




Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth



MassHealth
Eligibility Letter 204
March 15, 2011

TO: MassHealth Staff

FROM: Terence G. Dougherty, Medicaid Director 

RE: Revisions to Regulations about Estate Recovery

MassHealth is revising the regulations about estate recovery to comply with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

MassHealth will not recover certain Medicare cost-sharing benefits with dates of payment on or after January 1, 2010, for certain MassHealth members when they were aged 55 or older.

These emergency regulations are effective retroactive to January 1, 2010.

Please note that we have made a minor change in the format of the regulations in Chapters 501 and 515. We eliminated the double spaces between the (1)s and (2)s, (a)s and (b)s, and (i)s and (ii)s. This format now matches the official format for the Code of Massachusetts Regulations (CMR). We will reformat other chapters as time allows, and will reissue them via eligibility letters, since this will change the pagination. This change will streamline the processing of these regulations and ensure consistency among all the MassHealth regulations.

MANUAL UPKEEP

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501.001: Definition of Terms

The terms listed in 130 CMR 501.001 have the following meanings for the purposes of MassHealth, as described in 130 CMR 501.000 through 508.000.

Access to Health Insurance – the ability to obtain employer-sponsored health insurance for an uninsured family group member where an employer would contribute at least 50 percent of the premium cost, and the health insurance offered would meet the basic-benefit level.

American Indian or Alaska Native – a person who is a member of a federally recognized tribe, band, or group; or an Eskimo, Aleut, or other Alaska Native enrolled by the Secretary of the Interior, pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601 et seq.

Appeal – a written request, by an aggrieved applicant or member, for a fair hearing.

Appeal Representative – a person who

- (1) is sufficiently aware of an appellant's circumstances to assume responsibility for the accuracy of the statements made during the appeal process, and who has provided the Board of Hearings with written authorization from the appellant to act on the appellant's behalf during the appeal process;
- (2) has, under applicable law, authority to act on behalf of an appellant in making decisions related to health care or payment for health care. An appeal representative may include, but is not limited to, a guardian, conservator, executor, administrator, holder of power of attorney, or health-care proxy; or
- (3) is an eligibility representative meeting the requirements of 130 CMR 501.001: Appeal Representative (1) or (2).

Applicant – a person who completes and submits a Medical Benefit Request.

Basic-Benefit Level (BBL) – benefits provided under a health-insurance plan that are comprehensive and comparable to benefits provided by insurers in the small-group health-insurance market and also meet minimum creditable coverage requirements as defined in 956 CMR 5.03. Health-insurance plans that meet the requirements of 211 CMR 64.00 also meet the BBL.

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.

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Business Day – any day during which the MassHealth agency’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 MassHealth agency and includes all required information and verifications including, where applicable, a completed disability supplement.

Couple – two persons who are married to each other according to the rules of the Commonwealth of Massachusetts.

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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Disability Determination Unit – a unit that consists of physicians and disability evaluators who determine permanent and total disability using criteria established by the Social Security Administration under Title XVI, and criteria established under state law. This unit may be a part of a state agency or under contract with a state agency.

Eligibility Process – activities conducted for the purposes of determining, redetermining, and maintaining the eligibility of a MassHealth applicant or member.

Eligibility Representative – a person who

- (1) has, under applicable law, authority to act on behalf of an applicant or member in making decisions related to health care or payment for health care. An eligibility representative may include, but is not limited to, a guardian, conservator, executor, administrator, holder of power of attorney, or health-care proxy; or
- (2) is sufficiently aware of the applicant's or member's circumstances to assume responsibility for the accuracy of the statements made during the eligibility process, and who fulfills at least one of the following two conditions:
 - (a) has provided the MassHealth agency with written authorization from the applicant or member to act on the applicant's or member's behalf during the eligibility process; or
 - (b) is acting responsibly on behalf of an applicant or member for whom written authorization cannot be obtained.

Fair Hearing – an administrative, adjudicatory proceeding conducted according to 130 CMR 610.000 to determine the legal rights, duties, benefits, or privileges of applicants and members.

Family – persons who live together, and consist of: (1) a child or children under age 19, any of their children, and their parents; (2) siblings under age 19 and any of their children who live together even if no adult parent or caretaker relative is living in the home; or (3) a child or children under age 19, any of their children, and their caretaker relative when no parent is living in the home. A caretaker relative may choose whether or not to be part of the family. A parent may choose whether or not to be included as part of the family of a child under age 19 only if that child is: (a) pregnant; or (b) a parent. A child who is absent from the home to attend school is considered as living in the home. A parent may be a natural, step, or adoptive parent. Two parents are members of the same family group as long as they are both mutually responsible for one or more children who live with them.

Family Group – a family, couple, or individual.

Family Policy – a health-insurance policy that covers one or more adults, with one or more children. If an employer does not offer a couple policy, or a one-adult with one-child policy, a couple without children, or a family with one adult and one child may be covered by a family policy.

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Federal-Poverty Level (FPL) – income standards issued annually in the *Federal Register* to account for the last calendar year's increase in prices as measured by the Consumer Price Index.

Fee-for-Service – a method of paying for medical services provided by any MassHealth participating provider with no limit on provider choice.

Gross Income – the total money earned or unearned, such as wages, salaries, rents, pensions, or interest, received from any source without regard to deductions.

Health Insurance – coverage of health-care services by a health-insurance company, a hospital-service corporation, a medical-service corporation, a managed-care organization, or Medicare. Coverage of health-care services by MassHealth or Children's Medical Security Plan (CMSP) is not considered health insurance.

Health Safety Net – a source of funding for certain health care under 114.6 CMR 13.00 and 14.00.

Individual – an applicant, a member, a spouse who is acting on behalf of the applicant or member, or any person, court, or administrative body with the legal authority to act on behalf of or at the request of the applicant, member, or spouse and may include a trustee, guardian, conservator, or an agent acting under a durable power of attorney.

Individual Policy – a health-insurance policy that covers the policyholder only.

Insurance Partnership Agent (IPA) – the organization under contract with the MassHealth agency to help administer the Insurance Partnership, as described in 130 CMR 650.009.

Interpreter – a person who translates for an applicant or member who has limited English proficiency or a hearing impairment.

Large Employer – an employer that

- (1) has more than 50 employees who work 30 or more hours a week;
- (2) offers health insurance that meets the basic-benefit level; and
- (3) contributes at least 50 percent of the cost of the employees' health-insurance premiums.

Limited English Proficiency – an inadequate ability to communicate in the English language.

Managed Care – a system of primary care and other medical services that are provided and coordinated by a MassHealth managed-care provider in accordance with the provisions of 130 CMR 450.117 et seq. and 508.000 et seq.

Managed-Care Organization (MCO) – any entity with which the MassHealth agency contracts to provide primary care and certain other medical services to members on a capitated basis, including an entity that is approved by the Massachusetts Division of Insurance as a health-maintenance organization (HMO), or that otherwise meets the State Plan definition of an HMO.

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MassHealth Agency – the Executive Office of Health and Human Services in accordance with the provisions of M.G.L. c. 118E.

MassHealth Managed-Care Provider – a primary-care clinician or managed-care organization that has contracted with the MassHealth agency to provide and coordinate primary care and certain other medical services to certain MassHealth members.

Medical Benefit Request (MBR) – a form prescribed by the MassHealth agency to be completed by the applicant or an eligibility representative, and submitted to the MassHealth agency as a request for MassHealth benefits.

