IDAPA 16 – IDAHO DEPARTMENT OF HEALTH AND WELFARE

Division of Welfare

16.03.01 – Eligibility for Health Care Assistance for Families and Children

Who does this rule apply to?
For those seeking medical assistance (Medicaid, Children's Health Insurance Program – CHIP) through the Department of Health and Welfare.

What is the purpose of this rule?
These rules provide eligibility requirements for those seeking medical assistance through programs covered under Title XIX and Title XXI of the Social Security Act.

What is the legal authority for the agency to promulgate this rule?
This rule implements the following statutes passed by the Idaho Legislature:

Public Assistance and Welfare -
Public Assistance Law:
- Section 56-202, Idaho Code – Duties of the Director of State Department of Health & Welfare
- Section 56-203, Idaho Code – Powers of State Department
- Section 56-209, Idaho Code – Assistance to Families with Children

Where can I find information on Administrative Appeals?
Administrative appeals and contested cases are governed by the provisions of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings."

How do I request public records?
Unless exempted, all public records are subject to disclosure by the Department that will comply with Title 74, Chapter 1, Idaho Code, upon requests. Confidential information may be restricted by state or federal law, federal regulation, and IDAPA 16.05.01, "Use and Disclosure of Department Records."

Who do I contact for more information on this rule?

Idaho Department of Health and Welfare
Division of Welfare – Health Coverage Assistance
450 West State Street
Boise, ID 83702

P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5815 or 1-877-456-1233
Fax: (208) 334-4015
Email: SRProgramRules@dhw.idaho.gov
Webpage: https://healthandwelfare.idaho.gov/services-programs/medicaid-health/apply-medicaid-elderly-or-disabled-adults

Table of Contents

000. LEGAL AUTHORITY.
Sections 56-202, 56-203, 56-209, 56-239, 56-250, 56-253, 56-255, 56-256 and 56-257, Idaho Code, authorize the Department 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. (7-1-24)

001. WRITTEN INTERPRETATIONS.
The Department has written statements that pertain to the interpretation of, or documentation of compliance with, these rules. The documents are available for public inspection and copying at cost at the Department or at any of its Regional Offices. (7-1-24)

002. -- 009. (RESERVED)

010. DEFINITIONS (A THROUGH L).

01. Advanced Payment of Premium Tax Credit. Payment of federal tax credits specified in 26 USC 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 under Sections 1402 and 1412 of the Affordable Care Act. (7-1-24)

02. Adult. Any individual who has passed the month of their nineteenth birthday. (7-1-24)

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 (P L 111-152). (7-1-24)

04. Applicant. A person applying for public assistance from the Department, including individuals referred to the Department from a Health Insurance Exchange or Marketplace. (7-1-24)

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. (7-1-24)

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. (7-1-24)

07. Caretaker Relative. A relative of a 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 includes a child's natural, adoptive, or step-parents, grandparents, siblings, aunt, uncle, niece, nephew, or cousin. (7-1-24)

08. Child. Any individual from birth through the end of the month of their nineteenth birthday. (7-1-24)

09. Citizen. A person having status as a "national of the United States" defined in 8 USC 1101(a)(22)that includes both citizens of the United States and non-citizen nationals of the United States. (7-1-24)

10. Cost-Sharing. A participant payment for a portion of Medicaid service costs such as deductibles, co-insurance, or co-payment amounts. (7-1-24)

11. Creditable Health Insurance. 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. (7-1-24)

12. Department. The Idaho Department of Health and Welfare or its designee. (7-1-24)

13. Federal Poverty Guidelines (FPG). Issued annually by the Department of Health and Human Services (HHS).TheFPG are available on the U.S. Health and Human Services website at http://aspe.hhs.gov/poverty. (7-1-24)

14. Health Assessment. An examination performed by a primary care provider in order to determine the appropriate health plan for a Medicaid-eligible individual. (7-1-24)

