MMPI Massachusetts Medicaid Policy Institute

fact sheet

MassHealth and the Deficit Reduction Act of 2005: New Proof-of-Citizenship and Asset Rules

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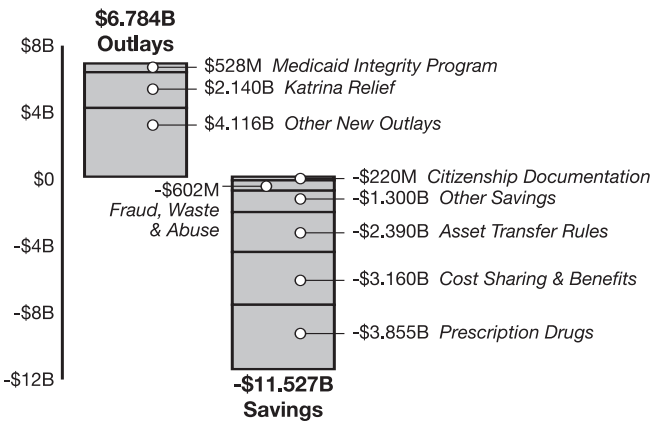
The Deficit Reduction Act of 2005 (DRA), enacted February 8, 2006, changes a number of entitlement programs, including Medicaid. These changes are intended to lower federal spending by nearly $40 billion over the next five years, with estimated Medicaid reductions nationwide of nearly $5 billion.[1] Total federal spending on Medicaid is projected to be $1.1 trillion over that period.

This fact sheet explores the impact of two particular changes: new proof-of-citizenship requirements and new rules regarding assets. The fact sheet explains the implications of these new changes for the MassHealth program, MassHealth applicants and many of its one million members, community health centers, and nursing homes. Finally, the fact sheet identifies a number of policy questions raised by the new rules.

Estimated FY2006-2010 Medicaid Outlays and Savings in the Deficit Reduction Act



New Medicaid Rules under the DRA

The DRA contains mandatory and optional Medicaid provisions.[2] Two of the mandatory provisions that affect eligibility and have the earliest required implementation dates are the new proof-of-citizenship (effective July 1, 2006) and asset rules (retroactive to February 8, 2006). The other mandatory changes will be implemented before January 1, 2007.

The DRA's **mandatory provisions** affect:

- **payments for services,** limiting federal payments for prescription drugs, and requiring states to enhance efforts to seek payments from other insurers that provide coverage to Medicaid recipients;
- **delivery of services,** defining case management services for children in foster care;
- **program integrity,** requiring certain Medicaid providers to educate their employees about penalties for making false claims, and tightening requirements for the detection of waste, fraud, or abuse; and
- **eligibility,** modifying the asset transfer rules that can affect when an applicant is eligible for Medicaid coverage of long-term care (including nursing homes), and demanding documented proof of US citizenship by applicants and beneficiaries. This last category is the focus of this fact sheet.

The **optional provisions** give states greater latitude to modify their Medicaid programs through a straightforward state plan amendment, rather than through a more laborious waiver request. The DRA allows for flexibility in cost sharing and benefits and expanded use of community-based long-term care services, and introduces or expands a number of pilot programs in financing care.

Many states are welcoming the new flexibility the DRA offers. There are concerns that some states may use the optional provisions to degrade coverage. Massachusetts, which already has a highly customized Medicaid program in MassHealth, and is administratively stretched implementing the mandatory DRA provisions and the Commonwealth's new health care reform law, is reviewing the DRA's optional provisions but has no current plans to adopt them.

The New Proof-of-Citizenship Rules[3]

To be eligible for Medicaid,[4] a person must be a U.S. citizen or a "qualified alien." Non-citizens must submit documentation of their immigration status to determine whether they are qualified aliens. The DRA leaves this rule intact, but changes the rules for U.S. citizens. **Before the DRA, applicants or recipients who claimed they were U.S. citizens could verify citizenship by sworn declaration, without submitting documentation. Beginning July 1, 2006, the DRA requires the submission of acceptable documentation to prove an applicant's or recipient's U.S. citizenship.** Individuals must document their US citizenship when first applying for Medicaid or, if they are already Medicaid recipients, at their first annual redetermination of Medicaid eligibility on or after July 1, 2006.

