MassHealth

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

MassHealth
Eligibility Letter 218
July 14, 2017

TO: MassHealth Staff

FROM: Daniel Tsai, Assistant Secretary for MassHealth

RE: **Revisions to Regulations at 130 CMR 501.000**

MassHealth is revising the regulations at 130 CMR 501.000.The revised regulations implement changes to clarify regulatory requirements, remove confusing or redundant information, reflect current operational processes, conform to federal and state law, and improve readability and administration

The revisions are as follows.

- Outdated references were deleted and, in 130 CMR 501.001, changes were made to align definitions.
- The definition of "appeal representative" was deleted and cross referenced to 130 CMR 610.004: *Definitions*.
- Clarifications were made to the existing definition of "authorized representative" to ensure compliance with federal law.
- The definition of "basic-benefit-level," to increase transparency and to ease of administration of the premium assistance program, was updated.
- The definition of "couple policy" was deleted.
- The definition of "disability determination unit" was replaced with the definition of "disability evaluation services."
- The definition of "family policy" was deleted.
- The definition of "individual policy" was deleted.
- The definition of "premium assistance payment" was revised to cross reference 130 CMR 506.012: *Premium Assistance Payments*.
- The definitions of "small business" and "small employer" were deleted.
- The Right to Nondiscrimination and Equal Treatment, the Right to Be Assisted by Others, and the Right to Interpreter Services were updated.
- The Right to a Certificate of Creditable Coverage was deleted.

- Language was added to define the responsibilities of applicants and members about corroborative information necessary to maintain eligibility, including obtaining and maintaining available health insurance.
- Language was added to 130 CMR 501.013(A), which provides that estate recovery claims for members who are aged 55 or older will be offset by premiums the member paid to MassHealth.

These regulations are effective July 14, 2017.

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. In the event that a definition conflicts with federal law, the federal law supersedes.

Access to Health Insurance – the ability to obtain employer-sponsored health insurance for an uninsured family 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

(1) is a member of a federally recognized tribe, band, or group as defined in Title 25 of U.S.C.;

(2) is an Eskimo, Aleut, or other Alaska Native enrolled by the Secretary of the Interior, pursuant to the Alaska Native Claims Settlement Act at 43 U.S.C. 1601 *et seq.*; or

(3) has been determined eligible to receive health care services from Indian Health Care Providers as an Indian pursuant to 42 CFR 136.12 or Title V of the Indian Health Care Improvement Act.

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

Appeal Representative – an Appeal Representative as defined in 130 CMR 610.004: *Definitions*.

Applicant – an individual who completes and submits an application for MassHealth.

Application – a request for health benefits that is received by the MassHealth agency and includes all required information and a signature by the applicant or his or her authorized representative. The application may be submitted at www.MAHealthConnector.org, or the applicant may complete a paper application, complete a telephone application, or apply in person at a MassHealth Enrollment Center (MEC).

Authorized Representative –

(1) a person or an organization identified as the authorized representative of an applicant or member in a completed Authorized Representative Designation Form or another form prescribed by the MassHealth agency that has been signed by the authorized representative and, if applicable, the applicant or member and submitted to the MassHealth agency and in which the authorized representative agrees to comply with applicable rules regarding confidentiality and conflicts of interest in the course of representing the applicant or member; provided that such person or organization must be

(a) a person or organization designated by the applicant or member in writing to act responsibly on his or her behalf in connection with the eligibility process and other ongoing communications with the MassHealth agency;

(b) a person acting responsibly on behalf of the applicant or member and who is sufficiently aware of such applicant's or member's circumstances to assume responsibility for the accuracy of the statements made on his or her behalf during the eligibility process and in other communications with the MassHealth agency, such as a family member or friend; provided that the applicant or member in this case cannot provide written designation and does not otherwise have an individual who can act on his or her behalf such as an existing authorized representative, guardian, conservator, personal representative of the estate, holder of power of attorney, or an invoked health care proxy; or

(c) a person who has, under applicable law, authority to act on behalf of the applicant or member in making decisions related to health care or payment for health care including, but not limited to, a guardian, conservator, personal representative of the estate of an applicant or member, holder of power of attorney, or an invoked health care proxy.

