

I.

Dr. Dynasaur Premium Grace Period

A. *Background*

The Children's Health Insurance Program (CHIP) is a Dr. Dynasaur group covering uninsured children up to age 18 with incomes over 225% of the federal poverty level (FPL) but less than or equal to 300% FPL. Congress reauthorized this program in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).

In section 504 of the Act, Congress instituted a statutory grace period during which CHIP enrollees may pay their monthly premiums before being disenrolled. The provision also includes new requirements for states to notify families of their rights and responsibilities with respect to payment of premiums.

In § E.309 of Act 63 of 2011, the Vermont legislature directed the agency to implement this new requirement and, in doing so, to expand its applicability to all children in state health programs who are subject to premium payments. In § E.307.3, it directed the agency to engage in emergency rulemaking to ensure implementation by July 1, 2011.

This rule implements the Dr. Dynasaur premium grace period. It also implements a federal CHIP regulation requiring that, as a component of its disenrollment process, states provide families with an opportunity to show that their circumstances have changed and as a result, may qualify for reduced or no cost sharing.

B. *Summary of Rule Changes and Additions*

Medicaid rule 4161 is amended to provide:

- New definitions to clarify premium-related concepts;
- A new one-month premium grace period for Dr. Dynasaur enrollees to pay their premiums before closure for nonpayment;
- Enhanced notice requirements, intended to ensure that Dr. Dynasaur enrollees understand their rights and responsibilities under the new premium paradigm;
- Dr. Dynasaur closure protection, affording individuals who are set to close for nonpayment, the opportunity to show that, due to changed household circumstances, they may be eligible for nonpremium-based coverage or a lower premium amount;
- A statement of Dr. Dynasaur enrollee's rights and responsibilities regarding reinstatement and reenrollment when premiums are paid after closure for nonpayment;
- Continuing household responsibility for grace-period premiums upon subsequent application for premium-based coverage; and

- A provision for waiver of past-due grace-period premium amounts that are older than 12 months.

The amended premium rules will be effective on July 1, 2011. This means that covered individuals who would otherwise have closed on July 31 for nonpayment will receive a grace period in the month of August. The new closure notices will issue beginning with the July closure notice run. The new grace-period notices will issue beginning on the fifth business day of August.

II.

Medicaid and CHIP Coverage of “Lawfully Residing” Children and Pregnant Women

A. *Background*

The enactment of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (Public Law 104-193) placed limitations of federal funding for health coverage for immigrant families. § 403 of the Act imposed a 5-year waiting period on certain groups of qualified aliens, including most children and pregnant women who were otherwise eligible for Medicaid. Medicaid coverage for individuals subject to the 5-year waiting period and for those who do not meet the definition of qualified alien was limited to treatment of an emergency medical condition as described in section 1903(v)(2)(A) of the Act. The 5-year waiting period also applied to children and pregnant women under CHIP.

Section 214 of CHIPRA permits states to cover certain children and pregnant women in both Medicaid and CHIP who are “lawfully residing in the United States.” The section 214 option may be applied to pregnant women in Medicaid and to children up to age 18 for CHIP or up to age 21 for Medicaid.

In § E.309.1 of Act 63 of 2011, the Vermont legislature directed the agency to implement this new option. In § E.307.3, it directed the agency to engage in emergency rulemaking to ensure implementation by July 1, 2011. This rule implements the new coverage option.

The term “lawfully residing in the U.S.” is broader than the term “qualified alien,” as used in § 431 of PRWORA. The amended rule identifies those additional immigration statuses that fall within this concept.

This new coverage option applies to the traditional Medicaid coverage groups and Dr. Dynasaur. It does not apply to the state’s 1115A waiver programs.

Coverage under the new option terminates when, within the five-year waiting period:

- The pregnancy or postpartum period ends;
- The child ages out of eligibility; or
- The individual is no longer lawfully residing in the U.S.

