



Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street
Boston, MA 02111
www.mass.gov/dma

MassHealth
Eligibility Letter 108
September 1, 2003

TO: Division Staff

FROM: Douglas S. Brown, Acting Commissioner

RE: Enrollment Cap for Adults in the CommonHealth and Family Assistance Programs

This letter transmits revised regulations that allow the Division to limit the number of adults (aged 19 or older) who are enrolled in MassHealth CommonHealth or Family Assistance through an enrollment cap. Applicants who could not be enrolled due to the enrollment cap would be placed on a waiting list. Parents who are eligible for Family Assistance for Adults pursuant to 130 CMR 505.005(C) are not subject to the enrollment cap.

These regulations are effective September 26, 2003.

MANUAL UPKEEP

<u>Insert</u>	<u>Remove</u>	<u>Trans. By</u>
501.002 (1 of 2)	501.002	E.L. 81
501.002 (2 of 2)	--	--
502.001	502.001	E.L. 95
505.005 (1 of 10)	505.005 (1 of 10)	E.L. 81
505.005 (6 of 10)	505.005 (6 of 10)	E.L. 100
505.005 (8 of 10)	505.005 (8 of 10)	E.L. 106
505.005 (9 of 10)	505.005 (9 of 10)	E.L. 106
505.005 (10 of 10)	505.005 (10 of 10)	E.L. 100
506.009 (2 of 2)	506.009 (2 of 2)	E.L. 51
506.011 (2 of 4)	506.011 (2 of 4)	E.L. 100

Trans. by E.L. 108**MASSHEALTH
GENERAL POLICIES****Rev. 09/26/03****Chapter 501
Page 501.002**

501.002: Introduction to MassHealth

(A) The Division of Medical Assistance is responsible for the administration and delivery of health care services to eligible low- and moderate-income individuals, couples, and families under MassHealth.

(B) 130 CMR 501.000 through 508.000 (Volume I) provide the MassHealth requirements for children, families, disabled persons, persons who are HIV positive, and certain individuals or couples who are under age 65 and not institutionalized. These requirements are prescribed under a 1115 Medicaid Research and Demonstration Waiver approved by the U.S. Department of Health and Human Services on April 24, 1995, and authorized by Chapter 203 of the Massachusetts Acts and Resolves of 1996: An Act Providing Improved Access to Health Care; and under Title XXI of the Social Security Act and authorized by Chapter 170 of the Massachusetts Acts and Resolves of 1997: An Act Expanding Access and Quality Health Care for Working Families, Children, and Senior Citizens in the Commonwealth.

(C) 130 CMR 515.000 through 522.000 (Volume II) provide the MassHealth requirements for persons who are institutionalized, aged 65 or older, or who would be institutionalized without community-based services as defined by Title XIX of the Social Security Act.

501.003: MassHealth Coverage Types

(A) The Division provides access to health care by determining eligibility for the coverage type that provides the most comprehensive benefits for an individual or family who may be eligible.

(B) MassHealth offers several coverage types: Standard, Prenatal, CommonHealth, Family Assistance, Basic, Buy-In, and Limited. The coverage type for which a person is eligible is determined based on the individual's income and circumstances, as described in 130 CMR 503.000 through 505.000.

(C) The Division may limit the number of people who can be enrolled in MassHealth CommonHealth and MassHealth Family Assistance. When the Division imposes such a limit, no new adult applicants (aged 19 or older) subject to these limitations will be added to these coverage types, and current adult members in these coverage types who have lost eligibility for more than 30 days for any reason will not be allowed to reenroll until the Division is able to reopen enrollment for adults in these coverage types. Excluded from these limitations are parents receiving benefits under 130 CMR 505.005(C).

(D) Applicants who cannot be enrolled under MassHealth CommonHealth or MassHealth Family Assistance pursuant to 130 CMR 501.003(C) will be placed on a waiting list when their eligibility has been determined. When the Division is able to open enrollment for adult applicants, the applications will be processed in the order they were placed on the waiting list.

