Trans. by E.L. 258
Rev. 02/13/26

130 CMR 519.000: MASSHEALTH: COVERAGE TYPES

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519.001: Introduction

(A) Categorical Requirements and Financial Standards. 130 CMR 519.000 explains the categorical requirements and financial standards that must be met to qualify for a MassHealth coverage type. The rules of financial responsibility and the calculation of financial eligibility are detailed in 130 CMR 520.000: *MassHealth: Financial Eligibility*.

(B) MassHealth Coverage Types. The MassHealth coverage types available to individuals 65 years of age and older, institutionalized individuals, and those who would be institutionalized without community-based services are the following:

(1) MassHealth Standard;
(2) MassHealth Limited;
(3) Medicare Savings Program (MSP) for Qualified Medicare Beneficiaries (QMBs) (Senior Buy-in);
(4) MSP for Specified Low-income Medicare Beneficiaries (SLMBs) and Qualifying Individuals (QIs) (Buy-in);
(5) MassHealth CommonHealth; and
(6) MassHealth Family Assistance.

(C) Determining Eligibility. The MassHealth agency determines eligibility for the most comprehensive coverage available to the applicant, although the applicant has the right to choose to have eligibility determined only for MSP for QMBs or MSP for SLMB and QI coverage. If no choice is made by the applicant, the MassHealth agency determines eligibility for all available coverage types.

519.002: MassHealth Standard

(A) Overview

(1) 130 CMR 519.002 through 130 CMR 519.007 contain the categorical requirements and asset and income standards for MassHealth Standard, which provides coverage for individuals aged 65 and older, institutionalized individuals, and those who would be institutionalized without community-based services.
(2) Individuals eligible for MassHealth Standard are eligible for medical benefits on a fee-for-service basis as defined in 130 CMR 515.001: *Definition of Terms*. The medical benefits are described in 130 CMR 450.105(A): *MassHealth Standard*.
(3) The start date of medical coverage for MassHealth Standard is established in accordance with 130 CMR 519.002(A)(3)(a) through (b).

(a) If covered medical services were received during the period for which coverage is requested, and the individual would have been eligible at the time services were provided, the start date of coverage is determined upon receipt of the application and may be retroactive to the first day of the third calendar month before the month of application, pursuant to 42 CFR 435.915. Retroactive eligibility does not apply to services rendered under a home- and community-based services waiver provided under § 1915(c) of the Social Security Act. An application is considered complete if it complies with 130 CMR 516.001(C).
(b) If covered medical services were not received during such period, or the individual would not have been eligible at the time services were provided, the start date of coverage is determined upon receipt of the application or upon receipt of any requested verifications, and coverage begins on the first day of the month in which the application was received.
(c) If more than one application has been submitted and not denied, the start date of coverage will be based on the earliest application that is approved.

(B) Automatic Eligibility for Supplemental Security Income (SSI) Recipients
(1) Individuals described in 130 CMR 519.002(A)(1) who meet basic, categorical, and financial requirements under the SSI Program are automatically eligible to receive MassHealth Standard and Medicare Savings Program (MSP) coverage.
(2) Eligibility for retroactive coverage must be established by the MassHealth agency in accordance with 130 CMR 516.005: *Time Standards for Eligibility Determination*.

(C) Extended Eligibility for SSI Recipients. An individual whose SSI assistance has been terminated, and who is determined to be potentially eligible for MassHealth, continues to receive MassHealth Standard coverage until a determination of ineligibility is made by the MassHealth agency.

(D) Automatic and Extended Eligibility for Emergency Aid to the Elderly, Disabled and Children (EAEDC) Recipients 65 Years of Age and Older
(1) Automatic Eligibility. Individuals 65 years of age and older who meet the requirements of the EAEDC Program administered by the Department of Transitional Assistance and who are United States citizens as described in 130 CMR 518.002: *U.S. Citizens* or qualified noncitizens, as described in 130 CMR 518.003(A)(1): *Qualified Noncitizens*, are automatically eligible for MassHealth Standard benefits.
(2) Extended Eligibility. Individuals described in 130 CMR 519.002(D)(1) whose EAEDC cash assistance ends will continue to receive MassHealth Standard benefits until the MassHealth agency determines that the member is ineligible.

(E) Medicare Premium Payment. The MassHealth agency, in accordance with the MSP as described at 130 CMR 519.010 and 519.011, pays the following:
(1) Medicare Part B premiums for members with countable income that is less than or equal to 225% of the federal poverty level (FPL);

(2) Medicare Part A premiums for adult members of MassHealth Standard who are entitled to Medicare Part A with a countable income that is less than or equal to 190% of the FPL; and
(3) the deductibles and coinsurance under Medicare Parts A and B for members with a countable income that is less than or equal to 190% of the FPL.

519.003: Pickle Amendment Cases

(A) Eligibility Requirements. Under the Pickle Amendment, former Supplemental Security Income (SSI) recipients whose income exceeds 100% of the federal poverty level are eligible for MassHealth Standard provided they
(1) or their spouse or both are receiving Retirement, Survivors, and Disability Insurance (RSDI) benefits;
(2) were eligible for and received SSI benefits after April 1977;
(3) would be currently eligible for SSI, in accordance with SSI payment standards at 130 CMR 519.003(B), if the incremental amount of RSDI cost-of-living increases paid to them since the last month subsequent to April 1977 for which they were both eligible for and receiving SSI and entitled to (but not necessarily receiving) RSDI were deducted from the current amount of RSDI benefits. Cost-of-living increases referred to in 130 CMR 519.003 include increases received by the applicant or member or by the spouse. The spouse need not be otherwise eligible for SSI; and
(4) have countable assets that are $2,000 or less for an individual and $3,000 or less for a married couple**.**

(B) SSI Payment Standards. The RSDI amount, as described in 130 CMR 519.003(A)(3), and any other countable-income amount, as defined in 130 CMR 520.009: *Countable-income Amount*, of the individual or couple is compared to the SSI payment standards to determine Pickle eligibility. Each calendar year, the SSI payment standards shall be made available on MassHealth's website.

(C) Financial Standards Not Met. Individuals whose income, assets, or both exceed the standards in 130 CMR 519.003 may establish eligibility by reducing assets in accordance with 130 CMR 520.004: *Asset Reduction*, meeting a deductible as described in 130 CMR 520.028 through 520.035, or both.