B. Summary of Rule Changes and Additions

Medicaid rule 4173 is amended to:

- Expand coverage to:
 - Pregnant women who are otherwise eligible for Medicaid (including women covered during the 60-day postpartum period) who are lawfully residing in the United States and
 - Children up to age 21 who are otherwise eligible for Medicaid or CHIP, who are lawfully residing in the United States.
- Define when an individual is lawfully residing in the United States; and
- Specify that the state will verify that the child or pregnant woman is lawfully residing in the United States at the time of the individual's original eligibility determination and at the time of eligibility redetermination.

Medicaid rule 4363 is amended to exempt those who are covered by the new coverage option from the sponsor's financial responsibilities that would otherwise be imposed under that rule.

III.
Rulemaking Process

A. Public Input Process and Filing

In § E.307.3, Act 63 of 2011, the legislature provided that the agency "shall be deemed to have met the standard for adoption of emergency rules as required by 3 V.S.A. § 844(a). Notwithstanding 3 V.S.A. § 844, the agency shall provide a minimum of five business days for public comment in advance of filing the emergency rules as provided for in 3 V.S.A. § 844(c)." The agency met this obligation by posting links to a draft of this emergency rule bulletin on the Department for Children and Families, Economic Services Division Rules Page.

In addition, the agency sent e-mail notices of the proposed emergency rule bulletin to:

- All of those individuals and groups that subscribe to Economic Services Division's electronic rules notifications;
- A broad array of community organizations who regularly receive health-care program communications;
- Members of the Medicaid Advisory Board; and
- A broad array of refugee and immigrant service providers who regularly receive agency communications from the state refugee coordinator.

Written comments were accepted up until 4:30 p.m. on June 28, 2011. The agency's responses to comments are set forth below.

On October 28, 2011, copies of the emergency rule are expected to be filed with the Secretary of State and the Legislative Committee on Administrative Rules (LCAR).

The rule is expected to be effective on October 29, 2011.

B. Responses to Public Comments

The agency received written comments from Vermont Legal Aid, Inc. and the Office of the Vermont Health Care Ombudsman. The comments are summarized in italics below and are followed by the agency's responses.

Dr. Dynasaur Premium Grace Period

4161(B)(5)(d) – Dr. Dynasaur Premium Grace Period Notices

The Dr. Dynasaur premium grace period notices must include information about Dr. Dynasaur closure protection and rules about reinstatement and enrollment. The state must also, under federal regulations, notify individuals of their right to challenge a proposed termination of coverage for failure to pay a premium. The notice rule should specify that this information will be part of the notice.

The provision in question will be amended to add the requirement that closure and grace-period notices provide information about Dr. Dynasaur closure protection.

Our notices currently inform people that, if they are closing for premium nonpayment, they can secure reinstatement and reenrollment by paying the amount due before the coverage end date. While our rules allow for additional reinstatement and reenrollment opportunities, we believe that adding this level of detail to notices would cause confusion and potentially promote undesirable coverage breaks.

Current Medicaid Rule 4150 generally specifies the required elements of notices of decision. That rule contains provisions requiring the department to notify individuals of their right to challenge decisions closing enrollment or cancelling eligibility. We will add a cross-reference in this section to Rule 4150.

This subparagraph will be amended as follows:

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

- ii. If the department does not receive a full premium payment before the fifth business day of the grace month, it will send a notice, advising that the individual is in grace status. The notice will advise that coverage will end at the end of the grace month.
- iii. At least 11 days before the end of the grace month, the department will mail a final closure notice, advising that coverage will end at the end of the grace month.
- iv. In addition to the above, the Dr. Dynasaur premium grace-period notices will:
 - (1) Advise of the Dr. Dynasaur closure protection, as provided in subparagraph 5(e) of this section; and
 - (2) Otherwise comply with the notice requirements set forth in Medicaid Rule 4150.