Trans. by E.L. 108

**MASSHEALTH
GENERAL POLICIES**

Rev. 09/26/03

**Chapter 501
Page 501.002**

- (E) (1) Medical coverage for MassHealth CommonHealth for persons who are enrolled from a waiting list will begin on the date that the application or new determination is processed from the waiting list.
- (2) (a) Family Assistance Premium Assistance payments for persons enrolled from the waiting list will begin in the month that the application or new determination is processed from the waiting list, or in the month that the health insurance deduction begins, whichever is later.
- (b) Medical coverage for Family Assistance Purchase of Medical Benefits for persons who are enrolled from a waiting list will begin on the date that the application or new determination is processed from the waiting list.

501.004: Administration of MassHealth

- (A) Division of Medical Assistance. MassHealth requirements are formulated and eligibility is determined by the Division.
- (B) Other Agencies.
- (1) Department of Transitional Assistance (DTA).
- (a) The Department of Transitional Assistance administers the Transitional Aid to Families with Dependent Children (TAFDC) Program. Persons who meet the requirements of section 1931 of Title XIX (42 U.S.C. § 1396u-1) are automatically eligible for Standard coverage.

Trans. by E.L. 108**MASSHEALTH
THE REQUEST FOR BENEFITS****Chapter 502
Page 502.001****Rev. 09/26/03**

502.001: Medical Benefit Request (MBR)

(A) To apply for MassHealth, a person or his or her eligibility representative must file a Medical Benefit Request (MBR) at a MassHealth Enrollment Center, or Division outreach site. All members of the family group, as defined in 130 CMR 501.001, must be listed on the MBR whether or not they are applying for MassHealth.

(B) The Division requests all corroborative information necessary to determine eligibility. Such information must be provided by the applicant within 60 days of the date of the Request for Information.

(C) If all necessary information is received, except verification of immigration status and/or verification of a person's HIV-positive status, within the 60-day period referenced in 130 CMR 502.001(B), the MBR is considered complete. The completed MBR activates the Division's eligibility process for determining the coverage type that will provide the most comprehensive medical benefits for which the applicant is eligible.

(D) If the necessary information is not received within the 60-day period referenced in 130 CMR 502.001(B), the Division notifies the applicant of the deactivation of the MBR.

502.002: Reactivating the Medical Benefit Request

Except as provided in 130 CMR 501.003(E), if all required information is received by the Division after the 60-day period described in 130 CMR 502.001(D), or after a denial of eligibility, the Division reactivates the MBR as of the date the information is received, and the medical coverage date is established in accordance with 130 CMR 502.006. A new MBR must be completed if all required information is not received within one year of receipt of the previous MBR.

502.003: Presumptive Eligibility for Children

(A) The Division may determine a child presumptively eligible for either MassHealth Standard or MassHealth Family Assistance based on the family group's self-declaration of gross income. A child may be presumptively eligible for medical benefits under Family Assistance only if he or she does not have health insurance.

(B) Coverage for services under Presumptive Eligibility begins on the 10th day before the date the Division receives the Medical Benefit Request. Presumptive Eligibility coverage ends 60 days from the begin date, or when the Division makes an eligibility determination, whichever is earlier.

(C) A child may receive Presumptive Eligibility only once in a 12-month period.

502.004: Matching Information

The Division initiates information matches with other agencies and information sources when an MBR is received. These agencies and information sources may include, but are not limited to, the following: The Department of Employment and Training, Department of Public Health's Bureau of Vital Statistics, Department of Industrial Accidents, Department of Veteran's

Trans. by E.L. 108

**MASSHEALTH
COVERAGE TYPES**

Rev. 09/26/03

**Chapter 505
Page 505.005**

(H) Use of Potential Health Insurance Benefits. Applicants and members must use potential health insurance benefits, including Medicare, in accordance with 130 CMR 503.007, and must enroll in health insurance if purchased by the Division in accordance with 130 CMR 505.002(H), 505.005, or 507.003.

(I) Medical Coverage Date.

- (1) Except as provided in 130 CMR 501.003(E)(1), the medical coverage date for CommonHealth begins on the 10th day before the date a Medical Benefit Request is received at any MassHealth Enrollment Center or received by a Division outreach worker at a designated outreach site, provided all required verifications, including a completed disability supplement, have been received within 60 days of the date of the Request for Information.
- (2) Except as provided in 130 CMR 501.003(E)(1), if required verifications listed on the Request for Information are received after the 60-day period referenced in 130 CMR 505.004(I)(1), the begin date of medical coverage is 10 days before the date on which the verifications were received, provided such verifications are received within one year of receipt of the MBR.
- (3) Persons described in 130 CMR 505.004(C) who have been notified by the Division that they must meet a one-time deductible have their medical coverage date established in accordance with 130 CMR 506.009(E).

(J) Extended CommonHealth Coverage. CommonHealth members, described in 130 CMR 505.004(B), who terminate their employment continue to be eligible for CommonHealth for up to three calendar months after termination of employment provided they continue to make timely payments of monthly premiums.

505.005: MassHealth Family Assistance

(A) Overview.

- (1) 130 CMR 505.005 contains the categorical requirements and financial standards for MassHealth Family Assistance. This coverage type provides coverage either through premium assistance payments or the purchase of medical benefits.
- (2) (a) Premium assistance payments under MassHealth Family Assistance are available to:
 - (i) children under age 19 who have health insurance or access to health insurance;
 - (ii) certain employed adults aged 19 through 64 who have health insurance; and
 - (iii) persons under age 65 who are HIV positive and who have health insurance or choose to purchase available health insurance.
- (b) The health insurance must meet the criteria of 130 CMR 505.005(B)(1)(a)(i), 130 CMR 505.005(C)(1)(e), or 130 CMR 505.005(D)(2).

Trans. by E.L. 108**MASSHEALTH
COVERAGE TYPES****Rev. 09/26/03****Chapter 505
Page 505.005**

(iv) either have or choose to purchase available health insurance that the Division has determined to be cost effective, in accordance with 130 CMR 505.005(D)(2).

(b) The Division establishes eligibility under the provisions of 130 CMR 505.005(D) for persons who are HIV positive and who also meet the requirements of 130 CMR 505.005(B) or (C).

(2) Cost Effectiveness Determination. The Division determines the cost effectiveness of the available insurance plan to establish the appropriate premium assistance payment amount, and notifies the applicant or member of its decision.

(3) Premium Assistance Payment. Except as provided in 130 CMR 501.003(E)(2)(a), the Division makes monthly premium payments on behalf of members through its Health Insurance Premium Program (HIPP). Health insurance premium payments are made directly to the insurance carrier, the employer, or to the most appropriate party, as determined by the Division. If a direct payment is made to a family group member, proof of health-insurance payments may be required from the parent or member.

(4) Premium Assistance Payment Amount. The Division provides premium assistance in accordance with 130 CMR 506.012(F).

(5) Eligibility Date.

(a) Premium assistance payments begin in the month of the Division's eligibility determination or the month in which the insurance deductions begin, whichever is later. These payments are for the following month's coverage.

(b) Persons eligible under the provisions of 130 CMR 505.005(D) are also eligible for services provided under the purchase of medical benefits as described in 130 CMR 450.105(H)(3) to the extent these services are not covered by the individual's employer-sponsored health insurance. The medical coverage date for these services is established in accordance with 130 CMR 505.005(F)(3).

(6) Premium Assistance for Persons Who Have Not Yet Verified HIV-Positive Status. The Division also provides premium assistance, in accordance with 130 CMR 505.005(D), to persons meeting the requirements of 130 CMR 505.005(G)(1)(a) who would otherwise be eligible for premium assistance under 130 CMR 505.005(C).

Trans. by E.L. 108

**MASSHEALTH
COVERAGE TYPES**

Rev. 09/26/03

**Chapter 505
Page 505.005**

- (i) are under the age of 65;
- (ii) have family group gross income that is less than or equal to 133 percent of the federal poverty level;
- (iii) are ineligible for MassHealth Standard or MassHealth CommonHealth; and
- (iv) do not have health insurance.

(b) The Division establishes eligibility under the provisions of 130 CMR 505.005(F) for persons who are under the age of 19 and are HIV positive, and who also meet the requirements of 130 CMR 505.005(E).

(2) Premium. Individuals who meet the requirements of 130 CMR 505.005(F) are assessed a monthly premium in accordance with 130 CMR 506.011(H).

(3) Medical Coverage Date.

(a) Except as provided in 130 CMR 501.003(E)(2)(a), the medical coverage date for the purchase of medical benefits under MassHealth Family Assistance begins on the 10th day before the date a Medical Benefit Request is received at any MassHealth Enrollment Center or received by a Division outreach worker at a designated outreach site. However, the medical coverage date will in no event begin before April 1, 2001.

(b) Except as provided in 130 CMR 501.003(E)(2)(a), if required verifications listed on the Request for Information are received after the 60-day period referenced in 130 CMR 505.005(G)(1)(b), the begin date of medical coverage is 10 days before the date on which the verifications were received if such verifications are received within one year of receipt of the Medical Benefit Request.

(G) Fee-for-Service Benefits for Persons Who Are HIV Positive.

(1) Persons Who Have Claimed on the MBR to be HIV Positive.

(a) Eligibility Requirements. Persons who have claimed on the MBR to be HIV positive may establish temporary eligibility for fee-for-service benefits if they:

- (i) are under the age of 65;
- (ii) have a verified family group gross income that is less than or equal to 133 percent of the federal poverty level; and
- (iii) are ineligible for MassHealth Standard or MassHealth CommonHealth.

Trans. by E.L. 108

**MASSHEALTH
COVERAGE TYPES**

Rev. 09/26/03

**Chapter 505
Page 505.005****(b) Time Frames for Verification.**

(i) Persons who have claimed on the MBR to be HIV positive must submit verification of their HIV-positive status within 60 days of their eligibility determination. If verifications are not submitted, the Division redetermines their eligibility as if they were not HIV positive.

(ii) Verification of HIV-positive status can be a letter from a doctor, qualifying health clinic, laboratory, or AIDS service provider or organization. The letter must indicate the member's name and his or her HIV-positive status.

(c) Members who have other health insurance must access those benefits and must show both their private health insurance card and their MassHealth card to providers at the time services are rendered.

(d) Premium. Individuals who meet the requirements of 130 CMR 505.005(G) are assessed a monthly premium in accordance with 130 CMR 506.011(H).

(e) Medical Coverage Date.

(i) Except as provided in 130 CMR 501.003(E)(2)(a), the medical coverage date for the purchase of medical benefits under MassHealth Family Assistance begins on the 10th day before the date a Medical Benefit Request is received at any MassHealth Enrollment Center or received by a Division outreach worker at a designated outreach site. However, the medical coverage date will in no event begin before April 1, 2001.

(ii) Except as provided in 130 CMR 501.003(E)(2)(a), if required verifications listed on the Request for Information are received after the 60-day period referenced in 130 CMR 505.005(G)(1)(b), the begin date of medical coverage is 10 days before the date on which the verifications were received if such verifications are received within one year of receipt of the Medical Benefit Request.

(f) Premium Assistance for Persons Who Have Not Verified HIV-Positive Status. Persons who meet the requirements of both 130 CMR 505.005(G)(1)(a) and 505.005(C) receive benefits under 130 CMR 505.005(D). If verification of their HIV-positive status is not submitted within 60 days, they receive benefits under 130 CMR 505.005(C), if otherwise eligible.

(2) Persons Who Have Verified Their HIV-Positive Status.

(a) Eligibility Requirements. Persons who have verified their HIV-positive status, in accordance with 130 CMR 505.005(G)(1)(b), may establish eligibility for fee-for-service benefits if they:

(i) are under the age of 65;

(ii) have a family group gross income that is less than or equal to 133 percent of the federal poverty level;

Trans. by E.L. 108

**MASSHEALTH
COVERAGE TYPES**

Rev. 09/26/03

**Chapter 505
Page 505.005**

- (iii) are ineligible for MassHealth Standard or MassHealth CommonHealth; and
 - (iv) have declared that they have other health insurance.
- (b) Members receive benefits on a fee-for-service basis:
 - (i) while the Division investigates the member's private health insurance to determine if premium assistance is available; or
 - (ii) if the Division determines the member's health insurance is not cost effective.
- (c) Members who have other health insurance must access those benefits and must show both their private health insurance card and their MassHealth card to providers at the time services are rendered. The fee-for-service benefit applies only to services not covered by the member's private health insurance.
- (d) Premium. Individuals who meet the requirements of 130 CMR 505.005(G) are assessed a monthly premium in accordance with 130 CMR 506.011 (H).
- (e) Medical Coverage Date.
 - (i) Except as provided in 130 CMR 501.003(E)(2)(b), the medical coverage date for the purchase of medical benefits under MassHealth Family Assistance begins on the 10th day before the date a Medical Benefit Request is received at any MassHealth Enrollment Center or received by a Division outreach worker at a designated outreach site. However, the medical coverage date will in no event begin before April 1, 2001.
 - (ii) Except as provided in 130 CMR 501.003(E)(2)(b), if required verifications listed on the Request for Information are received after the 60-day period referenced in 130 CMR 505.005(G)(1)(b), the begin date of medical coverage is 10 days before the date on which the verifications were received if such verifications are received within one year of receipt of the Medical Benefit Request.
- (H) Referral to Children's Medical Security Plan. The Division submits the names of children whose family group gross income exceeds 200 percent of the federal-poverty level to the Children's Medical Security Plan.

Trans. by E.L. 108**MASSHEALTH
FINANCIAL REQUIREMENTS****Rev. 09/26/03****Chapter 506
Page 506.009**

(E) Notification of the Deductible.

(1) Except as provided in 130 CMR 501.003(C), the applicant who has excess monthly income shall be informed that he or she is currently ineligible for MassHealth, but may establish eligibility by meeting the deductible. The applicant shall be informed in writing of the following:

- (a) the deductible amount; and
- (b) the start and end dates of the deductible period.

(2) A person who meets a deductible shall be eligible for MassHealth CommonHealth effective with the begin date of the deductible period.

(F) Persons Deemed to Have Met a Deductible. The following disabled adults shall be considered to have met a deductible.

- (1) Those who were receiving MassHealth on July 1, 1997 as the result of meeting a deductible.
- (2) Those who were denied eligibility with a deductible prior to July 1, 1997, but who submit medical bills on or after July 1, 1997 to meet the deductible.

(G) Submission of Bills to Meet the Deductible.

(1) Criteria. To establish eligibility, the applicant must submit verification of medical or remedial bills whose total equals or exceeds the deductible and that meets the following criteria.

- (a) The bill must not be subject to further payment by health insurance or other liable third-party coverage, including the Uncompensated Care Pool.
- (b) The bill must be for an allowable medical or remedial expense as provided in 130 CMR 506.009(G)(2). A remedial expense is a nonmedical support service made necessary by the medical condition of any individual in the family group.
- (c) The bill must be unpaid and a current liability, or, if paid, was paid during the six-month deductible period.
- (d) The bill may not be for one of the following services:
 - (i) cosmetic surgery;
 - (ii) rest-home care;
 - (iii) weight-training equipment;
 - (iv) massage therapy;

Trans. by E.L. 108

**MASSHEALTH
FINANCIAL REQUIREMENTS**

Rev. 09/26/03

**Chapter 506
(2 of 4) Page 506.011**

does not pay monthly premiums due subsequent to the establishment of the payment plan within 60 days of the date on the bill, the member's eligibility is terminated.

(C) Reactivating Coverage Following Termination Due to Delinquent Payment. If no waiting list has been established pursuant to 130 CMR 501.003(C) and (D), after the member has paid in full all payments due, or has established a payment plan with the Division, the Division will reactivate coverage. If a waiting list has been established, adults (aged 19 and over) whose eligibility has been terminated due to nonpayment of premiums will be placed on the waiting list upon payment of all payments due. They will not be allowed to reenroll until the Division is able to reopen enrollment for those placed on the waiting list. When the Division is able to open enrollment for those on the waiting list, their eligibility will be processed in the order they were placed on the waiting list..

(D) Waiver of Outstanding Premium Payments. If a member whose eligibility has been terminated due to nonpayment of premiums reapplies and is determined eligible for MassHealth after 24 months, the outstanding premium payments are waived.

(E) Waiver or Reduction of Premiums for Extreme Financial Hardship. If the Division determines that the requirement to pay a premium results in an extreme financial hardship for a MassHealth member, the Division may, in its sole discretion, waive payment of the premium or reduce the amount of the premiums assessed to a particular family. Requests for premium relief should be addressed to the Division.

(F) Voluntary Withdrawal. If a member voluntarily withdraws, coverage continues through the end of the calendar month of withdrawal. The member is responsible for the payment of all premiums through the calendar month of withdrawal.

(G) Change in Premium Calculation. The premium amount is recalculated when the Division is informed of changes in income, family group size, or health-insurance status, and whenever an adjustment is made in the CommonHealth premium schedule or the Family Assistance premium amount for the purchase of medical benefits.