Washington Health Law Manual — Fourth Edition
Washington State Society of Healthcare Attorneys (WSSHA)

Chapter 3: Rules Applicable to Certain Populations

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For reference purposes, this chapter was prepared from laws, cases, and materials selected by the authors, which were available as of February 2019.

Biographies

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Carla DewBerry practices in the areas of health care law; mergers and acquisitions; and federal, state and local tax. Ms. DewBerry represents health care clients in Medicare and Medicaid reimbursement matters, including related audits and litigation. In addition, she is an experienced tax and business counselor and represents clients in corporate restructurings, joint venture operations, licensing, and federal and state taxation matters. She provides counsel for clients outside the health care industry as well.

Ms. DewBerry's experience includes working as a practicing CPA at a large accounting firm where she was part of a firmwide health care group. She brings to her law practice a practical, in-depth understanding of how financial information is generated, stored and retrieved in the health care industry. This understanding is especially helpful in Medicare/Medicaid reimbursement matters.

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Rachel Sage serves as in-house counsel for the Swinomish Indian Tribal Community, practicing in the areas of health care, taxation, commercial transactions, federal Indian law, and litigation. Ms. Sage serves as general counsel to the Tribe’s enterprises, including its didgʷálič Wellness Center, an opioid use disorder treatment clinic that provides services to a four-county area in northwestern Washington. Prior to joining the Swinomish Tribe, Ms. Sage was an attorney with the law firm Garvey Schubert Barer in Seattle.

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This Chapter discusses legal issues impacting specific populations seeking access to health care. The population groups identified in this Chapter were selected because the authors perceived that the individuals in these groups experience health access issues in ways that may differ from the larger population in Washington. We acknowledge that we have not discussed many other groups who also have challenges in accessing health care.

I. Kids in Foster Care

In Washington foster care is available for children pursuant to RCW Chapter 74.13.250 – 74.13.902 (Foster Care) and RCW Chapter 13.34 (Juvenile Court Act in Cases Relating to Dependency of a Child and the Termination of a Parent and Child Relationship).

To better coordinate services for children in foster care, the state Legislature enacted Second Engrossed Second Substitute House Bill 1661 in 2017 and created a new state agency, the Department of Children, Youth and Families (DCYF) to become the state agency with responsibilities related to state-funded services that support children. Certain responsibilities and powers of the Department of Social and Health Services (DSHS) with respect to the state foster care system were transferred to DCYF. At the time that this Chapter was drafted (Spring 2019), certain changes set out in HB 1661 would not be effective until July 1, 2019.

The regulations adopted by DCYF with respect to foster care are found in WAC Title 110, including Chapter 110-90 (Extended Foster Care Program), Chapter 110-148 (Licensing Requirements for Child Foster Homes), Chapter 110-145 (Licensing Requirements for Group Care Facilities), and Chapter 110-147 (Licensing Requirements for Child Placing Agencies).

The DCYF will work with the Washington Health Care Authority (HCA) to meet the health care needs of children in foster care. HCA is the designated "single state agency" for purposes of Medicaid. *See* RCW 41.05.021. As required by Social Security Act Title IV-E (codified at 42 U.S.C. 671 - 679b) children in foster care are entitled to health coverage under a state's Medicaid program. Washington provides this care through the Apple Health Foster Care program (AHFC). AHFC coverage program generally ends on the child's 19th birthday, however coverage can be extended until age 26, if certain conditions are met. *See* WAC 110-90-0200, WAC 182-505-0211 and WAC 110-148-1305.

Foster care is available in a licensed foster care setting or in a relative's home. *See*. RCW 13.34.130 and RCW 13.34.260. While in foster care, children receive access to traditional home based health care from the foster parent. The foster home is required to have specific medical supplies available in the home, including protective non-latex gloves, bandages, scissors and tweezers, ace bandages, gauze and a non-breakable and mercury free thermometer. *See,* WAC 110-148-1550. In addition, the foster parent must ensure that the foster child receives appropriate medical and dental care, arrange for an early and periodic screening, diagnosis and treatment (EPSDT) exam for children who are in the foster parent's care for more than thirty days, and make plans to respond to illness and emergencies (in addition to undertaking other health care responsibilities).