The state must guarantee that individuals have the right to appeal a termination based on failure to pay cost sharing and to have continuing benefits pending a decision. The current rule on continuation of coverage pending appeal (4153) states that the billed premium amount must be paid to ensure continuing benefits, and this provision should be changed since it undercuts the premium closure protection requirements.

This issue exceeds the scope of this emergency rule. In any event, the agency is disinclined to change this longstanding policy: A rule that would permit individuals who appeal the amount of their premiums to pay the amount they claim they owe during the pendency of the appeal would be extremely difficult to administer, given the nature of the agency's integrated premium billing, collection, and eligibility system. Moreover, as the vast majority of premium-amount appeals are unsuccessful, this approach would give rise to a new and burdensome post-appeal collection process and subject appellants to potentially challenging financial liabilities.

While we recognize that the current approach could create a hardship for a few, we believe that, on balance, the better approach is to maintain the current system which requires payment of the billed amount pending appeal but offers full reimbursement if overpayment is ultimately established.

Medicaid and CHIP Coverage of “Lawfully Residing” Children and Pregnant Women

4173 – Five-Year Bar for Qualified Aliens

The Emergency Rule should be amended to exempt holders of U and T visas from the 5-year bar for qualified aliens. This change is in keeping with the spirit and the letter of Act 55 of 2011 (An Act Relating to Human Trafficking).

Under existing federal law and state rule, victims of severe forms of trafficking are currently exempt from the 5-year bar for qualified aliens. Individuals can document this status with either a T visa (issued to victims of human trafficking) or with a certification from The Office of Refugee Resettlement (ORR) of the U.S. Department of Health and Human Services.

U-visas give victims of certain crimes temporary legal status and work eligibility in the United States for up to 4 years. As they do not necessarily establish an individual’s status as a victim of severe forms of trafficking, a U visa cannot alone verify eligibility for the trafficking exemption.

This emergency rule broadly exempts from the five-year bar, lawfully-present immigrant children and pregnant women who are otherwise qualified for a covered program. This would cover—among others—all otherwise qualified children and pregnant women who hold U and T visas. The emergency rule cannot, however, be expanded to cover all such holders, as that would exceed the scope of the federal coverage option extended to the states in section 214 of CHIPRA.

Thus, while many U and T visa holders are now exempt from the five-year bar, there are still some holders of U visas (adults who are not pregnant) who do not qualify for this exemption. This means that, under existing federal law, the federal government will not financially participate in the extension of health-care benefits to these individuals.

Some states have opted to create state-only programs to provide coverage to those who do not qualify for the federal exemption. Implementation of a similar program in Vermont would require a legislative initiative. While the commenter points to Act 55 as authority for such an expansion, we do not read that statute so broadly. Act 55 does not create eligibility for health-care services. While it allows that support agencies may assist people potentially eligible to apply for such services, it does not provide coverage for those individuals who are not otherwise eligible. For these reasons, we are unable to honor this request.

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To get more information about the Administrative Procedures Act and the rules applicable to state rulemaking go to the website of the Office of the Vermont Secretary of State at: <http://vermont-archives.org/apa/rules.html> or call Louise Corliss at 828-2863.

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Vertical lines in the left margin indicate significant changes. Dotted lines at the left indicate changes to clarify, rearrange, correct references, etc., without changing content.

Manual Maintenance

Medicaid Rules

Remove

4161 (11-18)
4173 (11-18)
4373 (11-18)

Insert

4161 (11-28)
4173 (11-28)
4373 (11-28)

Cost Sharing

4161 Cost Sharing

A. Definitions

2. “Medical incapacity” means a serious physical or mental infirmity to the health of the adult beneficiary or beneficiaries responsible for paying the premium that prevented the adult beneficiary or beneficiaries from paying the premium timely, as verified in a physician's certificate furnished to the department. Notice by telephone or otherwise by the physician that such certificate will be forthcoming will have the effect of receipt, providing the certificate is in fact received within seven days.
3. “Physician's certificate” means a written statement on a form supplied by the department signed by a duly licensed physician certifying that an adult beneficiary suffered from medical incapacity that prevented the beneficiary from paying the premium timely. If the medical incapacity is expected to continue or recur, the department will encourage beneficiaries to designate an authorized representative to receive and pay future bills for as long as the anticipated duration of the condition.
4. “Premium” means a nonrefundable charge as a condition of initial and ongoing enrollment received in full by the department from applicants.
5. “Received” or “received and processed” means the department has posted the full premium payment and logged the transaction on the applicable case record on the department's computer system, thereby ensuring the information is available to authorized staff.