Medical Benefits – payment for health insurance or medical services provided to a MassHealth member.

Member – a person determined by the MassHealth agency to be eligible for MassHealth.

One-Adult-with-One-Child Policy – a health-insurance policy that covers a family consisting of one adult and one child.

Permanent and Total Disability – a disability as defined under Title XVI of the Social Security Act or under applicable state laws.

(1) For Adults and 18-Year-Olds.

(a) The condition of an individual, aged 18 or older, who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that

(i) can be expected to result in death; or

(ii) has lasted or can be expected to last for a continuous period of not less than 12 months.

(b) For purposes of 130 CMR 501.001: Permanent and Total Disability, an individual aged 18 or older is determined to be disabled only if his or her physical or mental impairments are of such severity that the individual is not only unable to do his or her previous work, but cannot, considering age, education, and work experience, engage in any other kind of substantial gainful work that exists in the national economy, regardless of whether such work exists in the immediate area in which the individual lives, whether a specific job vacancy exists, or whether the individual would be hired if he or she applied for work. "Work that exists in the national economy" means work that exists in significant numbers, either in the region where such an individual lives or in several regions of the country.

(2) For Children Under Age 18. The condition of an individual under the age of 18 who has any medically determinable physical or mental impairment, or combination of impairments, of comparable severity to an impairment or combination of impairments that disables an adult, or are of such severity that the child is unable to engage in age-appropriate activities, as defined in Title XVI as in effect on July 1, 1996.

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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 MassHealth agency that may be assessed to members of MassHealth Standard, MassHealth CommonHealth, MassHealth Family Assistance, or the Children’s Medical Security Plan (CMSP).

Premium Assistance Payment – an amount contributed by the MassHealth agency 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 MassHealth agency 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 MassHealth agency or its contractor 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.

Senior Care Organization – an organization that participates in MassHealth under a contract with the MassHealth agency and the Centers for Medicare & Medicaid Services to provide a comprehensive network of medical, health-care, and social-service providers that integrates all components of care, either directly or through subcontracts. Senior care organizations are responsible for providing enrollees with the full continuum of Medicare- and MassHealth-covered services.

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.

Spouse – a person married to the applicant or member according to the laws of the Commonwealth of Massachusetts. Effective for applications and eligibility review forms received on or after October 31, 2008, notwithstanding the unavailability of federal financial participation, no person who is recognized as a spouse under the laws of the Commonwealth will be denied benefits that are otherwise available under M.G.L. c. 118E due to the provisions of 1 U.S.C. § 7 or any other federal nonrecognition of spouses of the same gender. If a member’s eligibility changes as the result of updated or corrected information about marital status, the change in eligibility will be effective as of the date the MassHealth agency receives the new information, but no sooner than October 31, 2008.

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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.

501.002: Introduction to MassHealth

(A) The MassHealth agency 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 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 an 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 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.

(D) The MassHealth agency will determine eligibility for low-income subsidies under Medicare Part D, as set forth in the Medicare Prescription Drug and Improvement and Modernization Act of 2003 and as described in federal regulations at 20 CFR Part 418.

501.003: MassHealth Coverage Types

(A) The MassHealth agency 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 MassHealth agency may limit the number of people who can be enrolled in MassHealth CommonHealth, MassHealth Family Assistance, and MassHealth Essential. When the MassHealth agency 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 MassHealth agency 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).

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- (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 MassHealth agency 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.
- (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. Coverage before enrollment for MassHealth Essential members who are aliens with special status is described in 130 CMR 505.007(E).
- (b) Medical coverage for Essential Purchase of Medical Benefits for persons enrolled from a waiting list will begin on the date specified in MassHealth'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, except as described in 130 CMR 505.007(E) for aliens with special status eligible for MassHealth Essential with MassHealth Limited.

501.004: Administration of MassHealth

- (A) MassHealth. The MassHealth agency formulates requirements and determines eligibility for all MassHealth coverage types.
- (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. Eligibility requirements for aliens with special status, as described in 130 CMR 504.002(D), who are aged 19 through 64, and receiving EAEDC, are detailed in 130 CMR 505.007(E). 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, except as described in 130 CMR 505.007(E).

(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 MassHealth agency.

(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.

(1) 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:

- (a) the individual or family no longer lives in Massachusetts;
- (b) the individual enters an institution;
- (c) the individual turns 65;
- (d) the individual or all members of the family are deceased; or
- (e) the individual or family is no longer categorically eligible.

(2) Eligibility for continuing coverage will be reviewed toward the end of this one-year period.

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(B) Families Who Have Met a Deductible.

(1) Families (including caretaker relatives) with children under 18 who were receiving Medical Assistance on June 30, 1997, as a result of meeting a deductible, or who were denied with a deductible before July 1, 1997, and subsequently meet a deductible on or after July 1, 1997, and whose family group gross income exceeds MassHealth standards will be eligible for MassHealth Standard for one year from the end of the deductible period, except in the following circumstances:

- (a) the individual or family no longer lives in Massachusetts;
 - (b) the individual enters an institution;
 - (c) the individual turns 65;
 - (d) the individual or all members of the family are deceased; or
 - (e) the individual or family is no longer categorically eligible.
- (2) A determination of eligibility for MassHealth will be made toward the end of the one-year period.

(C) Disabled Individuals Who Have Met a Deductible. Disabled individuals who were receiving Medical Assistance on June 30, 1997, as a result of meeting a deductible, or who meet a deductible on or after July 1, 1997, will have their continuing eligibility for MassHealth determined in accordance with 130 CMR 506.009.

501.006: Children Receiving Benefits under the Children's Medical Security Plan on August 3, 1998

(A) Eligibility.

- (1) Children who were receiving benefits under the Children's Medical Security Plan on August 3, 1998, as well as any siblings in their family group, will be treated as a protected status group under MassHealth if they
- (a) have submitted a complete Medical Benefit Request as defined in 130 CMR 502.001 by March 31, 1999;
 - (b) meet the eligibility requirements of MassHealth; and
 - (c) have a family group gross income less than or equal to 200 percent of the FPL.
- (2) Families of children described in 130 CMR 501.006(A)(1) who are determined eligible for MassHealth Family Assistance will have the option of choosing purchase of medical benefits or premium assistance under MassHealth Family Assistance if the MassHealth agency determines the child has access to health insurance from an employer other than the Commonwealth of Massachusetts.

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(B) Loss of Protected Status. The protected status of a child described in 130 CMR 501.006(A) will end in the following circumstances:

- (1) the family group's gross income exceeds 200 percent of the FPL;
- (2) the family fails to cooperate with the MassHealth eligibility review; or
- (3) the child no longer meets MassHealth requirements.

501.007: Receiving Public Assistance from Another State

Persons who are receiving public assistance from another state are not eligible for MassHealth.

(130 CMR 501.008 Reserved)

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501.009: Rights of Applicants and Members

The policies of the MassHealth agency are administered in accordance with federal and state law. Applicants and members must be informed of their rights and responsibilities with respect to MassHealth.

