02. Married Couples. Married couples living together will be included in the household of the other spouse. (1-1-14)T

303. FINANCIAL ELIGIBILITY.
To be eligible for a Health Care Assistance program, a participant must meet the income limits. Income limits are available on the U.S. Health and Human Services website at http://aspe.hhs.gov/poverty. (1-1-14)T

304. -- 344. (RESERVED)

INCOME
(Sections 345 Through 394)

345. HOUSEHOLD INCOME.
The sum of calculated Modified Adjusted Gross Income (MAGI-based income) of every individual whose income must be included in the household budget minus a standard disregard in the amount of five percent (5%) of Federal Poverty Guidelines (FPG) by family size, if the disregard is used to establish eligibility. (1-1-14)T

346. DETERMINING INCOME ELIGIBILITY.

01. Financial Eligibility of Applicants. Financial eligibility for Medicaid applicants must be based on calculated monthly household income and household size. Eligibility for Health Care Assistance is determined by comparing the individual's calculated income against the income limit. (1-1-14)T

02. Financial Eligibility of Participants. To project annual household income of participants at the time of a change or at redetermination of continuing eligibility, include: (1-1-14)T

a. Reasonably predictable future income; (1-1-14)T

b. A predicted decrease or increase in future income, or both, as may be established by: (1-1-14)T

i. A signed contract for employment; (1-1-14)T

ii. A clear history of fluctuating income; or (1-1-14)T

iii. Other clear indicators of future changes in income. (1-1-14)T

c. Future projected increase or decrease in income must be verified in the same manner as other income, including by self-attestation if reasonably compatible with electronic data obtained by the Department. Eligibility for Health Care assistance is determined by comparing the calculated income against the income limit. (1-1-14)T

347. EARNED INCOME.

01. Earned Income. Earned income is derived from labor or active participation in a business. Earned income includes taxable wages, tips, salary, commissions, bonuses, self-employment and any other type of income defined as earnings by the Internal Revenue Service (IRS). Earned income is counted as income when it is received, or would have been received except for the decision of the participant to postpone receipt. Earnings over a period of time and paid at one (1) time, such as the sale of farm crops, livestock, or poultry are annualized and IRS allowable self-employment expenses deducted. (1-1-14)T

02. Determination of Income. The Department determines income eligibility based on calculated income in the month of application. (1-1-14)T

348. DEPENDENT CHILD'S EARNED INCOME.
A dependent child's earned income is excluded, unless the child is required to file a tax return based on his own income. (1-1-14)T

349. INCOME PAID UNDER CONTRACT.
The earned income of an employee paid on a contractual basis is prorated over the period of the contract by using the method described in Section 347 of these rules. (1-1-14)T

350. IN-KIND INCOME.
An individual who receives a service, benefit, or durable goods instead of wages is earning in-kind income. In-kind income is excluded. (1-1-14)T

351. SELF-EMPLOYMENT EARNED INCOME.
Income from self-employment is treated as earned income. Calculated self-employment income is the taxable self-employment income after gross receipts and the IRS allowable costs of producing the self-employment income, when the self-employment is expected to continue as provided in Title 26, U.S.C. (1-1-14)T

01. Allowable Costs of Producing the Self-Employment Income. For a non-farming enterprise, the allowable costs of producing the self-employment income are limited to those costs allowed by the IRS for federal tax purpose found on the IRS website at http://www.irs.gov. (1-1-14)T

02. Allowable Costs of Producing Farming Self-Employment Income. Allowable costs of producing farming self-employment income are limited to those costs allowed by the IRS for federal tax purposes found on the IRS website at http://www.irs.gov. (1-1-14)T

352. -- 369. (RESERVED)

370. UNEARNED INCOME.
Unearned income is any income the individual receives that is not gained through employment. Unearned income includes payments from pensions, non-business rental of real property, retirement, survivors, disability insurance (RSDI), unemployment compensation, spousal support payments, and capital investment returns, such as dividends and interest. (1-1-14)T

371. SUPPORT INCOME.
Support income is any payment made from a former spouse to the individual. (1-1-14)T

01. Child Support Payment. A received child support payment is excluded income. (1-1-14)T

02. Spousal Support Payment. A received spousal support payment is unearned income to the individual who receives it. (1-1-14)T

