

Part 12

Financial Eligibility

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109 What are the criteria for financial eligibility?

MassHealth eligibility is generally based on the gross income of all family group members not exceeding a specified percentage of the federal poverty level for a family of that size. The poverty level is published in the Federal Register, usually in January, and takes effect in MassHealth on March 1 or April 1. Table 5 in Appendix B shows the percentage of poverty that applies to different coverage types and the dollar values for different family sizes in 2008–2009 (March 1, 2008 to February 28, 2009). An updated table for 2009–2010 will be posted on www.masslegalservices.org.

People covered under the Section 1115 waiver (Medicaid reform) have income counted differently than people in traditional Medicaid. Also, assets are not considered in Medicaid reform, but to be eligible for traditional Medicaid, countable assets cannot exceed certain limits. Another route to MassHealth is through the receipt of cash assistance where eligibility is determined under rules applicable to the cash assistance program; see Part 3 for more information on cash assistance financial eligibility rules.

110 Whose income counts under Medicaid reform?

The MassHealth Section 1115 waiver included a waiver of federal Medicaid law regarding whose income counts and what counts as income.¹² The incomes of people who are included in the family group are counted in determining eligibility of any member of the family group who is applying for MassHealth. A family group can consist of:

- n an individual who is not included as a couple or a family;

¹² The Medicaid reform rules apply to those under 65 who do not need institutional care and are not eligible based on “deemed SSI” status; the Medicaid reform rules also apply to seniors who are eligible as parents or disabled workers.

- n a couple who are married, live together, and have no children under 19 living with them;
 - n As of October 31, 2008, the MassHealth agency will treat two people of the same sex who are married as a couple.
 - n Marriage can be an advantage or disadvantage for MassHealth eligibility and access to services depending on the circumstances, e.g., a spouse is not eligible to receive compensation as a personal care attendant or adult foster caregiver for his or her own spouse.
- n a family consisting of one or more children under 19, and the parents living with them;
- n a family consisting of one or more children under 19 and their children; if the parents of a minor parent or pregnant minor also live in the home, they (the grandparents) can choose whether or not to be included in the family group of the minor parent and child;
- n a family consisting of one or more children under 19 and, if no parent is in the home, a caretaker relative; the caretaker relative can choose whether or not to be included in the family group; or
- n a family consisting of siblings under the age of 19 and their children even if no adult parent or caretaker is in the home.

Example: A household consists of a 20-year-old girl living with her 40-year-old parents, brothers aged 10 and 12, and grandparents aged 67 and 70. It contains three MassHealth family groups: the 20-year-old is an individual; the parents and younger brothers are a family; and the grandparents are a couple. If all three family groups choose to apply for MassHealth, they must submit three application forms: one MBR for the 20-year-old, one MBR for her parents and brothers, and an S-MBR for her grandparents.

130 C.M.R. §§ 501.001, 506.002; 2008 Mass. c. 251 (MassHealth equality for married couples regardless of sex).

111 What counts as income under Medicaid reform?

Under the Section 1115 waiver (Medicaid reform), there is no asset test and the income standard is higher than traditional Medicaid but most of the Medicaid rules allowing for income deductions and disregards have been waived. As with traditional Medicaid, income from certain sources is not counted at all.

Countable income includes all nonexempt gross earned and unearned income of members of the family group. The following deductions from gross income are the only ones allowed:

- n business expenses allowable on a U.S. tax return can be deducted from income from self-employment, and
- n rental expenses allowable on a U.S. tax return can be deducted from rental income.

130 C.M.R. § 506.003.

The MassHealth agency will also count income that someone no longer receives if the income was transferred to someone else for the primary purpose of establishing eligibility for MassHealth.

130 C.M.R. § 506.006.

112 What does not count as income under Medicaid reform?

Income from certain sources is exempt and does not count as part of gross family income. Income from the following sources does not count:

- n income received by a TAFDC, EAEDC, or SSI recipient;
- n sheltered workshop earnings;

- n certain federal veteran's benefits;
- n income in kind, e.g., the value of free lodging;
- n roomer and boarder income from someone sharing the applicant's home; and
- n any other income excluded by federal laws other than the Social Security Act. A partial list of such federal laws that exclude income can be found in the SSI regulations at 20 C.F.R. Part 416, Appendix K (located after Section 416.1182).

130 C.M.R. § 506.004.

Other excluded income: Sometimes when treatment of income is not clear in a particular case, the MassHealth agency makes a legal/policy decision to exclude income without amending its regulations to clarify how the income is treated. Instead a sub-regulatory policy is communicated internally to the MECs but usually not provided to the public. From the resolution of past cases, we know the MassHealth agency has determined the following sources of income do not count: **adoption assistance subsidies to the adoptive parents, adult foster care stipends to the caregiver, Americorps stipends, and certain flexible benefit contributions** that may be recorded on a pay stub as part of gross income but can only be used for health insurance.

