Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth

MassHealth
Eligibility Letter 120
March 1, 2004

TO: Division Staff

FROM: Beth Waldman, Medicaid Director BW

RE: **MassHealth Standard/CommonHealth Premium Assistance (MSCPA)**

MassHealth will now require all persons who are eligible for MassHealth Standard or CommonHealth to obtain and/or maintain available group health insurance, provided that the health insurance:

- meets MassHealth's cost-effectiveness test and basic benefit level; and
- is available to the member at no greater cost than MassHealth coverage.

Members whose health insurance or potential health insurance is determined to meet these requirements will be denied MassHealth eligibility if they do not enroll in this health insurance, unless the member is under the age of 19 or pregnant.

MassHealth will provide a fee-for-service benefit while investigating the cost effectiveness and basic benefit level of the member's health insurance. If the health insurance meets these requirements, MassHealth will provide premium assistance to pay the health insurance premium, and will also provide fee-for-service coverage for services not covered by the group health insurance, including the group health insurance deductibles and copayments that are greater than the MassHealth copayments.

The Health Insurance Premium Program (HIPP) will now be referred to as "MassHealth Standard/CommonHealth Premium Assistance (MSCPA)."

These regulations are effective March 1, 2004.

MANUAL UPKEEP

Insert	Remove	Trans. By
503.006	503.006	E.L. 53
505.002 (1 of 6)	505.002 (1 of 5)	E.L. 114
505.002 (2 of 6)	505.002 (2 of 5)	E.L. 114
505.002 (3 of 6)	505.002 (3 of 5)	E.L. 117
505.002 (4 of 6)	505.002 (4 of 5)	E.L. 114
505.002 (5 of 6)	505.002 (5 of 5)	E.L. 114
505.002 (6 of 6)	-----	-----
505.003	505.003	E.L. 72
505.004	505.004	E.L. 112
507.000	507.000	E.L. 51
507.003 (1 of 2)	507.003	E.L. 81
507.003 (2 of 2)	-----	-----
508.004	508.004	E.L. 116
521.000	521.000	E.L. 60
521.001	521.001	E.L. 60
521.004 (1 of 2)	521.004 (1 of 2)	E.L. 117
521.004 (2 of 2)	521.004 (2 of 2)	E. L. 41

503.006: Assignment for Third-Party Recoveries

As a condition of eligibility, an applicant or member must inform any MassHealth Enrollment Center when a family group member is involved in an accident, or suffers from an illness or injury, or other loss that has resulted or may result in a lawsuit or insurance claim. The applicant or member must:

(A) file an insurance claim for compensation, if available; and

(B) agree to comply with all requirements of M.G.L. c. 118E, s. 22 including, but not limited to:

(1) assigning to MassHealth or its agent the right to recover an amount equal to the MassHealth benefits provided from the proceeds of any claim or other proceeding against a third party;

(2) providing information about the claim or any other proceeding and cooperating fully with MassHealth or its agent, unless MassHealth determines that cooperation would not be in the best interests of, or would result in serious harm or emotional impairment to, the applicant or member;

(3) notifying any MassHealth Enrollment Center in writing within 10 days of filing any claim, civil action, or other proceeding; and

(4) repaying MassHealth from the money received from a third party for all MassHealth benefits provided on or after the date of the accident or other incident. If the member is involved in an accident or other incident after becoming MassHealth eligible, repayment will be limited to MassHealth benefits provided as a result of the accident or incident.

503.007: Potential Sources of Health Care

MassHealth is the payor of last resort and pays for health care and related services only when no other source of payment is available, except as otherwise required by federal law.

(A) Health Insurance. Every applicant and member must obtain and maintain available group health insurance in accordance with 130 CMR 505.000 et seq and 507.003. Failure to do so may result in loss or denial of eligibility for all individuals within the family group unless the applicant or member is:

(1) receiving MassHealth Standard or MassHealth CommonHealth; and

(2) under age 19 or pregnant.

(B) Use of Benefits. MassHealth does not pay for any health care and related services that are available:

(1) through the member's health insurance, if any; or

(2) at no cost to the member including, but not limited to, any such services that are available through any agency of the local, state, or federal government, or any entity legally obligated to provide those services.