519.004: Disabled Adult Children

(A) Eligibility Requirements. Individuals who lose eligibility for Supplemental Security Income (SSI) benefits may retain eligibility for MassHealth Standard provided that they
(1) are 18 years of age or older;
(2) became blind or disabled before reaching 22 years old;
(3) receive or received SSI based on their blindness or disability;

(4) received an increase in child's insurance benefits under § 202(d) of the Social Security Act, or became entitled to those benefits on the basis of blindness or disability, on or after July 1, 1987;
(5) lose or lost SSI as a result of this entitlement or increase in child's insurance benefits under § 202(d) of the Social Security Act; and
(6) would still be eligible for SSI in the absence of such Retirement, Survivors, and Disability Insurance benefits or increase in benefits.

(B) Financial Standards Not Met. Individuals whose income, assets, or both exceed the standards set forth in 130 CMR 519.004(A) may establish eligibility for MassHealth Standard by reducing their assets in accordance with 130 CMR 520.004: *Asset Reduction*, meeting a deductible as described at 130 CMR 520.028 through 520.035, or both.

519.005: Community Residents 65 Years of Age and Older

(A) Eligibility Requirements. Except as provided in 130 CMR 519.005(C), noninstitutionalized individuals 65 years of age and older may establish eligibility for MassHealth Standard coverage provided they meet the following requirements:
(1) the countable-income amount, as defined in 130 CMR 520.009: *Countable-income Amount*, of the individual or couple is less than or equal to 100% of the federal poverty level; and
(2) the countable assets of an individual are $2,000 or less, and those of a married couple living together are $3,000 or less.

(B) Financial Standards Not Met. Except as provided in 130 CMR 519.005(C), individuals whose income, assets, or both exceed the standards set forth in 130 CMR 519.005(A) may establish eligibility for MassHealth Standard by reducing their assets in accordance with 130 CMR 520.004: *Asset Reduction*, meeting a deductible as described at 130 CMR 520.028: *Eligibility for a Deductible* through 520.035: *Conclusion of the Deductible Process*, or both.

(C) Parents and Caretaker Relatives of Children Younger Than 19 Years Old
(1) Eligibility Requirements. Adults who are 65 years of age and older and are the parents or caretaker relatives of a child younger than 19 years old receive MassHealth Standard if they meet the requirements of 130 CMR 505.002(C): *Eligibility Requirements for Parents and Caretaker Relatives* or (L): *Extended Eligibility*.
(2) Other Provisions. The following provisions apply to adults described in 130 CMR 519.005(C)(1) and 130 CMR 505.002(A)(6), 130 CMR 505.002(M): *Use of Potential Health Insurance Benefits*, 130 CMR 505.002(O): *Medicare Premium Payment*, and 130 CMR 505.002(P): *Medical Coverage Date*.
(3) Countable Income. Eligibility for adults described in 130 CMR 519.005(C)(1) is based on the individual's modified adjusted gross income (MAGI) of the MassHealth MAGI household and the income rules described at 130 CMR 506.002: *Household Composition* and 130 CMR 506.003: *Countable Household Income*.

(4) Exemption from Asset Limits. The asset limits in 130 CMR 520.003: *Asset Limit* do not apply to applicants or members described in 130 CMR 519.005(C)(1).

519.006: Long-term-care Residents

(A) Eligibility Requirements. Institutionalized individuals may establish eligibility for MassHealth Standard coverage subject to the following requirements. They must

(1) be younger than 21 years old or 65 years of age or older or, for individuals 21 through 64 years old, meet Title XVI disability standards or be pregnant;

(2) be determined medically eligible for nursing facility services by the MassHealth agency or its agent as a condition for payment, in accordance with 130 CMR 456.000: *Long Term Care Services*;

(3) contribute to the cost of care as defined at 130 CMR 520.026: *Long-term-care General Income Deductions*;

(4) have countable assets of $2,000 or less for an individual and, for married couples where one member of the couple is institutionalized, have assets that are less than or equal to the standards at 130 CMR 520.016(B): *Treatment of a Married Couple's Assets When One Spouse Is Institutionalized*; and

(5) not have transferred resources for less than fair market value, as described at 130 CMR 520.018: *Transfer of Resources Regardless of Date of Transfer* and 520.019: *Transfer of Resources Occurring on or after August 11, 1993*.

(B) Verification of Disability or Pregnancy

(1) Disability is verified by:

(a) certification of legal blindness by the Massachusetts Commission for the Blind (MCB);

(b) a determination of disability by the Social Security Administration; or

(c) a determination of disability by Disability Evaluation Services (DES). Until this determination is made, the applicant's submission of a completed disability supplement will satisfy the verification requirement.

(2) Pregnancy is verified by a written statement from a competent medical authority certifying the pregnancy.

519.007: Individuals Who Would Be Institutionalized

130 CMR 519.007 describes the eligibility requirements for MassHealth Standard coverage for individuals who would be institutionalized if they were not receiving home- and community-based services.

(A) The Kaileigh Mulligan Program. The Kaileigh Mulligan Program enables severely disabled children younger than 18 years old to remain at home. The income and assets of their parents are not considered in the determination of eligibility.

(1) Eligibility Requirements. Children younger than 18 years old may establish eligibility for the Kaileigh Mulligan Program by meeting the following requirements. They must

(a) 1. meet Title XVI disability standards in accordance with the definition of permanent and total disability for children younger than 18 years old in 130 CMR 515.001: *Definition of Terms* or have been receiving Supplemental Security Income (SSI) on August 22, 1996; and

2. continue to meet Title XVI disability standards that were in effect before August 22, 1996;

(b) have $2,000 or less in countable assets;

(c) 1. have a countable-income amount of $72.80 or less; or

2. if their countable income is greater than $72.80, meet a deductible in accordance with 130 CMR 520.028 through 520.035; and

(d) require a level of care equivalent to that provided in a hospital or nursing facility in accordance with 130 CMR 519.007(A)(3) and (4).

(2) Additional Requirements. The MassHealth agency must have determined

(a) that care provided outside an institution is appropriate; and

(b) that the estimated cost paid by the MassHealth agency would not be more than the estimated cost paid if the child were institutionalized.