B. Premium

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

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

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

The department will:

- a. send premium bills at least 25 days before the last day of the month, which is the date that coverage will end if the department does not receive the payment;
- b. mail beneficiaries a notice of impending closure at least 11 days before coverage ends for nonpayment of a premium;
- c. reinstate coverage without a break in benefits if the department receives the payment by the last day of the month, or the first business day following the last day of the month in which the due date falls.

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

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

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

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

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- b. moves from a premium-based coverage group to a non-premium-based group;
- c. becomes ineligible because of an increase of income; or
- d. dies.

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

- 4. Precedence. If there is a conflict between provisions in this rule and any other health-care rule, the provisions in this rule shall take precedence.
- 5. Special Dr. Dynasaur premium rules.
 - a. Definitions.
 - i. Billed month. The month that follows the coverage month and is associated with the department's most recent regular billing.
 - ii. Cancel. Determine that an individual no longer meets all of a health-care program's qualifications.
 - iii. Close. Cancel eligibility and disenroll from coverage.
 - iv. Coverage. The scope of benefits provided to an individual who is enrolled in a health-care program.
 - (1) Nonpremium-based coverage. Any coverage that is provided without a premium charge.
 - (2) Premium-based coverage. Any coverage that is provided with a premium charge.
 - v. Coverage month. The current month in which an enrolled individual is entitled to receive coverage. In the case of premium-based coverage, to be a coverage month, the full premium must have been received.
 - vi. Dr. Dynasaur. For the purposes of this rule, Dr. Dynasaur includes children in the group defined in rule 4312.6 and pregnant women in the group defined in rule 4312.7.

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- vii. Eligible. Status of an individual that meets all of a health-care program's qualifications.
- viii. Enroll. Begin to provide coverage to an eligible individual.
- ix. Grace month. A billed month in which coverage continues but for which the full premium has not been received.
- x. Health-care adverse-action approval deadline. Including the last day of the month, the twelfth day prior to the end of a month. However, if that day falls on a weekend or holiday, the health-care adverse-action approval deadline is the preceding business day. The health-care adverse-action approval deadline is the last day in a month that an action that negatively affects eligibility, enrollment, or benefits can be processed in the department's eligibility system if that action is to take effect by the first day in the following month. The purpose of this deadline is to ensure timely notification of the health-care adverse-action approval deadline.
- xi. Reenroll. Restore a reinstated individual's enrollment.
- xii. Reinstate. Restore an individual's eligibility after cancellation.
- b. Basic rule. Except as otherwise provided in this paragraph, all of the department's premium billing and collection rules apply to individuals who are eligible for Dr. Dynasaur.
- c. Dr. Dynasaur premium grace period. An individual who does not pay a monthly premium by the premium due date for the billed month shall have a one-month grace period to pay the premium before closure. The billed month becomes the grace month.
- d. Dr. Dynasaur premium grace period notices.
 - i. If the department does not receive a full premium payment before the premium due date, it will send a closure notice, advising that coverage will end at the end of the grace month.
 - ii. If the department does not receive a full premium payment before the fifth business day of the grace month, it will send a notice, advising that the individual is in grace status. The notice will advise that coverage will end at the end of the grace month.
 - iii. At least 11 days before the end of the grace month, the department will mail a final closure notice, advising that coverage will end at the end of the grace month.
 - iv. In addition to the above, the Dr. Dynasaur premium grace-period notices will:
 - (1) Advise of the Dr. Dynasaur closure protection, as provided in subparagraph 5(e) of this section; and