- (A) Right to Nondiscrimination and Equal Treatment. The MassHealth agency does not discriminate on the basis of race, color, sex, sexual orientation, religion, national origin, disability, or age in admission or access to, or treatment or employment in, its programs or activities. Grievance procedures for resolution of discrimination complaints are administered and applied by the MassHealth agency's Affirmative Action Office.
- (B) Right to Confidentiality. The confidentiality of information obtained by the MassHealth agency during the MassHealth eligibility process is protected in accordance with federal and state regulations. The use and disclosure of information concerning applicants, members, and legally liable third parties is restricted to purposes directly connected with the administration of MassHealth as governed by state and federal law.
- (C) Right to Timely Provision of Benefits. Eligible applicants and members have the right to the timely provision of benefits, as defined in 130 CMR 502.000.
- (D) Right to Information. Persons who inquire about MassHealth, either orally or through a written request, have the right to receive information about medical benefits, coverage type requirements, and their rights and responsibilities as applicants and members of MassHealth.
- (E) Right to Apply. Any person, individually or through an eligibility representative, has the right, and must be afforded the opportunity without delay, to apply for MassHealth.
- (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 MassHealth agency 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.

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(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 MassHealth agency. 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 MassHealth agency 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 MassHealth agency will provide either telephonic or other interpreter services whenever

- (1) the applicant or member who is seeking assistance from the MassHealth agency has limited English proficiency or sensory impairment and requests interpreter services; or
- (2) the MassHealth agency determines such services are necessary.

(J) Right to a Certificate of Creditable Coverage Upon Termination of MassHealth. The MassHealth agency provides 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 MassHealth agency issues 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 are included on the Certificate.

501.010: Responsibilities of Applicants and Members

(A) Responsibility to Cooperate. The applicant or member must cooperate with the MassHealth agency in providing information necessary to establish and maintain eligibility, and must comply with all the rules and regulations of MassHealth, including recovery and obtaining or maintaining available health insurance.

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(B) Responsibility to Report Changes. The applicant or member must report to the MassHealth agency, within 10 days or as soon as possible, changes that may affect eligibility. Such changes include, but are not limited to, income, the availability of health insurance, and third-party liability.

(C) Cooperation with Quality Control. The Quality Control Division periodically conducts an independent review of eligibility factors in a sampling of case files. When a case file is selected for review, the member must cooperate with the representative of Quality Control. Cooperation includes, but is not limited to, a personal interview and the furnishing of requested information. If the member does not cooperate, MassHealth benefits may be terminated for the family group.

501.011: Referrals to Investigative Units

Intentional false statements or fraudulent acts made in connection with obtaining medical benefits or payments under MassHealth are punishable under M.G.L. c. 118E, § 39 by fines, imprisonment, or both. In all cases of suspected fraud, MassHealth staff will make a referral to the Bureau of Special Investigations, or other appropriate agencies.

501.012: Recovery of Overpayment of Medical Benefits

The MassHealth agency has the right to recover payment for medical benefits to which the member was not entitled at the time the benefit was received, regardless of who was responsible and whether or not there was fraudulent intent. No provision under 130 CMR 501.012 will limit the MassHealth agency's right to recover overpayments.

501.013: Estate Recovery**(A) Introduction.**

(1) The MassHealth agency will recover the amount of payment for medical benefits correctly paid from the estate of a deceased member. Recovery is limited to payment for all services provided while the member was aged 55 or older.

(2) The estate includes all real and personal property and other assets in the member's probate estate.

(3) Notwithstanding 130 CMR 501.013(A)(1) and in accordance with 42 U.S.C. 1396p(b)(B), MassHealth will not recover Medicare cost-sharing benefits described at 42 U.S.C. 1396(a)(10)(E) with dates of payment on or after January 1, 2010, for persons who received such benefits under 130 CMR 505.002, 505.009, 515.010, and 519.011.

(a) The date of payment for Medicare cost-sharing deductibles, coinsurance, and copayments is the date the MassHealth agency received the claim.

(b) The date of payment for premium payments is the date the MassHealth agency paid the premium.

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(B) Deferral of Estate Recovery. Recovery will not be required until after the death of a surviving spouse, if any, or while there is a surviving child who is under 21 years of age, or a child of any age who is blind or permanently and totally disabled.

(C) Waiver of Estate Recovery Due to Financial Hardship. For claims presented on or after November 15, 2003, recovery will be waived if

(1) a sale of real property would be required to satisfy a claim against the member's probate estate; and

(2) an individual who was using the property as a principal place of residence on the date of the member's death meets all of the following conditions:

(a) the individual lived in the property on a continual basis for at least one year immediately before the now-deceased member became eligible for MassHealth or other assistance from the MassHealth agency and continues to live in the property at the time the MassHealth agency first presented its claim for recovery against the deceased member's estate;

(b) the individual has inherited or received an interest in the property from the deceased member's estate as defined in 130 CMR 501.013(A)(2) and 515.011(A)(2);

(c) the individual is not being forced to sell the property by other devisees or heirs at law; and

(d) at the time the MassHealth agency first presented its claim for recovery against the deceased member's estate, the gross annual income of the individual's family group, as defined in 130 CMR 501.001, was less than or equal to 133 percent of the applicable federal-poverty-level income standard for the appropriate family size.

(3) The waiver will be conditional for a period of two years from the date the MassHealth agency mails notice that the waiver requirements have been met, or from the date that a court of competent jurisdiction determines that the waiver requirements have been met. If at the end of that period, all circumstances and conditions that must exist for the MassHealth agency to waive recovery still exist, including meeting the same income standards under 130 CMR 501.013(C)(2)(d), and the real property has not been sold or transferred, the waiver will become permanent and binding. If at any time during the two-year period, the circumstances and conditions for the waiver no longer exist, including meeting the same income standards under 130 CMR 501.013(C)(2)(d), the property is sold or transferred, or the person does not use the property as their primary residence, the MassHealth agency will be notified and its claim will be payable in full.

(D) Outstanding Claims.

(1) For claims presented between April 1, 1995, and November 15, 2003, that are still outstanding, recovery will be waived if all requirements under the then-existing MassHealth regulations were met.

(2) For claims presented before April 1, 1995, a waiver for hardship did not exist.

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(E) Fair-Market Value and Equity Value. If there will be insufficient proceeds from the sale or transfer of the property to satisfy the MassHealth agency's claim in full, the fair-market value and equity value of all real property that is part of the deceased member's estate must be verified prior to the sale or transfer of said property.

(1) The executor or administrator of the probate estate or, in the case of real property that passes outside the probate estate, the person or entity to whom legal title or interest passed, must verify the fair-market value by sending to the MassHealth agency a copy of the most recent tax bill or the property tax assessment that was most recently issued by the taxing jurisdiction, provided that this assessment is not one of the following:

- (a) a special-purpose tax assessment;
- (b) based on a fixed-rate-per-acre method; or
- (c) based on an assessment ratio or providing only a range.

(2) The executor or administrator of the probate estate or, in the case of real property that passes outside the probate estate, the person or entity to whom legal title or interest passed, must also provide a comparable market analysis or a written appraisal of the property value from a knowledgeable source. A knowledgeable source includes one of the following: a licensed real-estate agent or broker, a real-estate appraiser, or an official of a bank, savings and loan association, or similar lending organization. The knowledgeable source must not have any real or apparent conflict-of-interest relationship with the estate.

(3) The MassHealth agency may also obtain an assessment from a knowledgeable source.

(F) Waiver of Estate Recovery Due to Hardship for American Indians and Alaska Natives.

