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

MassHealth
Eligibility Letter 208
August 1, 2012

TO: MassHealth Staff

FROM: Julian J. Harris, Medicaid Director

RE: **Revisions to Regulations about Missing Information on MassHealth Applications**

MassHealth is revising the regulations about missing information on MassHealth applications.

If the required information is not received within the time allowed, MassHealth will notify the applicant that eligibility for medical benefits cannot be determined, but will no longer return the incomplete application.

These regulations are effective September 1, 2012.

Please Note: We have made a minor change in the format of the regulations in Chapters 502 and 516. 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

Insert	**Remove**	**Trans. By**
502.000	502.000	E.L. 81
502.001	502.001	E.L. 197
502.002	502.002	E.L. 156
502.005	502.005	E.L. 137
502.007	502.007	E.L. 170
502.008	502.008	E.L. 169

Insert	**Remove**	**Trans. By**
516.000	516.000	E.L. 41
516.001	516.001	E.L. 197
516.002	516.002	E.L. 156
516.004	516.004	E.L. 156
516.007	516.007	E.L. 169

TABLE OF CONTENTS

Section

502.001: Medical Benefit Request (MBR)

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

(B) Corroborative Information. The MassHealth agency requests all corroborative information necessary to determine eligibility. The applicant must supply such information within 60 days of the date of the Request for Information.

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

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

(E) Missing or Inconsistent Information on the MBR.

(1) If an MBR is received at a MassHealth Enrollment Center or a MassHealth outreach site and the applicant did not answer all required questions on the MBR, the MassHealth agency is unable to determine the applicant's eligibility for MassHealth.

(2) The MassHealth agency requests responses to all of the unanswered questions necessary to determine eligibility. The MassHealth agency must receive such information within 14 days of the date of the request for the information.

(3) If responses to all unanswered questions necessary to determine eligibility are received within 14 days of the date of the notice referenced in 130 CMR 502.001(E)(2), the MBR activates the MassHealth eligibility process for determining

(a) the coverage type providing the most comprehensive medical benefits for which the applicant is eligible, based on the date the MBR was received by the MassHealth agency; or

(b) the need to request any corroborative information necessary to determine eligibility, as provided in 130 CMR 502.001(B), (C), and (D).

(4) If responses to all unanswered questions necessary for determining eligibility are not received within the 14-day period referenced in 130 CMR 502.001(E)(2), the MassHealth agency notifies the applicant that it is unable to determine eligibility for medical benefits. The date that the incomplete MBR was received will not be used in any subsequent eligibility determinations.

(5) Inconsistent answers are treated as unanswered.

502.002: Reactivating the Medical Benefit Request

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

502.003: Presumptive Eligibility for Children

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

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

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

502.004: Matching Information

The MassHealth agency initiates information matches with other agencies and information sources when an MBR is received in order to update or verify eligibility. These agencies and information sources may include, but are not limited to, the following: the Division of Unemployment Assistance, Department of Public Health's Bureau of Vital Statistics, Department of Industrial Accidents, Department of Veterans' Services, Department of Revenue, Bureau of Special Investigations, Internal Revenue Service, Social Security Administration, Alien Verification Information System, Department of Transitional Assistance**,** and health insurance carriers.

502.005: Time Standards for an Eligibility Determination

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

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

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

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

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

(D) The time standards described in 130 CMR 502.005(A) through (C) may be extended by the amount of time used by the applicant to respond to requests for additional information needed to make the disability determination.

502.006: Coverage Date

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

502.007: Eligibility Review

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

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

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

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

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

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

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

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

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

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

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

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

(b) Coverage for the purchase of medical benefits under Essential is effective upon the member's enrollment in the Primary Care Clinician (PCC) Plan. MassHealth Essential members who are aliens with special status are afforded eligibility under MassHealth Limited pursuant to 130 CMR 505.007(E).

(c) Coverage for premium assistance under Basic and Essential is effective in the calendar month following the date of the written notice. MassHealth Essential members receiving premium assistance who are aliens with special status are afforded eligibility under MassHealth Limited pursuant to 130 CMR 505.007(E).