(3) Level of Care That Must Be Required in a Hospital. To require the level of care provided in a hospital, the child must have a medical need for the following:

(a) direct administration of at least two discrete skilled-nursing services (as defined in 130 CMR 515.001: *Definition of Terms*) on a daily basis, each of which requires complex nursing procedures, such as administration of intravenous hyperalimentation, changing tracheotomy tubes, assessment or monitoring related to an uncontrolled seizure disorder, assessment or monitoring related to an unstable cardiopulmonary status, or other unstable medical condition;

(b) direct management of the child's medical care provided by a physician or directly by someone who is under the supervision of a physician on at least a weekly basis;

(c) ongoing use of invasive medical technologies or techniques to sustain life (such as ventilation, hyperalimentation, or gastrostomy tube feeding), or dialysis, or both; and

(d) at least one of the following:

1. assistance in one or more activities of daily living (ADLs), as defined in 130 CMR 515.001: *Definition of Terms*, beyond what is required at an age-appropriate activity level; or

2. one or more skilled therapeutic services (occupational therapy, physical therapy, or speech and language therapy), provided directly by or under the supervision of a licensed therapist at least five times a week.

(4) Level of Care That Must Be Required in a Skilled-nursing Facility. To require the level of care provided in a skilled-nursing facility, the child must be nonambulatory and meet the following requirements.

(a) A child 12 months of age or older must have global developmental skills (as defined in 130 CMR 515.001: *Definition of Terms*) not exceeding those of a 12-month-old child as indicated by a developmental assessment performed by the child's physician or by another certified professional. In addition, the child's developmental skills level must not be expected to improve.

(b) A child younger than 12 months old must have global developmental skills significantly below an age-appropriate level and such skills must not be expected to progress at an age-appropriate rate as indicated by a developmental assessment performed by the child's physician or by another certified professional.

(c) Regardless of age, the child must also require all of the following:

1. direct administration of at least two discrete skilled nursing services on a daily basis, each of which requires complex nursing procedures as described at 130 CMR 519.007(A)(3);
2. direct management of the child's medical care provided by a physician or directly by someone who is under the supervision of a physician on a monthly basis;
3. assistance in one or more ADLs beyond what is required at an age-appropriate activity level; and
4. any combination of skilled therapeutic services (physical therapy, occupational therapy, or speech and language therapy) provided directly by or under the supervision of a licensed therapist at least five times a week.

(5) Premium Assistance for Standard Kaileigh Mulligan. Individuals eligible for MassHealth Standard in 130 CMR 519.007(A) may be eligible for premium assistance if they meet the requirements described in 130 CMR 505.002(N): *Access to Employer-sponsored Insurance and Premium Assistance Investigations for Individuals Who Are Eligible for MassHealth Standard* and 506.012: *Premium Assistance Payments*.

(B) Home- and Community-based Services Waiver—Frail Elder

(1) Clinical and Age Requirements. The Home- and Community-based Services Waiver allows an applicant or member who is certified by the MassHealth agency or its agent to be in need of nursing-facility services to receive certain waiver services at home if they

(a) are 60 years of age or older and, if younger than 65 years old, are permanently and totally disabled in accordance with Title XVI standards; and

(b) would be institutionalized in a nursing facility, unless they receive one or more of the services administered by the Executive Office of Aging and Independence under the Home- and Community-based Services Waiver—Frail Elder authorized under § 1915(c) of the Social Security Act.

(2) Eligibility Requirements. In determining eligibility for MassHealth Standard and for waiver services, the MassHealth agency determines income eligibility based solely on the applicant's or member's income regardless of their marital status. The applicant or member must

(a) meet the requirements of 130 CMR 519.007(B)(1)(a) and (b);

(b) have a countable-income amount less than or equal to 300% of the federal benefit rate (FBR) for an individual; and

(c) have countable assets of $2,000 for an individual and, for a married couple if the initial waiver eligibility determination was on or after January 1, 2014, have assets that are less than or equal to the standards at 130 CMR 520.016(B): *Treatment of a Married Couple's Assets When One Spouse Is Institutionalized*; and

(d) not have transferred resources for less than fair market value, as described at 130 CMR 520.018: *Transfer of Resources Regardless of the Transfer Date* and 520.019: *Transfer of Resources Occurring on or after August 11, 1993*.

(3) Financial Standards Not Met. Individuals whose income, assets, or both exceed the standards set forth in 130 CMR 519.007(B)(2) may establish eligibility for MassHealth Standard by reducing their assets in accordance with 130 CMR 520.004: *Asset Reduction*, by meeting a deductible as described at 130 CMR 520.028 through 520.035, or by both.

(C) Program of All-inclusive Care for the Elderly (PACE)

(1) Overview. PACE is a comprehensive health program that is designed to keep frail, older individuals who are certified eligible for nursing facility services living in the community.

(a) A complete range of healthcare services is provided by one designated community-based program, with all medical and social services coordinated by a team of health professionals.

(b) The MassHealth agency administers the program in Massachusetts as the Elder Service Plan (ESP).

(c) Persons enrolled in PACE have services delivered through managed care

1. in day-health centers;
2. at home; and
3. in specialty or inpatient settings, if needed.

(2) Eligibility Requirements. In determining PACE eligibility, the MassHealth agency counts the income and assets of only the applicant or member regardless of their marital status. The applicant or member must meet all of the following criteria:

(a) be 55 years of age or older;

(b) meet Title XVI disability standards if 55 through 64 years old;

(c) be certified by the MassHealth agency or its agent to be in need of nursing facility services;

(d) live in a designated service area;

(e) have medical services provided in a specified community-based PACE program;

(f) have countable assets whose total value does not exceed $2,000 or, if assets exceed these standards, reduce assets in accordance with 130 CMR 520.004: *Asset Reduction*; and

(g) have a countable-income amount less than or equal to 300% of the FBR for an individual.

(3) Income Standards Not Met. Individuals whose income exceeds the standards set forth in 130 CMR 519.007(C)(2) may establish eligibility for MassHealth Standard by meeting a deductible as described at 130 CMR 520.028 through 520.035.

(D) Home- and Community-based Services Waivers for Persons with an Intellectual Disability

(1) Intensive Supports Waiver

(a) Clinical and Age Requirements. The Intensive Supports Home- and Community-based Services Waiver for Persons with an Intellectual Disability allows an applicant or member who is certified by the MassHealth agency or its agent to be in need of inpatient care at an intermediate-care facility for people with an intellectual disability to receive residential habilitation and other specified waiver services if they meet all of the following criteria:

1. have an intellectual disability/developmental disability in accordance with Department of Developmental Services standards;
2. need one or more of the services administered by the Department of Developmental Services under the Intensive Supports Home- and Community-based Services Waiver authorized under § 1915(c) of the Social Security Act;
3. need 24/7 support either in a 24-hour supervised residential setting or in the family home as provided under the Intensive Supports Waiver; and
4. are 22 years of age or older and, if younger than 65 years old, are totally and permanently disabled in accordance with Title XVI standards.