(1) For claims presented on or after July 1, 2009, recovery from the following American Indian and Alaska Natives income, resources, and property will be waived:

- (a) certain income and resources (such as interests in and income derived from tribal land and other resources currently held in trust status and judgment funds from the Indian Claims Commission and the U.S. Claims Court) that are exempt from Medicaid estate recovery by other laws and regulations;
- (b) ownership interest in trust and non-trust property, including real property and improvements
 - (i) located on a reservation (any federally recognized Indian tribe's reservation, pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act, and Indian allotments) or near a reservation as designated and approved by the Bureau of Indian Affairs of the U.S. Department of the Interior; or
 - (ii) for any federally recognized tribe not described in 130 CMR 501.013(F)(1)(b)(i), located within the most recent boundaries of a prior federal reservation.

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- (c) income left as a remainder in an estate derived from property protected in 130 CMR 501.013(F)(1)(b), that was either collected by an Indian or by a tribe or tribal organization and distributed to Indians, as long as the individual can clearly trace it as coming from protected property;
 - (d) ownership interests left as a remainder in an estate in rents, leases, royalties, or usage rights related to natural resources, including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, or fish products, resulting from the exercise of federally protected rights and income either collected by an Indian or by a tribe or tribal organization and distributed to Indians derived from these sources as long as the individual can clearly trace it as coming from protected sources; or
 - (e) ownership interests in or usage rights to items not covered by 130 CMR 501.013(F)(1)(a) through (d) that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional life style according to applicable tribal law or custom.
- (2) Protection of non-trust property described in 130 CMR 501.013(F)(1) is limited to circumstances when it passes from an Indian, as defined in section 4 of the Indian Health Care Improvement Act, to one or more relatives (by blood, adoption, or marriage), including Indians not enrolled as members of a tribe and non-Indians, such as spouses or step-children, that their culture would nevertheless protect as family members, to a tribe or tribal organization, or to one or more Indians.

501.014: Voter Registration

- (A) Voter registration forms are available through the MassHealth agency to applicants and members who are
- (1) U.S. citizens; and
 - (2) aged 18 or older, or who will be aged 18 on or before the date of the next election, in accordance with the National Voter Registration Act of 1993.
- (B) Applicants and members are
- (1) informed of the availability of voter registration forms at application, at the time of an eligibility review, and when there is an address change;
 - (2) offered assistance in completing the voter registration form unless such assistance is refused; and
 - (3) able to submit voter registration forms to the MassHealth agency for transmittal to the proper election offices.

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- (C) MassHealth agency staff must not
- (1) seek to influence an applicant's or member's political preference or party registration;
 - (2) display any political preference or party allegiance to the applicant or member;
 - (3) make any statement to an applicant or member or take any action intended to influence the applicant's or member's decision regarding voter registration; or
 - (4) make any statement to an applicant or member or take any action intended to lead the applicant or member to believe that the decision to register or not has any bearing on the availability of services or benefits.
- (D) Completed voter registration forms that are submitted to the MassHealth agency are transmitted to the proper local election office for processing within five days of receipt.

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515.001: Definition of Terms

The terms listed in 130 CMR 515.001 have the following meanings for purposes of MassHealth, as described in 130 CMR 515.000 through 522.000.

Activities of Daily Living (ADLs) – self-care activities including, but not limited to, bathing, grooming, dressing, eating, and toileting.

Affidavit – a written or printed statement of fact sworn to or affirmed before a person having legal authority to administer such an oath.

Annuity – a legal instrument that makes payments for a designated period of time or for life, regardless if the payments are principal, interest, or both.

Appeal – a written request, by an aggrieved applicant or member, for a fair hearing.

Appeal Representative – a person who

(1) is sufficiently aware of the appellant's circumstances to assume responsibility for the accuracy of the statements made during the appeal process, and who has provided the Board of Hearings with written authorization from the appellant to act on the appellant's behalf during the appeal process;

(2) has, under applicable law, authority to act on behalf of an appellant in making decisions related to health care or payment for health care. An appeal representative may include, but is not limited to, a guardian, conservator, executor, administrator, holder of power of attorney, or health-care proxy; or

(3) is an eligibility representative meeting the requirements of 130 CMR 515.001: Appeal Representative (1) or (2).

Applicant – a person who completes and submits an application for MassHealth, and is awaiting the decision of eligibility.

Application – see “Senior Medical Benefit Request (SMBR).”

Asset Limit – the maximum dollar value of assets that can be owned by, or available to, the applicant, member, or the spouse, which if exceeded, results in ineligibility.

Assets – property including, but not limited to, real estate, personal property, and funds. This term has the same meaning as “resources” as defined in 42 U.S.C. 1396p(e)(5).

Available – a resource that is countable under Title XIX of the Social Security Act.

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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.

Burial Trust – a trust established by an individual solely for funeral expenses, burial expenses, or both.

Business Day – any day during which the MassHealth agency’s offices are open to serve the public.

Caretaker Relative – an adult who is the primary caregiver 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.

Community Resident – a person who lives in a noninstitutional setting in the community.

Competent Medical Authority – a physician or psychiatrist licensed by any state, a psychologist licensed by the Commonwealth of Massachusetts, or both.

Countable Income – the types of income that are considered in the determination of eligibility.

Countable-Income Amount – gross income less certain business expenses and income deductions.

Couple – two persons married to each other according to the rules of the Commonwealth of Massachusetts.

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 Essential (Essential), MassHealth Limited (Limited), MassHealth Senior Buy-In (Senior Buy-In), and MassHealth Buy-In (Buy-In). The scope of services or covered benefits for each coverage type is found at 130 CMR 450.105.

Curing of a Transfer – the return, following the transfer for less than fair-market value of a portion of, or the full uncompensated value of, a resource to the individual.

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

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Deductible – the total dollar amount of incurred medical expenses that an applicant whose income exceeds MassHealth income standards at 130 CMR 520.028 et seq. must be responsible for before the applicant is eligible for MassHealth.

Deductible Period – a specified six-month period within which an applicant for MassHealth, whose income exceeds MassHealth income standards, may become eligible if the applicant or the spouse incurs medical bills equaling or exceeding the deductible.

Disability Determination Unit – a unit that consists of physicians and disability evaluators who determine permanent and total disability using criteria established by the Social Security Administration under Title XVI, and criteria established under state law. This unit may be a part of a state agency or under contract with a state agency.

Eligibility Process – activities conducted for the purpose of determining, redetermining, and maintaining the eligibility of a MassHealth applicant or member.

Eligibility Representative – a person who

- (1) has, under applicable law, authority to act on behalf of an applicant or member in making decisions related to health care or payment for health care. An eligibility representative may include, but is not limited to, a guardian, conservator, executor, administrator, holder of power of attorney, or health-care proxy; or
- (2) is sufficiently aware of the applicant's or member's circumstances to assume responsibility for the accuracy of the statements made during the eligibility process, and who fulfills at least one of the following two conditions:
 - (a) has provided the MassHealth agency with written authorization from the applicant or member to act on the applicant's or member's behalf during the eligibility process; or
 - (b) is acting responsibly on behalf of an applicant or member for whom written authorization cannot be obtained.

Fair Hearing – an administrative, adjudicatory proceeding conducted according to 130 CMR 610.000 to determine the legal rights, duties, benefits, or privileges of applicants and members.

Fair-Market Value – an estimate of the value of a resource if sold at the prevailing price. For transferred resources, the fair-market value is based on the prevailing price at the time of transfer.

Federal Poverty Level (FPL) – income standards issued annually in the *Federal Register* to account for the last calendar year's increase in prices as measured by the Consumer Price Index.