15. Health Care Assistance (HCA). Health coverage that includes Medicaid coverage under Title XIX or Title XXI and private health insurance plans purchased with a Premium Tax Credit described in Subsection 010.01 of this rule granted by the Department for persons or families within Idaho. (7-1-24)

16. Health Insurance Premium Program (HIPP). The Premium Assistance program in which Title XIX and Title XXI participants may participate. (7-1-24)

17. Health Plan. A set of health services paid for by Idaho Medicaid, or health insurance coverage obtained through the Health Insurance Exchange or Marketplace. (7-1-24)

18. Health Questionnaire. A tool used to assist Department staff in determining the correct Health Plan for the Medicaid applicant. (7-1-24)

19. Internal Revenue Code. The federal tax law used to determine eligibility under Title 26 USC for individual income and self-employment income. (7-1-24)

20. Internal Revenue Service (IRS). The US government agency in charge of tax laws. These laws are used to determine income eligibility. The IRS website is at http://www.irs.gov. (7-1-24)

21. Insurance Affordability Programs. Include Title XIX, Title XXI, and all insurance programs available in the Health Insurance Exchange or Marketplace. (7-1-24)

22. Lawfully Present. An individual who is a qualified non-citizen under Section 221 of these rules. (7-1-24)

011. DEFINITIONS (M THROUGH Z).

01. MAGI-Based Income. Income calculated using the same financial methodologies used by the IRS to determine modified adjusted gross income (MAGI) for federal tax filers, with the following exceptions: (7-1-24)

a. Educational income under Section 382 of these rules; (7-1-24)

b. Indian monies excluded by federal law are not included in MAGI-based income; (7-1-24)

c. Lump sum income is counted only in the month received under Section 384 of these rules; and (7-1-24)

d. For Medicaid applicants, MAGI-based income is calculated based on income received in the month of application. (7-1-24)

02. Medicaid. Idaho's Medical Assistance Program administered by the Department and funded with federal and state funds under Title XIX of the Social Security Act that provides medical care for eligible individuals. (7-1-24)

03. Modified Adjusted Gross Income (MAGI). Adjusted Gross Income as defined by the IRS, plus certain tax-exempt income. (7-1-24)

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 born under these conditions is eligible for Medicaid for the first year of their life. (7-1-24)

05. Non-Citizen. Same as "alien" under Section 101(a)(3) of the Immigration and Nationality Act (INA) (8 USC 1101 (a)(3)), and includes any individual who is not a citizen or national of the United States. (7-1-24)

06. Parent. For a household with a MAGI-based eligibility determination a parent can be: (7-1-24)

a. Natural; (7-1-24)

b. Biological; (7-1-24)

c. Adoptive; or (7-1-24)

d. Stepparent. (7-1-24)

07. Participant. An individual who is eligible for, and enrolled in, a Health Care Assistance program. (7-1-24)

08. 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. (7-1-24)

09. Qualified Non-Citizen. Same as "qualified alien" under 8 USC164(b) and (c). (7-1-24)

10. Reasonable Opportunity Period. A period 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. (7-1-24)

11. Sibling. For household with MAGI-based eligibility determination, a natural or biological, adopted, half- or stepsibling. (7-1-24)

12. Tax Dependent. A person, who is a related child, or other qualifying relative or person, under 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. (7-1-24)

13. 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. (7-1-24)

14. Title XIX of the Social Security Act. Also 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. (7-1-24)

15. Title XXI of the Social Security Act. Also 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. (7-1-24)

012. -- 099. (RESERVED)

APPLICATION REQUIREMENTS
(Sections 100-199)

100. PARTICIPANT RIGHTS.
The participant has rights protected by federal and state laws and Department rules. The Department will inform participants of the following rights during the application process and eligibility reviews. (7-1-24)

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. (7-1-24)

02. Right to Hearing. Any participant can request a hearing to contest a Department decision under IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Ruling." (7-1-24)

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 if an application is denied because an individual did not provide citizenship or identity documentation during a reasonable opportunity period allowed by the Department. (7-1-24)

