



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 114
December 1, 2003

TO: Division Staff

FROM: Beth Waldman, Acting Commissioner

A handwritten signature in cursive script that reads "Beth Waldman".

RE: MassHealth Standard for Women with Breast or Cervical Cancer

Effective January 1, 2004, the Division is expanding MassHealth coverage to women who:

- are under the age of 65;
- have been diagnosed with breast or cervical cancer through a federally funded screening program that is operated in Massachusetts by the Department of Public Health Women's Health Network;
- are uninsured or do not otherwise have "creditable" health insurance coverage;
- have income that is less than 250 percent of the federal poverty level; and
- meet other MassHealth eligibility requirements.

Women who meet these requirements and are citizens or qualified aliens are eligible for MassHealth Standard for the duration of their cancer treatment. Eligible women will receive benefits through enrollment in the Division's Primary Care Clinician (PCC) Plan. Applicants who do not meet MassHealth Standard citizenship requirements may still be eligible for coverage under MassHealth Limited.

Women covered under this expansion must be uninsured or must not otherwise have "creditable coverage" for treatment of breast or cervical cancer. A woman is not considered to have "creditable coverage" if she is in a period of exclusion for treatment of breast or cervical cancer, or if she has exhausted her lifetime limit on all benefits under her plan, including treatment for breast or cervical cancer. In addition, women with limited scope coverage (e.g., covered only for dental, vision, or long-term care) or coverage only for a specified disease are not considered to have "creditable coverage." In addition, a woman who is an American Indian or Alaska native who is provided care through a medical-care program of the Indian Health Service or of a tribal organization is not considered to have "creditable coverage."

Women who are eligible for MassHealth Standard under these provisions and have income that is greater than 133 percent of the federal-poverty level must pay a monthly premium based on the family group gross monthly income.

These regulations are effective January 1, 2004.

MANUAL UPKEEP

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Person Who Is HIV Positive – a person who has submitted verification that he or she has tested positive for the human immunodeficiency virus (HIV).

Premium – a charge for payment to the Division that may be assessed to members of MassHealth Standard, MassHealth CommonHealth, or MassHealth Family Assistance.

Premium Assistance Payment – an amount contributed by the Division toward the cost of employer-sponsored health-insurance coverage for certain MassHealth members.

Presumptive Eligibility – a time-limited period of conditional eligibility for children based on the applicant's declaration of family group gross income.

Primary-Care Clinician (PCC) Plan – a managed-care option administered by the Division through which enrolled members receive primary care and other medical services. See 130 CMR 450.118.

Qualified Employer – a small employer who:

- (1) purchases health insurance that meets the Basic-Benefit Level;
- (2) contributes at least 50 percent of the cost of employees' health-insurance premiums; and
- (3) has completed an Employer Application form and been approved by the Division or its contractor(s) as a qualified employer pursuant to 130 CMR 650.010(A).

Quality Control – a system of continuing review to measure the accuracy of eligibility decisions.

Small Business – see definition for small employer.

Small Employer – an employer that has no more than 50 employees who work 30 hours or more a week, or a self-employed individual.

Substantial Gainful Activity – generally, employment that provides a set amount of gross earnings as determined by the Social Security Administration (SSA) under Title XVI of the Social Security Act.

Third Party – any individual, entity, or program that is or may be responsible to pay all or part of the expenditures for medical benefits.

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Rev. 01/01/04**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, women with breast or cervical cancer, 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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(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 Public Health (DPH). The Department of Public Health administers the Women's Health Network, which provides breast and cervical cancer screening and diagnostic services to certain low-income women. Uninsured women who are screened or receive diagnostic services through the Women's Health Network are eligible for MassHealth Standard for the duration of their cancer treatment if they:

(a) are found to be in need of treatment for breast or cervical cancer; and

(b) meet the MassHealth program requirements described in 130 CMR 505.002(H), as determined by the Division.

(4) 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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Rev. 01/01/04505.001: Introduction

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, disabled individuals, and women with breast or cervical cancer;
- (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, parents and caretaker relatives described in 130 CMR 519.005(C)(1), and women with breast or cervical cancer.
- (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.

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(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:

(a) terminated from EAEDC or TAFDC and are determined to be potentially eligible for MassHealth; or

(b) terminated from TAFDC because of receipt of or an increase in spousal or child support payments.