113 How is monthly income determined?

MassHealth bases its income determinations on current monthly income. To arrive at monthly income, it multiplies weekly income by 4.333, two-week income by 2.166, and divides annual income by 12. Watch out for twice monthly income (24 paychecks per year) being mistakenly calculated as two-week income (26 paychecks per year).

For seasonal workers where earnings depend on the time of year, monthly income can be based on average annual income. The MBR has a space to identify someone as a seasonal worker and list annual income. A seasonal worker must also submit verification of annual income (rather than just two pay stubs) in order to have annual income divided by 12.

130 C.M.R. §§ 506.007, 506.003.

114 Do assets matter under Medicaid reform?

There is no asset test used to determine eligibility under Medicaid reform. Income derived from assets will be counted, such as interest on a savings account. Most lump sums, such as lottery winnings, will be income in the month of receipt. However, all individuals, regardless of age, who require long-term care in a nursing home or other medical institution, must meet the eligibility criteria for long-term care, which do include an asset test.

115 How is the CommonHealth one-time deductible calculated for disabled adults?

There is no upper income limit in CommonHealth, but disabled adults, age 19 to 64, with income in excess of the MassHealth Standard limit of 133 percent of poverty *and who are not working* must meet a one-time deductible or “spenddown” in order to become eligible for CommonHealth. Disabled adults who are HIV positive and who are not working do not have to meet a deductible unless gross family income exceeds 200 percent of the poverty level. Disabled children under age 19 and disabled working adults do not have to meet a deductible in order to qualify for CommonHealth.

For disabled adults with a spenddown, eligibility depends on incurring medical expenses that equal or exceed a deductible amount. The deductible amount is the difference between gross family income for a six month budget period and the deductible income standard for six months. The deductible income standard is not the same as the 133 percent of poverty standard for MassHealth Standard; it is much lower. See Table 3 below. Only after a disabled adult with a deductible incurs medical expenses that equal the amount of the deductible and provides proof to the MassHealth agency, will he or she be eligible for CommonHealth. He or she will never again have to meet a deductible to qualify for CommonHealth, but at age 65 will face a different set of eligibility rules as explained in Part 11. CommonHealth will not pay the expenses used to meet the deductible.

Example: A disabled 57-year-old woman has a monthly Social Security disability check of \$1,155, \$1 over the 133 percent of poverty income limit for MassHealth Standard in 2008. The CommonHealth deductible income standard used to calculate the deductible for a household of one is \$542, see Table 3 below. Her spenddown amount is $(\$1,155 - \$542) \times 6 = \$3,678$. Once she submits proof that she has incurred medical bills of \$3,678 she will be eligible for CommonHealth. She will not have to meet a deductible again to remain eligible for CommonHealth.

130 C.M.R. § 506.009.

Table 3: CommonHealth Income Standard Used to Calculate the Deductible

Family Group Size	Income Standards
1	\$542
2	670
3	795
4	911

See 130 C.M.R. § 506.009 for family sizes greater than four.

116 How does someone meet the deductible?

To become eligible by meeting a deductible, the individual must submit proof of medical bills that equal or exceed the amount of the deductible. The family must incur medical bills but does not have to pay them in order for the bills to be used to meet the deductible. Bills used to meet the deductible will not be paid by MassHealth.

The following criteria apply to bills that can be used to meet the deductible:

- n The bill may have been incurred at any time, but must be unpaid and a current liability in the six-month budget period, or paid within the six-month budget period.

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- n The bill may be for any member of the family group (not just the disabled adult).
- n Medicare and other health insurance premiums can be credited in advance for the six-month budget period.
- n Necessary medical and remedial care services covered under MassHealth rules count.
- n Necessary medical and remedial care services not covered under MassHealth rules but recognized under state law count.
- n Remedial expenses are defined as nonmedical support services made necessary by the medical condition of any individual in the family group.

Example: Expenses such as respite care, or installation of a wheelchair ramp should count as remedial expenses. If unsure whether a particular expense will count, ask the MassHealth Enrollment Center to check with the MassHealth central office policy hotline or consult a legal advocate.

- n The bill must not be subject to further payment by health insurance or other liable third-party coverage including the Health Safety Net.
 - n **The Health Safety Net.** A medical bill that is reimbursed by the Health Safety Net cannot be used to meet the spenddown. Because MassHealth now determines eligibility for the Health Safety Net, someone denied CommonHealth subject to a spenddown whose family income does not exceed 400 percent of poverty will be approved for full or partial Health Safety Net. In order to use a hospital bill to meet the CommonHealth spenddown, the applicant will have to arrange with the hospital not to submit the bill to the Safety Net.
- n Bills for the following services are specifically excluded:
 - n cosmetic surgery,
 - n rest-home care,
 - n weight-training equipment,
 - n massage therapy,
 - n special diets, and
 - n room and board in residential facilities.

- n Medical or remedial care expenses must be verified by a bill or statement from a health care provider, or, for nonprescription drugs, a receipt. A recent bill will be needed to show that an unpaid past expense is still a current liability.