(b) Eligibility Requirements. In determining eligibility for MassHealth Standard and for these waiver services, the MassHealth agency determines income eligibility based solely on the applicant's or member's income regardless of their marital status. The applicant or member must meet all of the following criteria:

1. meet the requirements of 130 CMR 519.007(D)(1)(a);
2. have countable income that is less than or equal to 300% of the FBR for an individual;
3. have countable assets of $2,000 or less for an individual and, for a married couple if the initial waiver eligibility determination was on or after January 1, 2014, have assets that are less than or equal to the standards at 130 CMR 520.016(B): *Treatment of a Married Couple's Assets When One Spouse Is Institutionalized*; and
4. not have transferred resources for less than fair market value, as described in 130 CMR 520.018: *Transfer of Resources Regardless of Date of Transfer* and 520.019: *Transfer of Resources Occurring on or after August 11, 1993*.

(c) Financial Eligibility Standards Not Met. Individuals whose income, assets, or both exceed the standards set forth in 130 CMR 519.007(D)(1)(b) may establish eligibility for MassHealth Standard by reducing their assets in accordance with 130 CMR 520.004: *Asset Reduction*, by meeting a deductible as described in 130 CMR 520.028 through 520.035, or by both.

(d) Enrollment Limits. Enrollment in the Intensive Supports Home- and Community-based Services Waiver for Persons with an Intellectual Disability is subject to a limit on the total number of waiver participants. The number of participants who can be enrolled in the waiver may be limited in a manner determined by the MassHealth agency.

(2) Community Living Waiver

(a) Clinical and Age Requirements. The Community Living Home- and Community-based Services Waiver for Persons with an Intellectual Disability allows an applicant or member who is certified by the MassHealth agency or its agent to be in need of inpatient care at an intermediate-care facility for people with intellectual disabilities to receive certain waiver services, other than residential habilitation, at home or in the community provided they

1. have an intellectual disability/developmental disability in accordance with Department of Developmental Services standards;
2. need one or more of the services administered by the Department of Developmental Services under the Community Living Home- and Community-based Services Waiver authorized under § 1915(c) of the Social Security Act;
3. need one or more of the services provided only under the Community Living Waiver; and
4. are 22 years of age or older and, if younger than 65 years of age, are totally and permanently disabled in accordance with Title XVI standards.

(b) Eligibility Requirements. In determining eligibility for MassHealth Standard and for these waiver services, the MassHealth agency determines income eligibility based solely on the applicant's or member's income regardless of their marital status. The applicant or member must meet all of the following criteria:

1. meet the requirements of 130 CMR 519.007(D)(2)(a);
2. have countable income that is less than or equal to 300% of the FBR for an individual;
3. have countable assets of $2,000 or less for an individual and, for a married couple, if the initial waiver eligibility determination was on or after January 1, 2014, have assets that are less than or equal to the standards at 130 CMR 520.016(B): *Treatment of a Married Couple's Assets When One Spouse Is Institutionalized*; and
4. not have transferred resources for less than fair market value, as described in 130 CMR 520.018: *Transfer of Resources Regardless of Date of Transfer* and 520.019: *Transfer of Resources Occurring on or after August 11, 1993*.

(c) Financial Eligibility Standards Not Met. Individuals whose income, assets, or both exceed the standards set forth in 130 CMR 519.007(D)(2)(b) may establish eligibility for MassHealth Standard by reducing their assets in accordance with 130 CMR 520.004: *Asset Reduction*, by meeting a deductible as described in 130 CMR 520.028 through 520.035, or by both.

(d) Enrollment Limits. Enrollment in the Community Living Home- and Community-based Services Waiver for Persons with an Intellectual Disability is subject to a limit on the total number of waiver participants. The number of participants who can be enrolled in the waiver may be limited in a manner determined by the MassHealth agency.

(3) Adult Supports Waiver

(a) Clinical and Age Requirements. The Adult Supports Home- and Community-based Services Waiver for Persons with an Intellectual Disability allows an applicant or member who is certified by the MassHealth agency or its agent to be in need of inpatient care at an intermediate-care facility for people with intellectual disabilities to receive certain waiver services, other than residential habilitation, at home or in the community provided they

1. have an intellectual disability/developmental disability in accordance with Department of Developmental Services standards;
2. need one or more of the services administered by the Department of Developmental Services under the Adult Supports Home- and Community-based Services Waiver authorized under § 1915(c) of the Social Security Act; and
3. are 22 years of age or older and, if younger than 65 years old, are totally and permanently disabled in accordance with Title XVI standards.

(b) Eligibility Requirements. In determining eligibility for MassHealth Standard and for these waiver services, the MassHealth agency determines income eligibility based solely on the applicant's or member's income regardless of their marital status. The applicant or member must meet all of the following criteria:

1. meet the requirements of 130 CMR 519.007(D)(3)(a);
2. have countable income that is less than or equal to 300% of the FBR for an individual;
3. have countable assets of $2,000 or less for an individual and, for a married couple, if the initial waiver eligibility determination was on or after January 1, 2014, have assets that are less than or equal to the standards at 130 CMR 520.016(B): *Treatment of a Married Couple's Assets When One Spouse Is Institutionalized*; and
4. not have transferred resources for less than fair market value, as described in 130 CMR 520.018: *Transfer of Resources Regardless of Date of Transfer* and 520.019: *Transfer of Resources Occurring on or after August 11, 1993*.

(c) Financial Eligibility Standards Not Met. Individuals whose income, assets, or both exceed the standards set forth in 130 CMR 519.007(D)(3)(b) may establish eligibility for MassHealth Standard by reducing their assets in accordance with 130 CMR 520.004: *Asset Reduction*, by meeting a deductible as described in 130 CMR 520.028 through 520.035, or by both.

(d) Enrollment Limits. Enrollment in the Adult Supports Home- and Community-based Services Waiver for Persons with an Intellectual Disability is subject to a limit on the total number of waiver participants. The number of participants who can be enrolled in the waiver may be limited in a manner determined by the MassHealth agency.

(E) Home- and Community-based Services Waiver for Young Children with Autism

(1) Clinical Requirements. The Home- and Community-based Services Waiver allows an applicant or member who is certified by the MassHealth agency or its agent to be in need of inpatient care at an intermediate-care facility for people with intellectual disabilities to receive certain waiver services at home or in the community provided they

(a) have a confirmed diagnosis of an autism spectrum disorder (which includes autistic disorder, pervasive developmental disorder—not otherwise specified (PDD-NOS), Rhett's syndrome, childhood disintegrative disorder, and Asperger's syndrome);

(b) would be institutionalized in an intermediate-care facility for people who are intellectually disabled unless they receive one or more of the services administered by the Department of Developmental Services under the Home- and Community-based Services Waiver authorized under § 1915(c) of the Social Security Act; and

(c) are able to be safely served in the community.