(2) Members of a family group who become ineligible for TAFDC for employment-related reasons continue to receive MassHealth Standard for a full 12-calendar month period beginning with the date on which they became ineligible for TAFDC if:

(a) the family group continues to include a child who is under age 19, or if he or she has reached age 19, is expected to complete his or her secondary level studies before his or her 20th birthday; and

(b) a parent or caretaker relative continues to be employed.

(3) Members of a family group who receive MassHealth Standard (whether or not they receive TAFDC) and have increased earnings that raise the family group's gross income above 133 percent of the federal-poverty level, continue to receive MassHealth Standard for a full 12-calendar month period that begins with the date on which the increase occurred if:

(a) the family group continues to include a child who is under age 19; and

(b) a parent or caretaker relative continues to be employed.

(4) The Division independently reviews the continued eligibility of the family group at the end of the extended period described in 130 CMR 505.002(B)(1), (2), and (3).

(5) If a family group who receives MassHealth under 130 CMR 505.002(B)(1) or (2) had income at or below 133 percent of the federal-poverty level during their extended period, and now has increased earnings that raise the family group's gross income above that limit, the family group is eligible for another full 12-calendar month period that begins with the date on which the increase occurred if:

(a) the family group continues to include a child who is under age 19; and

(b) a parent or caretaker relative continues to be employed.

(6) If a family group's gross income decreases to 133 percent of the federal poverty level or below during its extended eligibility period, and the decrease is timely reported to the Division, the family group's eligibility for MassHealth Standard may be redetermined. If the family group's gross income later increases above 133 percent of the federal poverty level, the family group will be eligible for a new extended eligibility period.

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(C) Eligibility Requirements for Children Under Age 19. Children under the age of 19 may establish eligibility for Standard coverage subject to the requirements described in 130 CMR 505.002(C).

(1) Children Under Age One.

(a) A child under age one born to a woman who was not receiving MassHealth Standard on the date of the child's birth is eligible if the gross income of the family group is less than or equal to 200 percent of the federal-poverty level.

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

(c) A child receiving MassHealth Standard who receives inpatient services on the date of his or her first birthday remains eligible until the end of the stay for which the inpatient services are furnished.

(2) Children Aged One through 18.

(a) A child aged one through 18 is eligible if the gross income of the family group is less than or equal to 150 percent of the federal-poverty level.

(b) A child receiving MassHealth Standard who receives inpatient services on the date of his or her 19th birthday remains eligible until the end of the stay for which the inpatient services are furnished.

(c) Eligibility for a child who is pregnant is determined under 130 CMR 505.002(E).

(3) 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.

(4) Presumptive Eligibility Requirements. The Division may determine a child presumptively eligible to receive Standard coverage in accordance with the requirements of 130 CMR 502.003 if the self-declared gross income of the family group meets the applicable income standards for children under age 19 as described in 130 CMR 505.002(C)(1) and (2).

(D) Eligibility Requirements for Parents and Caretaker Relatives.

(1) A natural, step, or adoptive parent is eligible for Standard coverage provided:

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

(b) the parent lives with his or her children, and, in the case of a parent who is separated or divorced, has custody of his or her children; or has children who are absent from home to attend school.

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(2) A caretaker relative is eligible for Standard coverage provided:

- (a) the caretaker relative chooses to be part of the family group;
- (b) the family group gross income is less than or equal to 133 percent of the federal-poverty level; and
- (c) the caretaker relative lives with children to whom he or she is related by blood, adoption, or marriage, or is a spouse or former spouse of one of those relatives, provided neither parent lives in the home.

(E) Eligibility Requirements for Pregnant Women.

- (1) A pregnant woman whose family group gross income is less than or equal to 200 percent of the federal-poverty level is eligible for Standard coverage. In determining the family group size, the unborn child or children are counted as if born and living with the mother.
- (2) Eligibility, once established, continues for the duration of the pregnancy. Eligibility for postpartum care continues for 60 days following the termination of the pregnancy plus an additional period extending to the end of the month in which the 60-day period ends.
- (3) The Division notifies pregnant women who are aliens with special status aged 19 or older and nonqualified aliens of their potential eligibility for the Healthy Start Program.

(F) Disabled Individuals.

- (1) Extended MassHealth Eligibility. Disabled persons whose SSI-Disability assistance has been terminated, and who are determined to be potentially eligible for MassHealth, continue to receive MassHealth Standard coverage until the Division makes a determination of ineligibility.
- (2) Disabled Adults. A disabled adult under age 65 may establish eligibility for MassHealth Standard coverage if he or she meets the following requirements:
 - (a) the individual is permanently and totally disabled as defined in 130 CMR 501.001; and
 - (b) the family group gross income is less than or equal to 133 percent of the federal-poverty level, or the individual is eligible under section 1634 of the Social Security Act (42 U.S.C. § 1383c) as a disabled adult child or as a disabled widow or widower, or is eligible under the provisions of the Pickle Amendment as described at 130 CMR 519.003.