Example: An applicant with a seizure disorder aggravated by heat who purchases an air conditioner on medical advice will need a letter from her doctor explaining why her medical condition makes the the air conditioner necessary in order to use the cost of the air conditioner as a remedial expense toward meeting her spenddown.

130 C.M.R. § 506.009(G).

117 What are the financial eligibility rules for traditional Medicaid?

The traditional Medicaid rules apply to those aged 65 and over who are not covered by the MassHealth Section 1115 waiver (Medicaid reform). The traditional Medicaid rules also apply to people under age 65 with “deemed SSI” status, disabled children eligible under Kaileigh Mulligan and to people applying for the Medicare Savings Programs. Special rules apply when someone is institutionalized or one spouse is institutionalized and the other is at home.

118 Whose income counts in traditional Medicaid?

Income of the following persons is counted in determining eligibility of a family member:

- n **Spouses living together:** the total countable income and assets of the individual and spouse who are living together are counted; however, if one

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spouse is eligible for either the home and community based waiver or the PACE program, the income of the other spouse will not count (see Part 11);

- n Effective October 31, 2008, MassHealth recognizes two people of the same sex who are married as spouses.
- n **Spouses living apart (for reasons other than admission to a medical institution):** the income and assets of the individual are counted; the assets and income of the absent spouse are not counted in the month following the month of separation;
- n **Unmarried individual:** the income and assets of the individual are counted.

130 C.M.R. § 520.002; 2008 Mass. Acts c. 251.

119 What deductions are allowed for community residents in traditional Medicaid?

Deductions from countable monthly income include:

- n Allowable business expenses for income from self-employment, room and board, or rental income. 130 C.M.R. § 520.010.
- n Standard income deduction of \$20.
- n Earned income deduction of \$65 and one-half of the remaining earned income. 130 C.M.R. § 520.012.
- n For disabled elders who need personal care attendant (PCA) services, a new unearned income deduction is available. The amount of the deduction represents the difference between 133 percent of the poverty level and the Senior Deductible Income Standard (the PCA deduction cannot be combined with the \$20 per month standard deduction). In order to obtain the deduction, the Disability Evaluation Service must make a presumptive determination that the individual is clinically eligible for PCA services. Once found presumptively eligible, the individual has 90 days to begin receiving PCA services paid for by MassHealth, or submit proof that efforts to receive PCA services are underway in order to remain eligible.

Example: A 67-year-old woman receives Social Security in the amount of \$1,000 per month. She has a personal care attendant to assist her in bathing, dressing, using a toilet, and getting in and out of bed. Because of the PCA income deduction, her adjusted monthly income is well below the MassHealth Standard income ceiling per month. Without the PCA deduction, she would have a deductible of thousands of dollars to meet in each six-month period in order to qualify for MassHealth.

130 C.M.R. § 520.013(B).

120 What income is not counted in traditional Medicaid?

Exempt income includes:

- n income of a recipient of EAEDC or SSI;
- n income disregarded for disabled adult children, or under the Pickle amendment (see Part 4 on deemed SSI);
- n income in kind;
- n reverse mortgage payments;
- n certain veteran's payments;
- n Social Security COLAs until the next annual poverty level adjustment;
- n retroactive SSI and RSDI; and
- n other income not countable under Title XIX.
 - n Title XIX of the Social Security Act is the federal Medicaid law; it uses the income methodology of cash assistance programs, for seniors, the SSI rules. 42 C.F.R. § 435.601. See 20 C.F.R. Part 416 (SSI); *An Advocate's Guide to Surviving the SSI System* (MLRI/MCLE, Inc. 2005) and Appendix K (located after 42 C.F.R. § 416.1182).

130 C.M.R. § 520.015.

121 What is the income limit for community residents 65 and over?

In order to be eligible for MassHealth, seniors who are not living in a nursing home must have adjusted family income that does not exceed 100 percent of the federal poverty level. See Table 5 in Appendix B. The poverty level is updated on March 1 or April 1 of each year. Cost of living adjustments (COLA) in Social Security take effect in January of each year, but the resulting increase in income does not count for MassHealth purposes until the following spring when the poverty level standard is also increased.

130 C.M.R. § 519.005.

122 What is the asset limit for traditional Medicaid?

For MassHealth Standard or Limited, the total value of countable assets cannot exceed:

- n \$2,000 for an individual or
- n \$3,000 for a couple.

For the Medicare Savings Programs, the total value of countable assets cannot exceed:

- n \$4,000 for an individual or
- n \$6,000 for a couple.