(2) Eligibility Requirements and Limitations

(a) The applicant or member must be younger than nine years old.

(b) The child must be eligible for MassHealth Standard in accordance with 130 CMR 505.002(B)(1): *Children Younger Than One Year Old* and (2): *Children One through 18 Years Old*.

(c) Assets are not considered in the eligibility determination.

(d) The number of children who can be enrolled in this waiver may be limited in a manner determined by the MassHealth agency or its agent.

(F) Home- and Community-based Services Waiver for Persons with Traumatic Brain Injury

(1) Clinical and Age Requirements. The Home- and Community-based Services Waiver for Persons with Traumatic Brain Injury allows an applicant or member who is certified by the MassHealth agency or its agent to be in need of nursing facility services or chronic or rehabilitation hospital services to receive specified waiver services in the home or community if they

(a) are 18 years of age or older and, if younger than 65 years old, are totally and permanently disabled in accordance with Title XVI standards;

(b) have traumatic brain injury, as defined in Massachusetts Rehabilitation Commission (MRC) regulations at 107 CMR 12.02: *Meaning of Terms in 107 CMR 12.00*;

(c) need one or more of the services administered by MRC under the Home- and Community-based Services Waiver authorized under § 1915(c) of the Social Security Act; and

(d) are able to be safely served in the community.

(2) Eligibility Requirements. In determining eligibility for MassHealth Standard and for waiver services, the MassHealth agency determines income eligibility based solely on the applicant's or member's income regardless of their marital status. The applicant or member must

(a) meet the requirements of 130 CMR 519.007(F)(1);

(b) have a countable income amount that is less than or equal to 300% of the FBR for an individual;

(c) have countable assets of $2,000 or less for an individual and, for a married couple, if the initial waiver eligibility determination was on or after January 1, 2014, have assets that are less than or equal to the standards at 130 CMR 520.016(B): *Treatment of a Married Couple's Assets When One Spouse Is Institutionalized*; and

(d) not have transferred resources for less than fair market value, as described in 130 CMR 520.018: *Transfer of Resources Regardless of Date of Transfer* and 520.019: *Transfer of Resources Occurring on or after August 11, 1993*.

(3) Enrollment Limits. Enrollment in this waiver is subject to a limit on the total number of waiver participants. The number of participants who can be enrolled in this waiver may be limited in a manner determined by the MassHealth agency or its agent.

(G) Home- and Community-based Services Waivers for Persons with Acquired Brain Injury

(1) Residential Habilitation Waiver for Persons with Acquired Brain Injury

(a) Clinical and Age Requirements. The Residential Habilitation Waiver for Persons with acquired brain injury, as authorized under § 1915(c) of the Social Security Act, allows an applicant or member who is certified by the MassHealth agency or its agent to be in need of nursing facility services or chronic disease or rehabilitation hospital services to receive residential habilitation and other specified waiver services in a provider-operated 24-hour supervised residential setting if they meet all of the following criteria:

1. are 22 years of age or older and, if younger than 65 years old, are totally and permanently disabled in accordance with Title XVI standards;
2. acquired, after reaching 22 years old, a brain injury including, without limitation, brain injuries caused by external force, but not including Alzheimer's disease and similar neurodegenerative diseases, the primary manifestation of which is dementia;
3. are an inpatient in a nursing facility or chronic disease or rehabilitation hospital with a continuous length of stay of 90 or more days at the time of application for the waiver;
4. need a residential support service available under the Residential Habilitation Waiver; and
5. are able to be safely served in the community within the terms of the Residential Habilitation Waiver.

(b) Eligibility Requirements. In determining eligibility for MassHealth Standard and for these waiver services, the MassHealth agency determines income eligibility based solely on the applicant's or member's income regardless of their marital status. The applicant or member must

1. meet the requirements of 130 CMR 519.007(G)(1)(a);
2. have countable income that is less than or equal to 300% of the FBR for an individual;
3. have countable assets of $2,000 or less for an individual and, for a married couple, if the initial waiver eligibility determination was on or after January 1, 2014, have assets that are less than or equal to the standards at 130 CMR 520.016(B): *Treatment of a Married Couple's Assets When One Spouse Is Institutionalized*; and

4. not have transferred resources for less than fair market value, as described in 130 CMR 520.018: *Transfer of Resources Regardless of Date of Transfer* and 520.019: *Transfer of Resources Occurring on or after August 11, 1993*.

(c) Enrollment Limits. Enrollment in the Residential Habilitation Waiver is subject to a limit on the total number of waiver participants. The number of participants who can be enrolled in this waiver may be limited in a manner determined by the MassHealth agency.

(d) Waiver Services. Eligible members who are enrolled as waiver participants in the Residential Habilitation Waiver are eligible for the waiver services described in 130 CMR 630.405(A): *Acquired Brain Injury with Residential Rehabilitation (ABI-RH) Waiver*.

(2) Non-residential Habilitation Waiver for Persons with Acquired Brain Injury

(a) Clinical and Age Requirements. The Non-residential Habilitation Waiver for Persons with acquired brain injury, as authorized under § 1915(c) of the Social Security Act, allows an applicant or member who is certified by the MassHealth agency or its agent to be in need of nursing facility services or chronic disease or rehabilitation hospital services to receive specified waiver services, other than residential support services, in the home or community if they meet all of the following criteria:

1. are 22 years of age or older and, if younger than 65 years old, are totally and permanently disabled in accordance with Title XVI standards;
2. acquired, after reaching 22 years old, a brain injury including, without limitation, brain injuries caused by external force, but not including Alzheimer's disease and similar neurodegenerative diseases, the primary manifestation of which is dementia;
3. are an inpatient in a nursing facility or chronic disease or rehabilitation hospital with a continuous length of stay of 90 or more days at the time of application for the waiver;
4. need one or more of the services under the Non-residential Habilitation Waiver; and
5. are able to be safely served in the community within the terms of the Non-residential Habilitation Waiver.