(2) An authorized representative shall have the authority to complete and sign an application on the applicant's behalf, select a health plan on the applicant's or member's behalf, complete and sign a renewal form on the member's behalf, receive copies of the applicant's or member's notices and other communications from the MassHealth agency (which may include protected health care information, personal data, and financial information), and act on behalf of the applicant or member in all other matters with the MassHealth agency or the Connector, including representing the applicant or member at an appeal provided that, with respect to a person serving as an authorized representative pursuant to 130 CMR 501.001: Authorized Representative (1)(c), authority to act on behalf of the applicant or member is determined by the applicable law or underlying legal document.

Basic-benefit Level (BBL) – benefits provided under a health-insurance plan that include a broad range of medical benefits as defined in the minimum creditable coverage core services requirements in 956 CMR 5.03(1)(a); provided that the sum of the annual deductible and the other annual out-of-pocket expenses required to be paid under that plan does not exceed the maximum amounts described at IRC § 223(c)(2) for high deductible health plans.

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.

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.

Certified Application Counselor (CAC) – an individual who is certified by the MassHealth agency and the Connector to provide assistance in completing applications and renewal forms.

Child – a person younger than 19 years old.

Citizen – see 130 CMR 504.002: *U.S. Citizen*.

Commonwealth Health Insurance Connector Authority or Health Connector or Connector – the entity established pursuant to M.G.L. c. 176Q, § 2.

ConnectorCare – the program administered by the Health Connector pursuant to M.G.L. c. 176Q to provide premium assistance payments and point-of-service cost-sharing subsidies to eligible individuals enrolled in health plans.

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

Coverage Date – the date medical coverage begins.

Coverage Type – a scope of medical services, other benefits, or both that is available to members who meet specific eligibility criteria. MassHealth coverage types include the following: MassHealth Standard (Standard), MassHealth CommonHealth (CommonHealth), MassHealth CarePlus (CarePlus), MassHealth Family Assistance (Family Assistance), Small Business Employee Premium Assistance Program (SBE Premium Assistance Program), and MassHealth Limited (Limited). The scope of services or covered benefits for each coverage type is found at 130 CMR 450.105: *Coverage Types*.

Custodial Parent –

(1) the parent with whom a child's physical custody has been established by a court order or binding separation, divorce, or custody agreement; or
(2) if no such order or agreement exists, the parent with whom the child spends most nights; or
(3) if the child spends an equal number of nights with each parent, it is determined by the Internal Revenue Service (IRS) tax rules.

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

Deductible – the total dollar amount of incurred medical expenses that an applicant whose income exceeds MassHealth income standards must be responsible for before the applicant is eligible for MassHealth as described at 130 CMR 506.009: *The One-Time Deductible*.

Deductible Period – a specified six-month period within which an applicant for MassHealth, whose income exceeds MassHealth income standards, may become eligible, on the basis of disability, through incurred and/or paid medical expenses of the applicant or any member of the MassHealth Disabled Adult Household as described in 130 CMR 506.009: *The One-Time Deductible*.

Disabled – having a permanent and total disability.

Disabled Adult Household – see 130 CMR 506.002(C): *MassHealth Disabled Adult Household*.

Disabled Working Adult – 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.

Disability Evaluation Services (DES) – a unit that consists of physicians and disability evaluators who determine permanent and total disability of an applicant or member seeking coverage under a MassHealth program for which disability is a criterion 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.

Duals Demonstration Dual Eligible Individual – for purposes of the Duals Demonstration Program, a MassHealth member must meet all of the following criteria:

(1) be aged 21 through 64 at the time of enrollment;
(2) be eligible for MassHealth Standard as defined in 130 CMR 450.105(A): *MassHealth Standard* or MassHealth CommonHealth as defined in 130 CMR 450.105(E): *MassHealth CommonHealth*;
(3) be enrolled in Medicare Parts A and B, be eligible for Medicare Part D, and have no other health insurance that meets the basic-benefit level as defined in 130 CMR 501.001; and
(4) live in a designated service area of an ICO.

Duals Demonstration Program – the MassHealth state Demonstration to Integrate Care for Duals Demonstration Dual Eligible Individuals.

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

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

Family Group – a family, couple, or individual.

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.

Filing Status – an Internal Revenue Service term. The five filing statuses are single, married filing a joint return, married filing a separate return, head of household, and qualifying widow(er) with dependent children. The rate at which income is taxed is determined by the filing status.