372. -- 373. (RESERVED)

374. INTEREST AND DIVIDEND INCOME.
Taxable interest or dividends are unearned income. (1-1-14)T

01. Interest Income. Interest posted to any financial institution account on a monthly, quarterly, or any other regular basis is unearned income in the month received. Interest is counted in the month received or in the total income considered for the tax year. (1-1-14)T

02. Dividend Income. Dividends are unearned income in the month received. (1-1-14)T

03. Tax-Exempt Interest. Tax-exempt interest is not counted as income. (1-1-14)T

375. RETIREMENT, SURVIVORS, AND DISABILITY INSURANCE (RSDI) INCOME OR RAILROAD RETIREMENT BOARD BENEFITS.

The amount of the entitlement to retirement, survivors, and disability insurance (RSDI) or railroad retirement board benefits is counted as unearned income, unless an overpayment is being withheld. If an overpayment is being withheld, the net amount is unearned income. (1-1-14)T

376. -- 377. (RESERVED)

378. DISABILITY INSURANCE PAYMENTS.
Taxable disability payments, paid to an individual through an insurance company, are unearned income in the month received. (1-1-14)T

379. INCOME FROM ROOMER OR BOARDER.
Taxable income from a commercial boarding house is earned income. Income from other room and board situations is unearned income. (1-1-14)T

380. RETIREMENT ACCOUNTS, PENSIONS, AND ANNUITY DISTRIBUTIONS.
Distributions received from an individual retirement account that is reported as income on the most recent year's tax return is included in gross income for the year when determining calculated income for Medicaid. Interest from a retirement account that is withdrawn in one (1) lump sum is unearned income in the month received. (1-1-14)T

381. INCOME FROM SALE OF REAL PROPERTY.
Monthly payments, minus prorated taxes and insurance costs, received by a participant for the sale of real property are unearned income. (1-1-14)T

382. EDUCATIONAL INCOME.
Any student financial assistance provided under Title IV of the Higher Education Act, the Bureau of Indian Affairs education program, Veteran's Administration educational benefits, grants, loans, scholarships, or work study is excluded. (1-1-14)T

383. (RESERVED)

384. LUMP SUM INCOME.
A non-recurring lump sum payment is income in the month the lump sum is received. Lump sum income is a retroactive monthly benefit or a windfall payment. The lump sum may be earned or unearned income that is paid in a single sum. Lump sum income includes retirement, survivors, and disability insurance (RSDI), severance pay, disability insurance, and lottery winnings. (1-1-14)T

01. Lump Sum Received in Initial Month of Eligibility. Lump sum income received in the application month is counted as income for that month. (1-1-14)T

02. Lump Sum Received in Any Other Month of Eligibility. If a lump sum income is anticipated, the lump sum is counted as income in the month the income is expected. (1-1-14)T

03. Prior-Year Tax Refund. Any portion of a prior-year tax refund, which is considered as income on the most recent year's tax return, is included in the gross calculated income for the year when determining calculated annual income for Medicaid. (1-1-14)T

385. INCOME EXCLUDED BY FEDERAL LAW.
Income excluded by federal law is not counted in determining income available to the participant. (1-1-14)T

386. -- 387. (RESERVED)

388. DEPENDENT CHILD'S UNEARNED INCOME.
A child's unearned income is countable towards his household's eligibility, only when the child must file a tax return based on his own income. (1-1-14)T

389. -- 394. (RESERVED)

DISREGARDS
(Section 395 Through 399)

395. INCOME DISREGARDS.
A standard disregard in the amount of five percent (5%) of Federal Poverty Guidelines (FPG) by family size is applied to the calculated income of an individual in those situations where the application of the disregard is necessary in order for the individual to be eligible for the highest income limit Health Care coverage for which they may be eligible. (1-1-14)T

396. -- 399. (RESERVED)

HEALTH COVERAGE FOR ADULTS
(Sections 400 Through 499)