(b) Eligibility Requirements. In determining eligibility for MassHealth Standard and for these waiver services, the MassHealth agency determines income eligibility based solely on the applicant's or member's income regardless of their marital status. The applicant or member must

1. meet the requirements of 130 CMR 519.007(G)(2)(a);
2. have countable income that is less than or equal to 300% of the FBR for an individual;
3. have countable assets of $2,000 or less for an individual and, for a married couple, if the initial waiver eligibility determination was on or after January 1, 2014, have assets that are less than or equal to the standards at 130 CMR 520.016(B): *Treatment of a Married Couple's Assets When One Spouse Is Institutionalized*; and

4. not have transferred resources for less than fair market value, as described in 130 CMR 520.018: *Transfer of Resources Regardless of Date of Transfer* and 520.019: *Transfer of Resources Occurring on or after August 11, 1993*.

(c) Enrollment Limits. Enrollment in the Non-residential Habilitation Waiver is subject to a limit on the total number of waiver participants. The number of participants who can be enrolled in this waiver may be limited in a manner determined by the MassHealth agency.

(d) Waiver Services. Eligible members who are enrolled as waiver participants in the Non-residential Habilitation Waiver are eligible for the waiver service described in 130 CMR 630.405(B): *Acquired Brain Injury Non-residential Habilitation (ABI-N) Waiver*.

(H) Moving Forward Plan Home- and Community-based Services Waivers

(1) Moving Forward Plan (MFP) Residential Supports Waiver

(a) Clinical and Age Requirements. The MFP Residential Supports Waiver, as authorized under § 1915(c) of the Social Security Act, allows an applicant or member who is certified by the MassHealth agency or its agent to be in need of nursing facility services or chronic disease or rehabilitation hospital services, or, for participants 18 through 21 years old or 65 years of age and older, psychiatric hospital services, to receive residential support services and other specified waiver services in a 24-hour supervised residential setting if they meet all of the following criteria:

1. are 18 years of age or older and, if younger than 65 years old, are totally and permanently disabled in accordance with Title XVI standards;
2. are an inpatient in a nursing facility or chronic disease or rehabilitation hospital or, for participants 18 through 21 years old or 65 years of age and older, psychiatric hospital with a continuous length of stay of 90 or more days, excluding rehabilitation days;
3. have received MassHealth benefits for inpatient services, and are MassHealth eligible at least the day before discharge;
4. have been assessed to need residential habilitation, assisted living services, or shared living 24-hour support services within the terms of the MFP Residential Supports Waiver;
5. are able to be safely served in the community within the terms of the MFP Residential Supports Waiver; and
6. are transitioning to the community setting from a facility, moving to a qualified residence, such as a home owned or leased by the applicant or a family member, an apartment with an individual lease, or a community-based residential setting in which no more than four unrelated individuals reside.

(b) Eligibility Requirements. In determining eligibility for MassHealth Standard and for these waiver services, the MassHealth agency determines income eligibility based solely on the applicant's or member's income regardless of their marital status. The applicant or member must

1. meet the requirements of 130 CMR 519.007(H)(1)(a);

2. have countable income that is less than or equal to 300% of the FBR for an individual;
3. have countable assets of $2,000 or less for an individual and, for a married couple, if the initial waiver eligibility determination was on or after January 1, 2014, have assets that are less than or equal to the standards at 130 CMR 520.016(B): *Treatment of a Married Couple's Assets When One Spouse Is Institutionalized*; and
4. not have transferred resources for less than fair market value, as described in 130 CMR 520.018: *Transfer of Resources Regardless of Date of Transfer* and 520.019: *Transfer of Resources Occurring on or after August 11, 1993*.

(c) Enrollment Limits. Enrollment in the MFP Residential Supports Waiver is subject to a limit on the total number of waiver participants. The number of participants who can be enrolled in this waiver may be limited in a manner determined by the MassHealth agency.

(d) Waiver Services. Eligible members who are enrolled as waiver participants in the MFP Residential Supports Waiver are eligible for the waiver services described in 130 CMR 630.405(C): *Moving Forward Plan Residential Supports (MFP-RS) Waiver*.

(2) Moving Forward Plan (MFP) Community Living Waiver

(a) Clinical and Age Requirements. The MFP Community Living Waiver, as authorized under § 1915(c) of the Social Security Act, allows an applicant or member who is certified by the MassHealth agency or its agent to be in need of nursing facility services or chronic disease or rehabilitation hospital services, or, for participants 18 through 21 years old or 65 years of age and older, psychiatric hospital services, to receive specified waiver services, other than residential support services in the home or community, if they meet all of the following criteria:

1. are 18 years of age or older and, if younger than 65 years old, are totally and permanently disabled in accordance with Title XVI standards;
2. are an inpatient in a nursing facility or chronic disease or rehabilitation hospital or, for participants 18 through 21 years old or 65 years of age and older, psychiatric hospital with a continuous length of stay of 90 or more days, excluding rehabilitation days;
3. have received MassHealth benefits for inpatient services, and are MassHealth eligible at least the day before discharge;
4. need one or more of the services under the MFP Community Living Waiver;
5. are able to be safely served in the community within the terms of the MFP Community Living Waiver; and
6. are transitioning to the community setting from a facility, moving to a qualified residence, such as a home owned or leased by the applicant or a family member, an apartment with an individual lease, or a community-based residential setting in which no more than four unrelated individuals reside.

(b) Eligibility Requirements. In determining eligibility for MassHealth Standard and for these waiver services, the MassHealth agency determines income eligibility based solely on the applicant's or member's income regardless of their marital status. The applicant or member must

1. meet the requirements of 130 CMR 519.007(H)(2)(a);
2. have countable income that is less than or equal to 300% of the FBR for an individual;
3. have countable assets of $2,000 or less for an individual and, for a married couple, if the initial waiver eligibility determination was on or after January 1, 2014, have assets that are less than or equal to the standards at 130 CMR 520.016(B): *Treatment of a Married Couple's Assets When One Spouse Is Institutionalized*; and
4. not have transferred resources for less than fair market value, as described in 130 CMR 520.018: *Transfer of Resources Regardless of Date of Transfer* and 520.019: *Transfer of Resources Occurring on or after August 11, 1993*.

(c) Enrollment Limits. Enrollment in the MFP Community Living Waiver is subject to a limit on the total number of waiver participants. The number of participants who can be enrolled in this waiver may be limited in a manner determined by the MassHealth agency.

(d) Waiver Services. Eligible members who are enrolled as waiver participants in the MFP Community Living Waiver are eligible for the waiver services described in 130 CMR 630.405(D): *Moving Forward Plan Community Living (MFP-CL) Waiver*.