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

- e. Dr. Dynasaur closure protection. Prior to closure, an individual who has received a nonpayment closure notice may contact the department to show that, due to changed household circumstances, the individual is eligible for nonpremium-based coverage or a lower premium amount.
 - i. If the showing indicates that the individual is eligible for nonpremium-based coverage, the department will reinstate and reenroll the individual and waive the past-due premium.
 - ii. If the showing indicates that the individual is eligible for premium-based coverage, but at a lower premium amount, the department will adjust any outstanding premium amounts due. Reinstatement and reenrollment will proceed as provided for in subparagraph f of this paragraph.
- f. Reinstatement and reenrollment.
 - i. Except as specified in subparagraph ii. below, the department will reinstate an individual whom it closed for premium nonpayment under the following circumstances:
 - (1) Without break in coverage.
 - (a) If the department receives a full premium payment for the grace month on or before the first business day of the month following the grace month:
 - (i) The payment will first be applied to cover the premium due for the grace month;
 - (ii) The individual will be reinstated; and
 - (iii) The individual will be reenrolled for coverage in the month following the grace month.
 - (b) If the payment is not enough to cover the premium due for the grace month and the following month, the following month becomes a new grace month.

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(2) With break in coverage.

- (a) If the department receives a full premium payment for the grace month after the first business day in the month following the grace month, but before the end of that month:
 - (i) The payment will first be applied to cover the premium due for the grace month;
 - (ii) The individual will be reinstated; and
 - (iii) The individual will be conditionally-approved for reenrollment, pending receipt of the full premium due for at least one new month of coverage.
 - 1) If the department receives such a payment before the monthly bills are created in the first month following the grace month, the individual will be reenrolled for coverage on the first day of the second month following the grace month.
 - 2) If the department receives such a payment after the monthly bills are created in the first month following the grace month, but before the health-care adverse-action approval deadline of the second month following the grace month, the individual will be reenrolled for coverage on the first day of the third month following the grace month.
 - 3) If the department does not receive such a payment by the health-care adverse-action approval deadline of the second month following the grace month, the individual is cancelled. However, if the department subsequently receives such a payment before the end of that month, the department will reinstate and reenroll the individual for coverage on the first day of the third month following the grace month.
- (b) If the department does not receive a full premium payment for the grace month before the end of the month following the grace month, the individual must reapply.

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- (c) If the department receives the full premium payment for the grace month, but subsequently cancels the reinstatement because it does not timely receive a premium payment for the full premium due for at least one new month of coverage, the department will again reinstate the individual if it subsequently receives such payment before the end of the month following the cancellation month. The individual will be reenrolled as follows:
 - (i) If the department receives such a payment and approves the reinstatement before the monthly bills are created in the first month following cancellation, the individual will be reenrolled for coverage on the first day of the second month following cancellation.
 - (ii) If the department receives such a payment or approves the reinstatement after the monthly bills are created in the first month following the cancellation, but before the end of the month following the cancellation month, the individual will be reenrolled for coverage on the first day of the third month following the cancellation month.
 - (d) If the department does not receive the full premium due for at least one new month of coverage before the end of the first month following the cancellation month, the individual must reapply.
 - (e) An individual who is reinstated and reenrolled under this subparagraph 5(f)(i)(2) may secure coverage for any or all of the months between the grace month and the reenrollment month by paying the full premiums due for that month or those months.
 - ii. Exception. Individuals will not be reinstated or reenrolled without submitting a new application if a review of the case is scheduled for the reinstatement month or the following month.
 - g. Partial payments. Partial payments will be applied to the premium owed for the grace month. However, the department must receive the full amount owed for the grace month before eligibility will be reinstated.
6. Households with outstanding grace-period premium balances. When any individual in a household applies for any health-care program and the household has an outstanding premium balance due to an unpaid grace period, the department will only enroll the individual if:
- a. Past due premiums and the first premium of the new coverage period are paid in full, or
 - b. All members of the household are eligible for nonpremium-based coverage.
7. Waiver of past-due premiums. The department will waive outstanding grace-period premium balances that are older than 12 months.