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, Health Safety Net (HSN), or Children's Medical Security Plan (CMSP) is not considered health insurance.

Health Safety Net – a source of funding for certain health care under 101 CMR 613.00: *Health Safety Net Eligible Services* and 614.00: *Health Safety Net Payments and Funding*.

Hospital-determined Presumptive Eligibility – the MassHealth agency will provide time-limited coverage, in accordance with 130 CMR 502.003(H): *Hospital Determined Presumptive Eligibility* for individuals who are determined to be presumptively eligible by a qualified hospital, as defined at 130 CMR 450.110(B).

Incarceration – the confinement in a penal institution of an individual. An individual is not incarcerated if he or she is on parole, probation, or home release, and does not return to the institution for overnight stays.

Inconsistency Period – the time frame that an individual has to provide verifications needed to determine eligibility for health insurance offered by the Connector.

Integrated Care Organization (ICO) – an organization with a comprehensive network of medical, behavioral-health care, and long-term services and supports providers that integrates all components of care, either directly or through subcontracts, and has contracted with the Executive Office of Health and Human Services (EOHHS) and the Centers for Medicare & Medicaid Services (CMS) and been designated as an ICO to provide services to dual eligible individuals under M.G.L. c. 118E. ICOs are responsible for providing enrollees with the full continuum of Medicare- and MassHealth-covered services.

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

Lawfully Present Immigrants – see 130 CMR 504.003(A): *Lawfully Present Immigrants*.

Limited English Proficiency – persons who are unable to communicate effectively in English because their primary language is not English and who have not developed fluency in the English language.

Lump-sum Payment – a one-time only payment that represents either a windfall payment, or the accumulation of recurring countable income, such as retroactive unemployment compensation or federal veterans' retirement benefits. Payments such as gifts, inheritances, and personal injury awards, to the extent that they are not included in modified adjusted gross income, are not considered lump-sum payments.

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: *Managed Care Participation* and 508.000: *Health Care Reform: MassHealth: Managed Care Requirements.*

Managed Care Organization (MCO) – any entity with which the MassHealth agency contracts to provide and coordinate care and certain other medical services to members on a capitated basis, including a senior care organization (SCO), an integrated care organization (ICO), or 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.

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

MassHealth MAGI Household – see 130 CMR 506.002(B): *MassHealth MAGI Household Composition*.

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

Member – an individual determined by the MassHealth agency to be eligible for MassHealth.

Modified Adjusted Gross Income (MAGI) – modified adjusted gross income as defined in section 36(B)(d)(2) of the Internal Revenue Code with the following exceptions:

(1) an amount received as a lump sum only counts as income in the month received;
(2) scholarships, awards, or fellowship grants used for education purposes and not for living expenses are excluded from income;
(3) certain taxable income received by American Indians and Alaska Natives is excluded from income as described in 42 CFR § 435.603(e).

Navigator – an individual who is certified by the Health Care Connector, to assist an applicant with electronic and paper applications to establish eligibility and enroll in coverage through the Health Care Connector. In addition, a navigator provides outreach and education about insurance options offered through the Health Connector.

Nonqualified Individuals Lawfully Present – see 130 CMR 504.003(A)(3): *Nonqualified Individuals Lawfully Present*.

Nonqualified Person Residing under Color of Law (Nonqualified PRUCOLs) – see 130 CMR 504.003(C): *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs)*.

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

Other Noncitizen – see 130 CMR 504.003(D): *Other Noncitizens*.

Parent of a Child Younger than 19 Years Old – natural, adoptive, or stepmother or stepfather of a 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 18 Years of Age and Older.

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

1. can be expected to result in death; or
2. 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 18 years of age 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 Younger than 18 Years Old. The condition of an individual younger than 18 years old 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.

Person with Breast or Cervical Cancer – an individual who has submitted verification that he or she has breast or cervical cancer.

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 health-insurance coverage for certain MassHealth members who meet the criteria in section 130 CMR 506.012: *Premium Assistance Payments*.

Premium Billing Family Group (PBFG) – a group of persons who live together.

(1) The group can be an individual, a couple who are two persons married to each other according to the rules of the Commonwealth of Massachusetts, or a family.

(2) Two parents are members of the same premium billing family group if they are mutually responsible for one or more children who live with them.