AHFC currently provides health care coverage to kids in foster care through "an integrated managed physical and behavioral health coverage statewide, known as integrated managed

care."[12] A managed care plan coordinates and pays for both the child's physical and behavioral health services. Behavioral health services include mental health and substance use disorder treatment services Apple Health. "Children in foster care (out of home placement) are [currently] auto-enrolled to Coordinated Care of Washington" as their health plan as of March 2019.[3] Coordinated Care of Washington is a managed care organization affiliated with Centene Corporation; Centene Corporation is not a state agency.[4] Foster care youth adult alumni [i.e. certain children who are past their 18th birthday] have the ability to opt out of managed care for their physical health coverage.[5]

Consistent with regulations under the federal Unaccompanied Refugee Minors Program (i.e. 45 C.F.R 400.113 and 45 C.F.R. 400.116[6]) unaccompanied refugee minors are also covered by the AHFC program if they do not otherwise qualify for Medicaid or the Children's Health Insurance Program (CHIP). Coverage for unaccompanied refugee minors who do not qualify for Medicaid or CHIP, however, cannot be funded with federal dollars; thus the cost of health coverage for these children is borne by the state.[7] Details about the federal Unaccompanied Refugee Minors program can be found on the U.S. Department of Health and Human Services web site at https://www.acf.hhs.gov/orr/programs/ucs/about , last accessed March 20, 2019.

II. American Indians and Alaska Natives

Background

For more than two hundred years, the United States has acknowledged its obligation to provide health care to Native Americans.[8] This obligation stems from the federal government's "unique

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[1] Washington Health Care Authority web site. https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage/foster-care, last accessed March 16, 2019.

[2] **Note:** In the first quarter of 2019 when this article was drafted, Washington State's transition to fully integrated managed care was in still under development.

[33] https://www.hca.wa.gov/health-care-services-and-supports/apple-health-medicaid-coverage/foster-care-behavioral-health , last accessed March 20, 2019.

[4] "You are automatically enrolled in apple health and do not need to submit an application if you are a: … (d) Child in foster care placement as described in WAC 182-505-0211." WAC 182-503-0010(4).

[5] "An AHFC enrollee may request to end enrollment in AHFC without cause if the client is in the adoption support or young adult alumni programs. WAC 182-538-130 [entitled "exemptions and ending enrollment in managed care"] does not apply to these requests." WAC 182-538-150.

[6] 42 C.F.R. 400.116 provides that 'A State must provide unaccompanied minors with the same range of child welfare benefits and services available in foster care cases to other children in the State. Allowable benefits and services may include foster care maintenance (room, board, and clothing) payments; medical assistance; support services; services identified in the State's plans under titles IV-B and IV-E of the Social Security Act; services permissible under title XX of the Social Security Act; and expenditures incurred in establishing legal responsibility."

[7] *See*, State Letter 15-02, January 29, 2015 from the Office of Refugee Resettlement, available on the internet at https://www.acf.hhs.gov/orr/resource/state-letter-15-02 , last accessed March 19, 2019.

[8] *Navajo Health Foundation—Sage Memorial Hospital, Inc. v. Burwell*, 263 F. Supp. 3d 1083, 1119–21 (D.N.M. 2016)

legal relationship" with and trust responsibility to Indian tribes[9] and people[10], which has its roots in the devastating consequences of early introduction of diseases to Native communities and other colonial impacts to Native health.

Accordingly, the Indian health care system is the result of a complex web of treaties between Indian nations and the United States, Indian-specific provisions in the U.S. Constitution, federal laws, Executive Orders and case law. *See* Executive Order No. 13175, 65 Fed. Reg. 67249 (November 6, 2000).[11] As an example, in the 1855 Treaty of Point Elliott, the United States promised "to employ a physician to reside [near the Reservation] . . . who shall furnish medicine and advice to their sick, and shall vaccinate them …."[12]

The basis for the modern Indian health care system is rooted in the following key statutes:

> (1) the **1921 Snyder Act** which authorized the appropriation and expenditure of federal monies for, among other things, the "relief of distress and conversation of health" for Native Americans[13],

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[9] "The term 'Indian tribe' is defined by federal law as "any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 U.S.C. 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians." 25 U.S.C. 1603(14).

