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 137
July 1, 2005

TO: MassHealth Staff

FROM: Beth Waldman, Medicaid Director BW

RE: **Expansion of Income Eligibility for the Frail Elders Home- and Community-Based Services Waiver and Revision to Program of All-Inclusive Care for the Elderly (PACE) Eligibility Requirements and Time Standards for Eligibility Determinations**

MassHealth is making three revisions to its regulations.

The Centers for Medicare and Medicaid Services (CMS) approved a request from MassHealth to increase the income level for members who are eligible for the Frail Elders Home- and Community-Based Services Waiver from 100% of the federal poverty level (FPL) to 300% of the SSI federal benefit rate for an individual.

A change is being made to the regulations about Program of All-Inclusive Care for the Elderly (PACE) to clarify that MassHealth counts the income and assets of only the applicant when determining eligibility for PACE.

Revisions to the time standards for eligibility determinations are being made to support the integration of community elders into the MA21 system.

These regulations are being issued as emergency regulations, effective July 1, 2005.

MANUAL UPKEEP

Insert	**Remove**	**Trans. By**
502.001	502.001	E.L. 108
502.005	502.005	E.L. 81
516.004	516.004	E.L. 123
519.003 (2 of 2)	519.002 (2 of 2)	E.L. 132
519.007 (3 of 4)	519.007 (3 of 4)	E.L. 69
519.007 (4 of 4)	519.007 (4 of 4)	E.L. 117

502.001: Medical Benefit Request (MBR)

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

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

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

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

502.002: Reactivating the Medical Benefit Request

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

502.003: Presumptive Eligibility for Children

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

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

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

502.004: Matching Information

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

Social Security Administration, Alien Verification Information System, Department of Transitional Assistance**,** and health insurance carriers.

502.005: Time Standards for an Eligibility Determination

(A) For applicants who do not apply on the basis of a disability, the MassHealth agency makes an eligibility determination:

(1) within 60 days from the date of receipt of the complete MBR if the applicant is potentially eligible for MassHealth Family Assistance; or

(2) within 45 days from the date of receipt of the complete MBR for all other nondisabled applicants.

(B) For applicants who apply on the basis of a disability, the MassHealth agency makes an eligibility determination within 90 days from the date of receipt of the complete MBR.

(C) Households with one or more applicants aged 65 or older who are not eligible for benefits under the regulations in 130 CMR 501.000 through 508.000 will be determined by the time standards described at 130 CMR 516.004 for the entire household.

(D) These time standards may be extended by the amount of time used by the applicant to respond to requests for additional information needed to make the disability determination.

502.006: Coverage Date

The date of coverage for MassHealth is determined by the coverage type for which the applicant may be eligible. 130 CMR 505.000 describes the rules for establishing this date.

502.007: Eligibility Review

(A) The MassHealth agency reviews eligibility at least every 12 months. Eligibility may also be reviewed as a result of a member's change in circumstances, or a change in MassHealth eligibility rules, or as a result of a member's failure to provide verification of immigration status or HIV-positive status. The MassHealth agency updates the case file based on information received as the result of such review. The MassHealth agency reviews eligibility:

(1) by information matching with other agencies, health insurance carriers, and information sources;

(2) through a written update of the member's circumstances on a prescribed form; or

(3) based on information in the member's case file.

(B) The MassHealth agency determines, as a result of this review, if:

(1) the member continues to be eligible for the current coverage type;

(2) the member's current circumstances require a change in coverage type, premium payment, or premium assistance payment; or

of Public Health's Bureau of Vital Statistics, Department of Industrial Accidents, Department of Veteran's Services, Department of Revenue, Bureau of Special Investigations, Internal Revenue Service, Social Security Administration, Alien Verification Information System, Department of Transitional Assistance, and banks and other financial institutions.

516.004: Time Standards for Eligibility Determination

(A) For applicants who do not apply on the basis of a disability, a determination of eligibility must be made within 45 days from the date of receipt of the complete application for MassHealth. All requested information must be received within 30 days of the date of request.

(B) For applicants who apply for MassHealth on the basis of a disability, a determination of eligibility must be made within 90 days from the date of receipt of the complete application, including a disability supplement, if required.

(C) If the MassHealth agency determines that unusual circumstances exist, the timeframes for determining eligibility are extended. Unusual circumstances include delay caused by the applicant, by an examining physician, or by other events beyond the control of the MassHealth agency.