(3) A family making up a PBFG may consist of

(a) a child or children younger than 19 years old, any of their children, and their parents. A child who is absent from the home to attend school is considered as living in the home;

(b) siblings younger than 19 years old and any of their children who live together even if no adult parent or caretaker relative is living in the home; or

(c) a child or children younger than 19 years old, any of their children, and their caretaker relative when no parent is living in the home.

Premium Tax Credit (PTC) – payment made pursuant to 26 U.S. C. § 36B on behalf of an eligible individual to reduce the costs of a health benefit plan premium to the individual.

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: *Primary Care Clinician (PCC) Plan*.

Protected Noncitizens – see 130 CMR 504.003(B): *Protected Noncitizens.*

Provisional Eligibility – approval for MassHealth benefits when an applicant's certain self-attested circumstances show eligibility for MassHealth benefits but further verification is required for continued eligibility. (See 130 CMR 502.003: *Verification of Eligibility Factors*.)

Qualified Noncitizens – see 130 CMR 504.003(A)(1): *Qualified Noncitizens*.

Qualified Noncitizens Barred – see 130 CMR 504.003(A)(2): *Qualified Noncitizens Barred*.

Quality Contro1 – a system of continuing review to measure the accuracy of eligibility decisions.

Qualified Health Plan (QHP) – a health plan licensed under M.G.L. c. 175, 176A, 176B, or 176G that has received the Commonwealth Health Insurance Connector's Seal of Approval as meeting the criteria under 45 CFR §155.1000 and is offered through the Health Connector in accordance with the provisions of 45 CFR §155.1010.

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

Senior Care Organization (SCO) – 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. SCOs are responsible for providing enrollees with the full continuum of Medicare- and MassHealth-covered services.

Sibling – natural (full or half-blood), adoptive, or stepbrother or stepsister.

Spouse – a person married to the applicant or member according to the laws of the Commonwealth of Massachusetts.

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.

Tax Dependent – a qualifying child or qualifying relative, other than the taxpayer or spouse, who entitles the taxpayer to claim a dependency exemption. An individual who files a return but is claimed as a dependent by someone else is still a tax dependent.

Tax Filer – any individual, including his or her spouse if married filing jointly, who intends to file a federal tax return for the year in which a member of the tax household is seeking or receives benefits and who claims an exemption for himself or herself. An individual who files a return but is claimed as a dependent by someone else is still a tax dependent.

Tax Household – all members who are claimed on the tax return, including the tax filer(s) and all dependents.

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

Young Adult – an individual aged 19 or 20.

501.002: Introduction to MassHealth

(A) The MassHealth agency is responsible for the administration and delivery of MassHealth services to eligible low- and moderate-income individuals, couples, and families.

(B) 130 CMR 501.000 through 508.000 provide the MassHealth requirements for children, young adults, parents and caretaker relatives, adults, pregnant women, disabled persons, persons who are HIV positive, individuals with breast or cervical cancer, and certain other individuals or couples who are under age 65 and not institutionalized. These requirements are prescribed in accordance with all applicable laws, including Title XIX, Title XXI, and MassHealth's 1115 Medicaid Research and Demonstration Waiver.

(C) 130 CMR 515.000: *MassHealth: General Policies* through 130 CMR 522.000: *MassHealth: Other Division Programs* provide the MassHealth requirements for persons who are institutionalized, aged 65 or older, or who would be institutionalized without community-based services in accordance with all applicable laws, including Title XIX, as amended.

(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 who may be eligible.

(B) MassHealth offers several coverage types: Standard, CommonHealth, CarePlus, Family Assistance, Small Business Employee Premium Assistance, 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: *Health Care Reform: MassHealth: Universal Eligibility Requirements* through 505.000: *Health Care Reform: MassHealth: Coverage Types*, and immigration status, as described in 130 CMR 504.000: *Health Care Reform: MassHealth: Citizenship and Immigration*.

(C) The MassHealth agency may limit the number of people who can be enrolled in MassHealth Family Assistance. When the MassHealth agency imposes such a limit, no new adult applicants (21 years of age or older) subject to these limitations will be added to MassHealth Family Assistance, 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 MassHealth Family Assistance.

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.