[10] 25 USC 1601.

[11] Executive Order No. 13175, Consultation and Coordination With Indian Tribal Governments, describes the relationship between Tribes and federal agencies as follows:

"In formulating or implementing policies that have tribal implications, agencies shall be guided by the following fundamental principles:

> (a) The United States has a unique legal relationship with Indian tribal governments as set forth in the Constitution of the United States, treaties, statutes, Executive Orders, and court decisions. Since the formation of the Union, the United States has recognized Indian tribes as domestic dependent nations under its protection. The Federal Government has enacted numerous statutes and promulgated numerous regulations that establish and define a trust relationship with Indian tribes.
>
> (b) Our Nation, under the law of the United States, in accordance with treaties, statutes, Executive Orders, and judicial decisions, has recognized the right of Indian tribes to self-government. As domestic dependent nations, Indian tribes exercise inherent sovereign powers over their members and territory. The United States continues to work with Indian tribes on a government-to-government basis to address issues concerning Indian tribal self-government, tribal trust resources, and Indian tribal treaty and other rights.
>
> (c) The United States recognizes the right of Indian tribes to self-government and supports tribal sovereignty and self-determination."

Executive Order No. 13175, Consultation and Coordination with Indian Tribal Governments, 65 Fed. Reg. 67249 (November 6, 2000).

[12] Article XIV, Treaty of Point Elliott, 12 Stat. 927 (1855).

[13] Public Law 67-85, codified at 25 U.S.C. 13.

(2) the **1955 Transfer Act** under which Congress transferred the responsibilities for Indian health care reform from the Bureau of Indian Affairs to the Division of Indian Health (later renamed Indian Health Service, or IHS) under the Public Health Service,

(3) the **Indian Self-Determination and Education Assistance Act of 1975** (ISDEAA)[14] which authorizes tribes and tribal organizations to enter into contracts and compacts with IHS to operate IHS or tribally-owned outpatient clinics and inpatient hospital facilities and which made it possible for many tribes to take over the responsibility of providing health care to their people in their own Indian communities, and

(4) the **Indian Health Care Improvement Act of 1976 and 2010** (IHCIA)[15], which permanently funded the provision of health care services in Indian country.

A detailed discussion of the earliest federal laws establishing federal funding for the Indian health care system can be found in Part I, Chapter 3, of the Indian Health Manual published by the Indian Health Service. *See* https://www.ihs.gov/IHM/pc/ , last accessed March 20, 2019.

As is generally true in the larger national health care system, the Patient Protection and Affordable Care Act (PPACA) also had an impact on the Indian health care system. One important feature of the PPACA is that it made permanent the reauthorization of the IHCIA. This was a significant event because authorizations for the IHCIA had expired in 2000. As amended by the PPACA, the IHCIA (*see* Section 25 U.S.C. 1680o) provides that –

> There are authorized to be appropriated such sums as are necessary to carry out this Act for fiscal year 2010 and each fiscal year thereafter, to remain available until expended.

Tribal Sovereignty and Government-to-Government Relationship

In addition to federal statutes, Tribal sovereignty is core to the Indian health care system. Beginning in the treaty era and continuing today, the relationship between the U.S. and the Tribes is a government-to-government relationship.

The State of Washington also acknowledges Tribal sovereignty and the government-to-government relationship it has with the Tribes.[16] The Washington State Health Care Authority ("HCA"), its Medicaid Agency, also recognizes Tribal sovereignty and has adopted a Tribal Consultation & Communication Policy.[17] Indeed, many state and federal actions that impact Tribes, Tribal members, or Tribal health programs must be carried out with active and meaningful consultation with Indian tribes and tribal organizations, and conference with urban Indian organizations.

Health Care Status of Native Americans

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[14] Pubic Law 93-638, previously codified at 25 U.S.C. 450 and recodified to 25 U.S.C. 5301.

[15] See 25 U.S.C. 1601 et seq.

[16] See *Centennial Accord between the Federally Recognized Indian Tribes in Washington State and the State of Washington*, Aug. 4, 1989, available at: https://goia.wa.gov/relations/centennial-accord

[17] https://www.hca.wa.gov/assets/program/tribal_consultation_policy.pdf

Despite the federal trust and statutory responsibility to provide for Native health care, Tribal members continue to suffer from significantly poor health outcomes compared to that of the general population.[18] It is against this backdrop that much of the law and policy governing health care in Indian country operates to address more than a century of inadequate or nonexistent access to basic health care for Native Americans.

