TABLE OF CONTENTS

Section

502.001: Application for Benefits

(A) Filing an Application. To apply for MassHealth, an individual or his or her authorized representative must file an application online at www.MAHealthConnector.org, complete a paper application, complete a telephone application, or apply in person at a MassHealth Enrollment Center (MEC).

(1) 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.

(2) Online or Telephone Application Requirements.

(a) Individuals, or their authorized representative, if applicable, completing an application for MassHealth online at www.MAHealthConnector.org or by telephone must be identity proofed pursuant to 130 CMR 502.001(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.

(c) When identity proof is received, the individual can submit an application and the eligibility process commences. The MassHealth agency will determine

1. 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 successful identity proofing; and

2. the need to request any corroborative information necessary to determine eligibility, as provided in 130 CMR 502.001(B) through (D).

(d) If identity proof is not received, the MassHealth agency is unable to determine eligibility for medical benefits.

(e) To prove his or her identity, an individual can submit the acceptable proofs of identity as described in 130 CMR 504.005(A)(1): *Acceptable Proof of Both Citizenship and Identity* or 130 CMR 504.005(A)(3): *Acceptable Proof of Identity*.

(4) Paper Applications or In-person Applications at the MEC Containing Missing or Inconsistent Information.

(a) If a paper application is received at a MassHealth Enrollment Center or a MassHealth outreach site and the applicant did not answer all required questions on the application or if the application is unsigned, 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 request referenced in 130 CMR 502.001(A)(4)(b), the eligibility process commences. The MassHealth agency will determine

1. 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
2. the need to request any corroborative information during the provisional eligibility period necessary to determine eligibility, as provided in 130 CMR 502.001(B) through (D).

(d) If responses to all unanswered questions necessary for determining eligibility are not received within the 15-day period referenced in 130 CMR 502.001(A)(4)(b), the MassHealth agency notifies the applicant that it is unable to determine eligibility for medical benefits. 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. Notwithstanding the foregoing, 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 verify eligibility in accordance with 130 CMR 502.003. The applicant must supply such information within 90 days of the receipt of the Request for Information Notice, as described at 130 CMR 502.003(C).

(C) Corroborative Information Received. If all necessary information is received within 90 days of the receipt of the Request for Information Notice, as described at 130 CMR 502.003(C), the MassHealth agency will determine the most comprehensive medical benefits for which the applicant is eligible.

(D) Corroborative Information Not Received. If the necessary information is not received within 90 days of the receipt of the Request for Information Notice, as described at 130 CMR 502.003(C), with the exception of the individuals described at 130 CMR 502.001(D)(1) through (4), the MassHealth agency will attempt to redetermine eligibility using electronic data sources, if available, but if such information is not available from these sources, the applicant's MassHealth benefits will be denied or terminated, as described in 130 CMR 502.003(D)(2). The MassHealth agency will notify the applicant accordingly.

(1) If the only necessary information not received within the provisional eligibility period referenced in 130 CMR 502.003(E) is verification of breast or cervical cancer, the individual will not be considered as an individual with breast or cervical cancer and will be determined for the most comprehensive coverage for which the individual qualifies without this factor.

(2) If the only necessary information not received within the provisional eligibility period referenced in 130 CMR 502.003(E) is verification of HIV-positive status, the individual will not be considered as an individual with HIV-positive status and will be determined for the most comprehensive coverage for which the individual qualifies without this factor.

(3) If the only necessary information not received within the provisional eligibility period referenced in 130 CMR 502.003(E) is verification of disability status, the individual will not be considered as a disabled individual and will be determined for the most comprehensive coverage for which the individual qualifies without this factor.

(4) If immigration status information is not received within the reasonable opportunity period referenced in 130 CMR 502.003(F) and the immigration status cannot be verified using electronic data sources, the individual's eligibility will be determined as an "other noncitizen" as described in 130 CMR 504.003(D): *Other Noncitizens*.