Fee-for-Service – a method of paying for medical services provided by any MassHealth participating provider with no limit on provider choice.

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Global Developmental Skills – a child's average developmental skill level, taking into account the physical, psychological, motor, intellectual, emotional, communicative, and social aspects of the child's functional capabilities.

Grantor – an individual or spouse who creates a trust.

Gross Income – the total money earned or unearned, such as wages, salaries, rents, pensions, or interest, received from any source without regard to deductions.

Guardian – an individual or entity appointed as guardian by the probate and family court under the provisions of M.G.L. c. 201.

Guardianship Fees and Related Expenses – fees for guardianship services and incurred expenses that are essential to enable an incompetent applicant or member to gain access to or consent to medical treatment.

Health Safety Net – a source of funding for certain health care under 114.6 CMR 13.00 and 14.00.

Income Deductions – specified deductions, as described in 130 CMR 520.011 through 520.014, that may be made from the gross income of an applicant or member.

Incompetent Applicant or Member – an applicant or member who has been adjudicated as incompetent and in need of a guardian by the probate and family court under the provisions of M.G.L. c. 201.

Individual – an applicant, a member, a spouse who is acting on behalf of the applicant or member, or any person, court, or administrative body with the legal authority to act on behalf of or at the request of the applicant, member, or spouse and may include a trustee, guardian, conservator, or an agent acting under a durable power of attorney.

Institution (Medical) – a public or private facility providing acute, chronic, or long-term care, unless otherwise defined within 130 CMR 515.000 through 522.000. This includes acute inpatient hospitals, licensed nursing facilities, state schools, intermediate-care facilities for the mentally retarded, public or private institutions for mental diseases, freestanding hospices, and chronic-disease and rehabilitation hospitals.

Institutionalization – placement of an individual in one or more medical institutions, where placement lasts or is expected to last for a continuous period of at least 30 days.

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Interpreter – a person who translates for an applicant or member who has limited English proficiency or a hearing impairment.

Irrevocable Trust – a trust that cannot be in any way revoked by the grantor.

Jointly Held Resources – resources that are owned by an individual in common with another person or persons in a joint tenancy, tenancy-in-common, or similar arrangement.

Life Estate – a life estate is established when all of the remainder legal interest in a property is transferred to another, while the legal interest for life rights to use, occupy, or obtain income or profits from the property is retained.

Limited English Proficiency – an inadequate ability to communicate in the English language.

Look-Back Period – a period of consecutive months that the MassHealth agency may review for transfers of resources to determine if a period of ineligibility for payment of nursing-facility services should be imposed.

Lump-Sum Income – a one-time payment, such as an inheritance or the accumulation of recurring income.

MassHealth Agency – the Executive Office of Health and Human Services in accordance with the provisions of M.G.L. c. 118E.

Medical Benefits – payment for medical services provided to a MassHealth member.

Member – a person determined by the MassHealth agency to be eligible for MassHealth.

Nursing-Facility Resident – an individual who is a resident of a nursing facility, is a resident in any institution, including an intermediate-care facility for the mentally retarded (ICF/MR), for whom payment is based on a level of care equivalent to that received in a nursing facility, is in an acute hospital awaiting placement in a nursing facility, or lives in the community and would be institutionalized without community-based services provided in accordance with 130 CMR 519.007(B).

Patient-Paid Amount – the amount that a member in a long-term-care facility must contribute to the cost of care under the laws of the Commonwealth of Massachusetts.

Period of Ineligibility – the period of time during which the MassHealth agency denies or withholds payment for nursing-facility services because the individual has transferred resources for less than fair-market value.

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Permanent and Total Disability – a disability as defined under Title XVI of the Social Security Act or under applicable state laws.

(1) For Adults and 18-Year-Olds.

(a) The condition of an individual, aged 18 or older, who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that

(i) can be expected to result in death; or

(ii) has lasted or can be expected to last for a continuous period of not less than 12 months.

(b) For purposes of 130 CMR 515.001: Permanent and Total Disability, an individual aged 18 or older is determined to be disabled only if his or her physical or mental impairments are of such severity that the individual is not only unable to do his or her previous work, but cannot, considering age, education, and work experience, engage in any other kind of substantial gainful work that exists in the national economy, regardless of whether such work exists in the immediate area in which the individual lives, whether a specific job vacancy exists, or whether the individual would be hired if he or she applied for work. "Work that exists in the national economy" means work that exists in significant numbers, either in the region where such an individual lives or in several regions of the country.

(2) For Children Under Age 18. The condition of an individual under the age of 18 who has any medically determinable physical or mental impairment, or combination of impairments, that causes marked and severe functional limitations, as defined in Title XVI of the Social Security Act, and can be expected to cause death or can be expected to last for a continuous period of not less than 12 months. Disability for children eligible for MassHealth CommonHealth under 130 CMR 519.012(B) is determined in accordance with the definition for permanent and total disability for children under the age of 18 in 130 CMR 501.001.

Personal Needs Allowance (PNA) – the designated portion of monthly income that a person in long-term care is allowed to retain for personal expenses. In some instances, the MassHealth agency pays all or a portion of the PNA to the member. The PNA must not be used for payment of any item included in the daily rate at the long-term-care facility.

Personal Needs Allowance (PNA) Account – an account administered by a long-term-care facility on behalf of a member. Regulations regarding the administration of PNA accounts are contained in 130 CMR 456.000.

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Pooled Trust – a trust that meets all the following criteria as determined by the MassHealth agency.

- (1) The trust was created by a nonprofit organization.
- (2) A separate account is maintained for each beneficiary of the trust, but the assets of the trust are pooled for investment and management purposes.
- (3) The account in a pooled trust was created for the sole benefit of the individual by the individual, the individual's parents or grandparents, or by a legal guardian or court acting on behalf of the individual.
- (4) The trust provides that the Commonwealth of Massachusetts will receive amounts remaining in the account upon the death of the individual up to the amount paid by the MassHealth agency for services to the individual. The trust may retain reasonable and appropriate amounts as determined by the MassHealth agency.
- (5) The individual was disabled at the time his or her account in the pool was created.

Promissory Note – a written promise to pay another.

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

Reapplication – the MassHealth agency's reopening of the application process when the application has been denied pursuant to 130 CMR 516.001(D).

Redetermination – a review of a member's circumstances to establish whether he or she remains eligible for benefits.

Resources – all income and assets owned by the individual or the spouse. For the purposes of determining eligibility, resources include income and assets to which the individual or the spouse is or would be entitled whether or not they are actually received. This term has the same meaning as "assets" as defined in 42 U.S.C. 1396p(e)(1).

Reverse Mortgage – a loan on the equity value of a house paid in installments by a lender to the homeowner who is aged 60 or older.

Revocable Trust – a trust whose terms allow the grantor to take action to regain any of the property or funds in the trust.

Senior Medical Benefit Request (SMBR) – a form prescribed by the MassHealth agency to be completed by the applicant or eligibility representative, and submitted to the MassHealth agency as a request for MassHealth benefits.

Skilled-Nursing Services – the planning, provision, and evaluation of goal-oriented nursing care that requires specialized knowledge and skills acquired under the established curriculum of a school of nursing approved by a board of registration in nursing. Such services include only those services that must be provided by a registered nurse, a licensed practical nurse, or a licensed vocational nurse.

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Special-Needs Trust – a special-needs trust is one that meets all the following criteria as determined by the MassHealth agency.