(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;

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

(c) the parent or caretaker relative complies with 130 CMR 505.002(I) and 507.003.

(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;

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

(c) the parent or caretaker relative complies with 130 CMR 505.002(I) and 507.003.

(4) MassHealth 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;

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

(c) the parent or caretaker relative complies with 130 CMR 505.002(I) and 507.003.

(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 MassHealth, 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 is eligible for a new extended eligibility period.

(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. MassHealth 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. MassHealth may determine a child presumptively eligible to receive MassHealth 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 MassHealth Standard coverage if:

(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.

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

(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, if neither parent lives in the home.

(3) The parent or caretaker relative complies with 130 CMR 505.002(I) and 507.003.

(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 MassHealth 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) MassHealth 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 MassHealth 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;

(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; and

(c) the individual complies with 130 CMR 505.002(I) and 507.003.

(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 MassHealth's Disability Determination Unit (DDU).

(G) Medicare Premium Payment. MassHealth 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 MassHealth's eligibility determination.

(1) The cost of the monthly Medicare Part B premiums;

(2) Where applicable, the cost of hospital insurance under Medicare 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 MassHealth.

(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

(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 greater cost to the applicant or member than he or she would pay without access to health insurance, or if purchased by MassHealth 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 MassHealth 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. 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, if 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.

505.003: MassHealth Prenatal

(A) Overview.

(1) 130 CMR 505.003 contains the categorical requirements and financial standards for Prenatal coverage.

(2) Persons eligible for Prenatal coverage are eligible for medical benefits as described in 130 CMR 450.105(F).

(B) Eligibility Requirements. A pregnant woman whose self-declared family group gross income is less than or equal to 200 percent of the federal-poverty level is eligible for Prenatal coverage.

(C) Medical Coverage Date. Prenatal coverage begins 10 days before the date a Medical Benefit Request is received at any MassHealth Enrollment Center or received by a MassHealth outreach worker at a designated outreach site. Coverage continues for 60 days from the begin date or until MassHealth makes an eligibility determination, whichever is earlier.

505.004: MassHealth CommonHealth

(A) Overview.

(1) 130 CMR 505.004 contains the categorical requirements and financial standards for CommonHealth coverage available to both disabled children and disabled adults, and to disabled working adults.

(2) Persons eligible for CommonHealth coverage are eligible for medical benefits as described in 130 CMR 450.105(E).

(B) Disabled Working Adults. Disabled working adults must meet the following requirements:

(1) be aged 19 through 64 (For those aged 65 and older, see 130 CMR 519.012.);

(2) be employed at least 40 hours per month, or if employed less than 40 hours per month, have been employed at least 240 hours in the six-month period immediately preceding the month of receipt of the MBR or MassHealth's eligibility review;

(3) be permanently and totally disabled (except for engagement in substantial gainful activity) as defined in 130 CMR 501.001;

(4) be ineligible for MassHealth Standard; and

(5) comply with 130 CMR 505.002(I) and 507.003.

(C) Disabled Adults. Disabled adults must meet the following requirements:

(1) be aged 19 through 64;

(2) be permanently and totally disabled, as defined in 130 CMR 501.001;

(3) be ineligible for MassHealth Standard;

(4) meet a one-time-only deductible in accordance with 130 CMR 506.009; and

(5) comply with 130 CMR 505.002(I) and 507.003.

(D) Disabled Children Under Age 18. Disabled children under age 18 must meet the following requirements:

(1) be permanently and totally disabled based on the disability criteria for children under age 18, as defined in 130 CMR 501.001; and

(2) be ineligible for MassHealth Standard.

(E) Disabled 18-Year-Olds. Disabled 18-year-olds must meet the following requirements:

(1) (a) be ineligible for MassHealth Standard; and

(b) if not working, be permanently and totally disabled based on the disability criteria for adults and 18-year-olds, as defined in 130 CMR 501.001; or

(2) if working, be permanently and totally disabled based on the disability criteria for adults and 18-year-olds (except for engagement in substantial gainful activity), as defined in 130 CMR 501.001.

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

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

(2) a determination of disability by the SSA; or

(3) a determination of disability by MassHealth's Disability Determination Unit (DDU).