Overview of Indian Health System

Under the modern Indian health statutes, there are three recognized components of the Indian health care system[19]

a. health programs administered directly by Indian Health Service (IHS);
b. tribal health programs operated pursuant to Title I (contracts) or V (compacts) of the ISDEAA; and
c. Indian tribes or tribal organizations to which the Secretary of Health and Human Services provides certain funding, such as urban Indian health programs.

IHS so-called "direct service" programs are operated by IHS employees on Indian reservations, in Indian communities, or in urban settings serving Indians in larger metropolitan areas. In contrast, Tribal health programs are considered to be IHS programs but are operated by the federally-recognized Tribes under the self-governance provisions of the ISDEAA. Contract and/or Compact tribes enter into annual or multi-year funding agreements so that IHS funding may flow to these programs. The majority of Tribes in Washington State operate such health programs under the ISDEAA on their Reservations. Finally, organizations like the Seattle Indian Health Board, a nonprofit, receive funding from IHS to deliver health services to eligible Tribal members who live in urban settings.

Funding Sources

Funding for Indian health programs derives from Congressional appropriations and receipts from third party billings for services, such as Medicare, Medicaid, Children's Health Insurance Program (CHIP), and other insurance programs.

From Congressional appropriations, IHS funds its direct services and its negotiated obligations under the ISDEAA contracts and compacts for Tribal health programs operated by Tribes.

In addition, IHS provides the Purchased and Referred Care (PRC) program to purchase essential health care services from private health care providers when such services are not available from IHS or tribal programs. This funding, however, is extremely limited. Because the PRC program is severely underfunded and cannot meet its level of need in providing services, IHS has special rules dealing with its eligibility and provider payments. Federal rules impose a stringent eligibility

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[18] See, e.g., Indian Health Service, "Disparities," available at https://www.ihs.gov/newsroom/factsheets/disparities/; U.S. Commission on Civil Rights, "Broken Promises: Continuing Federal Funding Shortfall for Native Americans, Briefing Report, Dec. 2018, available at: https://www.usccr.gov/pubs/2018/12-20-Broken-Promises.pdf; Whitney, Eric, "Native Americans Feel Invisible in the Health Care System," National Public Radio (Dec. 12, 2017), available at: https://www.npr.org/sections/health-shots/2017/12/12/569910574/native-americans-feel-invisible-in-u-s-health-care-system.

[19] See 25 U.S.C 1603.

system for PRC services, which is considered the payer of "last resort" after all other possible funding sources have been exhausted.

Historically, IHS has fallen far short of adequately funding health care needs in Indian country. As a result, Tribes often operate their health care clinics and service programs only partially funded by IHS and subsidize the remainder out of their own, limited tribal governmental resources.

Due to inadequate IHS funding, a critical source of supplemental funding for Indian health programs stems from billings to Medicaid for services rendered to eligible patients. Tribes that operate ISDEAA Tribal health programs are entitled to bill the Washington State Health Care Authority (HCA) to access Medicaid reimbursements to help cover the costs of providing health services to tribal members and other eligible beneficiaries of their services. Given that large numbers of eligible Indian patients qualify for Medicaid, these funds help close the gaps in funding provided by IHS Congressional appropriations.

Medicaid billings to HCA for services received by Medicaid-eligible American Indians and Alaska Natives (AI/AN) are federally funded at a rate of 100% when "received through" an IHS/Tribal facility. In other words, the Federal Medical Assistance Percentage (FMAP) rate for such services is 100%. If services are not received through an IHS/Tribal facility, the federal government will match the state's payment for the services at the state's regular FMAP rate, which ranges from 50% to approximately 76%.[20]

In addition, qualifying IHS facilities operated by Tribes may bill Medicaid at the "encounter rate" for outpatient services (also known as the OMB rate or all-inclusive rate) published annually in the Federal Register.[21]