101. -- 110. (RESERVED)

111. SIGNATURES.
An individual who is applying for benefits, receiving benefits, or providing additional information as required by these rules, 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. (7-1-24)

112. -- 129. (RESERVED)

130. APPLICATION TIME LIMITS.
Each application will 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. (7-1-24)

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. (7-1-24)

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. (7-1-24)

151. -- 199. (RESERVED)

NON-FINANCIAL REQUIREMENTS
(Sections 200-299)

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. (7-1-24)

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. (7-1-24)

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 US citizenship. (7-1-24)

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. (7-1-24)

221. U.S. CITIZENSHIP AND QUALIFIED NON-CITIZEN REQUIREMENTS.
Any individual who participates in Medicaid benefits must provide proof of US citizenship unless they have otherwise met the requirements under 42 CFR 435.406 Citizenship and Non-Citizen Eligibility. (7-1-24)

222. -- 249. (RESERVED)

250. EMERGENCY MEDICAL CONDITION.
An individual who meets eligibility criteria for a category of assistance but does not meet US citizenship requirements or eligible non-citizen requirements may receive medical assistance under a Title XIX or Title XXI coverage group as follows: (7-1-24)

01. Emergency Medical Conditions. An individual not meeting the US 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. (7-1-24)

02. Determination of Emergency Medical Conditions. The Department determines if a condition meets criteria of an emergency medical condition. (7-1-24)

03. Limitation on Medical Assistance. Medical assistance is limited to the period established for the emergency medical condition. (7-1-24)

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. (7-1-24)

251. SPONSOR DEEMING.
Income of a legal non-citizen's sponsor and the sponsor's spouse are counted in determining eligibility. (7-1-24)

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. (7-1-24)

253. -- 269. (RESERVED)

270. SOCIAL SECURITY NUMBER (SSN) REQUIREMENT.

01. SSN Required. An applicant must provide their SSN, or proof they have 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. (7-1-24)

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. (7-1-24)

b. The Department will notify the applicant in writing if eligibility is being denied or lost for failure to meet the SSN requirement. (7-1-24)

02. Application for SSN. The applicant must apply for an SSN, or a duplicate SSN when they cannot provide their SSN to the Department. If the SSN has been applied for, but not issued by the SSA, the Department cannot deny, delay, or stop benefits. The Department will help an applicant with required documentation when the applicant applies for an SSN. (7-1-24)

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: (7-1-24)

a. Is a member of a recognized religious sect or division of the sect; and (7-1-24)

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. (7-1-24)

04. SSN Requirement Waived. An applicant may have the SSN requirement waived when they are: (7-1-24)

a. Only eligible for emergency medical services under Section 250 of these rules; or (7-1-24)

b. A newborn deemed eligible child under Section 530 of these rules. (7-1-24)

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. (7-1-24)

281. MEDICAL EXCEPTION FOR INMATES.
An inmate can receive Medicaid while they are an inpatient in a medical facility, and must meet all Medicaid eligibility requirements. (7-1-24)

282. -- 289. (RESERVED)

290. ASSIGNMENT OF RIGHTS TO MEDICAL SUPPORT AND THIRD-PARTY LIABILITY.
Under 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. (7-1-24)

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. (7-1-24)

01. Cooperation Defined. Cooperation includes providing all information to identify and locate the non-custodial parent and identify other liable third party-payers. The participant must provide the first and last name of the non-custodial parent, and at least two (2) of the following pieces of information about the non-custodial parent: (7-1-24)

a. Birth-date; (7-1-24)

b. SSN; (7-1-24)

c. Current address; (7-1-24)

d. Current phone number; (7-1-24)

e. Current employer; (7-1-24)

f. Make, model, and license number of any motor vehicle owned by the non-custodial parent; or (7-1-24)

g. Names, phone numbers, and addresses of the parents of the non-custodial parent. (7-1-24)

