Welfare Reform and Immigrants: Medicaid Provisions

(P.L. 104-193, enacted 8/22/96)

Q&A

Summary of Medicaid-Related Provisions

- Most non-citizens (with limited exceptions) are barred from the Supplemental Security Income (SSI) program, potentially severing their link to Medicaid eligibility.
- *Qualified aliens* entering the U.S. on or after 8/22/96 are barred from Medicaid for five years (with the following exceptions: Refugees and asylees for their first five years in the U.S. and veterans and active duty military).
- After the five year bar, most sponsored immigrants are effectively barred from Medicaid through the enforcement of mandatory deeming provisions.
- States are prohibited from using Medicaid funds to cover costs associated with providing public health immunizations and public health services for testing and treatment of symptoms of communicable diseases for *not qualified aliens*.
- States are prohibited (with limited exceptions) from using Medicaid funds to cover costs associated with providing public health immunizations and public health services for testing and treatment of symptoms of communicable diseases for *qualified aliens* arriving in the U.S. on or after 8/22/96, until after their first five years in the U.S. (subject to state options and deeming provisions).
- States may use Medicaid funds to cover costs associated with specified public health measures for *qualified aliens* residing in the U.S. before 8/22/96 if the state opts to provide continued Medicaid coverage for this group. States will receive federal matching funds for providing specified public health services to *qualified aliens* who were in the U.S. before 8/22/97.
- As of January 1, 1997, states have the *option* to provide or deny Medicaid to *qualified alien(s)* already in the country (with some exceptions).
- States have the option to provide or deny Medicaid to future arrivals who are not deemed out of Medicaid after the five year period.
- All *not qualified aliens* (including undocumented persons and many PRUCOL immigrants) are barred from receiving Medicaid.

Q. What is the impact on Medicaid eligibility for legal immigrants who lose SSI?

A. SSI provides cash assistance to needy aged, blind, and disabled individuals who have little or no income and resources. Medicaid law generally requires states to cover persons receiving SSI. Thus, in most cases, the receipt of SSI establishes a categorical link (e. g. automatic qualification) to Medicaid. Because the federal welfare reform law bars all *qualified aliens* from SSI, these individuals are no longer eligible for SSI-related Medicaid. *Qualified aliens* who were in the U.S. before 8/22/96 and had SSI-related eligibility, remain Medicaid eligible *if*: (a) a state opts to cover any group(s) of *qualified aliens*, and (b) these individuals qualify under another eligibility category. State Medicaid agencies are required to conduct redeterminations for recipients losing SSI-related Medicaid eligibility to see whether he or she qualifies for Medicaid under an alternative coverage category. If a state's Medicaid plan does not have an optional coverage category under which these individuals may qualify for Medicaid, federal regulations require notice and hearing rights that are consistent with the due process standards set forth by the United States Supreme Court in *Goldberg v. Kelly*, 397 U.S. 254 (1970). Persons arriving in the U.S. on or after 8/22/96 are first subject to a five year bar followed by mandatory deeming before they may receive Medicaid, subject to a state option to make them eligible for the program and a coverage category for which he or she qualifies.

Q. Are there any other Medicaid eligibility categories under which *qualified* legal immigrants denied SSI-related Medicaid benefits may qualify for Medicaid?

A. Probably. Other possible routes to Medicaid eligibility for this population include: (1) optional medically needy programs; (2) optional categorically needy programs that provide Medicaid coverage to certain groups of elderly and disabled persons; (3) optional programs that cover individuals who are SSI-eligible but not receiving the cash benefit; and (4) optional "special income" programs for institutionalized individuals (see below).

Q. What are medically needy programs?

A. Medically needy is an *optional* Medicaid coverage category. States are permitted, *but not required*, to cover the medically needy under their state Medicaid plans. Medically needy individuals are those persons who do not fall within one of the mandatory Medicaid coverage categories, but may still be eligible for Medicaid because their income and resources are within limits set by a state under its Medicaid plan. This category also includes persons whose income and resources fall within the state defined limits after their incurred expenses for medical or remedial care are deducted. These individuals become medically needy by *spending down* or depleting their income and resources on the cost of needed medical care.