502.002: Reactivating the Application

If all required information is received by the MassHealth agency after the period described in 130 CMR 502.001(D), or after a denial of eligibility, the MassHealth agency reactivates the application and considers it submitted as of the date the information is received, and the medical coverage date is established in accordance with 130 CMR 502.006. A new application must be completed if all required information is not received within one year of receipt of the previous application.

502.003: Verification of Eligibility Factors

The MassHealth agency requires verification of eligibility factors including income, residency, citizenship, immigration status, and identity as described in 130 CMR 503.000: *Health Care Reform: MassHealth: Universal Eligibility Requirements*, 504.000: *Health Care Reform: MassHealth: Citizenship and Immigration*, and 506.000: *Health Care Reform: MassHealth: Financial Requirements*.

(A) Information Matches. The MassHealth agency initiates information matches with other agencies and information sources as described at 130 CMR 502.004 in the following order, when an application is received in order to verify eligibility

(1) the Federal Data Hub, which matches with the Social Security Administration, the Department of Homeland Security, and the Internal Revenue Service; and

(2) other federal and state agencies and other informational services.

(B) Electronic Data Sources. If electronic data sources are unable to verify or are not reasonably compatible with the attested information, additional documentation will be required from the individual.

(C) Request for Information Notice. If additional documentation is required including corroborative information as described at 130 CMR 502.001(B), a Request for Information Notice will be sent to the applicant listing all requested verifications and the deadline for submission of the requested verifications.

(D) Time Standards. The following time standards apply to the verification of eligibility factors.

(1) The applicant or member has 90 days from the receipt of the Request for Information Notice to provide all requested verifications.

(2) If the applicant or member fails to provide verification of information within 90 days of receipt of the MassHealth agency's request, the MassHealth agency does one of the following.

(a) If the required information is available from electronic data sources, the MassHealth agency uses that information to redetermine eligibility.

(b) If the required information is not available from electronic data sources, MassHealth coverage is denied or terminated except for individuals described at 130 CMR 502.001(D)(1) through (4).

(c) If the required verifications are received within one year from the date of the application or renewal form was received, coverage is reinstated to a date 10 days before the receipt of the verifications.

(d) If the required verifications are not received within one year of receipt of the previous application or renewal form, a new application must be completed.

(E) Provisional Eligibility. The MassHealth agency will provide benefits while the applicant provides the MassHealth agency outstanding corroborative information in accordance with 130 CMR 502.003(D)(1), except for individuals described at 130 CMR 502.003(E)(2). Except as further set forth below, the MassHealth agency will accept self-attestation for all eligibility factors other than citizenship and immigration status, and make a provisional eligibility determination as

if the applicant had supplied the information. MassHealth applicants can receive only one provisional eligibility approval during a 12-month period, unless the individual is a pregnant woman. MassHealth members are required to enroll in managed care during the provisional eligibility period, if enrollment is otherwise required as described in 130 CMR 508.004: *Members Excluded from Participation in Various Managed Care Options*. MassHealth members who have been assessed a premium are subject to payment of premiums during the provisional eligibility period. Premium assistance is not awarded during the provisional eligibility period. It is only provided when all corroborative information has been received and the health-insurance investigation is complete, as described in 130 CMR 505.000: *Health Care Reform: MassHealth: Coverage Types*. Provisional eligibility is subject to the following limitations.

(1) Coverage Date.

(a) Coverage for individuals younger than 21 years old and pregnant women who have been determined provisionally eligible begins 10 days before the date the application is received.

(b) Coverage for all other individuals who have been determined provisionally eligible begins on the date the notice of the provisional eligibility determination is sent.

(c) If all required verification are received before the end of the provisional eligibility period, retroactive coverage is provided for the verified coverage type in accordance with 130 CMR 505:000: *Health Care Reform: MassHealth: Coverage Types*.