400. PARENTS AND CARETAKER RELATIVES ELIGIBLE FOR MEDICAID COVERAGE.
In order for an adult in a household budget unit to be eligible for Medicaid coverage, the adult must meet the requirements in Subsections 400.01 through 400.06 of this rule. (1-1-14)T

01. Parent, Caretaker Relative, or a Pregnant Woman. The adult must be a parent, caretaker relative, or a pregnant woman in the household budget unit. (1-1-14)T

02. Responsible for Eligible Dependent Child. The adult must be responsible for an eligible dependent child, which includes the unborn child of a pregnant woman. (1-1-14)T

03. Live in Same Household. The adult must live in the same household with the eligible dependent child. (1-1-14)T

04. MAGI Income Eligibility. The adult must meet all income requirements of the Medicaid program for eligibility determined according to MAGI methodologies identified in Sections 300 through 303, and 411 of these rules. Eligibility is based on: (1-1-14)T

a. The number of members included in the household budget unit; and (1-1-14)T

b. All countable income for the household budget unit. (1-1-14)T

05. Member of More Than One Budget Unit. No person may receive benefits in more than one (1) budget unit during the same month. (1-1-14)T

06. More Than One Medicaid Budget Unit in Home. If there is more than one (1) Medicaid budget unit in a home, each budget unit is considered a separate unit. (1-1-14)T

401. FINANCIALLY ELIGIBLE CHILD.

01. Household Income. The household's calculated income does not exceed the threshold established and available on the U.S. Health and Human Services website at http://aspe.hhs.gov/poverty. (1-1-14)T

02. SSI Income. The child receives SSI income. (1-1-14)T

402. PERSONS EXEMPT FROM MAGI-BASED ELIGIBILITY DETERMINATION.

01. SSI Recipient. Persons who receive SSI benefits. (1-1-14)T

02. AABD State Supplemented Recipient. Persons who receive AABD cash benefits. (1-1-14)T

03. Ineligible Non-Citizen. Persons who are ineligible non-citizens. (1-1-14)T

04. Title IV-E Foster Child. A child who receives foster care payments from the Department. (1-1-14)T

05. Adoption Assistance. A child who receives adoption assistance payments from any federal, state, or local agency providing adoption assistance payments. (1-1-14)T

06. AABD. An individual who receives Medicaid based on disability, blindness, age (65 or older), or the need for long-term care service. (1-1-14)T

403. -- 409. (RESERVED)

410. DETERMINING MEDICAID ELIGIBILITY.
Calculated income for each individual is compared to the income payment standard. When income exceeds the standards, the individual is ineligible. Income standards are available on the U.S. Health and Human Services website at http://aspe.hhs.gov/poverty. (1-1-14)T

411. INCOME LIMITS FOR PARENTS AND CARETAKER RELATIVES.
The income limits are based on the number of household budget unit members. Parents and caretaker relatives, whose MAGI-based income does not exceed the guidelines listed in the table below for their household size, meet the income limit for parent and caretaker relative Medicaid.

TABLE 411 INCOME LIMITS

Number of Household Members	Income Limit
1	$233
2	$289
3	$365
4	$439
5	$515
6	$590
7	$666
8	$741
9	$816
10	$982
Over 10 Persons	Add $75 Each

(1-1-14)T

412. -- 419. (RESERVED)

420. EXTENDED MEDICAID FOR SPOUSAL SUPPORT INCREASE.
Participants are eligible for four (4) calendar months of Extended Medicaid if an increase in the participant's spousal support causes them to exceed the income limit for their household budget unit size. The participant must have received Medicaid in Idaho in at least three (3) of the six (6) months before the month the participant became income ineligible. (1-1-14)T

421. -- 499. (RESERVED)

PREGNANCY-RELATED HEALTH COVERAGE
(Sections 500 Through 519)

500. PREGNANT WOMAN COVERAGE.
A pregnant woman of any age is eligible for the Pregnant Woman coverage if she meets all of the non-financial and financial criteria of the coverage group. Health care assistance for Pregnant Woman coverage is limited to pregnancy-related and postpartum services. The Pregnant Woman medical assistance coverage extends through the sixty (60) day postpartum period if she applied for medical assistance while pregnant and was receiving medical assistance when the child was born. An individual who applies for Pregnant Woman medical assistance after the child is born is not eligible for the sixty-day (60) postpartum period. (1-1-14)T