- (1) The trust was created for a disabled individual under the age of 65.
- (2) The trust was created for the sole benefit of the individual by the individual's parent, grandparent, legal guardian, or a court.
- (3) The trust provides that the Commonwealth of Massachusetts will receive amounts remaining in the account upon the death of the individual up to the amount paid by the MassHealth agency for services to the individual.
- (4) When the member has lived in more than one state, the trust must provide that the funds remaining upon the death of the member are distributed to each state in which the member received Medicaid based on each state's proportionate share of the total amount of Medicaid benefits paid by all states on the member's behalf.

Spouse – a person married to the applicant or member according to the laws of the Commonwealth of Massachusetts. Effective for applications and eligibility review forms received on or after October 31, 2008, notwithstanding the unavailability of federal financial participation, no person who is recognized as a spouse under the laws of the Commonwealth will be denied benefits that are otherwise available under M.G.L. c. 118E due to the provisions of 1 U.S.C. § 7 or any other federal nonrecognition of spouses of the same gender. If a member's eligibility changes as the result of updated or corrected information about marital status, the change in eligibility will be effective as of the date the MassHealth agency receives the new information, but no sooner than October 31, 2008.

Stream of Income – income received on a regular basis.

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.

Supplemental Security Income (SSI) Program – a program that provides financial assistance to needy persons who are aged 65 or older, blind, or disabled. This program is established under Title XVI of the Social Security Act and is administered by the Social Security Administration. Such persons automatically receive MassHealth.

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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Trust – a legal device satisfying the requirements of state law that places the legal control of property or funds with a trustee. It also includes, but is not limited to, any legal instrument, device, or arrangement that is similar to a trust, including transfers of property by a grantor to an individual or a legal entity with fiduciary obligations so that the property is held, managed, or administered for the benefit of the grantor or others. Such arrangements include, but are not limited to, escrow accounts, pension funds, and similar devices as managed by an individual or entity with fiduciary obligations.

Trustee – any individual or legal entity that holds or manages a trust.

Uncompensated Value – the difference between the fair-market value of the resource or interest in the resource at the time of transfer less any outstanding debts and the actual amount the individual received for the resource. The MassHealth agency uses the uncompensated value in the calculation of the period of ineligibility.

515.002: Introduction to MassHealth

(A) The MassHealth agency is responsible for the administration and delivery of health-care services to low- and moderate-income individual and couples.

(B) 130 CMR 515.000 through 522.000 provide the requirements for noninstitutionalized persons aged 65 or older, institutionalized persons of any age, persons who would be institutionalized without community-based services, as defined by Title XIX of the Social Security Act and authorized by M.G.L. c. 118E, and certain Medicare beneficiaries. These regulations are intended to conform to all applicable federal and state laws and will be interpreted accordingly.

(C) 130 CMR 501.000 through 508.000 provide the MassHealth requirements for coverage of noninstitutionalized low- and moderate-income persons under age 65, as prescribed under an 1115 Medicaid Research and Demonstration Waiver.

(D) The MassHealth agency will determine eligibility for low-income subsidies under Medicare Part D, as set forth in the Medicare Prescription Drug and Improvement and Modernization Act of 2003 and as described in federal regulations at 20 CFR Part 418.

515.003: MassHealth Coverage Types

(A) The MassHealth agency provides access to health care by determining eligibility for the coverage type that provides the most comprehensive benefits for a person who may be eligible. Generally, members are provided services on a fee-for-service basis as defined at 130 CMR 515.001.

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(B) MassHealth offers the following types of coverage: MassHealth Standard, MassHealth Essential, MassHealth Limited, MassHealth Senior Buy-In, and MassHealth Buy-In. The type of coverage for which a person is eligible is based on the person's or the spouse's income and assets, as described in 130 CMR 519.000 and 520.000, and immigration status, as described in 130 CMR 518.000.

(C) The MassHealth agency may limit the number of people who can be enrolled in MassHealth Essential. When the MassHealth agency imposes such a limit, no new applicants aged 65 or older who are subject to these limitations will be added to MassHealth Essential, and current MassHealth Essential members who have lost eligibility for more than 30 days for any reason will not be allowed to reenroll until the MassHealth agency is able to reopen enrollment for adults.

(1) Applicants who cannot be enrolled under MassHealth Essential pursuant to 130 CMR 515.003(C), will be placed on a waiting list when their eligibility has been determined. When the MassHealth agency is able to open enrollment for adult applicants, the applications will be processed in the order they were placed on the waiting list.

(2) Medical coverage for MassHealth Essential for persons enrolled from a waiting list will begin on the date that the application or new determination is processed from the waiting list.

515.004: Administration of MassHealth

(A) MassHealth. The MassHealth agency formulates requirements and determines eligibility for all MassHealth coverage types.

(B) Other Agencies.

(1) Department of Transitional Assistance (DTA). The Department of Transitional Assistance administers the Emergency Aid for the Elderly, Disabled and Children (EAEDC) Program. Persons receiving EAEDC who are 65 or older are automatically eligible for MassHealth Standard coverage, if they meet the citizen and immigration rules for MassHealth Standard at 130 CMR 518.002. Aliens with special status described in 130 CMR 518.002(D) who are receiving EAEDC who are aged 65 or older are automatically eligible for MassHealth Essential coverage pursuant to 130 CMR 515.003(C).

(2) Social Security Administration (SSA). District Social Security offices administer the Supplemental Security Income (SSI) Program and determine the eligibility of persons aged 65 or older. Persons receiving SSI who are 65 or older are automatically eligible for MassHealth Standard coverage.

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515.005: Receiving Public Assistance from Another State.

Persons who are receiving public assistance from another state are not eligible for MassHealth.

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Rev. 01/01/10515.007: Rights of Applicants and Members

The policies of the MassHealth agency are administered in accordance with federal and state law. Applicants and members must be informed of their rights and responsibilities with respect to MassHealth.

(A) Right to Nondiscrimination and Equal Treatment. The MassHealth agency does not discriminate on the basis of race, color, sex, sexual orientation, religion, national origin, disability, or age in admission or access to, or treatment or employment in, its programs or activities. Grievance procedures for resolution of discrimination complaints are administered and applied by the MassHealth agency's Affirmative Action Office.

(B) Right to Confidentiality. The confidentiality of information obtained by the MassHealth agency during the MassHealth eligibility process is protected in accordance with federal and state regulations. The use and disclosure of information concerning applicants, members, and legally liable third parties is restricted to purposes directly connected to the administration of MassHealth as governed by state and federal law.

(C) Right to Timely Provision of Benefits. Eligible applicants and members have the right to the timely provision of benefits, as defined in 130 CMR 516.000.

(D) Right to Information. Persons who inquire about MassHealth, either orally or through a written request, have the right to receive information about medical benefits, coverage type requirements, and their rights and responsibilities as applicants and members of MassHealth.

(E) Right to Apply. Any person, individually or through an eligibility representative, has the right, and must be afforded the opportunity without delay, to apply for MassHealth.

(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 MassHealth agency 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 515.001.

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(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 MassHealth agency. 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 MassHealth agency 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 MassHealth agency will provide either telephonic or other interpreter services whenever

- (1) the applicant or member who is seeking assistance from the MassHealth agency has limited English proficiency or sensory impairment and requests interpreter services; or
- (2) the MassHealth agency determines such services are necessary.