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

C. Copayments

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

1. Copayments are never required from beneficiaries who are:
 - a. long-term care beneficiaries; or
 - b. SSI-related Medicaid beneficiaries under age 18; or
 - c. ANFC-related Medicaid beneficiaries under age 21; or
 - d. pregnant or in the 60-day post-pregnancy period.
2. Copayments are required for these services:
 - a. \$75.00 for the first day of an inpatient hospital stay in a general hospital.
 - b. \$3.00 per day per hospital for hospital outpatient services unless the individual is also covered by Medicare. An individual covered by Medicare has no copayment requirement for outpatient services.
 - c. Prescriptions for recipients age 21 and older as follows:
 - i. \$1.00 for each prescription, original or refill, having a usual and customary charge of \$29.99 or less,
 - ii. \$2.00 for each prescription, original or refill, having a usual and customary charge of \$30.00 or more.
 - iii. \$3.00 for each prescription, original or refill, having a usual and customary charge of \$50.00 or more.
 - iv. \$3.00 per date of service per provider for dental services for recipients age 21 and older.

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3. No copayments are required for the following services:
 - a. Services reimbursed by the Department of Developmental and Mental Health Services.
 - b. Emergency hospital services.
 - c. Home Health, Hospice, and Home and Community Based Services for the Elderly and Disabled.
 - d. Services provided by other licensed practitioners including:
 - i. Podiatry
 - ii. Audiology
 - iii. Psychological
 - iv. Optometric and Optician
 - v. Nurse practitioner
 - e. Services provided by rural health clinics and federally qualified health care facilities.
 - f. Independent laboratory.
 - g. X-ray interpretations performed by a physician who has no direct contact with the beneficiary.
 - h. Transportation including ambulance.
 - i. Medical supplies.
 - j. Durable Medical Equipment (DME) purchases and rental and nursing services.
 - k. Oxygen and respiratory equipment and supplies.
 - l. Family planning services.
4. The department is not responsible for copayments a provider may collect in error or a beneficiary makes on a service that is not paid for by Medicaid.

Five-Year Bar for Qualified Aliens

4173 Five-Year Bar for Qualified Aliens

- A. Immigrants who enter the United States on or after August 22, 1996 as qualified aliens are not eligible to receive Medicaid for five years from the date they enter the country. If they are not qualified aliens when they enter, the five-year bar begins the date they become a qualified alien. The following qualified aliens are subject to the five-year bar:
1. Lawful permanent residents (LPRs);
 2. Aliens granted parole for at least one year;
 3. Aliens granted conditional entry (however, as a practical matter the five-year bar will never apply to such aliens, since, by definition, they entered the U.S. and obtained qualified alien status prior to August 22, 1996); and
 4. Battered aliens.
- B. The following qualified aliens are not subject to the five-year bar:
1. Refugees;
 2. Asylees;
 3. Cuban and Haitian Entrants;
 4. Victims of a severe form of trafficking;
 5. Aliens whose deportation is being withheld;
 6. Qualified aliens who are (1) honorably discharged veterans, (2) on active duty in the U.S. military or (3) the spouse (including a surviving spouse who has not remarried) or unmarried dependent child of an honorably discharged veteran or individual on active duty in the U.S. Military;
 7. Aliens admitted to the country as Amerasian immigrants;
 8. Legal permanent residents who first entered the country under another exempt category (i.e., as a refugee, asylee, Cuban or Haitian entrant, trafficking victim, or alien whose deportation was being withheld) and who later converted to the LPR status.