01. Income Limit. The individual's calculated income must not exceed one hundred thirty-three percent (133%) of the Federal Poverty Guidelines (FPG) for her family size in the application month. (1-1-14)T

02. Household Size. The household budget unit consists of the pregnant woman, the unborn child or children if expecting more than one (1) child, and any individual determined to be part of the household budget unit based on MAGI methodologies as identified in Sections 300 through 303, and 411 of these rules. (1-1-14)T

03. Income Disregards. A standard disregard in the amount of five percent (5%) of Federal Poverty Guidelines (FPG) for family size is applied to the MAGI income of the pregnant woman if the disregard is necessary to establish income eligibility. (1-1-14)T

04. Continuing Eligibility. The pregnant woman remains eligible during the pregnancy regardless of changes in income. The woman must report the end of pregnancy to the Department within ten (10) days. (1-1-14)T

501. PREGNANT WOMAN INELIGIBLE BECAUSE OF EXCESS INCOME.
A pregnant woman who receives health care assistance and becomes ineligible because of an increase in income will continue to receive coverage through the end of the month in which the sixtieth day of her postpartum period falls. (1-1-14)T

502. PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN.
Presumptively eligible (PE) pregnant woman coverage is designed to provide some prenatal care during the time between the pregnancy diagnosis and the eligibility determination. (1-1-14)T

01. Pregnancy Diagnosis and Eligibility Determination. A pregnant woman can get limited ambulatory prenatal care as a presumptively eligible (PE) pregnant woman through the end of the month after the month the provider completes the PE determination. (1-1-14)T

02. Qualified Provider Completes Eligibility Determination. A qualified PE provider accepts written requests for these services and completes the eligibility determination. (1-1-14)T

03. Formal Application. The qualified PE provider must inform the participant how to complete the formal application process. (1-1-14)T

04. Notification of Eligibility Determination Results. Qualified PE providers are required to send the result of the PE decision and the completed application for the Pregnant Woman coverage to the Department within two (2) working days of the PE determination. (1-1-14)T

05. Presumptive Eligibility Decisions. Notice and hearing rights of the Title XIX Medicaid program do not apply to the PE decisions. An individual is eligible for only one (1) period of PE coverage during each pregnancy. (1-1-14)T

503. -- 519. (RESERVED)

HEALTH COVERAGE FOR CHILDREN

(Sections 520 Through 529)

520. FINANCIAL ELIGIBILITY.
Children are eligible for Health Care Assistance when the household's total MAGI-Based income minus a standard disregard in the amount of five percent (5%) of Federal Poverty Guidelines (FPG) by family size is less than or equal to the applicable income limit for the age of the child. (1-1-14)T

01. Title XIX Income Limit. For children age zero (0) to six (6), Title XIX income limit is one hundred forty-two percent (142%) of the FPG for the household size. For children age six (6) through age eighteen (18) the income limit is one hundred thirty three percent (133%) of the FPG for the household size. (1-1-14)T

02. Title XXI Income Limit. For children age zero to six (0-6), Title XXI income limit is between one hundred forty-two percent (142%) and one hundred eighty-five percent (185%) of the FPG for the household size. For children ages six (6) through eighteen (18) the income limit is between one hundred thirty-three percent (133%) and one hundred eighty five percent (185%) of the FPG for the household size. (1-1-14)T

03. Disregard Applied. A standard disregard in the amount of five percent (5%) of Federal Poverty Guidelines (FPG) by family size is applied to the calculated income used to establish the child's eligibility when applying the disregard is necessary for the child to be financially eligible. (1-1-14)T

521. HOUSEHOLD SIZE AND FINANCIAL RESPONSIBILITY.
Household size and financial responsibility for health coverage for children is determined using the methodology described in Section 300 of these rules. (1-1-14)T

522. (RESERVED)

523. ACCESS TO OR COVERAGE UNDER OTHER HEALTH PLANS.
A child is ineligible for coverage under the CHIP plan if they have access to or are enrolled in other health coverage plans as described below: (1-1-14)T