(130 CMR 519.008 Reserved)

519.009: MassHealth Limited

(A) Eligibility Requirements

(1) MassHealth Limited is available to community residents 65 years of age and older who meet the financial and categorical requirements of MassHealth Standard coverage as described at 130 CMR 519.005(A) and (B) and who are

(a) other noncitizens described in 130 CMR 518.003(D): *Other Noncitizens*;

(b) qualified noncitizens barred as described in 130 CMR 518.003(A)(2): *Qualified Noncitizens Barred*;

(c) nonqualified individuals lawfully present as described in 130 CMR 518.003(A)(3): *Nonqualified Individuals Lawfully Present*; or

(d) nonqualified persons residing under color of law (nonqualified PRUCOLs) as described in 130 CMR 518.003(C): *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs)*.

(2) Community residents 65 years of age and older who are qualified noncitizens barred as described in 130 CMR 518.003(A)(2): *Qualified Noncitizens Barred*, nonqualified individuals lawfully present as described in 130 CMR 518.003(A)(3): *Nonqualified Individuals Lawfully Present*, and nonqualified PRUCOLs as described in 130 CMR 518.003(C): *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs)* may also be eligible for MassHealth Family Assistance if they meet the categorical and financial requirements of 130 CMR 519.013.

(3) Persons eligible for MassHealth Limited coverage are eligible for medical benefits described at 130 CMR 450.105(F): *MassHealth Limited*.

(B) Use of Potential Benefits. All individuals who meet the requirements of 130 CMR 519.009 must use potential health-insurance benefits in accordance with 130 CMR 517.008: *Potential Sources of Healthcare* and must enroll in health insurance, including Medicare, if available at no greater cost to the applicant or member than they would pay without access to health insurance. Members must access those other health-insurance benefits and must show both their private health-insurance card and their MassHealth card to providers at the time services are provided.

(C) Coverage Date. The start date of medical coverage is established in accordance with 130 CMR 519.009(C)(1) through (3).

(1) If covered medical services were received during the period for which coverage was requested, and the individual would have been eligible at the time services were provided, the start date of coverage is determined upon receipt of the completed application and may be retroactive to the first day of the third calendar month before the month of application. An application is considered complete if it complies with 130 CMR 516.001(C).

(2) If covered medical services were not received during such period, or the individual would not have been eligible at the time services were provided, the start date of coverage is determined upon receipt of the completed application, and coverage begins on the first day of the month in which the application was received. An application is considered complete if it complies with 130 CMR 516.001(C).

(3) If more than one application has been submitted and not denied, the start date of coverage will be based on the earliest application that is approved.

519.010: Medicare Savings Program (MSP)—Qualified Medicare Beneficiaries (QMBs)

(A) Eligibility Requirements. MSP (Buy-in) QMB coverage is available to Medicare beneficiaries who

(1) are entitled to hospital benefits under Medicare Part A;

(2) have a countable-income amount (including the income of the spouse with whom they live) that is less than or equal to 190% of the federal poverty level; and

(3) meet the universal requirements of MassHealth benefits in accordance with 130 CMR 503.000: *Health Care Reform: MassHealth: Universal Eligibility Requirements* or 130 CMR 517.000: *MassHealth: Universal Eligibility Requirements*, as applicable.

(B) Benefits. The MassHealth agency pays for Medicare Part A and Part B premiums and for deductibles and coinsurance under Medicare Parts A and B for members who establish eligibility for MSP coverage in accordance with 130 CMR 519.010(A).

(C) Start Date. The start date for MSP coverage is the first day of the calendar month following the date of the MassHealth eligibility determination.

519.011: Medicare Savings Program (MSP)—Specified Low-income Medicare Beneficiaries (SLMBs) and Qualifying Individuals (QIs)

(A) Medicare Savings Program (MSP) (Buy-in) for Specified Low-income Medicare Beneficiaries (SLMBs)

(1) Eligibility Requirements. MSP is available for SLMBs who

(a) are entitled to hospital benefits under Medicare Part A;

(b) have a countable-income amount (including the income of the spouse with whom they live) greater than 190% and less than or equal to 210% of the federal poverty level (FPL). The MassHealth agency will disregard all assets or resources when determining eligibility for MSP only benefits; and

(c) meet the universal requirements of MassHealth benefits in accordance with 130 CMR 503.000: *Health Care Reform: MassHealth: Universal Eligibility Requirements* or 130 CMR 517.000: *MassHealth: Universal Eligibility Requirements*, as applicable.

(2) Benefits. The MassHealth agency pays the entire monthly Medicare Part B premium, in accordance with § 1933 of the Social Security Act (42 U.S.C. § 1396u-3), for members who establish eligibility for MSP for SLMB coverage in accordance with 130 CMR 519.011(A).

(3) Start Date. MSP for SLMB coverage, in accordance with 130 CMR 519.011(A), begins with the month of application and may be retroactive up to the first day of the third calendar month before the month of application.

(B) Medicare Savings Program (MSP) for Qualifying Individuals (QIs)

(1) Eligibility Requirements. MSP for QI coverage is available to Medicare beneficiaries who

(a) are entitled to hospital benefits under Medicare Part A;

(b) have a countable-income amount (including the income of the spouse with whom they live) that is greater than 210% of the FPL and less than or equal to 225% of the FPL; and

(c) meet the universal requirements of MassHealth benefits in accordance with 130 CMR 503.000: *Health Care Reform: MassHealth: Universal Eligibility Requirements* or 130 CMR 517.000: *MassHealth: Universal Eligibility Requirements*, as applicable.

(2) Benefits. The MassHealth agency pays the entire Medicare Part B premium, in accordance with § 1933 of the Social Security Act (42 U.S.C. § 1396u-3), for members who establish eligibility for MSP for QI coverage in accordance with 130 CMR 519.011(B).

(3) Eligibility Coverage Period

(a) MSP for QI coverage, in accordance with 130 CMR 519.011(B), begins with the month of application. Coverage may be retroactive up to the first day of the third calendar month before the month of application provided that

1. the retroactive date does not extend into a calendar year in which the expenditure cap described at 130 CMR 519.011(B)(4) has been met; and
2. the applicant was not receiving MassHealth benefits under the Medicaid State Plan during the retroactive period.

(b) Once determined eligible, a member who continues to meet the requirements of 130 CMR 519.011(B) is eligible for the balance of the calendar year. Such members are not adversely impacted by the provisions of 130 CMR 519.011(B)(4).