130 C.M.R. § 520.003.

123 What assets do not count for community residents age 65 and over?

The value of certain assets does not count against the asset limits. Some common assets that do not count include:

- n the home (130 C.M.R. § 520.008(A));
- n one car per household regardless of value (130 C.M.R. § 520.007(F));
- n the portion of jointly owned assets that is owned by someone else (130 C.M.R. § 520.005);
- n an asset that is inaccessible, e.g., property that cannot be sold based on a court order (130 C.M.R. § 520.006);
- n life insurance without a cash-surrender value (130 C.M.R. § 520.007(E));
- n life insurance if the total cash-surrender value of all policies does not exceed \$1,500 (130 C.M.R. § 520.007(E));
- n property essential to self-support, e.g., tools used to earn a living (130 C.M.R. § 520.008(D));
- n retroactive SSI and RSDI payment for six months from the date of receipt (130 C.M.R. § 520.007(H));
- n a loan or grant (130 C.M.R. § 520.008(E));
- n certain funeral and burial arrangements (130 C.M.R. § 520.008(F));
- n certain veteran's payments (130 C.M.R. § 520.008(G));
- n certain trusts established in accordance with special rules about Medicaid trusts (130 C.M.R. §§ 520.021–520.024);
- n proceeds for the replacement or repair of an asset do not count for nine months after receipt of the proceeds (130 C.M.R. § 520.009(E)(1)); and
- n certain annuities (130 C.M.R. § 520.007(J)).

124 How can seniors with excess income become eligible?

Seniors who are not eligible for MassHealth Standard or Limited because adjusted family income exceeds 100 percent of poverty can qualify for MassHealth after meeting a deductible or spenddown. The deductible is the difference between adjusted family income for six months and the deductible income standard for six months. The deductible income standard is not the same as the 100 percent of poverty standard; it is much lower. In fact, the deductible income standard has not been increased since 1988. See Table 4 below. Once a senior submits proof that he or she has incurred medical expenses that equal the amount of the deductible, she can establish MassHealth eligibility for the six-month budget period.

However, MassHealth will not pay for any of the expenses that were used to meet the deductible. The senior is only eligible through the end of the six-month budget period. At the end of the period, the MassHealth agency notifies the senior of a new six-month budget period and a new deductible amount that must be met.

Example: A 66-year-old woman lives alone and has a monthly Social Security retirement check of \$888. Her adjusted income exceeds 100 percent of poverty by \$1 in 2008. She is eligible for MassHealth in a six-month budget period only after she meets a deductible of \$2,076 in each period.

Gross Monthly Income	\$888
Less Standard Disregard	– <u>\$20</u>
Adjusted Income	\$868
Less Deductible Income Standard	– <u>\$522</u>
Excess Monthly Income	\$346
Times 6 Months	x <u>6</u>
6-Month Deductible	\$2076

130 C.M.R. §§ 520.028–.030.

Table 4: MassHealth Income Standard Used to Calculate the Deductible for Seniors

Family Group Size	Income Standard
1	\$522
2	\$650

130 C.M.R. § 520.030.

125 How is the senior deductible different from the CommonHealth deductible?

The MassHealth Senior and CommonHealth spenddown programs differ in several ways:

- n The CommonHealth deductible must be met only once and the individual will remain eligible until age 65; the senior deductible must be met every six months to be eligible for the balance of the six-month budget period.
- n The CommonHealth deductible uses gross family income, the senior deductible uses adjusted family income to compare to their respective income standards.
- n The CommonHealth monthly income standard used to calculate the deductible is \$20 higher than the senior monthly income standard (however, seniors are allowed a \$20 income disregard in calculating adjusted monthly income).
- n In both programs, the six-month deductible period can start on the first day of the month of application, but seniors also have the option of starting the deductible period up to three months before the first day of the month of application.

126 What expenses can be used to meet the deductible?

The rules on what expenses count against the deductible are the same as those in the CommonHealth program, see Question 116, above. 130 C.M.R. § 520.032.

127 How does the asset spenddown work?

A senior otherwise eligible for MassHealth Standard or Limited whose *assets* exceed the allowable limits may be eligible for MassHealth as of the earlier of:

- n the date assets have been spent to below allowable limits; or
- n the date medical bills have been incurred that equal the amount of excess assets, provided assets have been spent to below allowable limits within 30 days after receipt of notice of excess assets.¹³

Assets cannot be spent in a way that would violate the transfer of assets rule. See Question 130, below.

Example: A 66-year-old man applies for MassHealth on March 1 at which time he has \$5,000 in his savings account. His assets exceed the \$2,000 asset limit. He uses part of his savings to buy furniture and spends \$3,000 by March 17 leaving him with \$2,000. He submits his furniture receipts to the MassHealth agency and becomes eligible for Medicaid starting March 17, the first date that his assets did not exceed \$2,000.

130 C.M.R. § 520.004.

¹³ MassHealth recognizes the asset spenddown thanks to a lawsuit called *Haley v. Commissioner*.

128 What are the financial eligibility rules for nursing home residents?

Different financial eligibility rules apply when a person of any age requires long-term care in a nursing home or other medical institution. Individuals who were eligible for MassHealth Standard under Medicaid reform rules without regard to assets, upon becoming nursing home residents, will need to satisfy traditional Medicaid rules applicable to nursing home residents in order to remain eligible for MassHealth Standard. *See* 130 C.M.R. § 519.006.

