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**MASSHEALTH: THE ELIGIBILITY PROCESS**

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516.001: Overview

(A) Filing an Application.

(1) Application. To apply for MassHealth

(a) for an individual living in the community, an individual or his or her authorized representative must file a Senior Application online at [www.MAHealthConnector.org](http://www.MAHealthConnector.org), complete a paper application, complete a telephone application, or apply in person at a MassHealth Enrollment Center (MEC).

(b) for an individual in need of long-term-care services in a nursing facility, a person or his or her authorized representative must file a complete paper Senior Application and Supplements or apply in person at a MassHealth Enrollment Center (MEC).

(2) Online or Telephone Application Requirements.

(a) Individuals, or their authorized representative, if applicable, completing an application for MassHealth online or by telephone must be identity proofed pursuant to 130 CMR 516.002(A)(3). Eligibility based on an online or telephonic application cannot be determined until the identity is proven or a paper application is submitted.

(b) If an applicant submits a paper application or applies in person at a MassHealth Enrollment Center, identity proofing is not required.

(3) Identity Proofing Process. An individual or his or her authorized representative, if applicable, completing an online or telephonic application will be asked a series of questions to prove his or her identity.

(a) If the individual is successfully identity proofed, the application may be submitted and an eligibility determination will be performed.

(b) If the individual is not successfully identity proofed, the individual will be asked to provide one or two forms of acceptable documentation proving his or her identity. Documentation proving identity must be submitted to the MassHealth agency within 15 days from the date of the request.

(c) If identity proof is received within 15 days of the date of the notice referenced in 130 CMR 516.001(A)(3)(b), the eligibility process commences. The MassHealth agency will determine the coverage type providing the most comprehensive medical benefits for which the applicant is eligible, and the application is considered submitted on the date of the initial unsuccessful identity proofing.

(d) If identity proof is not received within the 15-day period referenced in 130 CMR 516.001(A)(3)(b), the MassHealth agency will notify the applicant or his or her authorized representative that it is unable to determine eligibility for medical benefits. If acceptable proof of identity is received after the 15-day period, the eligibility process commences and the application is considered submitted on the date the identity proof is received by the MassHealth agency, provided that if acceptable proof of identity or a paper application is received more than one year after the initial unsuccessful identity proofing, a new application must be submitted.

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(e) To prove his or her identity, an individual can submit the acceptable proofs of identify as described in 130 CMR 518.005(A)(3): *Acceptable Proof of Identity*.

(4) Paper Applications or In-Person Applications at the MassHealth Enrollment Center (MEC) — Missing or Inconsistent Information.

(a) If a paper application is received at a MassHealth Enrollment Center or MassHealth outreach site and the applicant did not answer all required questions on the senior application, the MassHealth agency is unable to determine the applicant's eligibility for MassHealth.

(b) The MassHealth agency requests responses to all of the unanswered questions necessary to determine eligibility. The MassHealth agency must receive such information within 15 days of the date of the request for the information.

(c) If responses to all unanswered questions necessary to determine eligibility are received within 15 days of the date of the notice, referenced in 130 CMR 516.001(A)(4)(b), the MassHealth agency eligibility process commences. The MassHealth agency will determine

(i) the coverage type providing the most comprehensive medical benefits for which the applicant is eligible, and the application is considered submitted on the date the initial incomplete application was received by the MassHealth agency; or

(ii) the need to request any corroborative information necessary to determine eligibility, as provided in 130 CMR 516.001(C) and (D).

(d) If responses to all unanswered questions necessary for determining eligibility are not received within the 15-day period referenced in 130 CMR 516.001(A)(4)(b), the MassHealth agency notifies the applicant that it is unable to determine eligibility. The date that the incomplete application was received will not be used in any subsequent eligibility determinations. If the required response is received after the 15-day period, the eligibility process commences and the application is considered submitted on the date the response is received, provided that if the required response is submitted more than one year after the initial incomplete application, a new application must be completed.

(e) Inconsistent answers are treated as unanswered.

(B) Corroborative Information. The MassHealth agency requests all corroborative information necessary to determine eligibility.

(1) The MassHealth agency sends the applicant written notification requesting the corroborative information generally within five days of receipt of the application.

(2) The notice advises the applicant that the requested information must be received within 30 days of the date of the request, and of the consequences of failure to provide the information.