01. Covered by Creditable Health Insurance. The child is covered by creditable health insurance at the time of application. (1-1-14)T

02. Eligible for Title XIX. The child is eligible under Idaho's Title XIX State Plan. (1-1-14)T

03. Idaho State Employee Benefit Plan. The child is eligible to receive health insurance benefits under Idaho's State employee benefit plan. (1-1-14)T

524. CONTINUOUS HEALTH CARE ASSISTANCE ELIGIBILITY FOR CHILDREN UNDER AGE NINETEEN.
Children under age nineteen (19), who are found eligible for health coverage in an initial determination or at renewal, remain eligible for a period of twelve (12) months. The twelve (12) month continuous eligibility period does not apply if, for any reason, eligibility was determined incorrectly. (1-1-14)T

01. Reasons Continuous Eligibility Ends. Continuous eligibility for children ends for one (1) of the following reasons: (1-1-14)T

a. The child is no longer an Idaho resident; (1-1-14)T

b. The child dies; (1-1-14)T

c. The participant requests closure; or (1-1-14)T

d. The child turns nineteen (19) years of age as defined in Subsection 010.05 of these rules. (1-1-14)T

02. Children Not Eligible for Continuous Eligibility. Children are not eligible for continuous eligibility for one (1) of the following reasons: (1-1-14)T

a. A child is approved for emergency medical services; or (1-1-14)T

b. A child is approved for pregnancy-related services. (1-1-14)T

525. FORMER FOSTER CHILD.
An individual who is between the age of eighteen (18) and twenty-six (26), who was in foster care in Idaho and became ineligible for Medicaid as a foster child due to age, may receive Medicaid coverage until his twenty-sixth birthday. There are no financial eligibility criteria. The only non-financial criteria are the receipt of foster care services and age. (1-1-14)T

526. -- 529. (RESERVED)

SPECIAL CIRCUMSTANCES FOR CHILDREN
(Sections 530 Through 549)

530. NEWBORN CHILD DEEMED ELIGIBLE FOR MEDICAID.
A child is deemed eligible for Medicaid for his first year of life when the following exists. (1-1-14)T

01. Mother Filing an Application. The child is born to a mother who files an application for medical assistance. (1-1-14)T

02. Mother Is Eligible for Medicaid. The mother is eligible for Medicaid in the newborn's birth month, including a month of retroactive coverage. This includes a mother who qualifies for coverage only for the delivery because of her alien status. (1-1-14)T

531. MINOR PARENT LIVING WITH PARENTS.
A minor parent is a child under the age of eighteen (18) who is pregnant or has a child. Minor parents who live with their parents may be eligible for Health Care Assistance for themselves and their children. The minor parent's eligibility is determined according to the Section 300 of these rules related to tax filing households. (1-1-14)T

532. RESIDENT OF AN ELIGIBLE INSTITUTION.
A resident of an eligible institution must meet all nonfinancial and financial criteria of Title XIX or Title XXI. Eligible institutions are medical institutions, intermediate care facilities, child care institutions for foster care, or publicly-operated community residences serving no more than sixteen (16) residents. (1-1-14)T

533. CHILDREN WITH SPECIAL CIRCUMSTANCES AND MEDICAID.
Children who receive foster care or are in adoptive placements are eligible for Medicaid. The children must meet nonfinancial criteria and must meet the financial requirements described for the children's coverage group. (1-1-14)T

534. ADOLESCENT RESIDENT OF IDAHO STATE HOSPITAL SOUTH.
A child, residing in Idaho State Hospital South, may be eligible for Health Care Assistance if the child is: (1-1-14)T

01. Age. The child must be under the age twenty-one (21). (1-1-14)T

02. Calculated Income. The child's calculated income is: (1-1-14)T

a. Two hundred thirty-three dollars ($233) or less; and (1-1-14)T

b. If necessary, a standard disregard of five percent (5%) of Federal Poverty Guidelines (FPG) by family size is applied to the child's calculated income in order for the child to be eligible for coverage. (1-1-14)T

535. TITLE IV-E FOSTER CARE CHILD.
A child may be eligible for Health Care Assistance as a Title IV-E foster care child if the following conditions are met. (1-1-14)T