(2) Limitations. Provisional eligibility is subject to the following limitations.

(a) Provisional eligibility is not available for adults 21 years of age or older who have not verified all income in their MAGI household, as described at 130 CMR 506.000: *Financial Requirements*, unless the individual is

1. a pregnant woman with attested MAGI income at or below 200% of the federal poverty level (FPL);

2. an individual 21 through 64 years of age who is HIV-positive with attested MAGI income at or below 200% of the FPL; or

3. an individual in active treatment for breast or cervical cancer who is younger than 65 years old with attested MAGI income at or below 250% of the FPL.

(b) The MassHealth agency will not accept self-attestation of disability. Disability must be verified as described in 130 CMR 505.002(E)(1): *Disabled Adults*. Eligibility for applicants who apply for benefits on the basis of disability will be determined as if they were not disabled until disability is verified as described in 130 CMR 505.002(E)(1): *Disabled Adults*.

(c) A member's coverage type will not be redetermined during the provisional eligibility period, except that members granted provisional eligibility who attest to pregnancy will be enrolled in MassHealth Standard.

(F) Reasonable Opportunity to Verify Citizenship and Identity or Immigration Status. The MassHealth agency provides applicants and members a reasonable opportunity period to provide satisfactory documentary evidence of citizenship and identity or immigration status if MassHealth's electronic data matches are unable to verify the applicant's citizenship or immigration status.

(1) Time Standards. The reasonable period begins on, and extends 90 days from, the date on which an applicant or member receives a reasonable opportunity notice.

(2) Coverage Start Date.

(a) Coverage for children younger than 21 years old and pregnant women who receive a reasonable-opportunity period begins 10 days before the date the application is received.

(b) Coverage for all other individuals who receive a reasonable-opportunity period begins on the date the Request for Information Notice is sent.

(c) If satisfactory documentary evidence of citizenship and identity or immigration status is received before the end of the reasonable-opportunity period, retroactive coverage is provided for the verified coverage type in accordance with 130 CMR 505.000: *Health Care Reform: MassHealth: Coverage Types*.

(G) Reasonable Opportunity Extension. Applicants or members who have made a good faith effort to resolve inconsistencies or obtain verification of immigration status may receive a 90-day extension. Requests for a reasonable opportunity extension must be made before the expiration of the verification time period.

(H) Hospital-determined Presumptive Eligibility.

(1) Presumptive Eligibility Determinations. A qualified hospital may make presumptive eligibility determinations for its patients in accordance with 130 CMR 450.110: *Hospital Determined Presumptive Eligibility*. Presumptive eligibility will be determined based on attested information. The MassHealth agency will use estimated gross household income rather than MassHealth MAGI to assess whether the financial requirements described below have been met. The qualified hospital may determine presumptive eligibility for the following:

(a) MassHealth Standard if the individual appears to meet categorical and financial requirements in 130 CMR 505.002: *MassHealth Standard* and the individual is

1. a child younger than one year old;
2. a child one through 18 years old;
3. a young adult 19 and 20 years old;
4. a pregnant woman;
5. a parent or caretaker relative;
6. an individual with breast or cervical cancer;
7. an individual who is HIV positive; or
8. an independent foster care adolescent up to age 26;

(b) MassHealth CarePlus if the individual appears to meet categorical and financial requirements in 130 CMR 505.008: *MassHealth CarePlus* and the individual is an adult 21 to 64 years old; or

(c) MassHealth Family Assistance if the individual appears to meet categorical and financial requirements in 130 CMR 505.005(C): *Eligibility Requirements for Children and Young Adults Who Are Nonqualified PRUCOLs with Modified Adjusted Gross Income of the MassHealth MAGI Household at or below 150 % of the Federal Poverty Level* or 130 CMR 505.005(E): *Eligibility Requirement for HIV-Positive Individuals Who Are Citizens or Qualified Noncitizens with Modified Adjusted Gross Income of the MassHealth MAGI Household Greater than 133 and Less than or Equal to 200 % of the Federal Poverty Level* and is

1. a child or a young adult who is a nonqualified PRUCOL as described in 130 CMR 504.003(C): *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs)*; or
2. an individual who is HIV positive.