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: (7-1-24)

a. Proof the child was conceived because of incest or rape; (7-1-24)

b. 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; (7-1-24)

c. A credible explanation is provided showing the participant cannot provide the minimum information regarding the non-custodial parent; or (7-1-24)

d. A participant who has good cause for not cooperating under Subsection 291.03.b of this rule. (7-1-24)

03. Conditions for Non-Denial of Medicaid. Medicaid cannot be denied for individuals who meet one (1) of the following conditions: (7-1-24)

a. A child or unmarried minor child who cannot legally assign their rights to medical support; or (7-1-24)

b. A pregnant woman whose income is at or below the FPG, and who does not cooperate in establishing paternity and obtaining medical support from, or derived from, the father of the unborn child. (7-1-24)

292. -- 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. (7-1-24)

297. -- 299. (RESERVED)

FINANCIAL REQUIREMENTS
(Sections 300-344)

300. HOUSEHOLD COMPOSITION AND FINANCIAL RESPONSIBILITY.
Household composition and financial responsibility are divided into two (2) categories: tax-filing and non-tax filing households. (7-1-24)

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. (7-1-24)

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, except when tax dependents meeting any of the following criteria will be treated as non-filers under Section 302 of these rules. Individuals: (7-1-24)

a. Claimed as a tax dependent by an individual other than a spouse or custodial parent; (7-1-24)

b. Under age nineteen (19) living with both parents, if the parents are not married, or married filing separately; and (7-1-24)

c. Under age nineteen (19) claimed as a tax dependent by a parent residing outside of the applicant household. (7-1-24)

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. (7-1-24)

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 this rule, the household consists of the individual and, if living with the individual the following: (7-1-24)

a. The individual's spouse; (7-1-24)

b. The individual's natural, adopted, and stepchildren under age nineteen (19); or (7-1-24)

c. If individuals are under age nineteen (19), the individual's natural, adopted, and step parents and natural, adoptive, and step siblings under age nineteen (19). (7-1-24)

02. Married Couples. Married couples living together will be included in the household of the other spouse. (7-1-24)

303. -- 344. (RESERVED)

INCOME
(Sections 345-394)

345. HOUSEHOLD INCOME.
The sum of calculated 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 by family size, if the disregard is used to establish eligibility. (7-1-24)

346. DETERMINING INCOME ELIGIBILITY.
Financial eligibility for Medicaid applicants will 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. (7-1-24)

347. 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. (7-1-24)

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. (7-1-24)

349. (RESERVED)

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. (7-1-24)

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 under Title 26, U.S.C. (7-1-24)

352. -- 369. (RESERVED)

370. UNEARNED INCOME.
Unearned income is any income the individual receives that is not gained through employment. Unearned income is not excluded income if it is taxable. (7-1-24)

371. – 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. (7-1-24)

385. -- 387. (RESERVED)

388. DEPENDENT CHILD'S UNEARNED INCOME.
A child's unearned income is countable towards their household's eligibility, only when the child must file a tax return based on their own income. (7-1-24)

389. -- 394. (RESERVED)

DISREGARDS
(Section 395-399)

395. INCOME DISREGARDS.
A standard disregard in the amount of five percent (5%) of federal poverty guidelines 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. (7-1-24)

396. -- 399. (RESERVED)

HEALTH COVERAGE FOR ADULTS
(Sections 400-499)

400. MEDICAID FOR ADULTS.
Medicaid is available for the following adults: (7-1-24)

01. Parent, Caretaker Relative, or a Pregnant Woman. The individual who: (7-1-24)

a. Is a parent, caretaker relative, or a pregnant woman in the household budget unit. (7-1-24)

b. Is responsible for an eligible dependent child, which includes the unborn child of a pregnant woman. (7-1-24)

c. Lives in the same household with the eligible dependent child. (7-1-24)

02. Adults Under Age 65. The individual must: (7-1-24)

a. Be age nineteen (19) or older and under age sixty-five (65); (7-1-24)

b. Not entitled to or enrolled in Medicare Part A or Part B; and (7-1-24)

c. Not otherwise eligible for any other coverage under the State Plan. (7-1-24)