01. Court Order or Voluntary Placement. The child must have been living in a parent's or relative's home during the month a court order removes the child or during the month a parent or relative voluntarily signs a written agreement with the Department for foster care. (1-1-14)T

02. Custody and Placement. The child's placement and care are the Department's responsibility and the child is living in a licensed foster home, licensed institution, licensed group home, detention center, or in a relative's home approved for the child by the Department. (1-1-14)T

03. IV-E Foster Care and SSI Eligibility. When a child is eligible for both IV-E-Foster Care and SSI, the caretaker relative or social worker must choose the Medicaid coverage group for the child. (1-1-14)T

536. TITLE XIX FOSTER CHILD.
A child living in a foster home, children's agency, or children's institution who does not meet the conditions of Title IV-E Foster Care may be Medicaid eligible if the following conditions are met: (1-1-14)T

01. Age. The foster child is under age twenty-one (21). (1-1-14)T

02. Department Responsibility. The Department assumes full or partial financial responsibility for the child. (1-1-14)T

03. Calculated Income. The child's calculated income is: (1-1-14)T

a. Two hundred thirty-three dollars ($233) or less; and (1-1-14)T

b. If necessary, a standard disregard of five percent (5%) of Federal Poverty Guidelines (FPG) by family size is applied to the child's calculated income in order for the child to be eligible for coverage. (1-1-14)T

537. STATE SUBSIDIZED ADOPTION ASSISTANCE CHILD.
A child in a state subsidized adoptive placement may be Medicaid eligible when the following conditions are met. (1-1-14)T

01. Age. The child is under age twenty-one (21). (1-1-14)T

02. Adoption Assistance. An adoption assistance agreement, other than under Title IV-E between the state and the adoptive parents, is in effect. (1-1-14)T

03. Special Needs. The child has special needs for medical or rehabilitative care that prevent adoptive placement without Medicaid. (1-1-14)T

04. Medicaid. The child received Medicaid in Idaho prior to the adoption agreement. (1-1-14)T

538. CHILD IN FEDERALLY-SUBSIDIZED ADOPTION ASSISTANCE.
A child in a federally-subsidized adoptive placement under Title IV-E foster care is eligible for Medicaid. No additional conditions must be met. (1-1-14)T

539. THE ADOPTIONS AND SAFE FAMILIES ACT.
The Adoptions and Safe Families Act of 1997 provides health insurance coverage for any child with special needs when they meet the following conditions. (1-1-14)T

01. Adoption Assistance Agreement. The child has an adoption assistance agreement. (1-1-14)T

02. Special Needs. The state has determined that due to the child's special needs for medical, mental health, or rehabilitative care, the child cannot be placed with adoptive parents without medical assistance. (1-1-14)T

540. -- 544. (RESERVED)

545. PRESUMPTIVE ELIGIBILITY FOR CHILDREN AND PARENTS.

Presumptive eligibility determination for qualifying medical coverage groups can only be provided by a qualified hospital defined in Section 011 or these rules. (1-1-14)T

01. Presumptive Eligibility Decisions. Decisions of presumptive eligibility can only be made for children up to age nineteen (19), parents with eligible children in their household, caretaker relatives, or pregnant women, who meet program requirements for MAGI-based Medicaid coverage for families and children. (1-1-14)T

02. Presumptive Eligibility Determination. Presumptive eligibility determinations are made by a qualified hospital when an individual receiving medical services is not covered by health care insurance and the financial assessment by hospital staff indicates the individual is eligible for Medicaid Coverage in Idaho. This determination is made by hospital staff through an online presumptive application process: (1-1-14)T

a. Prior to completion of a full Medicaid application; and (1-1-14)T

b. Prior to a determination being made by the Department on the full application. (1-1-14)T

03. Presumptive Eligibility Period. The presumptive eligibility period begins on the date the presumptive application is filed online and ends with the earlier of the following: (1-1-14)T

a. The date the full eligibility determination is completed by the Department; or (1-1-14)T

b. The end of the current month the qualified hospital completed the presumptive eligibility determination. (1-1-14)T