(4) Cap on Expenditures

(a) The MassHealth agency does not extend eligibility to individuals who meet the requirements of MSP for QI in accordance with 130 CMR 519.011(B) if the MassHealth agency estimates that the amount of assistance provided to these members during the calendar year will exceed the state's allocation, as described in the Social Security Act § 1933.

(b) The MassHealth agency gives preference to members who were eligible for MSP for SLMBs, as described in 130 CMR 519.011, or MSP for Qualified Medicare Beneficiaries, as described in 130 CMR 519.010, in December of the previous calendar year when determining an individual's eligibility for MSP for QI, as described in 130 CMR 519.011(B), in the subsequent calendar year.

519.012: MassHealth CommonHealth

(A) Disabled Adults

(1) Eligibility Requirements. MassHealth CommonHealth for disabled adults is available to community residents 65 years of age or older who meet the following criteria:

(a) they are employed at least 40 hours per month or, if employed less than 40 hours per month, have been employed at least 240 hours in the six-month period immediately before the month of receipt of the application or MassHealth's eligibility review;
(b) if they are not employed, they must have had CommonHealth for at least ten years before stopping working or turning 65 years old;
(c) they are permanently and totally disabled (except for engagement in substantial gainful activity) as defined in 130 CMR 515.001: *Definition of Terms*;
(d) they are a citizen as described in 130 CMR 518.002: *U.S. Citizens* or a qualified noncitizen as described in 130 CMR 518.003(A)(1): *Qualified Noncitizens*; and
(e) they are ineligible for MassHealth Standard.

(2) Other Provisions. The provisions of the following regulations apply to CommonHealth applicants and members 65 years of age or older: 130 CMR 505.004(A)(2), (H) through (J), (M)(1) and (2), and (N).

(B) Certain Disabled Institutionalized Children Who Are Noncitizens

(1) Eligibility Requirements. MassHealth CommonHealth is available to institutionalized disabled children who meet the requirements of 130 CMR 505.004(G): *Disabled Children Younger than 18 Years Old* and 130 CMR 519.006(A)(2) and who
(a) have attained the immigration status described in 130 CMR 518.003(A)(2): *Qualified Noncitizens Barred*, and five years have not passed from the date they attained such status;
(b) are noncitizens under the Immigration and Nationality Act (INA); or
(c) are noncitizens paroled into the US under the INA § 212(d)(5) for less than one year.

(2) Other Provisions. The following provisions apply to CommonHealth applicants and members who are described in 130 CMR 519.012(B)(1): 130 CMR 505.004(A)(2), (H) and (J), and (M)(1) and (2).

(C) Financial Eligibility. Financial eligibility for all MassHealth CommonHealth applicants and members is based on 130 CMR 506.000: *Health Care Reform: MassHealth: Financial Requirements*. 130 CMR 520.000: *MassHealth: Financial Eligibility* does not apply.

(D) Medicare Premium Payment

(1) MassHealth also pays the cost of the monthly Medicare Part B premium through the Qualifying Individual Program under 130 CMR 519.011(B) on behalf of members who meet the requirements of 130 CMR 505.004: *MassHealth CommonHealth* and who have modified adjusted gross income of the MassHealth disabled adult household that is less than or equal to 135% of the federal poverty level.

(2) The coverage described in 130 CMR 505.004(L)(1) begins on the first day of the month following the date of the MassHealth eligibility determination and may be retroactive up to the first day of the third calendar month before the month of application.

519.013: MassHealth Family Assistance

(A) Eligibility Requirements. MassHealth Family Assistance is available to community residents 65 years of age and older who meet the following requirements:

(1) are qualified noncitizens barred, as described in 130 CMR 518.003(A)(2): *Qualified Noncitizens Barred*; nonqualified individuals lawfully present, as described in 130 CMR 518.003(A)(3): *Nonqualified Individuals Lawfully Present*; or nonqualified persons residing under color of law (nonqualified PRUCOLs), as described in 130 CMR 518.003(C): *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs)*,

(a) with the countable-income amount, as defined in 130 CMR 520.009: *Countable-income Amount*, of the individual or married couple living together less than or equal to 100% of the federal poverty level (FPL);

(b) with the countable assets of an individual $2,000 or less and those of a married couple living together $3,000 or less; and

(c) without health insurance or access to health insurance; or

(2) are nonqualified PRUCOLs, as described in 130 CMR 518.003(C): *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs)*,

(a) with modified adjusted gross income of the MassHealth MAGI household, as described in 130 CMR 506.000: *Health Care Reform: MassHealth: Financial Requirements,* between 100% and 300% of the FPL; and

(b) without health insurance or access to health insurance.

(B) Financial Standards Not Met. Individuals described in 130 CMR 519.013(A)(1) whose income, assets, or both exceed the standards set forth in 130 CMR 519.013(A) may establish eligibility for MassHealth Family Assistance by reducing their assets in accordance with 130 CMR 520.004: *Asset Reduction*, meeting a deductible as described at 130 CMR 520.028 through 130 CMR 520.035, or by both.

(C) Benefits. Individuals eligible for MassHealth Family Assistance are eligible for medical benefits on a fee-for-service basis as defined in 130 CMR 515.001: *Definition of Terms*. These medical benefits are described in MassHealth regulations at 130 CMR 450.105(G): *MassHealth Family Assistance*.

(D) Coverage Date. The start date of medical coverage is established in accordance with 130 CMR 519.013(D)(1) through (3). MassHealth Family Assistance members are eligible for medical coverage under MassHealth Limited if otherwise eligible for MassHealth Limited as described in 130 CMR 519.009.

(1) If covered medical services were received during the period for which coverage was requested, and the individual would have been eligible at the time services were provided, the start date of coverage is determined upon receipt of the completed application and may be retroactive to the first day of the third calendar month before the month of application. An application is considered complete if it complies with 130 CMR 516.001(C).

(2) If covered medical services were not received during such period, or the individual would not have been eligible at the time services were provided, the start date of coverage is determined upon receipt of the application or upon receipt of any requested verifications, and coverage will begin on the first day of the month in which the application was received.
(3) If more than one application has been submitted and not denied, the start date will be based on the earliest application that is approved.

519.014: Severability

The provisions of 130 CMR 519.000 are severable. If any provision of 130 CMR 519.000 or application of any provision to an applicable individual, entity, or circumstance is held invalid or unconstitutional, that holding will not be construed to affect the validity or constitutionality of any remaining provisions of 130 CMR 519.000 or application of those provisions to applicable individuals, entities, or circumstances.

REGULATORY AUTHORITY

130 CMR 519.000: M.G.L. c. 118E.