The DRA spells out the kinds of documents that establish acceptable evidence of citizenship. The federal Centers for Medicare & Medicaid Services (CMS), which oversees the Medicaid program, has issued guidance to the states[5] and interim final regulations[6] for implementing the new rules. **CMS describes four tiers of documents, hierarchically ranked from the most to the least reliable forms of proof. CMS will monitor the extent to which states are using first- and second-tier documents to prove citizenship, and will require corrective action if states rely too heavily on documents regarded as less reliable.**

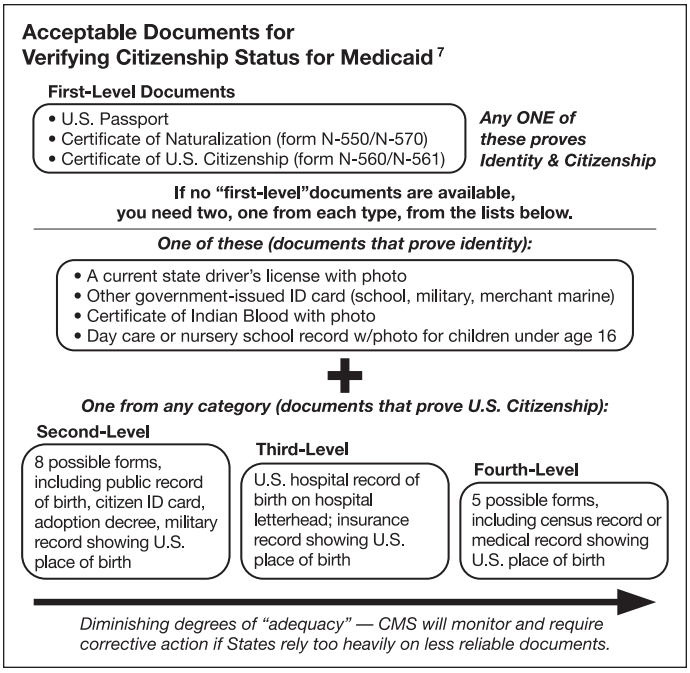


Chart based on a design by Community Partners.

Administrative Challenges for the Massachusetts Office of Medicaid

Collecting documentation. MassHealth's greatest challenge in implementing this new requirement is collecting the necessary documentation not only for new applicants, but for the current MassHealth members who are U.S. citizens and now must document their status. **Supplemental Security Income (SSI) and Medicare recipients are exempt from the new citizenship documentation rules because they established their citizenship upon enrollment in those programs.**[8] This will exempt approximately 300,000 of the just over 1 million MassHealth members from the requirement to submit documentation.

For Massachusetts, an administratively efficient way to ascertain proof of citizenship is by electronically comparing membership rolls with other programs that require documented proof of citizenship for eligibility. **CMS allows states to match electronic data with Medicare, Social Security (for SSI), and state vital statistics agencies.** In addition, CMS is soliciting suggestions of other electronic data sources that may contain reliable information on citizenship or identity. MassHealth is investigating all possible avenues for reliable data matching and will submit suggestions to CMS on any newly identified sources.

State accountability, federal monitoring and anti-fraud measures. CMS is requiring states to accept only those documents that are originals or certified by the issuing agency, and to maintain copies in the case record or database for federal audits. While states are entitled to matching funds (Federal Financial Participation, or FFP) for the costs of administering the proof-of-citizenship requirements, **CMS may deny FFP to states that do not comply with the new requirements, and will conduct audits to evaluate compliance.** Although it is so far limiting the types of electronic data-matching that can be used as a tool to prove citizenship, **CMS is requiring states to use data matching as a check against fraud.**

Outreach to Applicants and Recipients. MassHealth has been taking steps to educate members and applicants about the new proof-of-citizenship rules, in accordance with federal requirements.[9]

Impact on MassHealth Members, Potential Applicants, and Community Health Centers

Challenges to obtaining documented evidence of citizenship. While SSI and Medicare beneficiaries are exempt from this provision, most MassHealth applicants and members are not enrolled in these programs. In addition, while states may verify citizenship through data matching with state vital statistics agencies, MassHealth has not yet set up a system to match with the Massachusetts Department of Public Health, whose electronic records, in any event, date back only to 1988 and do not include the social security numbers needed to match with MassHealth files. Additionally, Massachusetts does not have data matching capability with the vital statistics agencies of other states — a problem for applicants and members born out-of-state. Consequently, for now, most applicants and members are going to have to cooperate with MassHealth in securing acceptable documentation of citizenship.