546. QUALIFIED HOSPITAL PRESUMPTIVE ELIGIBILITY PROCESSES.
A qualified hospital must have a Memorandum of Understanding (MOU) with the Department and follow all standards and processes agreed to in the MOU. (1-1-14)T

01. Acceptance of Application. The qualified hospital accepts the request for services in the same manner as all applications for assistance are accepted. (1-1-14)T

02. Standards and Processes. The presumptive eligibility determination must be based on standards and processes provided by the Department. (1-1-14)T

03. Assistance to Applicant. The qualified hospital must assist the applicant in completing the Department's application process. (1-1-14)T

04. Qualified Hospital Staff. Only qualified hospital staff who are trained in presumptive eligibility standards can make a presumptive eligibility determination. (1-1-14)T

05. Notice to Applicant. The qualified hospital or the Department will provide notice to the applicant within two business days on the presumptive eligibility determination. (1-1-14)T

06. Notice and Hearing Rights. Presumptive eligibility decisions are not appealable and do not have hearing rights under the Title XIX Medicaid program. (1-1-14)T

07. Number of Presumptive Eligibility Periods Allowed. Only one (1) presumptive eligibility period is allowed per applicant in any twelve (12) month period. (1-1-14)T

547. -- 549. (RESERVED)

MEDICAID DIRECT COVERAGE PLANS
(Sections 550 Through 559)

550. MEDICAID DIRECT COVERAGE GROUPS.
Based on the assessment of the participant’s health care needs they are enrolled in one (1) of the following plans:

(1-1-14)T

01. Medicaid Basic Plan. The Medicaid Basic Plan is similar to private health insurance plans. The services in this plan are described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." (1-1-14)T

02. Medicaid Enhanced Plan. The Medicaid Enhanced Plan includes all of the benefits found in the Basic Plan, plus additional benefits to cover needs of people with disabilities or special health needs. The services in this plan are described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (1-1-14)T

03. Medicare/Medicaid Coordinated Plan Benefits. The Medicare/Medicaid Coordinated Plan includes the Medicaid benefit plan option that coordinates and integrates health plan benefits for individuals who are eligible for and enrolled in both Medicare and Medicaid. (1-1-14)T

551. HEALTH ASSESSMENT.
A health assessment is required when a participant moves to the enhanced plan. Children who are receiving services from the Department, in foster care, receiving SSI, infant toddler program and children receiving developmentally delayed services, are eligible for the enhanced plan without the need for the health assessment. (1-1-14)T

552. -- 599. (RESERVED)

CASE MAINTENANCE REQUIREMENTS
(Sections 600 Through 701)

600. ANNUAL ELIGIBILITY RENEWAL.
Participants must have an annual eligibility review of all eligibility factors. Exceptions to the annual eligibility renewal are listed in Section 601 of these rules. (1-1-14)T

01. Continuing Eligibility. Continuing eligibility is determined using available electronic verification sources without participant contact, unless: (1-1-14)T

a. Information is not available; (1-1-14)T

b. Information sources provide conflicting information; or (1-1-14)T

c. Information is inconsistent with information provided by the participant. (1-1-14)T

02. Inconsistency Impacts Eligibility. When inconsistency exists from electronic verification sources that impact participant eligibility, information must be verified by the participant. The Department provides the participant a document that displays household information currently being used to establish eligibility and asks the participant to verify correctness, and if not correct to provide updated information. (1-1-14)T

601. EXCEPTIONS TO ANNUAL RENEWAL.
A participant who receives Title XIX or Title XXI through time-limited coverage does not require an annual renewal when the following exists. (1-1-14)T

01. Extended Medicaid. A participant who receives extended Medicaid is eligible as provided in Section 420 of these rules. (1-1-14)T

02. Pregnant Woman. A participant who receives Medicaid as a Low Income Pregnant Woman is eligible as provided in Section 500 of these rules. (1-1-14)T

03. Newborn Child of Medicaid-Eligible Mother. A participant receiving Medicaid as the newborn child of a Medicaid-eligible mother is eligible as provided in Section 530 of these rules. (1-1-14)T

602. -- 609. (RESERVED)