03. MAGI Income Eligibility. For any of the eligibility groups under Subsections 400.01 and 02, the individual must meet all income requirements of the Medicaid program for eligibility determined under MAGI methodologies identified in Sections 300 through 303, and 411 of these rules. Eligibility is based on: (7-1-24)

a. The number of members included in the household budget unit; (7-1-24)

b. All countable income for the household budget unit; and (7-1-24)

c. Eligible individuals will have income calculated using their MAGI. Individuals with MAGI not greater than one hundred thirty-three per cent (133%) after applying a five per cent (5%) disregard to income are eligible to receive Medicaid in this rule. (7-1-24)

04. Member of More Than One Budget Unit. No person may receive benefits in more than one (1) budget unit during the same month. (7-1-24)

05. 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. (7-1-24)

401. -- 410. (RESERVED)

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

(7-1-24)

412. -- 418. (RESERVED)

419. TRANSITIONAL MEDICAID FOR PARENT CARETAKER ADULTS.
Participants who no longer qualify for Medicaid due to an increase in earned income or working hours are eligible for an additional twelve (12) months of Medicaid. Participants must have been eligible for Medicaid during at least three (3) of the six (6) months immediately preceding the month in which the participant became ineligible. (7-1-24)

420. EXTENDED MEDICAID FOR SPOUSAL PARENT CARETAKER 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. (7-1-24)

421. 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. (7-1-24)

422. -- 519. (RESERVED)

HEALTH COVERAGE FOR CHILDREN
(Sections 520-529)

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 FPG by family size is less than or equal to the applicable income limit for the age of the child. (7-1-24)

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. (7-1-24)

02. Title XXI Income Limit. For children age zero (0) to six (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. (7-1-24)

03. Disregard Applied. A standard disregard in the amount of five percent (5%) of 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. (7-1-24)

521. HOUSEHOLD SIZE AND FINANCIAL RESPONSIBILITY.
Household size and financial responsibility for health coverage for children is determined using the methodology under Section 300 of these rules. (7-1-24)

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: (7-1-24)

01. Covered by Creditable Health Insurance. The child is covered by creditable health insurance at the time of application. (7-1-24)

02. Child is Eligible under Idaho's Title XIX State Plan. (7-1-24)

03. Idaho State Employee Benefit Plan. The child is eligible to receive health insurance benefits under Idaho's State employee benefit plan. (7-1-24)

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. (7-1-24)

01. Reasons Continuous Eligibility Ends. (7-1-24)

a. The child is no longer an Idaho resident; (7-1-24)

b. The child dies; (7-1-24)

c. The participant requests closure; or (7-1-24)

d. The child turns nineteen (19) years old under Subsection 010.05 of these rules. (7-1-24)

02. Reasons Children are not Eligible for Continuous Eligibility. (7-1-24)

a. A child is approved for emergency medical services; or (7-1-24)

b. A child is approved for pregnancy-related services. (7-1-24)

525. FORMER FOSTER CHILD.
An individual who is between the age of eighteen (18) and twenty-six (26), who was in foster care and became ineligible for Medicaid as a foster child due to age, may receive Medicaid coverage until their twenty-sixth birthday. There are no financial eligibility criteria. The only non-financial criteria are the receipt of foster care services and age. (7-1-24)

526. -- 529. (RESERVED)

SPECIAL CIRCUMSTANCES FOR CHILDREN
(Sections 530-549)

530. NEWBORN CHILD DEEMED ELIGIBLE FOR MEDICAID.
A child is deemed eligible for Medicaid for their first year of life when the following exists. (7-1-24)

01. Mother Filing an Application. The child is born to a mother who files an application for medical assistance. (7-1-24)

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. (7-1-24)

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 under Section 300 of these rules related to tax filing households. (7-1-24)