Finally, the IHCIA allows Tribal health programs operated as IHS programs to bill private insurance companies without regard to whether such program has a contract with the private insurance company. The IHCIA requires all insurance companies to reimburse tribes and tribal organizations for their "reasonable charges billed . . . or, if higher, the highest amount the [insurance company] would pay for care and services furnished by providers other than governmental entities."[22]

Program Participation by Individuals

Consistent with the government-to-government nature of the relationship between the United States and Indian tribes, and the special role of the federal government in the Indian health care system, laws of general application may be applied differently with respect to tribal facilities and tribal programs.[23] Differences include the following:

[20] https://fas.org/sgp/crs/misc/R43847.pdf

[21] *See,* for example the IHS Reimbursement Rates for Calendar Year 2019 published at 84 Fed. Reg. 2241 (February 6, 2019).

[22] 25 U.S.C. § 1621e(a).

[23] See also, a CMS website which addresses differences in the Medicare and Medicaid programs as applied to Tribes.

1. Indians are exempt from obligations to pay enrollment fees, premiums, or similar charges if they are furnished an item or service by IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U)) or through certain referrals.[24]

2. Indians are exempted paying deductibles, coinsurance, copayments, or similar charges for any item or service covered by Medicaid if the service is furnished directly by an Indian health care provider, I/T/U or through certain referrals. *Id*.

3. Washington's Medicaid Plan (Apple Health), which requires most Washington Medicaid recipients to be enrolled with a Medicaid managed care insurance plan to secure physical health coverage, does not impose this requirement on American Indians or Alaska Natives; thus American Indians and Alaska Natives can "[e]nroll in an Apple Health managed care plan, or [r]eceive Apple Health coverage without a managed care plan."[25]

4. Tribal enrollment or membership documents issued from a federally recognized Tribe must be accepted as verification of citizenship for purposes of Medicaid enrollment.[26]

Applicability of HIPAA

Although some federal and state laws are not applicable to services rendered under the Indian health systems, IHS has indicated that the HIPAA Administrative Simplification requirements applicable to health plans are applicable to the IHS, and to Tribes with Title I contracts or Title V compacts. The IHS has also taken the position that HIPAA's requirements apply to Tribes that meet HIPAA's definition of covered health care providers, i.e., health care providers that transmit health information in electronic form in connection with certain specified transactions for which the Secretary of Health and Human Services has adopted standards.[27]

III. Undocumented Aliens

Undocumented aliens without insurance or the capacity to otherwise pay for their care have limited access to publically funded health care in Washington State. Further, they do not have the ability to purchase insurance through the Washington Health Benefit Exchange. Section 1312(f)(2) of the PPACA (codified at 42 U.S.C. 18032), restricts access to coverage under an Exchange to lawful U.S. residents. The statute provides as follows:

> If an individual is not, or is not reasonably expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States, the individual shall not be treated as a

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[24] See CMS Letter to State Medicaid Director, SMDL # 10-001, January 22, 2010.

[25] See Apple Health web page- American Indians and Alaska/ Natives (AI/AN), last accessed March 10, 2019.

[26] *See* https://www.ihs.gov/hipaa/documents/Tribes%20responsible%20for%20HIPAA%20letter.pdf, last accessed March 15, 2019.

[27] *See, https://www.ihs.gov/hipaa/documents/Tribes%20responsible%20for%20HIPAA%20letter.pdf ,* last accessed March 15, 2019.

qualified individual and may not be covered under a qualified health plan in the individual market that is offered through an Exchange.

Despite the challenges which undocumented aliens face in securing funded health care services, there are some open doors, including the following:

1. Undocumented aliens can receive emergency services at a hospital that participates in Medicare. "As required the federal law Emergency Medical Treatment and Labor Act (i.e. EMTALA), hospitals participating in Medicare must medically screen all persons seeking emergency care and provide the treatment necessary to stabilize those who have an emergency condition, regardless of payment method or insurance status."[28]

2. Apple Health coverage may be available for certain emergency hospital services and for pregnant women (ages 19 to 64). "Medicaid provides payment for treatment of an emergency medical condition for people who meet all Medicaid eligibility criteria in the state (such as income and state residency), but don't have an eligible immigration status."[29]