516.005: Coverage Date

The begin date of MassHealth Standard, Essential, or Limited coverage may be retroactive to the first day of the third calendar month before the month of application, if covered medical services were received during such period, and the applicant or member would have been eligible at the time services were provided. If more than one application has been submitted and not denied, the begin date will be based on the earliest application that is approved. For MassHealth Essential, coverage can begin no earlier than June 1, 2004. For MassHealth Essential members enrolled from a waiting list, coverage is determined in accordance with 130 CMR 515.003(C)(2).

516.006: Eligibility Determination

(A) The MassHealth agency reviews eligibility at least every 12 months with respect to circumstances that may change. The MassHealth agency updates the file based on information received as the result of such review. Eligibility may be reviewed:

(1) as a result of a member's reported changes in circumstances;

(2) by external matching with other agencies; and

(3) where matching is not available, through a written update of the member's circumstances on a prescribed form.

(B) If the member fails to provide a written update or information within 30 days of the request, MassHealth coverage may be terminated.

(C) If the requested update or information is submitted within 30 days from the date of the termination, a second eligibility determination is made within 15 days. Eligibility may be established retroactive to the date of termination, if otherwise eligible.

(3) would be currently eligible for SSI, in accordance with SSI payment standards at 130 CMR 519.003(B), if the incremental amount of RSDI cost-of-living increases paid to them since the last month subsequent to April 1977, for which they were both eligible for and receiving SSI and entitled to (but not necessarily receiving) RSDI were deducted from the current amount of RSDI benefits. Cost-of-living increases referred to in 130 CMR 519.003 include increases received both by the applicant or member or by the spouse. The spouse need not be otherwise eligible for SSI; and

(4) have countable assets that are $2,000 or less for an individual, and $3,000 or less for a married couple**.**

(B) SSI Payment Standards. The RSDI amount, as described in 130 CMR 519.003(A)(3), and any other countable-income amount, as defined in 130 CMR 520.009, of the individual or couple is compared to the SSI payment standards to determine Pickle eligibility.

MASSACHUSETTS SSI PAYMENT STANDARDS

	LIVING ARRANGEMENT CATEGORY				
	A	**B**	**C**	**E**	**G**
	Full Cost of Living Expenses	**Shared Living Expenses**	**Household of Another**	**Licensed Rest Home**	**Assisted Living**
Individual					
Aged	$707.82	618.26	490.36	872.00	1033.00
Disabled	693.39	609.40	473.58	872.00	1033.00
Blind	728.74	728.74	728.74	728.74	1033.00
Member of a Couple					
Aged	$535.36	535.36	397.57	872.00	775.00
Disabled	524.53	524.53	386.76	872.00	775.00
Blind	728.74	728.74	728.74	728.74	775.00

NOTE: The SSI federal benefit rate (FBR) for an individual is $579.00.

NOTE: The personal-needs allowance in licensed rest homes is $60. The personal-needs allowance in nursing facilities and chronic-disease hospitals is $65.

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

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

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

(i) direct administration of a least two discrete skilled-nursing services on a daily basis, each of which requires complex nursing procedures as described at 130 CMR 519.007(A)(3);

(ii) direct management of the child's medical care by a physician or under the supervision of a physician on a monthly basis;

(iii) assistance in one or more ADLs beyond what is required at an age-appropriate activity level; and

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

(B) Home- and Community-Based Services Waiver.

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

(a) is 60 years of age or older, and, if under age 65, is permanently and totally disabled in accordance with Title XVI standards; and

(b) would be institutionalized in a nursing facility, unless he or she receives one or more of the services administered by the Executive Office of Elder Affairs under the Home- and Community-Based Services Waiver authorized under Section 1915(c) of the Social Security Act.

(2) Eligibility Requirements. In determining eligibility for MassHealth Standard and for waiver services, the MassHealth agency counts the income and assets of only the applicant or member regardless of his or her marital status. The applicant or member must:

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

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

(c) have countable assets of $2,000 or less and have not transferred resources for the sole purpose of obtaining MassHealth as described at 130 CMR 520.018 and 520.019.

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

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

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

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

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

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

(i) in day-health centers;

(ii) at home; and

(iii) in specialty or inpatient settings, if needed.

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

(a) be aged 55 or older;

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

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

(d) live in a designated service area;

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

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

(g) have a countable-income amount less than or equal to 100 percent of the federal poverty level, or establish eligibility by meeting a deductible as described in 130 CMR 520.028 et seq. if the income exceeds the 100 percent federal-poverty-level income standards.

(130 CMR 519.008 Reserved)