Not all states have an optional medically needy coverage category. As of October 1996, 33 states and the District of Columbia provided Medicaid to at least some groups of medically needy persons. The following seventeen states report *not* having a medically needy coverage category: Alabama, Alaska, Arizona, Colorado, Delaware, Idaho, Indiana, Louisiana, Mississippi, Missouri, Nevada, New Mexico, Ohio, South Carolina, South Dakota, Texas and Wyoming.

There is nothing in law that prohibits states from deciding to provide optional coverage for the medically needy. However, if a state provides Medicaid to any individual under an optional coverage category, it must also provide Medicaid to *all* individuals (citizen and non-citizen alike) who apply and meet the criteria for the particular category.

States are allowed to limit (or expand) the groups of individuals who may receive medically needy coverage. Thus states, under their medically needy programs, may opt to cover any group or groups of the following: aged, blind, disabled, specified relative caretakers and essential spouses, and pregnant women.

No state's medically needy program is required to cover the elderly, blind, or disabled, nor must a state's medically needy program necessarily cover nursing home care. Many elderly persons meet the financial standards for medically needy coverage as the result of needing nursing home care. However, not all states cover nursing home care under their medically needy programs. As of October 1996, 26 states with medically needy programs that cover the elderly included nursing home care as a covered service. The following states do *not* include nursing facility care as a covered service in their optional medically needy coverage category: Arkansas, Florida, Iowa, New Jersey, Oklahoma, and Oregon.

Q. What are optional categorically needy programs?

A. The optional categorically needy coverage category allows states to provide Medicaid for elderly or disabled persons under the following circumstances: (1) The individual is either aged 65 or older or the individual is disabled (under SSI criteria); (2) The elderly or disabled individual's income cannot exceed the level established by the state, and in no event may the level exceed 100 percent of the official nonfamily poverty guideline; and (3) the elderly or disabled individual's resources cannot exceed the applicable SSI resource standards, except where a state has an optional medically needy program that has higher resource standards, the higher resource standard may be used. Elderly and disabled individuals in the optional categorically needy coverage category must receive the same Medicaid benefits provided to the categorically needy under the approved state Medicaid Plan.

Mandatory services are those that states are federally required to provide under their approved state Medicaid plans. The mandatory services for the categorically needy are as follows: (1) inpatient and outpatient hospital services; (2) nursing facility services for individuals age 21 or older; (3) physicians' services; (4) laboratory and X-ray services; (5) early and periodic screening, diagnosis and treatment (EPSDT) services for individuals under age 21; (6) family planning services; (7) home health services for any individual entitled to nursing facility care; (8) rural health clinic and federally qualified health

center (FQHC) services; and (9) services of nurse-midwives, certified pediatric nurse practitioners, and certified family nurse practitioners (to the extent these individuals are authorized to practice under state law).

Q. What are optional programs that cover individuals who are eligible for SSI but not receiving cash benefits?

A. States are allowed to provide Medicaid to aged, blind and disabled persons who are eligible for SSI but not receiving cash benefits. The following twenty-two states do *not* have this optional coverage category: Alabama, Arkansas, California, Delaware, Florida, Georgia, Illinois, Indiana, Kansas, Kentucky, Michigan, Mississippi, Missouri, Nebraska, New Mexico, North Dakota, Ohio, South Carolina, South Dakota, Texas, Utah and Wyoming.

Q. Is there a way for states to continue to keep elderly *qualified aliens living in nursing homes* Medicaid-eligible after the loss of SSI-related Medicaid eligibility?

A. Maybe. If the state opts to continue to provide Medicaid to *qualified aliens*, a state may be able to provide Medicaid to elderly *qualified aliens* who live in nursing homes under an optional Medicaid coverage provision known as the *300 percent rule*.