(J) Right to a Certificate of Creditable Coverage Upon Termination of MassHealth. The MassHealth agency provides a Certificate of Creditable Coverage to members whose coverage under MassHealth Standard, CommonHealth, Essential, or Basic has ended. The MassHealth agency issues 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 are included on the Certificate.

515.008: Responsibilities of Applicants and Members

(A) Responsibility to Cooperate. The applicant or member must cooperate with the MassHealth agency in providing information necessary to establish and maintain eligibility, and must comply with all the rules and regulations of MassHealth, including recovery and obtaining or maintaining other health insurance.

(B) Responsibility to Report Changes. The applicant or member must report to the MassHealth agency, within 10 days or as soon as possible, changes that may affect eligibility. Such changes include, but are not limited to, income, assets, inheritances, gifts, transfers of and proceeds from the sale of real or personal property, distributions from or transfers into trusts, address, the availability of health insurance, immigration status, and third-party liability.

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(C) Cooperation with Quality Control. The Quality Control Division periodically conducts an independent review of eligibility factors in a sampling of case files. When a case file is selected for review, the member must cooperate with the representative of Quality Control. Cooperation includes, but is not limited to, a personal interview and the furnishing of requested information. If the member does not cooperate, MassHealth benefits may be terminated.

515.009: Referrals to Investigative Units

Intentional false statements or fraudulent acts made in connection with obtaining medical benefits or payments under MassHealth are punishable under M.G.L. c. 118E, § 39 by fines, imprisonment, or both. In all cases of suspected fraud, MassHealth staff will make a referral to the Bureau of Special Investigations, or other appropriate agencies.

515.010: Recovery of Overpayment of Medical Benefits

The MassHealth agency has the right to recover payment of medical benefits to which the member was not entitled at the time the benefit was received, regardless of who was responsible and whether or not there was fraudulent intent. No provision under 130 CMR 515.010 will limit the MassHealth agency's right to recover overpayments.

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515.011: Estate Recovery

(A) Introduction.

(1) The MassHealth agency will recover the amount of payment for medical benefits correctly paid from the estate of a deceased member. Recovery is limited to payment for all services that were provided

(a) while the member was 65 or older, except on or after October 1, 1993, while the member was aged 55 or older; or

(b) on or after March 22, 1991, while the member, regardless of age, was institutionalized, and the MassHealth agency determined that the member could not reasonably be expected to return home.

(2) The estate includes all real and personal property and other assets in the member's probate estate.

(3) Notwithstanding 130 CMR 515.011(A)(1) and in accordance with 42 U.S.C. 1396p(b)(B), MassHealth will not recover Medicare cost-sharing benefits described at 42 U.S.C. 1396(a)(10)(E) with dates of payment on or after January 1, 2010, for persons who received such benefits under 130 CMR 505.002, 505.009, 515.010, and 519.011, when they were aged 55 or older.

(a) The date of payment for Medicare cost-sharing deductibles, coinsurance, and copayments is the date the MassHealth agency received the claim.

(b) The date of payment for premium payments is the date the MassHealth agency paid the premium.

(B) Exception. No recovery for nursing facility or other long-term-care services may be made from the estate of any person who

(1) was institutionalized;

(2) notified the MassHealth agency that he or she had no intent of returning home; and

(3) on the date of admission to the long-term-care institution, had long-term-care insurance that met the requirements of 130 CMR 515.014 and the Division of Insurance regulations at 211 CMR 65.09(1)(e)(2).

(C) Deferral of Estate Recovery. Recovery will not be required until after the death of a surviving spouse, if any, or while there is a surviving child who is under 21 years of age, or a child of any age who is blind or permanently and totally disabled.

(D) Waiver of Estate Recovery Due to Financial Hardship.

(1) For claims presented on or after November 15, 2003, recovery will be waived if

(a) a sale of real property would be required to satisfy a claim against the member's probate estate; and

(b) an individual who was using the property as a principal place of residence on the date of the member's death meets all of the following conditions:

(i) the individual lived in the property on a continual basis for at least one year immediately before the now-deceased member became eligible for MassHealth or other assistance from the MassHealth agency and continues to live in the property at the time the MassHealth agency first presented its claim for recovery against the deceased member's estate;

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- (ii) the individual has inherited or received an interest in the property from the deceased member's estate as defined in 130 CMR 501.013(A)(2) and 515.011(A)(2);
 - (iii) the individual is not being forced to sell the property by other devisees or heirs at law; and
 - (iv) at the time the MassHealth agency first presented its claim for recovery against the deceased member's estate, the gross annual income of the individual's family group, as defined in 130 CMR 501.001, was less than or equal to 133 percent of the applicable federal-poverty-level income standard for the appropriate family size.
- (2) The waiver will be conditional for a period of two years from the date the MassHealth agency mails notice that the waiver requirements have been met, or from the date that a court of competent jurisdiction determines that the waiver requirements have been met. If at the end of that period, all circumstances and conditions that must exist for the MassHealth agency to waive recovery still exist, including meeting the same income standards under 130 CMR 515.011(D)(1)(b)(iv), and the real property has not been sold or transferred, the waiver will become permanent and binding. If at any time during the two-year period, the circumstances and conditions for waiver no longer exist, including meeting the same income standards under 130 CMR 515.011(D)(1)(b)(iv), the property is sold or transferred, or the individual does not use the property as their primary residence, the MassHealth agency will be notified and its claim will be payable in full.

(E) Outstanding Claims.

- (1) For claims presented between April 1, 1995, and November 15, 2003, that are still outstanding, recovery will be waived if all requirements under the then-existing MassHealth regulations were met.
- (2) For claims presented before April 1, 1995, a waiver for hardship did not exist.

(F) Fair-Market Value and Equity Value. If there will be insufficient proceeds from the sale or transfer of the property to satisfy the MassHealth agency's claim in full, the fair-market value and equity value of all real property that is part of the deceased member's estate must be verified prior to the sale or transfer of said property.

- (1) The executor or administrator of the probate estate or, in the case of real property that passes outside the probate estate, the person or entity to whom legal title or interest passed, must verify the fair-market value by sending to the MassHealth agency a copy of the most recent tax bill or the property tax assessment that was most recently issued by the taxing jurisdiction, provided that this assessment is not one of the following:
 - (a) a special-purpose assessment;
 - (b) based on a fixed-rate-per-acre method; or
 - (c) based on an assessment ratio or providing only a range.

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- (2) The executor or administrator of the probate estate or, in the case of real property that passed outside the probate estate, the person or entity to whom legal title or interest passed, must also provide a comparable market analysis or a written appraisal of the property value from a knowledgeable source. A knowledgeable source includes one of the following: a licensed real-estate agent or broker, a real-estate appraiser, or an official from a bank, savings and loan association, or similar lending organization. The knowledgeable source must not have any real or apparent conflict-of-interest relationship with the estate.
- (3) The MassHealth agency may also obtain an assessment from a knowledgeable source.

(G) Waiver of Estate Recovery Due to Hardship for American Indians and Alaska Natives.