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(3) Determination of Disability. Disability is established by:

- (a) certification of legal blindness by the Massachusetts Commission for the Blind (MCB);
- (b) a determination of disability by the SSA; or
- (c) a determination of disability by the Division's Disability Determination Unit (DDU).

(G) Medicare Premium Payment. The Division also pays the following on behalf of members who meet the requirements of 130 CMR 505.002(F) and 519.005(C). The coverage described in 130 CMR 505.002(G)(1), (2), and (3) begins on the first day of the month following the date of the Division's eligibility determination.

- (1) The cost of the monthly Medicare Part B premiums;
- (2) Where applicable, the cost of hospital insurance under Part A for members who are entitled to Medicare Part A; and
- (3) Where applicable, for the deductibles and coinsurance under Medicare Parts A and B.

(H) Women with Breast or Cervical Cancer.

(1) Eligibility Requirements. A woman whose application has been received through the Department of Public Health in accordance with 130 CMR 501.005 and who is under the age of 65 is eligible for MassHealth Standard provided she meets all of the following requirements.

- (a) She is a United States citizen or qualified alien as described at 130 CMR 504.002(A) and (B).
- (b) She has provided a social security number in accordance with the requirements at 130 CMR 503.003.
- (c) She has been screened or has received diagnostic services through the Department of Public Health (DPH) Women's Health Network and found to need treatment for breast or cervical cancer, including precancerous conditions.
- (d) She has family group income less than or equal to 250 percent of the federal poverty level in accordance with DPH requirements as certified by DPH to the Division.
- (e) She is uninsured as defined at 130 CMR 505.002(H)(2).
- (f) She does not meet the requirements for MassHealth Standard described at 130 CMR 505.002(C)(2), (D), (E) or (F).

(2) Availability of Health Insurance. To receive benefits under the provisions of 130 CMR 505.002(H), a woman must:

- (a) be uninsured; or

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(b) have insurance that does not provide creditable coverage. A woman is not considered to have creditable coverage when the woman:

(i) is in a period of exclusion for treatment of breast or cervical cancer;

(ii) has exhausted her lifetime limit on all benefits under her plan, including treatment for breast or cervical cancer; or

(iii) has limited scope coverage or coverage only for a specified disease; or

(c) be an American Indian or Alaska Native who is provided care through a medical care program of the Indian Health Service or of a tribal organization.

(3) Premiums. Women who meet the requirements of 130 CMR 505.002(H) are assessed a monthly premium in accordance with 130 CMR 506.011.

(4) Duration of Eligibility. Women meeting the requirements of 130 CMR 505.002(H) are eligible for MassHealth Standard for the duration of their cancer treatment.

(I) Use of Potential Health Insurance Benefits. With the exception of women described at 130 CMR 505.002(H), applicants and members must use potential health insurance benefits in accordance with 130 CMR 503.007, and must enroll in health insurance, including Medicare, if available at no cost to the member, or if purchased by the Division in accordance with 130 CMR 507.003 or 505.002(G).

(J) Medical Coverage Date.

(1) The medical coverage date for MassHealth Standard 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. However, the medical coverage date will in no event begin before January 1, 2004, for women described at 130 CMR 505.002(H).

(2) If these required verifications listed on the Request for Information are received after the 60-day period referenced in 130 CMR 505.002(J)(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) The begin and end dates for medical coverage under Presumptive Eligibility are described in 130 CMR 502.003.

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(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(G), 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).

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506.011: MassHealth Standard, CommonHealth, and Family Assistance Premiums

(A) MassHealth Standard, CommonHealth, and Family Assistance Premiums. The Division may charge a premium to certain disabled MassHealth Standard members with incomes above 114 percent of the federal poverty level and to certain other MassHealth Standard members with incomes above 133 percent of the federal poverty level, including women with breast and cervical cancer who receive Standard in accordance with 130 CMR 505.002(H). The Division may charge a premium to certain MassHealth CommonHealth and Family Assistance members with incomes above 100 percent of the federal poverty level. Only one premium per family group will be assessed. Certain members are exempt from paying premiums, in accordance with 130 CMR 506.011(K).