(2) Coverage Start Date. Benefits provided through the hospital presumptive eligibility process will begin on the date that the hospital determines presumptive eligibility and will continue until

(a) the end of the month following the month in which the hospital determined presumptive eligibility, if the individual has not submitted a complete application as described in 130 CMR 502.001 by that date; or

(b) an eligibility determination is made based upon the individual's submission of a complete application as described in 130 CMR 502.001, if the complete application was submitted before the end of the month following the month of the hospital-presumptive eligibility determination.

(3) Premium Assessment. Individuals who are determined eligible through hospital-determined presumptive eligibility will not be assessed a premium. Premium assistance is not awarded during the presumptive eligibility period.

(4) Continued Eligibility. The individual must submit a complete application as described in 130 CMR 502.001 to determine continued eligibility for MassHealth.

(I) Verification Exceptions for Special Circumstances. Except with respect to the verification of citizenship and immigration status, the MassHealth agency will permit, on a case-by-case basis, self-attestation of individuals for all eligibility criteria when documentation does not exist at the time of application or renewal, or is not reasonably available, such as in the case of individuals who are homeless or have experienced domestic violence or a natural disaster.

502.004: Matching Information

The MassHealth agency may initiate information matches with other agencies and information sources when an application is received, at annual renewal, and periodically, in order to update or verify eligibility. These agencies and information sources may include, but are not limited to, the following: the Federal Data Services Hub, the Department 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**,** and health insurance carriers.

502.005: Time Standards for an Eligibility Determination

(A) For applicants who do not apply on the basis of a disability, the MassHealth agency makes an eligibility determination

(1) within 60 days from the date of receipt of the complete application if the applicant is potentially eligible for MassHealth Family Assistance; or

(2) within 45 days from the date of receipt of the complete application for all other nondisabled applicants.

(B) For applicants who apply on the basis of a disability, the MassHealth agency makes an eligibility determination within 90 days from the date of receipt of the complete application.

(C) Households with one or more applicants aged 65 or older who are not eligible for benefits under the regulations in 130 CMR 501.000: *Health Care Reform: MassHealth: General Policies* through 508.000: *Health Care Reform: MassHealth: Managed Care Requirements* will be determined by the time standards described at 130 CMR 516.005: *Time Standards for Eligibility Determination* for the entire household.

(D) The time standards described in 130 CMR 502.005(A) through (C) may be extended by the amount of time used by the applicant to respond to requests for additional information needed to make the disability determination.

502.006: Coverage Dates

(A) Start Date of Coverage for Applicants. For individuals applying for coverage, the date of coverage for MassHealth is determined by the coverage type for which the applicant may be eligible. 130 CMR 505.000: *Health Care Reform: MassHealth: Coverage Types* describes the rules for establishing this date, except as specified in 130 CMR 502.003(E)(1), (F)(2), and (H)(2).

(1) The start date of coverage for individuals approved for benefits under provisional eligibility is described at 130 CMR 502.003(E)(1).

(2) The start date of coverage for individuals who do not meet the requirements for provisional eligibility, as described at 130 CMR 502.003(E)(2)(a), is described at 130 CMR 502.006(A)(2)(a) through (c), except individuals described at 130 CMR 502.006(C).

(a) For individuals who submit all required verifications within the 90-day time frame, the start date of coverage is determined upon receipt of the requested verifications and coverage begins ten days prior to the date of application, except as specified in 130 CMR 506.006(C).

(b) For individuals who fail to provide verifications of information within 90 days of the receipt of the MassHealth agency's request and the MassHealth agency used information received from electronic data sources to determine eligibility, the start date of coverage is determined upon the agency's eligibility determination and coverage begins ten days prior to the date of application, except as specified in 130 CMR 502.006(C).