Income standard. The MassHealth income standard for nursing home residents is currently \$72.80 per month (SFY 2009). This amount is also called the Personal Needs Allowance. The monthly income that remains to a nursing home resident after allowable deductions and the \$72.80 personal needs allowance must be paid to the nursing home as the patient's contribution to the costs of his or her care or Patient Paid Amount. 130 C.M.R. §§ 520.009 (A)(3), 520.025, 520.026.

- n The income of the spouse remaining at home is not counted in determining the income of the institutionalized spouse. 130 C.M.R. § 520.002(B).
- n Deductions from the resident's income are allowed for maintenance of an at-home spouse and certain other dependents, health insurance premiums and other medical and remedial expenses not covered by MassHealth or other insurance, certain fees and expenses related to guardianship, and if the individual is expected to return home within six months, a deduction for maintenance of the home. 130 C.M.R. § 520.026.
- n If an individual has monthly income greater than the Massachusetts nursing facility payment rate but less than the private pay rate, the resident is subject to a six-month spenddown. 130 C.M.R. § 520.027.

Asset standard. Nursing home residents must have countable assets of \$2,000 or less, *see* 130 C.M.R. § 520.002, but special deductions and allowances apply. *See* 130 C.M.R. § 520.016.

- n **Treatment of the home.** The former home of a nursing home resident does not count toward the \$2,000 asset limit if a spouse or certain other relatives are living in the home, the resident intends to return home, the resident has long-term care insurance meeting certain criteria, or the home is jointly owned and a sale would cause the other owner to lose housing. If none of these

exceptions apply, a resident will be allowed time to sell an otherwise countable former home. For applications after January 1, 2006, an equity interest in the home that exceeds \$750,000 makes the owner ineligible for payment of nursing home care unless a spouse or child lives in the home, or a hardship waiver applies. See 130 C.M.R. §520.007(G)(3), (8)–(13).

- n **Trusts and annuities.** Special rules apply to trusts and annuities. 130 C.M.R. §§ 520.021–520.024 (trusts), 520.007(J) (annuities).
- n **Transfer of assets.** There are restrictions on certain transfers of assets for less than fair market value that may result in a period of ineligibility for MassHealth payment of nursing home care. Some transfers are permissible. Some disqualifying transfers may be cured, and a waiver of the period of ineligibility is available in cases of undue hardship. 130 C.M.R. §§ 520.018, 520.019.

Return home. If an individual is expected to return home within six months of admission, he or she is allowed a deduction from income in order to maintain the home. 130 C.M.R. § 520.026(D). Further, the home is not counted as a resource if an individual intends to return home. 130 C.M.R. § 520.007(G)(8).

For more information on this topic, see *Estate Planning for the Aging or Incapacitated Client in Massachusetts* (MCLE, Inc. rev. ed. 1998 & Supp. 2002, 2005, 2007).

129 What are the rules if one spouse is in a nursing home and one is at home?

For married couples where one spouse is a nursing home resident but one remains at home, the community spouse is entitled to enough of the couples' joint income and assets to meet his or her needs. 130 C.M.R. §§ 520.026(B), 520.016(B).

Income. The income of the community (at home) spouse is not attributed to the nursing home resident. If the community spouse's gross income is less than the "monthly maintenance needs allowance" (MMNA) as calculated by the agency, it will allow a deduction from the institutionalized spouse's income to be allocated to the community spouse. In determining the MMNA, the agency combines a

standard minimum MMNA with an excess shelter allowance that takes account of actual costs in excess of a standard shelter to arrive at an MMNA up to a maximum level. However, the MMNA maximum may be increased as the result of a fair hearing decision showing exceptional circumstances or based on a court order for support. In SFY 2009, the minimum MMNA is \$1,750 per month and the maximum MMNA is \$2,610 per month. 130 C.M.R. § 520.026.

Assets. Generally, the assets of both spouses are considered together regardless of how title is held, but the at-home spouse may retain or have transferred to him or her assets up to the maximum spousal asset allowance. In 2009 the maximum spousal asset allowance will be \$109,560. A higher asset allowance may be ordered by a court or fair hearing. The asset allowance may also be increased if a deduction from the institutionalized spouse's income is not sufficient and additional income-generating assets are required to bring the community spouse's income up to the MMNA. The countable assets remaining to the nursing home resident must not exceed the \$2,000 asset standard in order for him or her to be eligible. 130 C.M.R. § 520.016.

130 What are the transfer of asset rules?

A nursing home resident (or applicant for services under the HCBS waiver) who transfers resources for less than fair market value, in some circumstances, will be ineligible for MassHealth for a period of time. However, certain transfers for less than fair market value, such as transfers for the sole benefit of a spouse, are permitted. The penalty period may be eliminated in cases of undue hardship.