- (1) For claims presented on or after July 1, 2009, recovery from the following American Indian and Alaska Natives income, resources, and property will be waived:
- (a) certain income and resources (such as interests in and income derived from tribal land and other resources currently held in trust status and judgment funds from the Indian Claims Commission and the U.S. Claims Court) that are exempt from Medicaid estate recovery by other laws and regulations;
 - (b) ownership interest in trust and nontrust property, including real property and improvements
 - (i) located on a reservation (any federally recognized Indian tribe's reservation, pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act, and Indian allotments) or near a reservation as designated and approved by the Bureau of Indian Affairs of the U.S. Department of the Interior; or
 - (ii) for any federally recognized tribe not described in 130 CMR 515.011(G)(1)(b)(i), located within the most recent boundaries of a prior federal reservation.
 - (c) income left as a remainder in an estate derived from property protected in 130 CMR 515.011(G)(1)(b), that was either collected by an Indian or by a tribe or tribal organization and distributed to Indians, as long as the individual can clearly trace it as coming from protected property;
 - (d) ownership interests left as a remainder in an estate in rents, leases, royalties, or usage rights related to natural resources, including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, or fish products, resulting from the exercise of federally protected rights and income either collected by an Indian or by a tribe or tribal organization and distributed to Indians derived from these sources as long as the individual can clearly trace it as coming from protected sources; or
 - (e) ownership interests in or usage rights to items not covered by 130 CMR 515.011(G)(1)(a) through (d) that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional life style according to applicable tribal law or custom.

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(2) Protection of non-trust property described in 130 CMR 515.011(G)(1) is limited to circumstances when it passes from an Indian, as defined in section 4 of the Indian Health Care Improvement Act, to one or more relatives (by blood, adoption, or marriage), including Indians not enrolled as members of a tribe and non-Indians, such as spouses or stepchildren, that their culture would nevertheless protect as family members, to a tribe or tribal organization, or to one or more Indians.

515.012: Real Estate Liens

(A) Liens. A real estate lien enables the MassHealth agency to recover the cost of medical benefits paid or to be paid on behalf of a member. Before the death of a member, the MassHealth agency will place a lien against any property in which the member has a legal interest, subject to the following conditions:

- (1) per court order or judgement; or
- (2) without a court order or judgement, if all of the following requirements are met:
 - (a) the member is an inpatient receiving long-term or chronic care in a nursing facility or other medical institution;
 - (b) none of the following relatives lives in the property:
 - (i) a spouse;
 - (ii) a child under the age of 21, or a blind or permanently and totally disabled child;
 - or
 - (iii) a sibling who has a legal interest in the property and has been living in the house for at least one year before the member's admission to the medical institution;
 - (c) the MassHealth agency determines that the member cannot reasonably be expected to be discharged from the medical institution and return home; and

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(d) the member has received notice of the MassHealth determination that the above conditions have been met and that a lien will be placed. The notice includes the member's right to a fair hearing.

(B) Recovery. If property against which the MassHealth agency has placed a lien under 130 CMR 515.012(A) is sold during the member's lifetime, the MassHealth agency may recover all payment for services provided on or after April 1, 1995. This provision does not limit the MassHealth agency's ability to recover from the member's estate in accordance with 130 CMR 515.011.

(C) Exception. No recovery for nursing-facility or other long-term-care services may be made under 130 CMR 515.012(B) if the member

- (1) was institutionalized;
- (2) notified the MassHealth agency that he or she had no intention of returning home; and
- (3) on the date of admission to a long-term-care institution had long-term-care insurance whose coverage met the requirements of 130 CMR 515.014 and the Division of Insurance regulations at 211 CMR 65.09(1)(e)(2).

(D) Repayment Deferred.

- (1) In the case of a lien on a member's home, repayment under 130 CMR 515.012 is not required while any of the following relatives are still lawfully living in the property:
 - (a) a sibling who has been living in the property for at least one year before the member's admission to the nursing facility or other medical institution; or
 - (b) a son or daughter who
 - (i) has been living in the property for at least two years immediately before the member was admitted to a nursing facility or other medical institution;
 - (ii) establishes to the satisfaction of the MassHealth agency that he or she provided care that permitted the parent to live at home during the two-year period before institutionalization; and
 - (iii) has lived lawfully in the property on a continual basis while the parent has been in the institution.
- (2) Repayment from the estate of a member that would otherwise be recoverable under any regulation is still required even if the relatives described in 130 CMR 515.012(D) are still living in the property.

(E) Dissolution. The MassHealth agency will discharge a lien placed against property under 130 CMR 515.012(A) if the member is released from the medical institution and returns home.

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(F) Verification. The applicant or member must cooperate in providing verification as to whether the conditions under 130 CMR 515.012(A) exist, and in providing any information necessary for the MassHealth agency to place a lien.

(G) Recording Fee. The MassHealth agency is not required to pay a recording fee for filing a notice of lien or encumbrance, or for a release or discharge of a lien or encumbrance under 130 CMR 515.012.

515.013: Voter Registration

(A) Voter registration forms are available through the MassHealth agency to applicants and members who are

- (1) U.S. citizens; and
- (2) aged 18 or older, or who will be aged 18 on or before the date of the next election, in accordance with the National Voter Registration Act of 1993.

(B) Applicants and members are

- (1) informed of the availability of voter registration forms at application, at the time of an eligibility review, and when there is an address change;
- (2) offered assistance in completing the voter registration application form unless such assistance is refused; and
- (3) able to submit voter registration forms to the MassHealth agency for transmittal to the proper election offices.

(C) MassHealth agency staff must not

- (1) seek to influence an applicant's or member's political preference or party registration;
- (2) display any political preference or party allegiance to the applicant or member;
- (3) make any statement to an applicant or member or take any action intended to influence the applicant's or member's decision regarding voter registration; or
- (4) make any statement to an applicant or member or take any action intended to lead the applicant or member to believe that the decision to register or not has any bearing on the availability of services or benefits.

(D) Completed voter registration application forms that are submitted to the MassHealth agency are transmitted to the proper local election office for processing within five days of receipt.

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Rev. 01/01/10**515.014: Long-Term-Care Insurance Minimum Coverage Requirements for MassHealth Exemptions**

For purposes of the financial eligibility exemption under 130 CMR 520.007(G)(8)(d), concerning treatment of the former home as an asset, and the exemption under 130 CMR 515.011(B) and 515.012(C), concerning repayment of assistance provided for nursing facility and other long-term-care services (hereafter collectively referred to as “MassHealth exemptions”), a long-term-care insurance policy must provide certain minimum coverage requirements as determined by the Division of Insurance.

(A) Under Division of Insurance regulations at 211 CMR 65.09(1)(e)(2), to qualify for the MassHealth exemptions, an individual must be a covered person under an individual, group, or employment-based group policy issued on or after March 15, 1999, that meets the individual policy minimum standards of 211 CMR 65.05 and all of the following requirements.

- (1) Scope of Benefits. The policy must cover nursing and custodial care in a nursing facility licensed by the Department of Public Health.
- (2) Daily Dollar Benefits. The policy must have available benefits of at least \$125 per coverage day in a nursing facility, except where the actual expense incurred is less, regardless of whether accrued benefits are measured in terms of days or dollar amount.
- (3) Nursing Facility Coverage Days: Lifetime Benefit Period. The policy must have benefits available sufficient to cover at least 730 days in a nursing facility.
- (4) Elimination Period. No policy may have an elimination period (days on which services are provided to an insured before the policy begins to pay benefits) longer than 365 days in a nursing facility. The application of more than one elimination period is not allowed unless the insured has received no benefits for a period of at least 180 consecutive days. In lieu of an elimination period, the policy may have a deductible of no more than \$54,750.

(B) All policies issued prior to March 15, 1999, need only comply with the minimum standards of 211 CMR 65.05, and the limitations and exclusion provision of 211 CMR 65.06, that were effective from April 1, 1989, through September 2, 1999.