(1) MassHealth Standard premiums for children and disabled members are based on family group gross countable income, family group size as it relates to the federal poverty level guidelines, and whether or not the member has other health insurance. Premiums for women with breast and cervical cancer are based on family group gross countable income and family group size as it relates to the federal poverty guidelines.

(2) MassHealth CommonHealth premiums are based on family group gross countable income, family group size as it relates to the federal poverty level income guidelines, and whether or not the member has other health insurance.

(3) MassHealth Family Assistance premiums for the purchase of medical benefits, as described in 130 CMR 505.005(E), are based on the number of eligible members in the family group.

(4) When the family group contains members in more than one coverage type who are responsible for a premium or member share, the family group is responsible for only the higher premium amount or member share.

(B) Premium Payments. The Division may charge monthly premiums to persons described in 130 CMR 501.006, 505.002(C)(2), (F)(2), and (H), 505.004(B), (C), (D), and (E), and 505.005(B)(3), (E), (F), and (G).

(1) Persons described in 130 CMR 501.006, 505.002(C)(2), (F)(2), and (H), 505.004(B), (C), (D), and (E), and 505.005(B)(3), (E), (F), and (G) who are assessed a premium are responsible for monthly premium payments beginning with the calendar month following the date of the Division's eligibility determination.

(2) Persons described in 130 CMR 505.004(C) who are assessed a premium, are responsible for monthly premium payments beginning with the calendar month following the date the deductible period ends, or the calendar month following the month in which the member has verified that the deductible has been met, whichever is later.

(3) Members who are assessed a revised premium as the result of a reported change, or any adjustment in the premium schedule are responsible for the new premium payment beginning with the calendar month following the reported change.

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(4) Members who have been assessed premiums but who are subsequently determined eligible for a coverage type other than Standard, CommonHealth, or Family Assistance are not charged a premium for the calendar month in which the coverage type changes or thereafter.

(C) Delinquent Premium Payments. If the Division has billed a member for a premium payment, and the member does not pay all of the amount billed within 60 days of the date on the bill, then the member's eligibility for benefits is terminated, except as provided below. The member receives a notice of termination before the date of termination. The member's eligibility will not be terminated if, before the date of termination, the member:

- (1) pays all amounts that have been billed 60 days or more before the date such payment is made; or
- (2) establishes a payment plan acceptable to the Division. After such a payment plan has been established, the Division bills the member for:
 - (a) payments in accordance with the payment plan; and
 - (b) monthly premiums due subsequent to the establishment of the payment plan. If the member does not make payments in accordance with the payment plan within 30 days of the date on the bill, the member's eligibility is terminated. If the member 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.

(D) Reactivating Coverage Following Termination Due to Delinquent Payment.

- (1) 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.
- (2) If a waiting list has been established, adults (aged 19 or older) 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.

(E) 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.

(F) 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.

(G) 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.

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(H) 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, the Standard premium schedule, or the Family Assistance premium amount for the purchase of medical benefits.

(I) The Monthly MassHealth Standard and CommonHealth Premium Schedule. 130 CMR 506.011(I) provides the formulas that the Division uses to determine the monthly premiums for people who are receiving MassHealth Standard or CommonHealth, and for certain MassHealth Family Assistance members who are HIV positive.

(1) Monthly Full Premium Formula for CommonHealth and Certain Family Assistance Members Receiving Benefits under 130 CMR 505.005(F) and (G). Full payment is required of members who have no health insurance and of members for whom the Division is paying a portion of their health-insurance premium. The full premium formula is provided below.

FULL PREMIUM FORMULA		
Base Premium	Additional Premium Cost	Range of Premium Cost
Above 100% to 150%	\$15 per family group	\$15
Above 150% FPL— start at \$15	Add \$5 for each additional 10% FPL until 200% FPL	\$15 — \$35
Above 200% FPL— start at \$40	Add \$8 for each additional 10% FPL until 400% FPL	\$40 — \$192
Above 400% FPL— start at \$202	Add \$10 for each additional 10% FPL until 600% FPL	\$202 — \$392
Above 600% FPL— start at \$404	Add \$12 for each additional 10% FPL until 800% FPL	\$404 — \$632
Above 800% FPL— start at \$646	Add \$14 for each additional 10% FPL until 1000%	\$646 — \$912
Above 1000% FPL— start at \$928	Add \$16 for each additional 10% FPL	\$928 + greater

(2) Monthly Supplemental Premium Formula. A lower supplemental payment is required of members who have health insurance to which the Division does not contribute. The supplemental premium formula is provided below.