The law regarding transfers of assets changed in 2006 based on a change in federal law effective for transfers after February 8, 2006. The MassHealth agency will review transfers that took place during a "look back" period going back 36 months from the first date the resident was both in a nursing facility and applied for MassHealth. After February 8, 2006, the look back period will increase month by month until it reaches the new look back period of 60 months on February 8, 2011. If there is a disqualifying transfer after February 8, 2006, the penalty period begins on the date the applicant would otherwise be eligible or the date of the transfer, whichever is later. For transfers prior to February 8, 2006, the disqualification begins on the date of the transfer.

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Special care should be taken in advising clients on asset transfers. Poor planning may result in a client who is ineligible for MassHealth but has no other means to pay for his or her care. For more information on this topic, see *Estate Planning for the Aging or Incapacitated Client in Massachusetts* (MCLE, Inc. rev. ed.2007).

130 C.M.R. §§ 520.007(J), 520.018, 520.019; 42 U.S.C. § 1396p.

Part 13

Eligibility Rules About Citizenship and Immigration Status

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131 How does citizenship affect eligibility for MassHealth?

United States citizens are eligible for all MassHealth coverage types. (See Part 4 for more information on verification of U.S. citizenship.) Undocumented noncitizens are only eligible for emergency Medicaid under MassHealth Limited. Some noncitizens known to the U.S. Citizenship and Immigration Service (C.I.S.)¹⁴ are eligible for more comprehensive coverage than emergency Medicaid depending on many factors, including: their current and former immigration status, the date they entered the United States, the date of obtaining status, as well as factors unrelated to immigration such as domestic violence, service in the military, age, and disability.

The federal welfare reform law enacted on August 22, 1996 imposed new restrictions on the Medicaid eligibility of noncitizens in the United States legally or residing under color of law (PRUCOL) who previously were eligible for Medicaid. Most legal permanent residents (green card holders) who entered the United States after August 22, 1996 are barred from federal Medicaid eligibility for five years after obtaining their status.¹⁵ Massachusetts provides MassHealth using state-only funds to some of the lawfully present noncitizens who are not eligible under the restrictive 1996 federal Medicaid rules. Noncitizens who are “protected aliens” as well as children, the disabled and the elderly who are “special status or PRUCOL aliens,” as defined below, are still eligible for health coverage under state law.

Federal Medicaid restrictions: 8 U.S.C. §§ 1612(b), 1613, 1641.

State law: G.L. c. 118E, § 16D (MassHealth); G.L. c. 118H, § 1 (definition of “resident” in Commonwealth Care).

See Tables 10–16 in Appendix B for charts summarizing immigrant eligibility rules and lists of documents and codes on documents that verify different types of immigration status.

¹⁴ The CIS is one of several agencies under the U.S. Department of Homeland Security that has taken over the functions of the former Immigration and Naturalization Service (INS).

¹⁵ Federal law uses the term “qualified aliens” to describe both noncitizens currently eligible for Medicaid and those barred for five years. MassHealth uses the term “qualified alien” to mean only currently eligible immigrants and has created the term “special status alien” to include those who are barred for 5 years. This Guide will follow the MassHealth terminology.

132 Which noncitizens are “qualified aliens” eligible for *all* MassHealth coverage types (including long-term institutional care)?

1. **Qualified aliens who have satisfied or are exempt from the five-year bar.** People with the following immigration status at the time they apply for benefits are eligible for all MassHealth coverage types if they entered the country before August 22, 1996 (regardless of status at the time of entry) and remained continuously present until obtaining status; or if they entered the country after August 22, 1996 and have had their status for five or more years:

- n legal permanent residents,
- n conditional entrants, or
- n persons granted parole for at least one year.

130 C.M.R. §§ 504.002(B), 518.002(B).

2. **Qualified aliens to whom the five-year bar never applies.** Noncitizens are eligible for all MassHealth coverage types *regardless of their date of entry, or how long they had their status*, if they currently have one of the statuses listed below or previously had one of these statuses before attaining current legal permanent resident status:

- n refugees and persons granted political asylum;
- n persons whose deportation has been withheld;
- n veterans and the spouses or widows and dependent children of veterans;
- n certain people (and their dependent children) subjected to battery or extreme cruelty by a spouse, parent, or sponsor who no longer live with the batterer;
- n certain Cubans and Haitians who are Cuban/Haitian entrants;
- n Native Americans born outside the United States;
- n certain Amerasians from Vietnam;

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- n victims of severe forms of trafficking (and their dependent children); and
- n special immigrants from Iraq for their first six months, and special immigrants from Afghanistan for their first eight months in the United States. After six or eight months Iraqi/Afghani special immigrants will no longer be “qualified” but will be aliens with “special status” under MassHealth rules.