Potential for chilling effect ...

...on MassHealth enrollment. A criticism of the new proof-of-citizenship rules is that, rather than keep illegal immigrants off of Medicaid, they will instead place burdensome requirements on legitimate US citizens that might result in otherwise eligible people being denied benefits. The basis for this concern rests in the realities of the lives of many people who live in poverty: severely restricted financial resources;[10] limited English proficiency; age; physical and mental disabilities; homelessness; or fear of government agencies. It can be truly difficult, even impossible, for people living with these challenges to obtain the required documentation.

...on access to care for undocumented immigrants. Another potential consequence of the new proof-of-citizenship rules is that poor, undocumented immigrants might be dissuaded from seeking health care through the Free Care Pool. To qualify for free care in Massachusetts, a patient must first apply for and be denied MassHealth benefits. The new proof-of-citizenship rules may deter many undocumented immigrants from applying for MassHealth. They will then be denied free care, and may forgo seeking care altogether, which can have broader public health implications.

Potential for increases in bad debt. Community health centers and hospitals may see an increase in the number of patients who do not qualify for Medicaid because of their inability to submit documented proof of citizenship. These patients, as explained above, will be ineligible for free care. Community health centers and hospitals could see a rise in bad debt as a result.

Potential litigation. A federal class action lawsuit pending in Chicago claims that the DRA's new citizenship rules violate the constitutional guarantees of due process and equal protection, and that federal regulations to implement the rules run afoul of the statute.[11]

CMS is treating proof-of-citizenship as a criterion for eligibility, expecting that states will deny Medicaid to those who are unable to provide documentation. In Massachusetts, some advocates for MassHealth members are developing an argument that proof of citizenship is an administrative requirement only. If they litigate on this issue[12] and prevail, the effect would be twofold: MassHealth would (1) be required to provide Medicaid assistance to those who are otherwise eligible but have not documented their citizenship, and (2) be unable to claim FFP in those cases.

New Asset Rules for Long-Term Care Coverage[13]

Nationally, 66 percent of nursing home residents have Medicaid as their primary payer; in Massachusetts, that number is 68 percent.[14] As a financing partner, the federal government pays at least half of these costs in every state. **The DRA's new asset rules are part of a larger strategy by the federal government to rein in long-term care spending, a significant cost driver in Medicaid. These rules affect Medicaid eligibility by (1) establishing new thresholds and penalties for asset transfers made by individuals applying for long-term care Medicaid coverage, and (2) changing the requirements regarding annuities and home equity.** The federal government estimates that these changes in the asset rules will lower federal Medicaid spending by $2.4 billion over the next five years.[15]

Asset Transfer Rules Before and After the DRA

To be eligible for Medicaid nursing home care services, applicants must meet certain requirements regarding income and assets. In Massachusetts, they must have income that does not exceed the federal poverty level (or, if higher, contribute to the cost of care), and they are permitted a certain level of assets-up to $2,000 for an individual, $3,000 for a couple. Certain assets are exempt. Applicants exceeding the asset limit cannot qualify for Medicaid long-term care until the assets are "spent down."

Before the DRA, applicants in Massachusetts who transferred assets for below fair market value, or as cash gifts, within three years prior to applying for Medicaid nursing home coverage — the "look back" period — faced a penalty period during which they were ineligible for Medicaid. The penalty period started on the first day of the month in which the disqualifying transfer was made, and lasted for a time calculated under a formula based on the amount of the transfer and the average cost of nursing care in Massachusetts. **The DRA makes two changes in the asset transfer rules: (1) it extends the "look back" period from three to five years, and (2) it advances the start of the penalty period to either the month of the transfer or the date of eligibility for nursing home coverage, whichever is later.** The new rules apply to asset transfers made on or after February 8, 2006.