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(C) Receipt of Corroborative Information. If the requested information, with the exception of verification of citizenship, identity, and immigration status, is received within 30 days of the date of the request, the application is considered complete. The MassHealth agency will determine the coverage type providing the most comprehensive medical benefits for which the applicant is eligible. If such information is not received within 30 days of the date of the request, MassHealth benefits may be denied.

(1) If the requested information is received within 30 days of the date of the denial, the date of receipt of one or more of the verifications is considered the date of reapplication.

(2) The date of reapplication replaces the date of the denied application. The applicant's earliest date of eligibility for MassHealth is based on the date of reapplication.

(3) If a reapplication is subsequently denied and not appealed, the applicant must submit a new application to pursue eligibility for MassHealth. The earliest date of eligibility for MassHealth is based on the date of the new application.

516.002: Date of Application

(A) The date of application for an online, telephonic, or in-person application is the date the application is submitted to the MassHealth agency.

(B) The date of application for a paper application that is either mailed or faxed is the date the application is received by the MassHealth agency.

(C) An application is considered complete as provided in 130 CMR 516.001(C).

(D) If an applicant described in 130 CMR 519.002(A)(1) has been denied SSI in the 30-day period before the date of application for MassHealth, the date of application for MassHealth is the date the person applied for SSI.

516.003: Matching Information

The MassHealth agency initiates information matches with other agencies and information sources when an application is received in order to update or verify eligibility. These agencies and information sources may include, but are not limited to, the following agencies: Federal Data Services Hub, the Division of Unemployment Assistance, Department of Public Health's Bureau of Vital Statistics, Department of Industrial Accidents, Department of Veterans' Services, Department of Revenue, Bureau of Special Investigations, Social Security Administration, Systematic Alien Verification for Entitlements, Department of Transitional Assistance, health-insurance carriers, and banks and other financial institutions.

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516.004: Time Standards for Eligibility Determination

(A) For applicants who do not apply on the basis of a disability, a determination of eligibility must be made within 45 days from the date of receipt of the completed application. All requested information must be received within 30 days of the date of request.

(B) For applicants who apply for MassHealth on the basis of a disability, a determination of eligibility must be made within 90 days from the date of receipt of the completed application, including a disability supplement, if required.

(C) If the MassHealth agency determines that unusual circumstances exist, the timeframes for determining eligibility are extended. Unusual circumstances include delay caused by the applicant, by an examining physician, or by other events beyond the control of the MassHealth agency.

516.005: Coverage Date

The begin date of MassHealth Standard, Family Assistance, or Limited coverage may be retroactive to the first day of the third calendar month before the month of application, if covered medical services were received during such period, and the applicant or member would have been eligible at the time services were provided. If more than one application has been submitted and not denied, the begin date will be based on the earliest application that is approved.

516.006: Continuing Eligibility

(A) Annual Renewals. The MassHealth agency reviews eligibility once every 12 months. Eligibility may also be reviewed as a result of a member's changes in circumstances or a change in MassHealth eligibility rules, or as a result of a member's failure to provide verification of immigration status. The MassHealth agency updates eligibility based on information received as the result of such review. The MassHealth agency reviews eligibility

- (1) by information matching with other agencies, health insurance carriers, and information sources;
- (2) through a written update of the member's circumstances on a prescribed form;
- (3) through an update of the member's circumstances, in person, by telephone, or on the MAHealthConnector.org account; or
- (4) based on information in the member's case file.

(B) Eligibility Determinations. The MassHealth agency determines, as a result of this review, if

- (1) the member continues to be eligible for the current coverage type;
- (2) the member's current circumstances require a change in coverage type; or
- (3) the member is no longer eligible for MassHealth.