3. Important to individuals who may be seeking a Green Card, Medicaid coverage will not act as a barrier to a non-US Citizen's application for a Green Card. "Under Section 212(a)(4) of the Immigration and Nationality Act (INA), an individual seeking admission to the United States or seeking to adjust status to that of an individual lawfully admitted for permanent residence (Green Card) is inadmissible if the individual, at the time of application for admission or adjustment of status, is likely at any time to become a public charge."[30] Neither Medicaid benefits (except for long-term institutional care), nor coverage under the Children's Health Insurance Program (CHIP) is deemed a "Public Charge". *Id.*[31]

4. States can, and do, provide state-only funded coverage for undocumented aliens. Washington provides limited coverage for certain medical services for undocumented aliens. This program is described in WAC 182-507-0110.[32]

5. Community Health Centers (CHCs) provide care to undocumented aliens, consistent with 42 C.F.R. § 51c.303(v) which provides that CHCs "supported with grant funds for the operation of a prepaid health care plan

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[28] *See,* https://www.cms.gov/newsroom/fact-sheets/emergency-health-services-undocumented-aliens n, last accessed March 14, 2019.

[29] https://www.healthcare.gov/immigrants/lawfully-present-immigrants/ , last accessed March 14, 2019.

[30] https://www.uscis.gov/greencard/public-charge , last accessed March 14, 2019.

[31] *See,* also Section 212(a)(4)(A) of INA, codified at 8 USC 1182(a)(4).

[32] See, https://www.hca.wa.gov/health-care-services-supports/program-administration/apple-health-alien-emergency-medical , last accessed March 15, 2019.

also must provide … services to all residents of the catchment area without regard to method of payment or health status."

6. In addition, indirect funding for care provided to undocumented aliens is available through Medicaid and Medicare DSH payments.

The state of Washington published an eligibility resource entitled "*Citizenship and Immigrant Eligibility Toolkit*."[33] This Toolkit provides detailed information about state funded plans covering immigrants and it includes the following eligibility chart.

Citizen and Immigration Eligibility Chart

Program	Citizen or National	Lawful Permanent Residents (age 19 and over)	Lawful Permanent Residents (under age 19)	Lawfully Present Qualified Immigrants (Refugees, Asylees, and other humanitarian entrants)	Lawfully Present Non-Qualified Immigrants	Undocumented Immigrants
Health Insurance Premium Tax Credits & Cost Sharing Reductions	✓	✓	✓	✓	✓	—
Washington Apple Health for Adults (ages 19-64)	✓	✓ 3	NA	✓ 1	— 2	—
Washington Apple Health for Pregnant Women (ages 19-64)	✓	✓	NA	✓	✓	✓ 4
Washington Apple Health for Kids (ages 1 – 18)	✓	NA	✓	✓	✓	✓ 4
Alien Emergency Medical	—	✓ 5	—	—	✓	✓ 4

✓ Eligible — Not Eligible **NA** Not Applicable

[33] The toolkit can be downloaded at this website: https://www.wahbexchange.org/new-customers/who-can-sign-up/immigrants/.

1. **Lawfully Present "Qualified" Immigrants: Must meet 5-year bar unless exempt. (*) indicates exempt from 5- year bar.**
   - Lawful Permanent Residents (LPR) – including:
   - *Amerasians who were born to U.S. citizen armed services members in SE Asia during the Vietnam War.
   - *Refugees – including:
     - *Hmong and Highland Laotions;
     - *Special immigrants from Iraq or Afghanistan; and
     - *Victims of trafficking.

- *Asylees.
- *Cuban/Haitian entrants.
- *Persons granted withholding of deportation or removal.
- Parolees - if granted parole for at least one year.
- Certain abused spouses/children – including those with:

  An I-130 notice of "prima facie" approval of a pending or approved self-petition under the Violence Against Women Act (VAWA).
- Admitted to the U.S. as conditional entrants prior to April 1, 1980.
- *Lawful Permanent Residents, parolees, or battered aliens who are also an armed services member or veteran, or a family member of a veteran as described below:
  - *On active duty in the US military, other than active duty for training;
  - *An honorably discharged US veteran;
  - *A Veteran of the military of the Philippines who served prior to 07/01/46;
  - *The spouse, an un-remarried widow or widower; or
  - *Unmarried dependent child of a veteran or active duty service member.