(G) MassHealth CommonHealth Premium. Disabled adults, disabled working adults, and disabled children who meet the requirements of 130 CMR 505.004 may be assessed a premium in accordance with the premium schedule provided in 130 CMR 506.011(I). No premium is assessed during a deductible period.

TABLE OF CONTENTS

Section

507.003: MassHealth Standard/CommonHealth Premium Assistance (MSCPA)

(A) Introduction. MassHealth may provide group health insurance subsidies to eligible MassHealth Standard or CommonHealth members or to Family Assistance members described at 130 CMR 505.005(D) if the member has:

(1) group health insurance; or

(2) potential access to group health insurance.

(B) Benefits.

(1) Persons who meet the categorical and financial requirements described at 130 CMR 505.002(D) and (F) and 505.004(B) and (C), and have health insurance or potential access to health insurance will receive MassHealth Standard or CommonHealth fee-for-service benefits for a time-limited period while MassHealth investigates the insurance to determine the following criteria:

(a) the availability of the health insurance to all family members;

(b) the cost effectiveness of the health insurance; and

(c) that the insurance meets the basic benefit level as described at 130 CMR 501.001.

(2) If MassHealth determines that the insurance meets the criteria at 130 CMR 507.003(B)(1), the applicant is notified in writing that MassHealth will provide benefits through MSCPA.

(3) Applicants may be eligible for an additional 60-day time-limited fee-for-service eligibility period if it is determined that the insurance meets the requirements, but additional time is needed for the applicant to enroll in the health insurance plan.

(4) Once enrolled in the health insurance plan, MassHealth provides premium assistance payments as described at 130 CMR 507.003(D). In addition, MassHealth pays for services not covered by the group health insurance, including the group health insurance deductibles and copayments that are greater than the MassHealth copayments.

(5) If MassHealth determines that the health insurance does not meet the criteria at 130 CMR 507.003(B)(1), the applicant is notified in writing of his or her continued eligibility for MassHealth Standard or CommonHealth.

(C) Period of Eligibility. MassHealth continues to pay the health insurance premiums as long as MassHealth determines that the health insurance plan continues to be cost effective and meets the basic benefit level, and the member continues to be eligible for MassHealth Standard or CommonHealth.

(D) Method of Premium Payment. Monthly payments of health insurance premiums are made directly to the policyholder as determined by MassHealth. Proof of health insurance premium payments may be required from the parent or member. Premium assistance payments begin in the month of MassHealth's eligibility determination for MSCPA, or in the month the health-insurance deduction begins, whichever is later. Each monthly payment is for coverage in the following month.

(E) Review of Cost Effectiveness and Basic Benefit Level Requirements. MassHealth reviews the cost effectiveness of each case at least once every 12 months for health insurance plans. In addition, reviews of the cost effectiveness are completed by MassHealth whenever the cost of the health insurance plan changes, when any persons under the policy are no longer eligible for MassHealth Standard, CommonHealth, or Family Assistance under rules described at 130 CMR 505.005(D), or when there is a change in the services covered under the policy that affects the basic benefit level requirements.

(F) Conditions of Eligibility. The member, or a person acting on the member's behalf, must cooperate in providing information necessary for MassHealth to determine the availability and cost effectiveness of group health insurance. Persons who are eligible to enroll in a group health insurance plan that MassHealth has determined to be cost effective, and who are otherwise eligible for MassHealth Standard or CommonHealth, must apply for enrollment and continue to be enrolled in the plan as a condition of MassHealth Standard or CommonHealth eligibility pursuant to 130 CMR 503.007.

(G) Failure to Cooperate. A child's eligibility for MassHealth Standard or CommonHealth is not affected by the parent's failure to cooperate.

508.004: Members Excluded from Participation in Managed Care

The following members are excluded from required participation in MassHealth'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, except for MassHealth Standard members who may voluntarily enroll in a senior care organization in accordance with the requirements under 130 CMR 508.008;

(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 MassHealth, 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, Family Assistance, or CommonHealth member who has presumptive or time-limited eligibility is excluded from enrolling in the PCC Plan or an MCO for primary care.

TABLE OF CONTENTS

Section

521.001: Introduction

130 CMR 521.000 contains related program benefits that a MassHealth member may receive. These services include reimbursement of certain out-of-pocket medical expenses, and enrollment in a group health insurance plan when MassHealth determines it is cost effective.