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

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

(E) If the member fails to provide a written update of his or her circumstances within 45 days of the MassHealth agency's request, MassHealth coverage is terminated, except as provided in 130 CMR 502.007(G). If the member subsequently submits a written update, the MassHealth agency determines his or her eligibility as of the date the written update is received. If the applicant is determined eligible, the medical coverage date is established in accordance with the rules in 130 CMR 502.006.

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

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

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

(G) The MassHealth agency matches files of MassHealth members who appear on the Department of Revenue (DOR) records as "new hires" or for whom DOR has received quarterly wage reporting information. If the DOR records contain data that is inconsistent with information previously recorded on the MassHealth case file, the MassHealth agency sends a notice with a Job Update form to the MassHealth member whose name appears on the DOR file. The MassHealth agency must receive the completed Job Update form within 30 days from the date on the notice. If the Job Update form is not received within the 30-day period, MassHealth coverage for the family group is terminated. If the member submits a written update after the end of the 30-day period, the MassHealth agency determines family group eligibility as of the date the written update is received and the start date of MassHealth coverage is established in accordance with 130 CMR 502.006.

502.008: Notice

(A) All applicants and members receive a written notice of the eligibility determination for MassHealth. The notice contains an eligibility decision for each member of the family group who has requested MassHealth, and either provides information so the applicant or member can determine the reason for any adverse decision or directs the applicant or member to such information.

(B) Members also receive a notice, in accordance with 130 CMR 610.015, of any loss of coverage, or any changes in coverage type, premium, or premium assistance payments.

(C) The notices described in 130 CMR 502.008(A) and (B) provide information about the applicant's and member's right to a fair hearing, with the exception of notices about eligibility for presumptive coverage as described at 130 CMR 505.002(C)(3) and 505.005(C)(2), and for prenatal coverage as described at 130 CMR 505.003. Information about the appeal process is found at 130 CMR 610.000.

502.009: Voluntary Withdrawal

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

502.010: Issuance of a MassHealth Card

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

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

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

TABLE OF CONTENTS

516.001: Overview

(A) Eligibility Process. The eligibility process consists of the activities conducted for the purpose of determining, redetermining, and maintaining eligibility.

(B) Filing an Application. To apply for MassHealth, a person or his or her eligibility representative must file a Senior Medical Benefit Request (SMBR) at a MassHealth Enrollment Center or MassHealth outreach site.

(C) Corroborative Information. The MassHealth agency requests all corroborative information necessary to determine eligibility.

(1) The MassHealth agency sends the applicant written notification requesting the corroborative information generally within five days of the receipt of the SMBR.

(2) The notice advises the applicant that the requested information must be received within 30 days of the date of the request, and of the consequences of failure to provide the information.

(D) Receipt of Corroborative Information. If the requested information, with the exception of verification of citizenship, identity, and immigration status, is received within 30 days of the date of the request, the SMBR is considered complete. The completed SMBR activates the MassHealth eligibility process for determining the coverage type providing the most comprehensive medical benefits for which the applicant is eligible. If such information is not received within 30 days of the date of the request, MassHealth benefits may be denied.

(1) Except as provided in 130 CMR 515.003(C), if the requested information is received within 30 days of the date of the denial, the date of receipt of one or more of the verifications is considered the date of reapplication.

(2) The date of reapplication replaces the date of the denied SMBR. The applicant's earliest date of eligibility for MassHealth is based on the date of reapplication.

(3) If a reapplication is subsequently denied and not appealed, the applicant must submit a new SMBR to pursue eligibility for MassHealth. The earliest date of eligibility for MassHealth is based on the date of the new SMBR.

(E) Missing or Inconsistent Information on the SMBR.

(1) If an SMBR is received at a MassHealth Enrollment Center or MassHealth outreach site and the applicant did not answer all required questions on the SMBR, the MassHealth agency is unable to determine the applicant's eligibility for MassHealth.

(2) The MassHealth agency requests responses to all of the unanswered questions necessary to determine eligibility. The MassHealth agency must receive such information within 14 days of the date of the request for the information.