(c) For individuals denied for failure to provide verification of requested information who then provide requested verifications or report changes after the denial, the start date of coverage is ten days prior to the date of receipt of all requested verifications or a reported change, except as specified in 130 CMR 502.003(D)(2)(d) and 502.006(C).

(B) Coverage Dates for Existing Members who Have a Change in Benefits. The date of coverage for existing members whose MassHealth coverage type changes due to a change in circumstances are:

(1) for existing members when an eligibility determination results in a more comprehensive benefit, except as described at 130 CMR 502.006(C), the start date of the new coverage is ten days prior to

(a) the receipt of the requested verifications;
(b) the receipt date of the annual renewal;
(c) the date of the eligibility determination for reported changes that do not result in request for verification; or
(d) the date of the MassHealth agency's eligibility determination due to information in the member's case file;

(2) for existing members when an eligibility determination results in a less comprehensive benefit, the end date of the existing coverage is no sooner than 14 days from the date of the notice unless the MassHealth member files an appeal in a timely manner and requests continued MassHealth benefits pending such an appeal or reinstatement of benefits as described at 130 CMR 610.036: *Continuation of Benefits Pending Appeal* and the start date of the new coverage is ten days prior to

(a) the receipt of the requested verifications;
(b) the receipt date of the annual renewal;
(c) the date of the eligibility determination for reported changes; or
(d) the date of the MassHealth agency's eligibility determination due to information in the member's case file;

(3) for existing members, effective dates for changes in premium payments are described at 130 CMR 506.011(C).

(C) Limitations. MassHealth coverage start dates are subject to the following limitations.

(1) The start date for Medicare premium payments for individuals determined eligible for MassHealth Standard, MassHealth CommonHealth, and MassHealth Senior Buy-in and Buy-in is described at 130 CMR 505.002(O), 505.004(L), and 505.007.

(2) The start date for Premium Assistance Payment for individuals eligible for MassHealth Standard, MassHealth CommonHealth, MassHealth Family Assistance, and MassHealth CarePlus is described at 130 CMR 506.012(F)(1)(d).

(3) The start date for MassHealth CommonHealth for persons described at 130 CMR 505.004(C) who have been notified by the MassHealth agency that they must meet a one-time deductible have their medical coverage start date established in accordance with 130 CMR 506.009(E): *Notification of the Deductible*.

(D) End Date of Coverage. Except as specified in 130 CMR 502.003(H)(2), MassHealth benefits terminate or downgrade no sooner than 14 days from the date of termination or downgrade notice unless the MassHealth member timely files an appeal and requests continued MassHealth benefits pending such appeal or reinstatement of benefits as described at 130 CMR 610.036: *Continuation of Benefits Pending Appeal*. MassHealth will extend coverage to the end of the month only for those individuals whose MassHealth eligibility is terminated and who become eligible for the Premium Tax Credit (PTC). If the effective date of the termination is on or before the 15th of the

month, MassHealth coverage will end on the last day of that month. If the effective date of the termination is after the 15th of the month, MassHealth coverage will end on the last day of the following month.

502.007: 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 change in circumstances, or a change in MassHealth eligibility rules, or as a result of a member's failure to provide verification within requested time frames. The MassHealth agency updates eligibility based on information received as a 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, premium payment, or premium assistance payment; or

(3) the member is no longer eligible for MassHealth.

(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) If the data match results in no change in benefits or in a more comprehensive benefit for all members of the household, the MassHealth agency will notify the head of household that eligibility has been reviewed using the automatic renewal process.

(b) In addition, if the member's coverage type changes to a more comprehensive benefit, the member will be sent a notice informing him or her of the start date for the new coverage. The start date of the new coverage is described at 130 CMR 502.006, except that premium assistance payments under MassHealth Family Assistance begin in the month of the MassHealth agency's eligibility determination or in the month that the insurance deduction begins, whichever is later in accordance with 130 CMR 506.012(F)(1)(d).