521.002: Reserved

521.003: MassHealth Standard/CommonHealth Premium Assistance (MSCPA)

MassHealth pays for the cost of enrolling an eligible MassHealth Standard member who has access to employer-based group insurance when MassHealth determines it is cost effective to do so and the insurance meets the basic benefit level as described at 130 CMR 501.001.

(A) Period of Eligibility. MassHealth continues to pay the health insurance premiums as long as the health insurance plan continues to be cost effective and meets the basic benefit level as described at 130 CMR 501.001.

(B) Method of Premium Payment. Monthly payments of health insurance premiums are made directly to the policyholder, as determined by MassHealth. Proof of health insurance premium payments may be required from the parent or member. Premium assistance payments begin in the month of MassHealth's eligibility determination for MSCPA or in the month the health-insurance deduction begins, whichever is later. Each monthly payment is for coverage in the following month.

(C) Review of Cost Effectiveness and Basic Benefit Level Requirement. MassHealth reviews the cost effectiveness of each case at least once every 12 months for health insurance plans. In addition, reviews of the cost effectiveness are completed by MassHealth whenever the cost of the group health insurance plan changes, when any individuals under the policy are no longer eligible for MassHealth, or when there is a change in the services covered under the policy that affects the basic benefit level requirements.

(D) Time Frames for Determining Cost Effectiveness and Basic Benefit Level Requirement. MassHealth determines the cost effectiveness of the insurance plan and notifies the member of the decision regarding payment of the premiums within 60 days of the date MassHealth is notified of a request to enroll in MSCPA. Additional time may be granted when, for reasons beyond the control of MassHealth or the member, information needed to establish cost effectiveness or the basic benefit level cannot be obtained within the 60-day period.

(E) Conditions of Eligibility. The member, or a person acting on the member's behalf, must cooperate in providing information necessary for MassHealth to determine the availability and cost effectiveness of group health insurance. Individuals who are eligible to enroll in a group health insurance plan that MassHealth has determined to be cost effective, and who are otherwise eligible for MassHealth Standard, must apply for enrollment and continue to be enrolled in the plan as a condition of MassHealth eligibility.

(F) Failure to Cooperate. The eligibility of a child or spouse for MassHealth is not affected by the parent's or spouse's failure to cooperate.

521.004: Reimbursement of Certain Out-of-Pocket Medical Expenses

(A) Eligibility Requirements. The following Standard coverage members are entitled to reimbursement for certain medical expenses for which they paid, subject to the provisions of 130 CMR 521.004.

(1) An individual who:

(a) applied for Supplemental Security Income (SSI);

(b) was denied SSI benefits by the Social Security Administration; and

(c) had his or her initial Social Security Administration denial overturned through a reconsideration process, administrative hearing, appeals counsel review, federal court review, or reopening under the Social Security Administration rules on administrative finality.

(2) An individual who:

(a) applied for MassHealth;

(b) was denied MassHealth; and

(c) had his or her initial denial overturned by a subsequent decision, MassHealth, the fair hearing process, or the judicial review process.

(B) Limitations.

(1) Reimbursement is limited to bills incurred on or after the date of initial MassHealth eligibility, and paid between the date of the erroneous eligibility decision and the date on which the member is notified of MassHealth eligibility. The bill must have been paid by the member, the member's spouse, the parent of a member, or a legal guardian.

(2) Reimbursement is also limited to amounts actually paid for care or services that would have been covered under MassHealth had eligibility been determined correctly, even if these amounts exceed the MassHealth rate. Before reimbursing a member for care or services that would have required prior authorization, MassHealth may require submission of medical evidence for consideration under the prior-authorization standards. Reimbursement is available even though the medical care or services were furnished by a provider who does not participate in MassHealth.

(C) Verification.

(1) Applicants or members seeking reimbursement must provide MassHealth with:

(a) a bill for medical services that includes:

(i) the provider's name;

(ii) a description of the services provided; and

(iii) the date the service was provided; and

(b) proof of payment of the bill presented, such as a canceled check or receipt.

(2) Recipients of SSI must also provide documents from the Social Security Administration establishing the date of application and the date of application denial.