130 C.M.R. §§ 504.002(B), 518.002(B).

U.S. entry prior to August 22, 1996 and continuous presence: Some recent permanent residents are not subject to the five year bar if they were living in the United States prior to becoming legal permanent residents (LPRs). To qualify, the applicant must have been continuously present in the United States from the time of his or her last entry into the United States before August 22, 1996 until the date of obtaining LPR status. Continuous presence requires no absence longer than 30 consecutive days or 90 days in total prior to attaining LPR status. To benefit from this provision of federal law, immigrants must declare the U.S. entry date on the MassHealth application, and make sure the agency has used the U.S. entry date, not the later date on the green card showing the date LPR status was obtained.

133 Which noncitizens are “protected aliens” eligible for *all* MassHealth coverage types (including long-term institutional care)?

People who were receiving Medical Assistance or CommonHealth on June 30, 1997 (in the community or in a nursing home) or who were residing in a nursing facility on June 30, 1997 and who are otherwise eligible can receive MassHealth Standard or any other coverage type for which they are eligible. The MassHealth rules refer to people in this category as “protected aliens.”

130 C.M.R. §§ 504.002(C), 518.002(C).

134 Which noncitizens are “special status or PRUCOL aliens” eligible for only some MassHealth coverage types or Commonwealth Care?

Individuals under age 19, disabled or elderly who are known to CIS but not “qualified aliens,” either because they are legal permanent residents subject to the five year bar or because they are not qualified but are residing in the United States under color of law (PRUCOL), are not eligible for MassHealth Standard, but may be eligible for other coverage types. Children may be eligible for CommonHealth or Family Assistance; adults who are disabled or elderly may be eligible for MassHealth Essential. 130 C.M.R. §§ 504.002(F) (children and disabled adults), 519.013 (elderly). Other uninsured adults may be eligible for Commonwealth Care. 956 C.M.R. § 3.04 (definition of “resident”).

Special status and PRUCOL aliens include:

- n Individuals with the following status who are not “qualified aliens” because they entered the country on or after August 22, 1996 and have had their status for less than five years:
 - n legal permanent residents,
 - n conditional entrants,
 - n persons granted parole for at least one year.

130 C.M.R. §§ 504.002(D)(2), 518.002(D).

- n Individuals who are not “qualified aliens” but who are permanently residing in the United States under color of law (PRUCOLs). These are people who are residing in the United States with the knowledge of immigration officials who are not contemplating deporting them. Prior to 1996, people who were PRUCOL were eligible for Medicaid and other federal benefits. It is not a status conferred by immigration officials, PRUCOL is a status created by

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public benefit law. The MassHealth regulations give 12 examples of PRUCOL status.¹⁶ Some examples of PRUCOL include:

- n a person who is the subject of a pending immediate relative petition, or who is covered by an approved petition and has a pending application for adjustment of status;
- n a person granted Temporary Protected Status;
- n a person with a pending application for asylum; and
- n any person who immigration officials know is resident in the United States and whose departure DHS does not contemplate enforcing.

130 C.M.R. §§ 504.002(D), (F); 518.002(D), (F). *See also Cruz v. DPW*, 395 Mass. 107 (1985) (PRUCOL). 956 C.M.R. § 3.04 (definition of “resident” in Commonwealth Care).

135 How does one prove an eligible immigration status?

Unfortunately, there are few publications from MassHealth to help applicants and outreach workers identify which immigration documents prove an eligible status. However, MassHealth has published subregulatory guidance with examples of documents that verify that someone is a Cuban-Haitian entrant or a person permanently residing in the United States under color of law (PRUCOL). The MassHealth guidance is posted on www.masslegalserives.org.

Part 20 lists several sources of useful information about immigration documents. Consult Tables 12–16 in Appendix B for help identifying some of the more common documents used to prove an eligible immigration status including a key to codes on the documents.

¹⁶ Under the regulations, PRUCOLs are included as aliens with special status, however in practice the MECS often reserve the term special status to describe those subject to the five-year bar; to avoid confusion this Guide uses the phrase “special status and PRUCOL.”

136 What MassHealth coverage is available to noncitizens who are not documented?

Noncitizens who are not qualified immigrants, protected immigrants, or special status/PRUCOL immigrants are referred to as “nonqualified aliens.” Nonqualified aliens include undocumented persons. They are eligible for MassHealth Limited (emergency Medicaid) if they would qualify for MassHealth Standard except that they do not have an eligible immigration status. Nonqualified immigrants do not have to submit proof of immigration status or have Social Security numbers. However, Limited only covers emergency services, including labor and delivery.

130 C.M.R. §§ 505.008, 519.009.

137 What other health programs are available to nonqualified immigrants?

Public health and safety net programs generally do not have eligibility rules related to citizenship or immigration status. However, most of these programs are limited to Massachusetts residents; this will exclude visitors who intend to return to a home outside of Massachusetts. The following health programs, described in Part 19, Health Programs Other than MassHealth, do not ask about immigration status:

- n The Children’s Medical Security Plan—primary and preventive insurance coverage for children.
- n The Health Safety Net—free or reduced cost care at acute care hospitals and community health centers.
- n Healthy Start—prenatal care for pregnant women.
- n Prescription Advantage—prescription drug coverage for seniors and people with disabilities.