(2) Prepopulated Renewal Application. Households whose continued eligibility cannot be determined based on electronic data matches with federal and state agencies and households whose eligibility would change to a less comprehensive benefit for at least one member of the household as a result of the data matches will be required to complete a prepopulated renewal application.

(a) The MassHealth agency will notify the head of the household of the need to complete the renewal application.

(b) The head of the household will be given 45 days from the date of the request to return the paper prepopulated renewal application, log onto his or her MAHealthConnector.org account to complete the renewal application online, or call the MassHealth agency to complete the renewal application telephonically.

1. If the renewal application 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 and the individual continues to receive benefits pending verification.

2. If the renewal application is not completed within 45 days, the MassHealth agency will

a. use information received from electronic sources, if available, and redetermine eligibility; or

b. if information is not available from electronic sources, terminate MassHealth coverage as described at 130 CMR 502.006(B).

3. If the individual submits the prepopulated renewal application within 90 days of the termination date, as described in 130 CMR 502.007(C)(2)(b)2., and is determined eligible for a MassHealth benefit, the date of coverage for MassHealth is determined by the coverage type for which the individual is now eligible, in accordance with 130 CMR 502.006(A). The begin date of MassHealth coverage may be retroactive to the date of the termination if the individual requests retroactive coverage and has incurred covered medical services since the date of the termination.

4. If the prepopulated renewal application 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.

5. If the prepopulated renewal application 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 determined as follows.

1. If the member's coverage type changes, the start date for the new coverage type is effective as described in 130 CMR 502.006(A).

2. However, premium assistance payments under MassHealth Family Assistance begin in the month of the MassHealth agency's eligibility determination or in the month the insurance begins, whichever is later in accordance with 130 CMR 506.012(F)(1)(d).

(3) Periodic Data Matches. The MassHealth agency matches files of MassHealth members with other agencies and information sources as described in 130 CMR 502.004 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.

1. 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.

2. If the member responds within 30 days and provides new information, eligibility will be determined using the information provided by the member. Additional verification from the member will be required.

3. If the member does not respond within 30 days, eligibility will be determined using available information received from the electronic data sources. If information necessary for eligibility determination is not available from electronic data sources, MassHealth coverage will be terminated.

(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 automatically update the case using the information received from the electronic data match and redetermine eligibility. If the member's coverage type changes to a more comprehensive benefit, the member will be sent a notice informing him or her of the start date for the new benefit. The effective date of the more comprehensive benefit is determined in accordance with 130 CMR 502.006(A).

502.008: Notice

(A) The MassHealth agency provides all applicants and members a written notice of the eligibility determination for MassHealth. The notice contains an eligibility decision for each member who has requested MassHealth, and either provides information so the applicant or member can determine the reason for any adverse decision or directs the applicant or member to such information.

(B) The MassHealth agency also provides members a notice, in accordance with 130 CMR 610.015: *Time Limits*, of any loss of coverage, or any changes in coverage type, premium, or premium assistance payments.

(C) The notices described in 130 CMR 502.008(A) and (B) provide information about the applicant's and member's right to a fair hearing, with the exception of notices about hospital-determined presumptive eligibility, as described in 130 CMR 502.003(H), 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*.

502.009: Voluntary Withdrawal

The applicant or authorized representative may voluntarily withdraw his or her application for MassHealth.

502.010: Issuance of a MassHealth Card

(A) The MassHealth agency issues a MassHealth card to new members, with the exception of those who receive premium assistance under MassHealth Small Business Employee Premium Assistance as described in 130 CMR 505.009: *MassHealth Small Business Employee Premium Assistance*.

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

REGULATORY AUTHORITY

130 CMR 502.000: M.G.L. c. 118E, §§ 7 and 12.