532. RESIDENT OF AN ELIGIBLE INSTITUTION.
A resident of an eligible institution must meet all non-financial and financial criteria of Title XIX, Title XXI, or any other applicable program. (7-1-24)

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 non-financial criteria and the financial requirements described for the children's coverage group. (7-1-24)

534. (RESERVED)

535. TITLE IV-E FOSTER CARE CHILD.
A child may be eligible for Medicaid under the Title IV-E foster care program if they meet the eligibility requirements in IDAPA 16.06.01, "Child and Family Services," Section 425. (7-1-24)

536. -- 539. (RESERVED)

540. YOUTH EMPOWERMENT SERVICES (YES) PROGRAM CHILDREN.

01. Payments for Children Under Eighteen (18) Years Old with SED. Under Section 56-254(2), Idaho Code, the Department will make payments for medical assistance for a child under eighteen (18) years old with serious emotional disturbance (SED), as defined in Section 16-2403, Idaho Code, and verified by an independent assessment: (7-1-24)

a. Whose family income does not exceed three hundred percent (300%) of the FPG as determined using MAGI-based eligibility standards; or (7-1-24)

b. Who meets other Title XIX Medicaid eligibility standards under the rules of the Department. (7-1-24)

02. Youth Empowerment Services (YES) Benefits. Applicants whose family income is equal to or less than three hundred percent (300%) of the FPG for children zero (0) to eighteen (18) years old and who meet the non-financial eligibility criteria in Sections 200 through 299 of these rules may receive the following benefits: (7-1-24)

a. YES State Plan option services and supports under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 635 through 638; and (7-1-24)

b. Additional covered services under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 075 through 799. (7-1-24)

03. Additional Eligibility Criteria and Program Requirements for YES. Additional eligibility criteria and program requirements applicable to the YES State Plan option are under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 635 through 638. (7-1-24)

541. -- 544. (RESERVED)

545. PRESUMPTIVE ELIGIBILITY FOR CHILDREN AND ADULTS.
Presumptive eligibility determination for qualifying medical coverage groups can only be provided by a qualified hospital defined in Section 011 of these rules. (7-1-24)

01. Presumptive Eligibility Decisions. Decisions of presumptive eligibility can be made for individuals who meet program requirements for MAGI-based Medicaid coverage. (7-1-24)

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: (7-1-24)

a. Prior to completion of a full Medicaid application; and (7-1-24)

b. Prior to a determination being made by the Department on the full application. (7-1-24)

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: (7-1-24)

a. The date the full eligibility determination is completed by the Department; or (7-1-24)

b. The end of the month after the month the qualified hospital completed the presumptive eligibility determination. (7-1-24)

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. (7-1-24)

01. Acceptance of Application. The qualified hospital accepts the request for services in the same manner as all applications for assistance are accepted. (7-1-24)

02. Standards and Processes. The presumptive eligibility determination must be based on standards and processes provided by the Department. (7-1-24)

03. Assistance to Applicant. The qualified hospital must assist the applicant in completing the Department's application process. (7-1-24)

04. Qualified Hospital Staff. Only qualified hospital staff who are trained in presumptive eligibility standards can make a presumptive eligibility determination. (7-1-24)

05. Notice to Applicant. The qualified hospital or the Department will provide notice to the applicant within two (2) business days on the presumptive eligibility determination. (7-1-24)

06. Notice and Hearing Rights. Presumptive eligibility decisions are not appealable and do not have hearing rights under the Title XIX Medicaid program. (7-1-24)

07. Number of Presumptive Eligibility Periods Allowed. Only one (1) presumptive eligibility period is allowed per applicant in any twelve (12) month period. (7-1-24)

547. -- 599. (RESERVED)

CASE MAINTENANCE REQUIREMENTS
(Sections 600-701)

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. (7-1-24)

01. Continuing Eligibility. Is determined using available electronic verification sources without participant contact, unless information: (7-1-24)

a. Is not available; (7-1-24)

b. Sources provide conflicting information; or (7-1-24)

c. Is inconsistent with information provided by the participant. (7-1-24)