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- (C) Eligibility Reviews. MassHealth reviews eligibility in the following ways.
- (1) Automatic Renewal. Households whose continued eligibility can be determined based on electronic data matches with federal and state agencies will have their eligibility automatically renewed.
- (a) The MassHealth agency will notify the member if eligibility has been reviewed using the automatic renewal process. The notice will include information about the data that was received through electronic data matches and used to determine continued eligibility.
- (b) If the member's coverage type changes to a more comprehensive benefit, the start date for the new coverage is the date of the written notice,
- (2) Prepopulated Review Form. If the individual is residing in the community and his or her continued eligibility cannot be determined based on reliable information contained in his or her account or electronic data match with federal and state agencies, a prepopulated eligibility review form must be completed.
- (a) The MassHealth agency will notify the member of the need to complete the prepopulated review form.
- (b) The member will be given 45 days from the date of the request to return the paper prepopulated review form, log onto his or her MAHealthConnector.org account to complete the review online, or call the MassHealth agency to complete the review telephonically.
- (i) If the review is completed within 45 days, eligibility will be determined using the information provided by the individual with verification confirmed through electronic data matches if available. If verification through electronic data match is unsuccessful, the MassHealth agency will request required verifications as described in 130 CMR 502.003: *Verification of Eligibility Factors* and the individual continues to receive benefits pending verification.
- (ii) If the review is not completed within 45 days, eligibility will be terminated within 14 days from the date of determination.
- (iii) If the individual submits the prepopulated review within 90 days of the termination date and is determined eligible for a MassHealth benefit, eligibility for that benefit is the date of the previous termination.
- (iv) If the prepopulated review is returned, but the required verifications are not submitted with the form, a second 90-day period starts on the date that the prepopulated form is returned.
- (v) If the prepopulated review is not submitted within 90 days of the previous termination date, a new application is required.
- (c) If the member's coverage type changes, the start date for the new coverage type is effective as of the date of the written notice.

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- (3) Review Form for Individuals In need of Long-Term-Care Services in a Nursing Facility. If the individual is in need of long-term-care services in a nursing facility and his or her continued eligibility cannot be determined based on reliable information contained in his or her account or electronic data match with federal and state agencies, a written update of the member's circumstances on a prescribed form must be completed.
- (a) The MassHealth agency will notify the member of the need to complete the prescribed review form.
  - (b) The member will be given 45 days to return the review form to the MassHealth agency.
    - (i) If the review is completed within 45 days, eligibility will be determined using the information provided by the individual with verification confirmed through electronic data matches if available.
    - (ii) If the review is not completed within 45 days, eligibility will be terminated within 14 days from the date of determination.
    - (iii) If the requested review form is submitted within 30 days from the date of the termination, a second eligibility determination is made within 15 days. Eligibility may be established retroactive to the date of termination, if otherwise eligible.
  - (c) If the member's coverage type changes, the start date for the new coverage type is effective as of the date of the written notice.
- (4) Periodic Data Matches. The MassHealth agency matches files of MassHealth members with other agencies and information sources as described in 130 CMR 516.003 to update or verify eligibility,
- (a) If the electronic data match indicates a change in circumstances that would result in potential reduction or termination of benefits, the MassHealth agency will notify the member of the information that was received through the data match and require the member to respond within 30 days of the date of the notice.
    - (i) If the member responds within 30 days and confirms the data is correct, eligibility will be determined using the confirmed data from the electronic data match.
    - (ii) If the member responds within 30 days and provides new information, eligibility will be determined using the information provided by the member. Additional verification will be required.
    - (iii) If the member does not respond within 30 days, eligibility will be determined using the data from the electronic data match.
  - (b) If the electronic data match indicates a change in circumstances that would result in an increase or no change in benefits, the MassHealth agency will notify the member of the information that was received through the data match and automatically update the case using the information received from the electronic data match and redetermine eligibility. The effective date of the change is the date of the redetermination of eligibility.

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516.007: Notice

(A) All applicants and members, as well as certain others described below in 130 CMR 516.007, receive written notice of the determination of their eligibility for MassHealth. The notice contains an eligibility decision for each member who has requested MassHealth, and provides information enabling the applicant or member to determine the reason for any adverse decision.

(B) Members also receive notice of any changes in coverage type or patient-paid amount, or loss of coverage.

(C) In addition to sending notices to applicants and members, such written notices are provided to the institution or authorized representative, as well as to the community spouse, as defined at 130 CMR 520.016(B)(1)(c): *Right to Appeal*. This may include, in the case of death, the executor, administrator, or legal representative of the deceased individual's estate.

(D) All notices provide information about the right of the applicant or member to a fair hearing, with the exception of asset assessments described at 130 CMR 520.016: *Long-Term Care: Treatment of Assets* and notices about federal or state law requiring an automatic change adversely affecting some or all members as described in 42 CFR 431.220(b). Information about the appeal process is found at 130 CMR 610.000: *MassHealth: Fair Hearing Rules*.

516.008: Voluntary Withdrawal

The applicant or authorized representative may voluntarily withdraw his or her application for MassHealth. An authorized representative may also withdraw a request for MassHealth on behalf of a deceased applicant.

516.009: Issuance of a MassHealth Card

(A) The MassHealth agency issues a MassHealth card to new members, with the exception of those who receive MassHealth Buy-In coverage.

(B) A temporary card may be issued to a member if there is an immediate need.