(3) If responses to all unanswered questions necessary to determine eligibility are received within 14 days of the date of the notice, referenced in 130 CMR 516.001(E)(2), the SMBR activates the MassHealth agency's eligibility process for determining:

(a) the coverage type providing the most comprehensive medical benefits for which the applicant is eligible, based on the date the SMBR was received by the MassHealth agency; or

(b) the need to request any corroborative information necessary to determine eligibility, as provided in 130 CMR 516.001(C) and (D).

(4) If responses to all unanswered questions necessary for determining eligibility are not received within the 14-day period referenced in 130 CMR 516.001(E)(2), the MassHealth agency notifies the applicant that it is unable to determine eligibility for MassHealth. The date that the incomplete SMBR was received will not be used in any subsequent eligibility determinations.

(5) Inconsistent answers are treated as unanswered.

516.002: Date of Application

(A) The date of application is the date that a completed SMBR is received at a MassHealth Enrollment Center or MassHealth outreach site. An SMBR is considered complete as provided in 130 CMR 516.001(D).

(B) If an applicant described in 130 CMR 519.002(A)(1) has been denied SSI in the 30-day period before the date of application for MassHealth, the date of application for MassHealth is the date the person applied for SSI.

516.003: Matching Information

The MassHealth agency initiates information matches with other agencies and information sources when an SMBR is received in order to update or verify eligibility. These agencies and information sources may include, but are not limited to, the following agencies: the Division of Unemployment Assistance, Department of Public Health's Bureau of Vital Statistics, Department of Industrial Accidents, Department of Veterans' Services, Department of Revenue, Bureau of Special Investigations, Internal Revenue Service, Social Security Administration, Alien Verification Information System, Department of Transitional Assistance, and banks and other financial institutions.

516.004: Time Standards for Eligibility Determination

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

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

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

516.005: Coverage Date

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

516.006: Eligibility Determination

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

(1) as a result of a member's reported changes in circumstances;
(2) by external matching with other agencies; and
(3) where matching is not available, through a written update of the member's circumstances on a prescribed form.

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

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

(D) The MassHealth agency matches files of MassHealth members who appear on the Department of Revenue (DOR) records as "new hires" or for whom DOR has received quarterly wage reporting information. If the DOR records contain data that is inconsistent with information previously recorded on the MassHealth case file, the MassHealth agency sends a notice with a Job Update form to the MassHealth member whose name appears on the DOR file. The MassHealth agency must receive the completed Job Update form within 30 days from the date on the notice. If the Job Update form is not received within the 30-day period, MassHealth coverage for the family group is terminated. If the member submits a written update after the end of the 30-day period, the MassHealth agency determines family group eligibility as of the date the written update is received and the start date of MassHealth coverage is established in accordance with 130 CMR 516.005.

516.007: Notice

(A) All applicants and members, as well as certain others described below in 130 CMR 516.007, receive written notice of the determination of their eligibility for MassHealth. The notice contains an eligibility decision for each member who has requested MassHealth, and provides information enabling the applicant or member to determine the reason for any adverse decision.

(B) Members also receive notice of any changes in coverage type or patient-paid amount, or loss of coverage.

(C) In addition to sending notices to applicants and members, such written notices are provided to the institution or eligibility representative, as well as to the community spouse, as defined at 130 CMR 520.016(B)(1)(c). This may include, in the case of death, the executor, administrator, or legal representative of the deceased individual's estate.

(D) All notices provide information about the right of the applicant or member to a fair hearing, with the exception of asset assessments described at 130 CMR 520.016. Information about the appeal process is found at 130 CMR 610.000.

516.008: Voluntary Withdrawal

The applicant or eligibility representative may voluntarily withdraw his or her request for MassHealth. An eligibility representative may also withdraw a request for MassHealth on behalf of a deceased applicant.

516.009: Issuance of a MassHealth Card

(A) The MassHealth agency issues a MassHealth card to new members, with the exception of those who receive MassHealth Buy-In coverage.

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