Under the *300 percent rule*, states are allowed to establish special income standards for institutionalized persons. Individuals may qualify for Medicaid under the *300 percent rule* as long as: (a) their income does not exceed a certain amount; (b) they meet the state's resource standard; *and,* (c) they currently reside in nursing homes or other medical care institutions. States would not be allowed to limit eligibility under the 300 percent rule to institutionalized *qualified immigrants*. Thus, states that have the optional 300 percent rule coverage category must cover citizens as well as *qualified aliens* residing in nursing homes.

Q. Does the new law give states the *option* to provide or deny *qualified alien(s)* access to Medicaid?

A. Yes. States are given the option to grant or deny some or all *qualified aliens* (with limited exceptions) access to Medicaid. States that choose to cover *qualified aliens* on a selective basis may face Fourteenth Amendment Equal Protection challenges. Even if a state opts to provide Medicaid for *qualified aliens*, those arriving after the enactment of the federal welfare reform law (8/22/96) are subject to a five year bar and subsequent deeming for either 10 years (40 qualifying quarters) or until citizenship. The exceptions are:

1. Refugees, asylees and persons whose deportation is being withheld (*only* for their first five years in such status);
2. Honorably discharged veterans, active duty military (not including training) their spouses and unmarried, dependent children; and,
3. Lawful permanent residents who have worked in the U.S. for 10 years (e.g. earned 40 qualifying quarters under Title II of the Social Security Act). [*Note:* After December 31, 1996, a quarter will not count if the individual receives any Federal means-tested public benefit during the quarter. HHS has not yet defined "Federal means-tested public benefit.]

Q. What does *deeming* mean?

A. Deeming means that the income and resources of the immigrant's sponsor and the sponsor's spouse must be taken into consideration (or *deemed* available to the sponsored immigrant) when making program eligibility determinations. Deeming lasts until the sponsored immigrant either (a) works 10 years (or accrues 40 qualifying quarters) or (b) until the sponsored immigrant naturalizes (becomes a citizen).

Q. Can states continue to provide Medicaid coverage to refugees, asylees and persons whose deportation is being withheld after their first five years in the U.S.?

A. Yes. The law only prohibits the denial of Medicaid to these groups during their first five years in the U.S. Thereafter, states have the option to continue their Medicaid benefits or to bar them just as they would other *qualified aliens*. Refugees and asylees are not sponsored immigrants and therefore, are not subject to sponsor deeming provisions.

Q. In order to continue to serve *qualified aliens* in the Medicaid program, does the new law require states to take affirmative action (e.g. enact a law, etc.)?

A. No. There is no express language in the new law that compels states to take affirmative steps in order to exercise their option to continue to extend Medicaid coverage to *qualified aliens*. States must act (e.g. amend their Medicaid state plans) *only* if they intend to deny Medicaid to *qualified aliens*.

Q. Are all *not qualified aliens* barred from Medicaid?

A. Yes. Undocumented persons, nonimmigrants and all persons in PRUCOL categories who are not expressly listed as *qualified aliens* are ineligible to receive Medicaid (with the exception of emergency Medicaid *if* they otherwise meet program requirements. see explanations below). Undocumented persons and nonimmigrants have long been barred from receiving Medicaid, with the exception of emergency medical services, *if* they otherwise met the program requirements. However, previously eligible categories of PRUCOL aliens, such as persons granted indefinite voluntary departure and aliens granted stays or suspension of deportation, are newly affected by this prohibition.

Q. Can Medicaid funds be used to pay for emergency medical services for *qualified and not qualified aliens?*

A. Yes, for some individuals. Under the new law, care and services that are necessary for the treatment of an emergency medical condition, including *all* labor and delivery (except organ transplant procedures) are reimbursable under the Medicaid program for aliens who are *otherwise qualified* to receive Medicaid.

The recently enacted immigration reform law authorizes the federal government to reimburse hospitals for costs associated with providing services for the care and treatment of emergency medical conditions to undocumented persons who are *not* otherwise qualified to receive Medicaid.