Five-Year Bar for Qualified Aliens

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

1. Immigrants who are applying for treatment of an emergency medical condition only;
2. Immigrants who entered the United States and became qualified aliens prior to August 22, 1996; and
3. Immigrants who entered prior to August 22, 1996 and remained “continuously present” in the United States until becoming a qualified alien on or after that date. Any single absence of more than 30 consecutive days or a combined total absence of 90 days before obtaining qualified alien status is considered to interrupt “continuous presence.”
 - a. Immigrants who do not meet “continuous presence” are subject to the five-year bar beginning from the date they become a qualified alien.
 - b. Immigrants do not have to remain continuously present in the United States after obtaining qualified alien status.
4. Members of a Federally-recognized Indian tribe; and
5. American Indians born in Canada to whom Section 289 of the INA applies.
6. Children up to 21 years of age and women during pregnancy and the 60-day postpartum period, who are lawfully residing in the United States and are otherwise eligible for assistance. This exemption applies only to traditional Medicaid coverage groups, children in the group defined in rule 4312.6, and pregnant women in the group defined in rule 4312.7.
 - a. A child or pregnant woman will be considered to be lawfully residing in the United States if he or she is:
 - i. A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641) (see, Medicaid Rule 4172);
 - ii. An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;
 - iii. An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;
 - iv. An alien who belongs to one of the following classes:
 - (1) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);

Five-Year Bar for Qualified Aliens

- (2) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;
 - (3) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);
 - (4) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;
 - (5) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
 - (6) Aliens currently in deferred action status; or
 - (7) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;
- v. A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;
 - vi. An alien who has been granted withholding of removal under the Convention Against Torture;
 - vii. A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J)).
- b. The state will verify that the child or pregnant woman is lawfully residing in the United States at the time of the individual's original eligibility determination and at the time of eligibility redetermination.

Five-Year Bar for Qualified Aliens

4173.1 Documentation of Entry Date

- D. The following are the documents that may be used to determine the five-year bar:
1. Form I-94. The date of admission should be found on the refugee stamp. If missing, contact USCIS to verify the date of admission by filing a G-845 with a copy of the document.
 2. If a person presents Forms I-688B or I-766 (Employment Authorization Documents), and I-57 (refugee travel document), ask the alien to present Form I-94. If not available, contact USCIS by filing a G-845 with a copy of the document presented.
 3. Grant letters or court orders. Derive the date status is granted from the date of the letter or court order. If missing, contact USCIS to verify date of grant by filing a G-845 with a copy of the document.
- E. If a person presents a receipt indicating that he or she has applied to USCIS for a replacement document for one of the documents identified above, contact the USCIS to verify status by filing a G-845 with the local USCIS district office with a copy of the receipt. Contact the USCIS any time there is a reason to question the authenticity of a document presented or the information on the document is insufficient to determine whether alien status requirements are met.

Sponsored Aliens

4363 Sponsored Aliens

In determining the financial eligibility of a noncitizen who is admitted to the United States on or after August 22, 1996, based on a sponsorship under section 204 of the Immigration and Nationalization Act (INA), the income and resources of the sponsor and the sponsor's spouse, if living with the sponsor, must be counted as available to the noncitizen when all four of the following conditions are met:

- A. the sponsor has signed an affidavit of support on a form developed by the United States Attorney General as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 to conform to the requirements of Section 213A(b) of INA;
- B. the noncitizen is lawfully admitted for permanent residence, and a five-year period of ineligibility for Medicaid following entry to the United States has ended;
- C. the noncitizen is not battered; and
- D. the noncitizen is not indigent, defined as unable to obtain food and shelter without assistance, because his or her sponsor is not providing adequate support.

The above financial responsibility of a sponsor continues until the noncitizen is naturalized or credited with 40 qualifying quarters of coverage by the Social Security Administration (see section on Qualifying Quarters of Coverage).

Children and pregnant women who are exempt from the five-year bar pursuant to rule 4173.C.6 are not subject to the provisions of this rule.