SUPPLEMENTAL PREMIUM FORMULA	
% of Federal Poverty Level (FPL)	Premium Cost
Above 100% to 150%	60% of full premium
Above 150% to 200%	60% of full premium
Above 200% to 400%	65% of full premium
Above 400% to 600%	70% of full premium
Above 600% to 800%	75% of full premium
Above 800% to 1000%	80% of full premium
Above 1000%	85% of full premium

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(3) Monthly Premium Schedule for Standard Disabled (Not Applicable for Parents and Children).

% of Federal Poverty Level (FPL)	Premium Cost
Up to 114%	No premium
Above 114%	\$12 per family group
Supplemental Premium	60% of full premium

(4) Monthly Premium Schedule for Standard Children.

% of Federal Poverty Level (FPL)	Premium Cost
Above 133% to 150%	\$12 per child to \$15 maximum per family group
Supplemental Premium	60% of full premium

(5) Monthly Premium Schedule for Women with Breast or Cervical Cancer. Women with breast or cervical cancer who are described at 130 CMR 505.002(H) and have income above 133 percent of the federal poverty level in accordance with DPH requirements as certified by DPH to the Division are assessed a monthly premium in accordance with the following premium schedule.

% of Federal Poverty Level (FPL)	Premium Cost
Above 133% to 160%	\$15
Above 160% to 170%	\$20
Above 170% to 180%	\$25
Above 180% to 190%	\$30
Above 190% to 200%	\$35
Above 200% to 210%	\$40
Above 210% to 220%	\$48
Above 220% to 230%	\$56
Above 230% to 240%	\$64
Above 240% to 250%	\$72

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(J) Monthly Family Assistance Premiums for the Purchase of Medical Benefits.

(1) MassHealth Family Assistance members with income greater than 150 percent up to 200 percent of the federal poverty level for whom the Division purchases medical benefits under 130 CMR 505.005(B)(3) and (E) are assessed a monthly premium of \$12 per child, with a maximum of \$36 per family.

(2) MassHealth Family Assistance members with income between 100 and 150 percent of the federal poverty level for whom the Division purchases medical benefits under 130 CMR 505.005(B)(3) and (E) are assessed a monthly premium of \$12 per child, with a maximum of \$15 per family.

(K) Members Exempted from Premium Payment. The following members are exempt from premium payments.

(1) Members who are eligible under section 1634 of the Social Security Act as a disabled adult child or as a disabled widow or widower, or who are eligible under the provisions of the Pickle Amendment, as described in 130 CMR 519.003.

(2) Pregnant women and children under the age of six who are receiving MassHealth Standard.

(3) MassHealth Family Assistance members who are American Indians or Alaska Natives, as defined in 130 CMR 501.001.

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508.001: MassHealth Managed Care Requirement

(A) Member Participation.

(1) MassHealth Standard members described in 130 CMR 505.002(B), (C), (D), (E), and (F), 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) and MassHealth Standard members described at 130 CMR 505.002(H) 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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(C) Parents and Caretaker Relatives of Children Under Age 19.

- (1) Eligibility Requirements. Adults who are aged 65 and older and are the parents or caretaker relatives of a child under age 19 receive MassHealth Standard if they meet the requirements of 130 CMR 505.002(B) or (D).
- (2) Other Provisions. The following provisions apply to adults described in 130 CMR 519.005(C)(1): 130 CMR 505.002(A)(2), (G), (I), and (J).
- (3) Countable Income. Eligibility for adults described in 130 CMR 519.005(C)(1) is based on the applicant's or member's family group countable earned and unearned income, and the income rules described at 130 CMR 506.002, 506.003, and 506.004.
- (4) Exemption from Asset Limits. The asset limits in 130 CMR 520.003 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 under age 18 or aged 65 or older; or, for individuals aged 18 to 64 inclusive, meet Title XVI disability standards or be pregnant;
- (2) be determined medically eligible for nursing-facility services by the Division or the Division's agent as a condition for payment, in accordance with 130 CMR 456.000;
- (3) contribute to the cost of care as defined at 130 CMR 520.026;
- (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); and
- (5) not have transferred resources for the sole purpose of obtaining MassHealth as described at 130 CMR 520.018 and 520.019.

(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 (SSA); or
 - (c) a determination of disability by the Division's Disability Determination Unit (DDU). Until this determination is made, the applicant's submission of a completed disability supplement will satisfy the verification requirement.