Beginning January 1, 1997, an institution may be reimbursed by the federal government (subject to the availability of appropriated funds) if: (a) the costs of providing services are not reimbursable through any other federal program; and (b) the institution cannot recover its costs from the undocumented individual or some other person. In order to receive reimbursement under this provision, the institution *must* be able to show that it has verified the immigration status of the individual to whom the care has been rendered.

Q. How does the new law affect the definition of conditions that qualify for emergency medical services under Medicaid?

A. The Act does not amend the current law definition of an emergency medical condition However, the Conference Report indicates that the conferees intended to narrow the definition to exclude prenatal or delivery care assistance that is not strictly of an emergency nature. Conference report language **does not** have the force of law. In a recent communication with state Medicaid agencies, the Health Care Financing Administration defined *all* labor and delivery as an emergency condition for purposes of Medicaid.

Q. What conditions qualify for receipt of Medicaid emergency medical services?

A. The term emergency medical condition means: "...[A] medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part." All labor and delivery services fall within the definition of emergency medical services.

Q. Are Medicaid funds allowed to be used to cover costs associated with providing public health immunizations and public health testing and treatment for communicable diseases?

A. Yes and No. Under the new law, the use of Medicaid funds to cover costs associated with providing public health immunizations and public health testing and treatment of symptoms of communicable disease for *not qualified aliens* and legal immigrants arriving on or after 8/22/96 (for their first five years in the U.S.) is **not** permitted.

Medicaid funds may be used to cover costs associated with public health immunizations and public health testing and treatment for communicable diseases for *qualified aliens* residing in the U.S. *before* 8/22/96, *provided* that a state opts to continue to make *qualified aliens* Medicaid eligible.

Finally, Medicaid funds may be used to cover costs associated with the specified public health measures for *qualified aliens* who arrive in the U.S. *on* or *after* 8/22/96: (a) after their first five years in the country (with some exceptions); provided that (b) they are not deemed out of eligibility for the program, and (c) the state opts to provide coverage for *qualified aliens.*

Definitions

Qualified Aliens:

Lawful permanent residents;
refugees;
asylees;
aliens paroled into the U.S. for a period of at least 1 year;
aliens granted withholding of deportation by the INS;
aliens granted conditional entry into the U.S.; and,
certain battered alien spouses and children.

Not Qualified Aliens:

Undocumented persons
All other persons lawfully admitted into the U.S. under color of law (PRUCOL) who do not fall within the categories specified as *qualified aliens.*

Parolee: A parolee is a person who is allowed to enter the U.S. under emergency (humanitarian) conditions or when the individual's entry is determined to be in the public interest. Parole does not constitute a formal admission to the U.S. and confers temporary admission status only, requiring parolees to leave the U.S. when the conditions supporting their parole cease to exist. The length of time that a person is paroled into the U.S. can vary. However, for purposes of the new welfare reform law, persons must be paroled into the U.S. for a period of at least one year (e.g. the period of time that they are allowed to stay in the country) in order to come within the definition of *qualified alien.*

Withholding of deportation: This is an immigration category that refers to individuals who would be deportable but who, at the discretion of the Attorney General (AG), are not being deported because the AG has determined that the individual's life or freedom would be threatened if returned to his/her home country because of race, religion, nationality, membership in a particular social group, or political opinion.

PRUCOL: The permanently residing under color of law (PRUCOL) status is a legal term that applies to "aliens here (in the U.S.) under statutory authority and those effectively allowed to remain in the U.S under administrative discretion." Prior to the enactment of the new welfare reform law, PRUCOL status meant that an alien was considered to be legally residing in the country for an indefinite period *for the purpose* of determining benefit eligibility for public assistance, including Medicaid.

Examples of PRUCOL individuals are:

Persons granted indefinite voluntary departure;
Persons residing in the U.S. under orders of supervision;
Persons who have lived in the U.S. continuously since January 1, 1972;
Aliens granted stays or suspension of deportations; and
Other aliens whose departure INS does not contemplate enforcing.

Prepared by the Immigrant Policy Project at NCSL, 9/30/96
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Revised: 4/10/97