NOTE: The 5-year bar does not apply to individuals that have obtained a "qualified alien" status within the last 5 years, if they entered the U.S. prior to 8/22/96 and have continuously lived in the U.S. since 8/22/96. See WAC 182-503-0535.

NOTE: The code on the green card indicates how an LPR entered the U.S. If an individual entered the U.S. under a status that is exempt from the 5-year bar and they have had LPR status for less than 5 years, they are still exempt from the 5-year bar.

- *Asylees.
- *Cuban/Haitian entrants.
- *Persons granted withholding of deportation or removal.
- Parolees - if granted parole for at least one year.
- Certain abused spouses/children – including those with:
  An I-130 notice of "prima facie" approval of a pending or approved self-petition under the Violence Against Women Act (VAWA).
- Admitted to the U.S. as conditional entrants prior to April 1, 1980.
- *Lawful Permanent Residents, parolees, or battered aliens who are also an armed services member or veteran, or a family member of a veteran as described below:
  - *On active duty in the US military, other than active duty for training;
  - *An honorably discharged US veteran;
  - *A Veteran of the military of the Philippines who served prior to 07/01/46;
  - *The spouse, an un-remarried widow or widower; or
  - *Unmarried dependent child of a veteran or active duty service member.

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2. **Lawfully Present "Non-Qualified" Immigrants**:

These are non-citizens who are lawfully present in the U.S. and are not included in the definition of qualified aliens listed above. Common non-qualified aliens include:

- Citizens of Marshall Islands, Micronesia or Palau.
- Immigrants paroled into the U.S. for less than one year.
- Immigrants granted temporary protected status (TPS).
- Nonimmigrants who are allowed entry into the U.S. for a specific purpose usually for a limited time, such as:
  - Business visitors;
  - Students; and
  - Tourists.
- Abused aliens who are a relative of a U.S. citizen with an approved I-130 petition but not meeting the other requirements of battered immigrants, as described in WAC 182-503-0530. Abused aliens who have self-petitioned under VAWA but not yet received "Notice of "Prima Facie" eligibility, as described in WAC 182-503-0530.
- Applicants for adjustment of status, asylum, cancellation of removal, suspension of deportation, or withholding of deportation or removal.
- Cancellation of removal, deferred action {*with the exception of Deferred Action Childhood Arrival (DACA)} or suspension of deportation granted. (Note: if a person is granted cancellation of removal or suspension of deportation based on having been abused

  or granted deferred action based on an approved self-petition as an abused alien, they are a "qualified alien".)
- Deferred enforced departure granted.
- Family unity granted.
- "K", "S", "U" or "V" statuses, designated on a person's visa, allow holders to work and eventually to adjust to Lawful Permanent Resident (LPR) status.
- Lawful temporary residents under the amnesty program of the Immigration Reform and control Act (IRCA), including those admitted under Sections 210 ("special agricultural workers") and 245A of the INA.
- Order of suspension granted.
- Eligible to petition as special immigrant juveniles. These are juveniles who have been declared a "dependent of the state" and eligible for long-term foster care due to abuse, neglect or abandonment.
- Stay of deportation or removal granted.
- Voluntary departure granted - definite or indefinite time.

*An individual granted DACA status is not eligible for federally-funded Apple Health programs or eligible to purchase health care coverage through a QHP/HIPTC. They are potentially eligible for the following programs: State-funded Apple Health for Kids and Pregnant Women, Alien Emergency Medical program, and Medical Care Services.

3. **Adult Lawful Permanent Residents** who entered the U.S. after 8/22/1996 must be in LPR status for five years before they become eligible for Washington Apple Health Adult coverage. This five year federal waiting period does not apply to Washington Apple Health for Pregnant Women or the Alien Emergency Medical program.

4. The **Washington Apple Health program is an "umbrella program"** that encompasses various programs for very specific populations. It is important to note that some Washington Apple Health Programs are funded in part by the Federal Government, and some programs are funded only by Washington State.

5. **Adult Lawful Permanent Residents** that are not pregnant and who have not satisfied the 5-year federal waiting period and are not exempt, may be eligible for Alien Emergency Medical if they have a qualifying emergent medical condition.

Washington Apple Health Citizenship and Alien Status Chart: