



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 109
October 1, 2003

TO: Division Staff

FROM: Beth Waldman, Acting Commissioner *Beth Waldman*

RE: MassHealth Essential: New MassHealth Coverage for the Long-Term Unemployed

The Massachusetts Legislature has passed, and the governor has signed into law, legislation allowing the Division to offer medical benefits to certain unemployed adults under the age of 65. These benefits will be available to persons:

- who are not eligible for MassHealth Basic;
- whose family group gross income is less than or equal to 100 percent of the federal poverty level;
- who are currently unemployed and either have been unemployed for more than one year, or in the past year, have earned less than the minimum amount of earnings necessary to qualify for unemployment compensation;
- who are not eligible for unemployment compensation; and
- who meet certain other eligibility criteria.

In addition, these unemployed persons must be U.S. citizens, qualified aliens, or protected aliens to receive benefits.

Coverage will be offered under a new coverage type, MassHealth Essential, which will provide:

- purchase of medical benefits for persons who have no health insurance; and
- premium assistance for persons who have health insurance.

Persons eligible for the purchase of medical benefits under MassHealth Essential must enroll with a primary care clinician before they can receive benefits. They are not required to pay premiums for their coverage. However, they are required to pay copayments for prescription drugs and nonemergency services provided in a hospital emergency room.

Because the authorizing legislation does not allow the Division to exceed allotted expenditures, the Division will freeze enrollment as soon as 36,000 people are enrolled. Once the enrollment cap is reached, the Division will notify applicants who, although

they meet MassHealth Essential eligibility criteria, will not be able to receive Essential benefits due to the enrollment freeze. These applicants will be placed on a waiting list. If and when enrollment numbers fall below set limits, these applicants will be processed from the waiting list in the order of placement. The MassHealth Essential program is currently funded through September 30, 2004.

In addition, members eligible for MassHealth Basic will now receive coverage through the purchase of medical benefits if they are uninsured, and through premium assistance if they are insured. As a result, all references to MassHealth Buy-In as a coverage type have been deleted. This change has been made to provide cross-programmatic consistency in terminology. No change has been made to members' benefits or the rules or processes through which they receive benefits.

These emergency regulations are effective October 1, 2003.

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Blindness – a visual impairment, as defined in Title XVI of the Social Security Act. Generally "blindness" means visual acuity with correction of 20/200 or less in the better eye, or a peripheral field of vision contracted to a 10-degree radius or less, regardless of the visual acuity.

Business Day – any day during which the Division's offices are open to serve the public.

Caretaker Relative – an adult who is the primary care giver for a child, is related to the child by blood, adoption, or marriage, or is a spouse or former spouse of one of those relatives, and lives in the same home as that child, provided that neither parent is living in the home.

Case File – the permanent written collection of documents and information required to determine eligibility and to provide benefits to applicants and members.

Child – a person under age 19.

Complete Medical Benefit Request – a Medical Benefit Request that is received by the Division and includes all required information and verifications including, where applicable, a completed disability supplement.

Couple – two persons who are married to each other, live together, and have no children under the age of 19 living with them.

Couple Policy – a health-insurance policy that covers a married couple. If an employer does not offer a couple policy, a married couple may be covered under a family policy.

Coverage Date – the date medical coverage begins.

Coverage Types – a scope of medical services, other benefits, or both that are available to members who meet specific eligibility criteria. These coverage types include the following: MassHealth Standard (Standard), MassHealth CommonHealth (CommonHealth), MassHealth Family Assistance (Family Assistance), MassHealth Basic (Basic), MassHealth Essential (Essential), MassHealth Prenatal (Prenatal), and MassHealth Limited (Limited). The scope of services or covered benefits for each coverage type is found at 130 CMR 450.105.

Day – a calendar day unless a business day is specified.

Disabled – having a permanent and total disability.

Disabled Working Adult or 18-Year-Old – a person who is engaged in substantial gainful activity but otherwise meets the definition of disabled, as defined in Title XVI of the Social Security Act.

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Rev. 10/01/03501.002: 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, Essential, 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, MassHealth Family Assistance, and MassHealth Essential. 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, MassHealth Family Assistance, or MassHealth Essential, 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.

(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.

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- (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.
- (3) (a) Essential Premium Assistance payments for persons enrolled from the waiting list will begin in the calendar month following verification of the member's health insurance information.

(b) Medical coverage for Essential Purchase of Medical Benefits for persons enrolled from a waiting list will begin on the date specified in the Division's notice of enrollment in the MassHealth Primary Care Clinician (PCC) Plan. There is no coverage for Essential members before the member's effective enrollment date.

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 MassHealth Standard coverage.

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(b) DTA also administers the Emergency Aid to the Elderly, Disabled and Children (EAEDC) Program. Uninsured individuals and members of a couple receiving EAEDC cash assistance are automatically eligible for the purchase of medical benefits under MassHealth Basic upon managed-care enrollment, in accordance with the requirements of 130 CMR 508.000. Insured individuals and members of a couple receiving EAEDC cash assistance are automatically eligible for premium assistance under MassHealth Basic. Families receiving EAEDC are automatically eligible for MassHealth Standard coverage and are provided choices of enrollment in a managed care plan, unless exempt in accordance with 130 CMR 508.004.

(2) Social Security Administration (SSA). District Social Security Offices administer the SSI program and determine the eligibility of disabled individuals. Individuals receiving SSI are automatically eligible for MassHealth Standard coverage. Individuals without health insurance are provided choices of enrollment in a managed care plan.

(3) Department of Employment and Training (DET). The Department of Employment and Training administers the Medical Security Plan that provides health insurance to persons who are receiving, or who are eligible to receive, state or federal unemployment benefits. Coverage is offered either through direct purchase of coverage or partial reimbursement for insurance premium payments.

501.005: Individuals and Families Eligible for or Receiving Medical Assistance on June 30, 1997

(A) Members Who Were Not Subject to a Deductible. Individuals and families (including caretaker relatives) who were receiving Medical Assistance on June 30, 1997, and whose family group gross income on June 30, 1997 exceeded MassHealth eligibility standards will be provided MassHealth Standard coverage for one year after the date of MassHealth implementation, except in the following circumstances: 1) the individual or family no longer lives in Massachusetts; 2) the individual enters an institution; 3) the individual turns 65; 4) the individual or all members of the family are deceased; or 5) the individual or family is no longer categorically eligible. Eligibility for continuing coverage will be reviewed toward the end of this one-year period.

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(F) Right to be Assisted by Others.

(1) The applicant or member has the right to be accompanied and represented by an eligibility representative during the eligibility process, and by an appeal representative during the appeal process. The Division must provide copies of all eligibility notices to an applicant's or member's eligibility representative, and must provide copies of all documents related to the fair hearing process to an applicant's or member's appeal representative.

(2) An application for MassHealth may be filed by an eligibility representative on behalf of a deceased person.

(3) An appeal on behalf of a deceased person may be filed by an appeal representative, as defined in 130 CMR 501.001.

(G) Right to Inspect the MassHealth Case File. The applicant or member has the right to inspect information in his or her MassHealth case file and contest the accuracy of the information.

(H) Right to Appeal. The applicant or member has the right to appeal and request a fair hearing as the result of any adverse action or inaction taken by the Division. The request will not be granted if the sole issue is a federal or state law requiring an automatic change adversely affecting members.

(I) Right to Interpreter Services. The Division will inform applicants and members of the availability of interpreter services. Unless the applicant or member chooses to provide his or her own interpreter services, the Division will provide either telephonic or other interpreter services whenever:

(1) the applicant or member who is seeking assistance from the Division has limited English proficiency or sensory impairment and requests interpreter services; or

(2) the Division determines such services are necessary.

(J) Right to a Certificate of Creditable Coverage Upon Termination of MassHealth. The Division will provide a Certificate of Creditable Coverage to members whose coverage under MassHealth Standard or CommonHealth, or a MassHealth health plan under Family Assistance, Basic, or Essential has ended. The Division will issue a Certificate to members within one week of their MassHealth termination, or within one week of the request for a Certificate, as long as the request is made within 24 months of their MassHealth termination. The Certificate may allow members to waive or reduce the length of preexisting-condition waiting periods when they enroll in a new health plan offered by other insurance. If a member's MassHealth termination also terminates the coverage of his or her dependents, the dependents will be included on the Certificate.

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

(C) The Division will not notify the member if there is no change in the member's coverage type, premium payment, or premium assistance payment.

(D) If the member's coverage type changes, the start date for the new coverage type is determined as follows.

(1) If the new coverage type provides more comprehensive benefits to the member, coverage is effective as of the date of the written notice with the following exceptions.

(a) Coverage for the purchase of medical benefits under Basic is effective upon the member's enrollment with a MassHealth managed care provider.

(b) Coverage for the purchase of medical benefits under Essential is effective upon the member's enrollment in the Primary Care Clinician (PCC) Plan.

(c) Coverage for premium assistance under Basic and Essential is effective in the calendar month following the date of the written notice.

(d) Premium assistance payments under Family Assistance begin in the month of the Division's eligibility determination, or in the month the insurance deduction begins, whichever is later.

(2) If the new coverage type provides less comprehensive benefits to the member, coverage is effective subsequent to the member's receipt of a timely written notice in accordance with 130 CMR 610.015.

(E) If the member fails to provide a written update of his or her circumstances within 30 days of the Division's request, MassHealth coverage is terminated. If the member subsequently submits a written update, the Division determines his or her eligibility as of the date the written update is received. If the applicant is determined eligible, the medical coverage date is established in accordance with the rules in 130 CMR 502.006.

(F) If the member fails to provide verification of information within 60 days of the Division's request, MassHealth coverage is terminated.

(1) Except as provided at 130 CMR 501.003(E), if required verifications are received within one year of receipt of the previous MBR or written update on a prescribed form, coverage is reinstated 10 days before receipt of the verifications unless the member is determined eligible for the purchase of medical benefits under MassHealth Basic or Essential, or premium assistance under Basic, Essential, or Family Assistance. For those members, the medical coverage date is established in accordance with the rules in 130 CMR 502.006. Coverage under Essential is also subject to the funding restrictions described at 130 CMR 505.007.

(2) If required verifications are not received within one year of receipt of the previous MBR or written update on a prescribed form, a new MBR must be completed.

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502.008: Notice

(A) All applicants and members receive a written notice of the eligibility determination for MassHealth. The notice contains an eligibility decision for each member of the family group 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) Members also receive a notice, in accordance with 130 CMR 610.015, 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 eligibility for presumptive coverage as described at 130 CMR 505.002(C)(4) and 505.005(C)(2), and for prenatal coverage as described at 130 CMR 505.003. Information about the appeal process is found at 130 CMR 610.000.

502.009: Voluntary Withdrawal

The applicant or eligibility representative may voluntarily withdraw his or her request for MassHealth.

502.010: Issuance of a MassHealth Card

(A) The Division issues a MassHealth card to a new member, with the exception of those who receive premium assistance under:

- (1) MassHealth Family Assistance for children, as described at 130 CMR 505.005(B);
- (2) MassHealth Family Assistance for adults, as described at 130 CMR 505.005(C);
- (3) MassHealth Basic, as described at 505.006(C); or
- (4) MassHealth Essential, as described at 505.007(C).

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

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(c) MassHealth Family Assistance, if they are children under age 19 or persons under age 19 who are HIV positive, who meet the categorical requirements and financial standards of Family Assistance, as described at 130 CMR 505.005. The Division will not pay the copayments, coinsurance, and deductibles described in 130 CMR 505.005(B)(6) for children who receive premium assistance; or

(d) MassHealth Limited, if they are adults who are parents, pregnant, or disabled and meet the categorical requirements and financial standards of MassHealth Standard, as described in 130 CMR 505.002(D), (E), and (F).

(3) Nonqualified aliens may only receive MassHealth Limited if otherwise eligible for MassHealth Standard.

(4) Aliens with special status are not eligible for MassHealth Basic or Essential.

(G) Verification of Immigration Status.

(1) A determination of eligibility is made as of the date the MBR and all required information, except verification of immigration status, is received by the Division.

(2) The Division submits the names of qualified aliens to the DHS for confirmation of immigration status.

(3) The Division requests verification of immigration status subsequent to the eligibility determination from:

(a) qualified aliens who did not submit verification of their immigration status with the MBR, and for whom the DHS has been unable to confirm their status, as described at 130 CMR 504.002(G)(2); and

(b) aliens with special status who did not submit verification of their immigration status with the MBR.

(4) Aliens who fail to submit verification of their immigration status, as described in 130 CMR 504.002(G)(3), within 60 days of the Division's Request for Information will subsequently be:

(a) eligible only for MassHealth Limited if they meet the categorical requirements and financial standards of MassHealth Standard; or

(b) ineligible for any MassHealth coverage type if not otherwise eligible for MassHealth Standard.

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130 CMR 505.000 explains the categorical requirements and financial standards that must be met to qualify for a MassHealth coverage type. The rules of financial responsibility and calculation of financial eligibility are detailed in 130 CMR 506.000.

(A) The MassHealth coverage types are the following:

- (1) Standard – for families, pregnant women, children, and disabled individuals;
- (2) Prenatal – for pregnant women;
- (3) CommonHealth – for disabled adults and disabled children who are not eligible for MassHealth Standard;
- (4) Family Assistance – for children, certain employed adults, and persons who are HIV positive who are not eligible for MassHealth Standard or CommonHealth;
- (5) Basic – for the long-term unemployed who have income at or below 100 percent of the federal poverty level, and who are receiving services or are on a waiting list to receive services from the Department of Mental Health (DMH), as identified by the DMH to the Division, or for individuals or members of a couple who receive EAEDC cash assistance;
- (6) Essential – for the long-term unemployed who have income at or below 100 percent of the federal poverty level and are not eligible for MassHealth Basic; and
- (7) Limited – for nonqualified aliens and aliens with special status.

(B) The financial standards referred to in 130 CMR 505.000 et seq. depend on the family group size, which may be composed of an individual, couple, or family, as defined in 130 CMR 501.001.

505.002: MassHealth Standard

(A) Overview.

- (1) 130 CMR 505.002 contains the categorical requirements and financial standards for MassHealth Standard serving families, children under 19, pregnant women, disabled individuals, and parents and caretaker relatives described in 130 CMR 519.005(C)(1).
- (2) Persons eligible for Standard coverage are eligible for medical benefits as described in 130 CMR 450.105(A) and 130 CMR 508.000.
- (3) Persons who do not otherwise meet the requirements of 130 CMR 505.002, but who meet the AFDC rules that were in effect on July 16, 1996, are eligible for MassHealth Standard.

(B) Extended Eligibility.

- (1) Members of a family group whose cash assistance terminates continue to receive four months of MassHealth Standard coverage beginning in the month the family group became ineligible if they are:

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505.006: MassHealth Basic

(A) Overview. 130 CMR 505.006 contains the categorical requirements and financial standards for MassHealth Basic. This coverage type is available to individuals or members of a couple who receive EAEDC cash assistance, or who are receiving services or are on a waiting list to receive services from the Department of Mental Health (DMH), as identified by the DMH to the Division. MassHealth Basic coverage is available either through the purchase of medical benefits or through premium assistance payments.

(1) The Purchase of Medical Benefits under MassHealth Basic.

(a) The purchase of medical benefits under MassHealth Basic is available to unemployed adults aged 19 through 64 who:

(i) do not have, or have access to, health insurance, including health insurance offered by the college or university that they attend; or

(ii) have health insurance that the Division has determined does not cover the applicant's chronic medical condition requiring frequent treatment and medical services, or is of significant cost to the applicant.

(b) Persons eligible for the purchase of medical benefits are eligible for medical benefits, as described in 130 CMR 450.105(B) and 130 CMR 508.000.

(2) Premium Assistance under MassHealth Basic.

(a) Premium assistance under MassHealth Basic is available to unemployed adults aged 19 through 64 who have health insurance that:

(i) the Division has determined covers the applicant's chronic medical condition requiring frequent treatment and medical services and for which they must pay a premium;

(ii) is not of significant cost to the applicant;

(iii) is not available from the college or university that they attend; and

(iv) meets the Division's cost-effective analysis.

(b) Persons eligible for premium assistance payments are eligible for payment of part or all of their health insurance premium.

(B) The Purchase of Medical Benefits.

(1) Eligibility Requirements for Active DMH Clients as Identified by the DMH to the Division. Active DMH clients are those individuals or members of a couple who are receiving services or are on a waiting list to receive services from the DMH. These active DMH clients who are under age 65 are eligible for the purchase of medical benefits under MassHealth Basic if they are uninsured, in accordance with 130 CMR 505.006(A)(1)(a), and meet all of the following conditions.

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- (a) They are currently unemployed and:
 - (i) have been unemployed for more than one year; or
 - (ii) during the past 12 months have earned less than the minimum amount of earnings necessary to qualify for unemployment compensation.
- (b) They are not eligible for unemployment compensation.
- (c) They have family group gross income less than or equal to 100 percent of the federal-poverty level.
- (d) Their spouse is:
 - (i) not employed more than 100 hours a month; or
 - (ii) employed 100 hours or less a month, and not eligible for premium assistance payments that provide couple or family coverage in accordance with 130 CMR 505.005(C).

(2) EAEDC Recipients. Individuals and members of couples who receive EAEDC cash assistance are eligible for the purchase of medical benefits under MassHealth Basic if they have no health insurance.

(3) Extended Eligibility for the Purchase of Medical Benefits when EAEDC Ends. Individuals or couples whose EAEDC cash assistance ends and who are determined to be potentially eligible for MassHealth continue to receive medical benefits under MassHealth Basic until a determination of ineligibility is made by the Division.

(4) Extended Coverage for the Purchase of Medical Benefits. Basic members who are no longer eligible for Basic coverage due to employment will continue to receive medical benefits under MassHealth Basic for up to six calendar months after their date of employment if health insurance is not available to them from their employer or their spouse's employer.

(5) Medical Coverage Date. Members, after they have received notice from the Division stating that they meet the eligibility requirements for the purchase of medical benefits under MassHealth Basic at 130 CMR 505.006(B), receive medical coverage effective on the date specified in the Division's notice of enrollment with a MassHealth managed care provider. There is no medical coverage for MassHealth Basic members before the member's effective enrollment date. Enrollment of a Basic member with a MassHealth managed care provider may occur only in accordance with 130 CMR 508.002(I).

(C) Premium Assistance.

(1) Eligibility Requirements for Active DMH Clients as Identified by the DMH to the Division. Active DMH clients are those individuals or members of a couple who are receiving services or are on a waiting list to receive services from the DMH. These active DMH clients who are under age 65 are eligible for premium assistance under MassHealth Basic if they have health insurance, in accordance with 130 CMR 505.006(A)(2)(a), and meet all of the following conditions.

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- (a) They are currently unemployed and:
 - (i) have been unemployed for more than one year; or
 - (ii) during the past 12 months have earned less than the minimum amount of earnings necessary to qualify for unemployment compensation.
 - (b) They are not eligible for unemployment compensation.
 - (c) They have family group gross income less than or equal to 100 percent of the federal-poverty level.
 - (d) Their spouse is:
 - (i) not employed more than 100 hours a month; or
 - (ii) employed 100 hours or less a month, and not eligible for premium assistance payments that provide couple or family coverage in accordance with 130 CMR 505.005(C).
- (2) EAEDC Recipients. Individuals and members of couples who receive EAEDC cash assistance are eligible for premium assistance under MassHealth Basic if they have health insurance.
- (3) Eligibility Date. Once the Division has determined eligibility, premium assistance payments begin in the calendar month following the verification of the member's health insurance information.
- (4) Extended Premium Assistance. Persons who are no longer eligible for premium assistance payments under MassHealth Basic due to earnings continue to have their premiums paid for a six-calendar-month period following their date of employment if they or their spouse are not otherwise eligible for premium assistance payments, in accordance with 130 CMR 505.005(C).

505.007: MassHealth Essential

(A) Overview. 130 CMR 505.007 contains the categorical requirements and financial standards for MassHealth Essential. This coverage type is available to individuals or members of a couple who are long-term unemployed and do not meet the eligibility criteria for MassHealth Basic, as described in 130 CMR 505.006. MassHealth Essential coverage is available either through the purchase of medical benefits or through premium assistance payments.

(1) The Purchase of Medical Benefits under MassHealth Essential.

- (a) The purchase of medical benefits under MassHealth Essential is available to unemployed adults aged 19 through 64 who:

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(i) do not have, or have access to, health insurance, including health insurance offered by the college or university that they attend; or

(ii) have health insurance that the Division has determined does not cover the applicant's chronic medical condition requiring frequent treatment and medical services, or is of significant cost to the applicant.

(b) Persons eligible for the purchase of medical benefits are eligible for medical benefits, as described in 130 CMR 450.105(I) and 130 CMR 508.000.

(2) Premium Assistance under MassHealth Essential.

(a) Premium assistance under MassHealth Essential is available to unemployed adults aged 19 through 64 who have health insurance that:

(i) the Division has determined covers the applicant's chronic medical condition requiring frequent treatment and medical services and for which they must pay a premium;

(ii) is not of significant cost to the applicant;

(iii) is not available from the college or university that they attend; and

(iv) meets the Division's cost-effective analysis.

(b) Persons eligible for premium assistance payments are eligible for payment of part or all of their health insurance premium.

(B) The Purchase of Medical Benefits.

(1) Eligibility Requirements. Individuals and members of couples under age 65 are eligible for Essential coverage if they are uninsured, in accordance with 130 CMR 505.007(A)(1)(a), and meet all of the following conditions.

(a) They are not eligible for MassHealth Basic.

(b) They are currently unemployed and:

(i) have been unemployed for more than one year; or

(ii) during the past 12 months have earned less than the minimum amount of earnings necessary to qualify for unemployment compensation.

(c) They are not eligible for unemployment compensation.

(d) They have family group gross income less than or equal to 100 percent of the federal poverty level.

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(e) Their spouse is:

(i) not employed more than 100 hours a month; or

(ii) employed 100 hours or less a month, and not eligible for premium assistance payments that provide couple or family coverage, in accordance with 130 CMR 505.005(C).

(2) Medical Coverage Date. Except as provided in 130 CMR 501.003(E)(3), members, after they have received notice from the Division stating that they meet the eligibility requirements for the purchase of medical benefits under MassHealth Essential at 130 CMR 505.007(B), receive medical coverage effective on the date specified in the Division's notice of enrollment in the MassHealth Primary Care Clinician (PCC) Plan. There is no medical coverage for MassHealth Essential members before the member's effective enrollment date.

(C) Premium Assistance.

(1) Eligibility Requirements. Individuals and members of couples under age 65 are eligible for premium assistance under MassHealth Essential if they are insured, in accordance with 130 CMR 505.007(A)(2)(a), and meet all of the following conditions.

(a) They are not eligible for MassHealth Basic.

(b) They are currently unemployed and:

(i) have been unemployed for more than one year; or

(ii) during the past 12 months have earned less than the minimum amount of earnings necessary to qualify for unemployment compensation.

(c) They are not eligible for unemployment compensation.

(d) They have family group gross income less than or equal to 100 percent of the federal poverty level.

(e) Their spouse is:

(i) not employed more than 100 hours a month; or

(ii) employed 100 hours or less a month, and not eligible for premium assistance payments that provide couple or family coverage, in accordance with 130 CMR 505.005(C).

(2) Eligibility Date. Except as provided in 130 CMR 501.003(E)(3), once the Division has determined eligibility, premium assistance payments under MassHealth Essential begin in the calendar month following the verification of the member's health insurance information.

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(D) Funding. State legislation does not provide funding for MassHealth Essential after September 30, 2004. Essential benefits will not be provided after this date unless a legislative extension is authorized.

505.008: MassHealth Limited(A) Eligibility Requirements.

(1) MassHealth Limited is available to persons who meet the financial and categorical requirements of MassHealth Standard and are:

(a) nonqualified aliens described in 130 CMR 504.002(E) (nonqualified aliens are not required to furnish or apply for a social security number);

(b) aliens with special status described in 130 CMR 504.002(D) who are under age 19 and are eligible for premium assistance under MassHealth Family Assistance; or

(c) aliens with special status who are adults described in 130 CMR 504.002(F)(2)(d).

(2) Persons eligible for Limited coverage are eligible for medical benefits as described in 130 CMR 450.105(G). These aliens are eligible for medical benefits under Limited only to the extent that such benefits are not covered by their health insurance.

(3) Aliens lawfully admitted for a temporary purpose such as students, visitors, and diplomats are eligible for Limited coverage if they meet all other eligibility requirements including residence.

(4) A child born to a woman who was receiving MassHealth Limited on the date of the child's birth is automatically eligible for MassHealth Standard for one year provided the child continues to live with the mother.

(B) Medical Coverage Date.

(1) The medical coverage date for MassHealth Limited 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, if all required verifications, including a completed disability supplement, have been received within 60 days of the date of the Request for Information.

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(2) If these required verifications listed on the Request for Information are received after the 60-day period referenced in 130 CMR 505.008(B)(1), the begin date of medical coverage is 10 days before the date on which the verifications were received, if these verifications are received within one year of receipt of the MBR.

(C) Referral to Children's Medical Security Plan. The Division submits the names of children who are eligible for MassHealth Limited coverage to the Children's Medical Security Plan.

(D) Referral to Healthy Start Program. The Division submits names of pregnant women who are eligible for MassHealth Limited coverage to the Healthy Start Program.

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All family group members are required to avail themselves of all potential income.

(A) If the Division determines that income has been transferred for the primary purpose of establishing eligibility for MassHealth, the income is counted as if it were received.

(B) If the Division is unable to determine the amount of available income, the family group remains ineligible until such information is made available.

506.007: Calculation of Financial Eligibility

(A) The financial eligibility for various MassHealth coverage types is determined by comparing the family group's gross monthly income with the applicable income standard for the specific coverage. In determining gross monthly income, the Division multiplies average weekly income by 4.333.

(B) Generally, eligibility is based on 100 percent of the federal-poverty level for long-term unemployed adults, 133 percent of the federal-poverty level for parents, disabled nonworking adults, and persons who are HIV positive, and 200 percent of the federal-poverty level for children and pregnant women, as well as for adults working for qualified employers. Disabled persons with income in excess of these applicable standards may be eligible for MassHealth CommonHealth. There is no income cap for premium-based CommonHealth.

(C) The monthly federal-poverty-level income standards are determined according to annual standards published in the *Federal Register* using the following formula. The Division adjusts these standards in April of each calendar year.

(1) Divide the annual federal-poverty-level income standard as it appears in the *Federal Register* by 12.

(2) Multiply the unrounded monthly income standard by the applicable federal-poverty-level standard.

(3) Round up to the next whole dollar to arrive at the monthly income standards.

506.008: Cost-of-Living Adjustment (COLA) Protections

Members whose income increases each January as the result of a COLA remain eligible until the subsequent federal-poverty-level adjustment.

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508.001: MassHealth Managed Care Requirement

(A) Member Participation.

(1) All MassHealth Standard members, as well as certain MassHealth Family Assistance members described in 130 CMR 505.005(E), and Basic members described in 130 CMR 505.006(B), must enroll in one of the following managed care options unless excluded from participation in 130 CMR 508.004:

- (a) Primary Care Clinician (PCC) Plan; or
- (b) Division-contracted managed care organization (MCO).

(2) MassHealth Family Assistance members described in 130 CMR 505.005(F) must enroll in the PCC Plan, unless excluded from participation in 130 CMR 508.004; and

(3) MassHealth Essential members described in 130 CMR 505.007(B) must enroll in the PCC Plan.

(B) Obtaining Services.

(1) Primary Care. When the member selects or is assigned to either a PCC or MCO, that MassHealth managed care provider will deliver the member's primary care, decide if the member needs medical care from other providers, and make referrals for such necessary medical services.

(2) Other Medical Services (Excluding Behavioral Health Services).

(a) Service Delivery to Members Enrolled in the PCC Plan. All medical services to members enrolled in the PCC Plan, except those services listed in 130 CMR 450.118(J), require a referral or authorization from the PCC. MassHealth members enrolled in the PCC Plan may receive those services listed in 130 CMR 450.118(J), for which they are otherwise eligible, without a referral from their PCC.

(b) Service Delivery to Members Enrolled in an MCO. All medical services to members enrolled in an MCO, except those services not covered under the MassHealth contract with the MCO, are subject to the referral requirements of the MCO. Members enrolled with an MCO should contact their MCO for information about covered services and referral requirements.

(3) Behavioral Health Services.

(a) Members Enrolled in the PCC Plan. All members who enroll in the PCC Plan receive behavioral health (mental health and substance abuse) services through the Division's behavioral health contractor. See 130 CMR 508.003.

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(b) Members Enrolled in an MCO.

(i) Members who enroll in a MassHealth-contracted MCO that is under contract to provide behavioral health services receive behavioral health services through that MCO.

(ii) All behavioral health services to members enrolled in an MCO, except those services not covered under the MassHealth contract with the MCO, are subject to the authorization requirements of the MCO. Members enrolled with an MCO should contact their MCO for information about covered services and authorization requirements.

(c) Members with Presumptive or Time-Limited Eligibility, or Fee-for-Service. Members with presumptive or time-limited eligibility, or fee-for-service receive behavioral health services through any qualified participating MassHealth provider.

508.002: Choosing a MassHealth Managed Care Provider

All MassHealth members, except those excluded under 130 CMR 508.004, must enroll with a MassHealth managed care provider. For MassHealth Basic members, described at 130 CMR 505.006(B), and MassHealth Essential members, described at 130 CMR 505.007(B), services are available only as of the member's enrollment effective date, as established by the Division in accordance with 130 CMR 508.002(I), with a MassHealth managed care provider.

(A) Selection of a Managed Care Provider.

(1) Procedure. The Division will notify the member of the availability of MassHealth managed care providers in the member's service area, and of the member's obligation to select such a provider within the time period specified by the Division. The member may select any provider from the Division's list of MassHealth managed care providers in his or her service area, if the provider is able to accept new patients.

(2) Member's Service Area. The member's service area is determined by the Division based on zip codes. Service area listings may be obtained from the Division.

(B) Assignment to a Managed Care Provider. If a member does not choose a managed care provider within the time period specified by the Division in a notice to the member, the Division will assign the member to a MassHealth managed care provider.

(C) Criteria for Assigning Members.

(1) The Division will assign a member eligible to enroll with a managed care provider only if the provider is:

(a) in the member's service area as described in 130 CMR 508.002(A)(2);

(b) physically accessible to the member, if the member is disabled;

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(2) the travel time or distance to the requested out-of-area MassHealth managed care provider is equal to or less than the travel time to a MassHealth managed care provider in the member's service area, or the medical benefit of receiving care from a MassHealth managed care provider in the member's service area is substantially outweighed, as determined by the Division, by the medical benefit of receiving care from the out-of-area MassHealth managed care provider requested by the member.

(G) Disenrollment or Transfer of Members. The Division may disenroll or transfer a member from a MassHealth managed care provider where the provider demonstrates to the Division's satisfaction a pattern of noncompliant or disruptive behavior by the member or for other good cause. In each case, the Division will state the good cause basis for disenrollment or transfer in a notice to the member.

(H) Reenrollment. Any member who loses and then regains managed care eligibility may be automatically reenrolled with the MassHealth managed care provider with which the member was most recently enrolled.

(I) Enrollment of MassHealth Basic and MassHealth Essential Members.

(1) After the Division has sent members a notice of eligibility for the purchase of medical benefits, the Division will enroll them with a MassHealth managed care provider. MassHealth Basic members, described at 130 CMR 505.006(B), must enroll in a Primary Care Clinician Plan or with a Division-contracted managed-care organization. MassHealth Essential members, described at 130 CMR 505.007(B), must enroll in the Primary Care Clinician Plan. Enrollment is accomplished in one of the following ways and within the following time frames.

(a) After the Division has approved eligibility for the purchase of medical benefits, the member may contact the Division directly by telephone at the number indicated on the eligibility notice, or in person, and provide all information needed to enroll the member with a MassHealth managed care provider. If complete information is provided, the Division will enroll the member, in accordance with the member's selection, effective no later than 10 business days after the Division receives this information.

(b) After the Division has approved eligibility for the purchase of medical benefits, the Division will send the member enrollment material and a managed care provider selection form. If the member completes and returns this form to the Division within the time frame specified by the Division, and if the information provided is complete, the Division will enroll the member, in accordance with the member's selection, effective no later than 10 business days after the Division receives the completed enrollment form. The Division will consider only such forms that the member sends to the Division after the Division has approved the member's eligibility.

(c) If the member fails to notify the Division of his or her enrollment selection, either by telephone, in person, or by submitting a completed enrollment form within the time frame specified by the Division, the Division will select a MassHealth managed care provider for the member. The Division will enroll the member effective no later than 35 days after the date the Division determined the member to be eligible for the purchase of medical benefits. The member will be notified in writing of the enrollment selection and the effective date of enrollment.

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(d) If the Division has determined a member to be eligible for the purchase of medical benefits under MassHealth Basic or MassHealth Essential, and if that member was enrolled with a MassHealth managed care provider during an earlier period of MassHealth eligibility, the Division may automatically enroll that member with the same provider pursuant to 130 CMR 508.002(H).

(2) If, at any time after the Division enrolls the member with a MassHealth managed care provider, the member wants to transfer to or from an available managed care provider, the member may notify the Division, and the effective date of medical coverage with the newly selected provider will be effective no later than 10 business days after the Division receives notification of the requested change.

(3) The time frames for establishing an effective date of enrollment may be extended if:

(a) the member asks the Division to delay any action described in 130 CMR 508.002(I) or otherwise causes a delay;

(b) the Division needs additional time to resolve conflicting information; or

(c) the Division does not have sufficient information to enroll or reenroll the member.

(4) In no event will a MassHealth Basic or MassHealth Essential member who is eligible for the purchase of medical benefits be enrolled with a MassHealth managed care provider with an effective date that is before the date of the Division's issuance of a notice to the member stating that the member is eligible for MassHealth Basic or MassHealth Essential.

508.003: Behavioral Health Contractor

The following applies to MassHealth members who receive behavioral health services through the Division's behavioral health contractor. See 130 CMR 508.001(C).

(A) Nonemergency Behavioral Health Services. All behavioral health services, except for emergency services, may be obtained only from a provider that has entered into an agreement with the Division's behavioral health contractor. The Division's behavioral health contractor is responsible for authorizing or denying behavioral health services based on the member's medical need for those services.

(B) Emergency Behavioral Health Services. Members may obtain emergency behavioral health services from any qualified participating MassHealth provider as well as any provider that has entered into an agreement with the Division's behavioral health contractor.

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Rev. 10/01/03**508.004: Members Excluded from Participation in Managed Care**

The following members are excluded from required participation in the Division's managed care options, and receive those MassHealth services for which they are eligible from any qualified participating MassHealth provider of those services:

- (A) a MassHealth Standard or CommonHealth member who has other health insurance, including Medicare;
- (B) a MassHealth Family Assistance, Basic, or Essential member who has or has access to other health insurance;
- (C) a member who is aged 65 or older;
- (D) a MassHealth Standard member institutionalized in:
 - (1) a nursing facility;
 - (2) a chronic disease or rehabilitation hospital;
 - (3) a state school for the mentally retarded; or
 - (4) a state psychiatric hospital;
- (E) a member who is eligible solely for:
 - (1) MassHealth Limited; or
 - (2) MassHealth Prenatal;
- (F) a MassHealth Standard or CommonHealth member who is receiving hospice care through the Division, or who is terminally ill as documented by a medical prognosis of a life expectancy of six months or less;
- (G) a member who is receiving medical services through the Emergency Aid to the Elderly, Disabled and Children Program pursuant to 130 CMR 450.106; and
- (H) a MassHealth Standard or MassHealth Family Assistance member who has presumptive or time-limited eligibility is excluded from enrolling in the PCC Plan or an MCO for primary care.

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508.016: Copayments Required by the Division

(A) The Division requires MassHealth members who are not enrolled in MCOs to make the copayments described in 130 CMR 508.018, except as excluded in 130 CMR 508.017. MassHealth members who are enrolled in MassHealth MCOs must make copayments in accordance with the MCO's MassHealth copayment policy. Those MCO copayment policies must be approved by the Division, must exclude the services and persons listed in 130 CMR 508.017, and may not exceed the MassHealth copayment amounts set forth in 130 CMR 508.018. (See also 130 CMR 450.130.)

(B) Certain MassHealth Family Assistance, Basic, and Essential members, whose health insurance premiums are paid in whole or in part by the Division are exempt from the copayment requirement described in 130 CMR 508.018, but must pay any copayments required of them under their health insurance, except as provided in 130 CMR 505.005(B)(6).

(C) The Division will pay certain copayments required by employer-sponsored health insurance for certain MassHealth Family Assistance members. See 130 CMR 505.005(B)(6).

508.017: Copayment Requirement Exclusions

The following are excluded from the copayment requirement described in 130 CMR 508.018:

- (A) MassHealth members who have not reached their 19th birthday;
- (B) MassHealth members who are pregnant;
- (C) MassHealth members who are in the postpartum period described in 130 CMR 505.002(E)(2);
- (D) MassHealth Limited members;
- (E) MassHealth members who are inpatients in hospitals, nursing facilities, chronic-disease or rehabilitation hospitals, and intermediate-care facilities for the mentally retarded;
- (F) family-planning services and supplies such as oral contraceptives, contraceptive devices such as condoms and diaphragms, and contraceptive jellies, creams, foams, and suppositories;
- (G) emergency services;
- (H) hospice-care services; and
- (I) persons receiving medical services through the Emergency Aid to the Elderly, Disabled and Children Program pursuant to 130 CMR 450.106, if they do not receive MassHealth Basic or MassHealth Standard.