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. (7-1-24)

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. (7-1-24)

01. Extended Medicaid. A participant who receives extended Medicaid is eligible under Section 420

of these rules. (7-1-24)

02. Pregnant Woman. A pregnant woman of any age is eligible for the Pregnant Woman coverage if she meets all the non-financial and financial criteria of the coverage group. Coverage includes services as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." 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. (7-1-24)

03. Newborn Child of Medicaid-Eligible Mother. A participant receiving Medicaid as the newborn child of a Medicaid-eligible mother is eligible under Section 530 of these rules. (7-1-24)

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. (7-1-24)

611. TYPES OF CHANGES THAT MUST BE REPORTED.
Changes in circumstances the participant must report are the following: (7-1-24)

01. Name or Address. A name change for any participant or a change of address or location. (7-1-24)

02. Household Composition. Changes in family composition if a parent or relative caretaker receives Medicaid. (7-1-24)

03. Marital Status. Marriages or divorces of any family member if a parent or relative caretaker receives Medicaid. (7-1-24)

04. New SSN. SSN is newly assigned to a Medicaid Health Care Assistance program participant. (7-1-24)

05. Health Insurance Coverage. Enrollment or disenrollment of a participant in a health insurance plan. (7-1-24)

06. End of Pregnancy. Pregnant participants must report when pregnancy ends. (7-1-24)

07. Earned Income. Changes in the amount or source of earned income if a parent or relative caretaker receives Title XIX benefits. (7-1-24)

08. Unearned Income. Changes in the amount or source of unearned income if a parent or relative caretaker receives Title XIX benefits. (7-1-24)

09. Support Income. Changes in the amount of spousal support received by an adult household member. (7-1-24)

10. Disability. A family member who becomes disabled or is no longer disabled if a parent or relative caretaker receives Title XIX benefits. (7-1-24)

612. -- 619. (RESERVED)

620. NOTICE OF CHANGES IN ELIGIBILITY.
The Department will notify the participant of changes in their Health Care Assistance. The notice must give the effective date, the reason for the action, the rule that supports the action, and appeal rights. (7-1-24)

621. NOTICE OF CHANGE OF PLAN.

The Department can 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 they will be switched from the Enhanced Plan to the Basic Plan. (7-1-24)

622. ADVANCE NOTICE RESPONSIBILITY.
The Department must notify the participant at least ten (10) calendar days before the effective date when a reported change results in Health Care Assistance closure. (7-1-24)

623. ADVANCE NOTICE NOT REQUIRED.
Advance notice is not required when a condition under this rule exists. The participant will be notified no later than the date of the action. (7-1-24)

01. The Department has Proof of the Participant's Death. (7-1-24)

02. The Participant Requests Closure in Writing. (7-1-24)

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. (7-1-24)

04. Nursing Care. The participant is placed in a nursing facility or Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/IID). (7-1-24)

05. The Participant's Address is Unknown. (7-1-24)

06. The Participant is Approved for Medical Assistance in Another State. (7-1-24)

07. Eligible One Month. The participant is eligible for aid only during the calendar month of their application for aid. (7-1-24)

08. Retroactive Medicaid. The participant's Title XIX or Title XXI eligibility is for a prior period. (7-1-24)

624. -- 699. (RESERVED)

700. OVERPAYMENTS.
Health Care Assistance overpayments occur when a participant receives benefits during a month they were not eligible. (7-1-24)

701. RECOVERY OF OVERPAYMENTS.
All Health Care Assistance overpayments are subject to recovery. Overpayments are recovered by direct payment from the participant. (7-1-24)

01. Notice of Overpayment. The participant must be informed of the Health Care Assistance overpayment and appeal rights. (7-1-24)

02. Notice of Recovery. The participant must be informed when their Health Care Assistance overpayment is fully recovered. (7-1-24)

702. -- 999. (RESERVED)