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- n Massachusetts Home Care Assistance—home care for seniors and people with Alzheimer’s.
- n Programs of the Department of Public Health (DPH)—DPH funds a wide variety of public health programs such as cancer screening programs, HIV drug assistance programs, and substance abuse treatment programs.

Commonwealth Care. The new Commonwealth Care health insurance program is available to uninsured Massachusetts residents who are U.S. citizens, or noncitizens who are qualified, special status aliens or PRUCOL. However, it is not available to undocumented immigrants. For more information, see Part 10.

Long-term care. There are few options for nonqualified and special status/PRUCOL immigrants who need long-term care. See MLRI, *Practice Memo: Services available to noncitizens denied MassHealth long-term care services*, in the “Health” section of www.masslegalservices.org.

138 Will an immigrant who receives MassHealth be a public charge or face other immigration problems?

Immigrants sometimes fear that there will be negative consequences if they receive a public benefit like MassHealth. They fear that they will be unable to adjust to legal permanent resident (LPR) status because they will be considered likely to become a “public charge.” If they are already LPRs, they fear that they will be unable to sponsor relatives or become a citizen if they use public benefits. Most of these fears are unwarranted. According to the CIS, receipt of medical benefits like MassHealth will not be considered evidence that the immigrant is likely to become a public charge, and has no bearing on the ability to sponsor a relative or become a citizen. The CIS has issued detailed guidance and a handy fact sheet containing all this information. MassHealth also includes information for immigrants including referral resources in the booklet containing the MBR.

There are two circumstances in which receipt of MassHealth may have negative immigration consequences and both relate to the use of MassHealth for nursing home care. If someone has gotten MassHealth to pay for nursing home care, the CIS may consider that fact in determining whether someone is likely to become a

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public charge. Someone who is likely to become a public charge may not be able to reenter the United States after an absence or adjust status to lawful permanent resident status. The only other circumstance in which receipt of MassHealth may jeopardize immigration status is when all of these factors are true: the person was in a nursing home for reasons that existed before entering the United States, entered the nursing home within five years of entry to the United States, and the person or sponsor had a legal debt to repay Medicaid, and refused to repay after the government filed a lawsuit and won. In these very rare circumstances, an immigrant can be deported.

See the 2000 USCIS publication: *A Quick Guide to “Public Charge” and Receipt of Public Benefits* (Mass. Edition) at www.uscis.gov/graphics/publicaffairs/factsheets/Charge.pdf.

Sponsor deeming: Family members sponsoring immigrants after December 19, 1997, are required to sign a legally enforceable affidavit of support. The federal agency governing Medicaid (CMS) has not issued any regulations on how the sponsor’s obligation to support should affect the determination of Medicaid eligibility. Currently, MassHealth does not consider the sponsor’s income to be available to the immigrant when it is not (a practice called sponsor deeming), and sponsor deeming is specifically prohibited in G.L. c. 118E, § 16D.

139 What services are available for people who have limited English proficiency?

All recipients of federal funds, including all Medicaid providers as well as the MassHealth agency, the Connector and their contractors, must be able to serve people with limited English proficiency (LEP). This may include providing translation services at no cost to the LEP person, providing written notices in the primary language of the LEP person, and ensuring the availability of qualified interpreters. Also, under state law, all acute care hospital emergency rooms and psychiatric hospitals are required to provide competent interpreter services.¹⁷

¹⁷ See Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d (courts have interpreted discrimination against non-English speakers as national origin discrimination); *Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency*, revised, 67 Fed. Reg. 47311 (Aug. 8, 2003), www.hhs.gov/ocr/lep. G.L. c. 111 § 25J(b)

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The MassHealth agency will provide interpreter services by telephone or in person when the applicant requests it or the MassHealth agency determines that it is necessary. 130 C.M.R. § 501.009(I). The state also has a contract with QWEST to provide interpreters by telephone.

The Managed Care Organizations must also be able to provide care to LEP members and this may include translating materials into languages other than English, having network providers who speak languages other than English, and having available interpreters to communicate with LEP members.

The MassHealth agency currently provides the MBR (application form) in English and Spanish. It provides the MassHealth member booklet in 10 languages. Each application also includes a primary language declaration form with the toll-free number for the Customer Service Center. Eligibility notices are only in English or Spanish, but are accompanied by a flyer translated into 10 languages informing people that they have received an important notice and should get it translated.

The Board of Hearings will provide an interpreter at no cost to LEP appellants, and the hearing officer has a duty to inform appellants of this right. All statements of all persons participating in the hearing must be translated to enable non-English speaking appellants to understand and fully participate in the entire hearing. 130 C.M.R. § 610.065(A)(9).

(acute hospital emergency room); G.L. c. 23, § 23 (psychiatric hospitals); and 105 C.M.R. 130.1100 (DPH regulations).