610. REPORTING REQUIREMENTS.
Changes in family circumstances must be reported to the Department by the tenth of the month following the month in which the change occurred. Report of changes may be made verbally, in writing, through personal contact, telephone, fax, electronic mail, or mail. (1-1-14)T

611. TYPES OF CHANGES THAT MUST BE REPORTED.
Changes in circumstances the participant must report are the following: (1-1-14)T

01. Name or Address. A name change for any participant must be reported. A change of address or location must be reported. (1-1-14)T

02. Household Composition. Changes in family composition must be reported if a parent or relative caretaker receives Medicaid. (1-1-14)T

03. Marital Status. Marriages or divorces of any family member must be reported if a parent or relative caretaker receives Medicaid. (1-1-14)T

04. New Social Security Number. A Social Security Number (SSN) that is newly assigned to a Medicaid Health Care Assistance program participant must be reported. (1-1-14)T

05. Health Insurance Coverage. Enrollment or disenrollment of a participant in a health insurance plan must be reported. (1-1-14)T

06. End of Pregnancy. Pregnant participants must report when pregnancy ends. (1-1-14)T

07. Earned Income. Changes in the amount or source of earned income must be reported if a parent or relative caretaker receives Title XIX benefits. (1-1-14)T

08. Unearned Income. Changes in the amount or source of unearned income must be reported if a parent or relative caretaker receives Title XIX benefits. (1-1-14)T

09. Support Income. Changes in the amount of spousal support received by an adult household member. (1-1-14)T

10. Disability. A family member who becomes disabled or is no longer disabled must be reported if a parent or relative caretaker receives Title XIX benefits. (1-1-14)T

612. -- 619. (RESERVED)

620. NOTICE OF CHANGES IN ELIGIBILITY.
The Department will notify the participant of changes in his Health Care Assistance. The notice must give the effective date, the reason for the action, the rule that supports the action, and appeal rights. (1-1-14)T

621. NOTICE OF CHANGE OF PLAN.
The Department is allowed to switch a participant from the Medicaid Basic Plan to the Medicaid Enhanced plan within the same month. Advance notice must be given to the participant when there is a decrease in their benefits and he will be switched from the enhanced plan to the basic plan. (1-1-14)T

622. ADVANCE NOTICE RESPONSIBILITY.
The Department must notify the participant at least ten (10) calendar days before the effective date of when a reported change results in Health Care Assistance closure. The effective date must allow for a five (5) day mailing period for any notice. (1-1-14)T

623. ADVANCE NOTICE NOT REQUIRED.
Advance notice is not required when a condition listed in Subsections 623.01 through 623.08 of this rule exists. The participant must be notified no later than the date of the action. (1-1-14)T

01. Death of Participant. The Department has proof of the participant's death. (1-1-14)T

02. Participant Request. The participant requests closure in writing. (1-1-14)T

03. Participant in Institution. The participant is admitted or committed to an institution. Further payments to the participant do not qualify for federal financial participation under the state plan. (1-1-14)T

04. Nursing Care. The participant is placed in a nursing facility or Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID). (1-1-14)T

05. Participant Address Unknown. The participant's whereabouts are unknown. (1-1-14)T

06. Medical Assistance in Another State. A participant is approved for medical assistance in another state. (1-1-14)T

07. Eligible One Month. The participant is eligible for aid only during the calendar month of his application for aid. (1-1-14)T

08. Retroactive Medicaid. The participant's Title XIX or Title XXI eligibility is for a prior period. (1-1-14)T

624. -- 699. (RESERVED)

700. OVERPAYMENTS.
Health Care Assistance overpayments occur when a participant receives benefits during a month he was not eligible. (1-1-14)T

701. RECOVERY OF OVERPAYMENTS.
All Health Care Assistance overpayments are subject to recovery. Overpayments are recovered by direct payment from the participant. (1-1-14)T

01. Notice of Overpayment. The participant must be informed of the Health Care Assistance overpayment and appeal rights. (1-1-14)T

02. Notice of Recovery. The participant must be informed when his Health Care Assistance overpayment is fully recovered. (1-1-14)T

702. -- 999. (RESERVED)

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