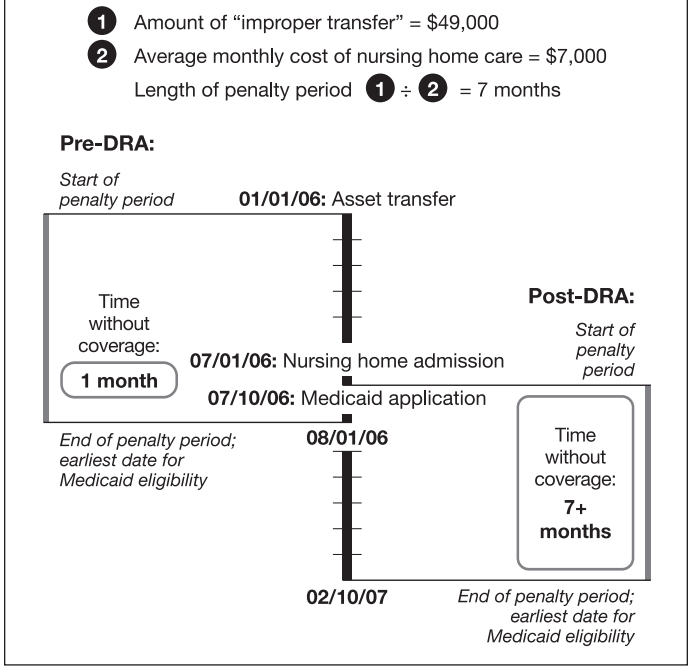
Impact on Applicants for Long-Term Care Medicaid Coverage

A perception exists that Medicaid, a health insurer primarily for the poor, has become an insurer of nursing home services for many middle class elderly. It is believed that some elderly intentionally plan to impoverish themselves to qualify for Medicaid assistance: they systematically transfer their assets in anticipation of the day they will need nursing home care. Though there is evidence that some seniors engage in long-term care financial and legal planning, research shows that few elders have significant assets to transfer. The few who do appear to transfer their wealth for reasons independent of establishing Medicaid eligibility.[16] Nevertheless, the new DRA rules are an attempt to give teeth to the penalty period during which elderly who transfer their assets for less than fair market value are ineligible for Medicaid.

Under pre-DRA law, the penalty period started when the asset was transferred, usually before the date of application for Medicaid nursing home coverage. Therefore, the period would often have expired by the time an applicant entered a nursing home. Medicaid coverage would typically be available at the time the applicant needed it. Under the DRA, the penalty period begins later, on the date of application for Medicaid (if later than the transfer), shifting everything forward. This means that elderly applicants who have run afoul of the asset transfer rules are more likely to need nursing home care while the penalty period is still in effect, putting them in the position of incurring long-term care costs, potentially without any insurance coverage or other means of paying for it.

Consider this example. An elderly patient is discharged from the hospital to a Massachusetts nursing home for a short stay, to be covered by Medicare. The patient's condition changes and she is unable to return home. The patient applies for Medicaid coverage, and is discovered to have sold a second home, worth $100,000, for $51,000 six months ago. The difference between the sale price and the fair market value is considered an improper transfer of assets. As the accompanying chart shows, under pre-DRA law, the patient would be ineligible for Medicaid for a month. Under the DRA's new asset transfer rules, she would be ineligible for seven months from the time of application.

Example Comparing Pre- and Post-DRA Asset Transfer Rules



In theory, Medicaid applicants can avoid this predicament by "curing the transfer": recovering the transferred assets. Once they spend their recovered assets paying for their nursing care (or for long-term care insurance or other medical costs), they can then qualify for Medicaid.

In practice, however, recovery of a gift or transferred asset may not be possible. **If the applicant cannot recover the assets, she can apply to Medicaid for a waiver of the penalty period for reasons of undue hardship.** The DRA says there is "undue hardship" when the penalty period of Medicaid ineligibility would deprive the applicant of medical care "such that the individual's health or life would be endangered," or "deprive the individual of food, clothing, shelter, or other necessities of life."[17] MassHealth has promised to review petitions for hardship waivers in a timely fashion.

Impact on Nursing Homes

The new asset transfer rules potentially put nursing homes at risk of losing reimbursement for the services they provide to patients during the penalty period. For ethical, legal, and practical reasons,

it is very difficult for nursing homes to discharge patients who still require institutional nursing care. Using the example above, who pays the nursing home bill for the seven months that the patient is ineligible for Medicaid?

Nursing homes have several options, none of which entirely remedies the problem. They might ask patients' family members to "cure the transfer." Family members are, however, under no legal obligation to do so, nor are they legally obligated to care for the patient. Alternatively, nursing homes might require the applicant and/or family members to sign statements that there were no improper transfers of assets. Massachusetts law, however, prohibits treating nursing home patients differently because they have applied for Medicaid; thus, the homes may have to admit the patient regardless of whether family members sign the statements, or even if they sign them falsely. There is also the potential that some nursing homes will adopt a policy to admit only short-term stays covered by Medicare or other insurance (some skilled nursing facilities in Massachusetts have taken this route), or those who are already eligible for Medicaid before they enter the home. Finally, some nursing homes may choose not to participate in MassHealth at all.

The most promising way nursing homes can protect themselves is by filing a hardship waiver on the patient's behalf, which they can do with the family's consent. It remains to be seen how often nursing homes will need to apply for hardship waivers on behalf of residents, and how likely it is MassHealth will grant the waivers.

Home Equity and Other Assets

Before the DRA, an applicant's home was treated as a non-countable asset for determining Medicaid eligibility. Effective January 1, 2006, if the applicant has equity in the home exceeding $750,000, unless a spouse or a minor or disabled child lives there, she is ineligible for Medicaid long-term care services.

Previously, the federal Medicaid program did not require states to count certain assets, including annuities, promissory notes, and mortgages, when determining an applicant's eligibility. Under the DRA, it does, and the state now has a claim on an individual's annuity after his or her death.

Conclusion

The new citizenship documentation requirements and asset transfer rules are new and their impact is speculative at this point. Here are some of the issues and questions they raise, the answers to which will become clear as the rules take effect:

Regarding the citizenship requirements:

- How many people will be denied MassHealth benefits solely because they lack adequate documentation of citizenship?
- How many of these people are, in fact, ineligible based on their immigration status?
- What are the administrative costs of implementing the new requirement? Do the benefits to MassHealth exceed these costs?
- Will people deemed ineligible for MassHealth coverage because they lacked documentation have access to health care? Who will finance that care?

Regarding the asset transfer rules:

- What standards is the state using to make hardship waiver determinations?
- Will there be a change in the volume of hardship waiver applications, or a change in the frequency with which they are granted?
- What happens when a hardship waiver is denied and the patient has no means to pay for the care? For example, are families having to provide more home care? Are children paying for their parents' care?
- Will nursing homes see an increase in uncompensated care they are providing, or will they change their policies to protect themselves from such an increase?

These changes enacted by the DRA should be monitored for effects on applicants, recipients, and administrators of the program, especially in light of the current impulse toward expansion of medical coverage among policy makers in Massachusetts.

The author thanks the reviewers whose suggestions and factual clarifications on earlier drafts contributed helpfully to this fact sheet.

[1] http://www.whitehouse.gov/news/releases/2006/02/20060208-9.html
[2] For a complete list of the mandatory and optional provisions, see http://www.thearc.org/ga/DRATimeline3.23.06.doc
[3] Section 6037 of the Deficit Reduction Act of 2005.
[4] The exception is MassHealth Limited, which offers Medicaid coverage for emergency services to people whose immigration status bars them from additional services under federal law.
[5] CMS letter to State Medicaid directors, June 9, 2006. Viewable at: http://www.cms.hhs.gov/MedicaidEligibility/Downloads/SMD%20Letter%20Improved%20Documentation%20of%20Citizenship.pdf
[6] http://www.cms.hhs.gov/MedicaidEligibility/downloads/Citizenship_Documentation_Interim_Regulation.pdf
[7] Source: Massachusetts Office of Medicaid, "New Citizenship Documentation Requirements." Available at http://www.mass.gov/Eeohhs2/docs/masshealth/memlibrary/cifs-0606.pdf. Accessed July 21, 2006.
[8] http://www.cms.hhs.gov/MedicaidEligibility/downloads/Citizenship_Documentation_Interim_Regulation.pdf
[9] See, for example, the flyer MassHealth has distributed across the state, at http://www.mass.gov/Eeohhs2/docs/masshealth/memlibrary/cifs-0606.pdf
[10] The FY 2007 state budget waives fees for those seeking Massachusetts birth records for purposes of qualifying for Medicaid, which somewhat relieves the financial burden.
[11] Bell, et al., v. Leavitt, Docket No. 06C3520; http://www.povertylaw.org//news-and-events/misc/medicaid-lawsuit/bell-complaint.pdf
[12] Plaintiffs in the federal class action suit are making a similar argument.
[13] Sections 6011-6016 of the DRA of 2005.
[14] http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi
[15] http://www.kff.org/medicaid/upload/7465.pdf
[16] A forthcoming MMPI policy brief will address this topic.
[17] Section 6011 of the DRA of 2005.