(b) DTA also administers the Emergency Aid to the Elderly, Disabled and Children (EAEDC) Program. MassHealth provides coverage to those persons receiving EAEDC cash assistance as follows:

1. MassHealth Standard: children younger than 19 years old, young adults 19 and 20 years of age who are citizens, qualified noncitizens, qualified noncitizens barred, and nonqualified individuals lawfully present, and parents and caretakers who are citizens or qualified noncitizens;
2. Mass Health CarePlus: adults aged 21 through 64 who are citizens or qualified noncitizens; and

3. MassHealth Family Assistance: children younger than 19 years old, young adults 19 and 20 years of age who are nonqualified persons living under color of law (PRUCOLs), parents and caretakers who are qualified noncitizens barred, nonqualified individuals lawfully present, nonqualified PRUCOLs, and adults 21 through 64 who are qualified noncitizens barred, nonqualified individuals lawfully present, and nonqualified PRUCOLs.

(2) Social Security Administration (SSA). The Social Security Administration administers the Supplemental Security Income (SSI) program and determines 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) Health Connector. The Health Connector is Massachusetts's health insurance marketplace where individuals, families, and small businesses can shop among qualified health insurance carriers and choose a health insurance plan. The Health Connector administers Qualified Health Plans (QHP), premium tax credits (PTC), and the ConnectorCare program. The single, streamlined application is used to determine eligibility for both Health Connector and MassHealth programs as described in 130 CMR 502.000: *Health Care Reform: MassHealth: The Eligibility Process*. The Health Connector and MassHealth also coordinate eligibility notices and eligibility appeals.

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.

(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: *The One-Time Deductible*.

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, will be treated as a protected status group under MassHealth if they

(a) have submitted a complete application (formerly known as Medical Benefit Request) as defined in 130 CMR 502.001: *Application for Benefits* by March 31, 1999;
(b) meet the eligibility requirements of MassHealth; and
(c) have an 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.

(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 income exceeds 200% 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)

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 complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, religion, creed, sexual orientation, or sex (including gender identity and gender stereotyping). A compliance coordinator is designated to administer grievance procedures for discrimination complaints.

(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: *Health Care Reform: MassHealth: The Eligibility Process*.

(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 authorized 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 by any individual of their choice and the right to be represented by an appeal representative as defined in 130 CMR 610.004 during the appeal process.

(2) An application for MassHealth may be filed by an authorized representative as described in the definition of authorized representative in 130 CMR 501.001.

(3) An appeal of a MassHealth decision, including one brought on behalf of a deceased person, may be filed by an appeal representative if such appeal representative meets the requirements in 130 CMR 610.016: *Appeal Representative*.

(4) The extent of the authorized representative's and appeal representative's authority to act on behalf of the applicant or member is determined by the applicant or member's delegation of authority, applicable law, or underlying legal document.

(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. The case file may include electronic records used to determine eligibility.

(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 provides free aids and services to applicants and members with a disability or limited English proficiency, such as qualified interpreters and written information in other formats or languages, in accordance with the requirements of federal and state law.

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. The MassHealth agency may request corroborative information necessary to maintain eligibility, including obtaining or maintaining available health insurance. The applicant or member must supply such information within 30 days of the receipt of the agency's request. If the member does not cooperate, MassHealth benefits may be terminated.

(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.

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 agency 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 55 years of age 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), the MassHealth agency 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: *MassHealth Standard*, 505.007: *MassHealth Senior Buy-In and Buy-In*, 519.010: *MassHealth Senior Buy-In*, and 519.011: *MassHealth Buy-In*.

(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.

(4) Effective for dates of death on or after December 31, 2016, MassHealth will offset the estate recovery claim by the total of any premiums paid to the MassHealth agency on behalf of the member when the member was 55 years of age or older.

(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 younger than 21 years old, 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 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 individual 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.

(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

1. 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
2. for any federally recognized tribe not described in 130 CMR 501.013(F)(1)(b)1., 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 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.

(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.

501.015: Reimbursement of Certain Out-of-pocket Medical Expenses

(A) Eligibility Requirements. The following persons shall be entitled to reimbursement for certain medical expenses for which they paid, subject to the provisions of 130 CMR 501.015.

(1) A member who
  (a) applied for SSI;
  (b) was denied SSI benefits by the Social Security Administration; and
  (c) had his or her initial Social Security Administration denial overturned through a reconsideration process, administrative hearing, appeals counsel review, federal court review, or reopening under the Social Security Administration rules on administrative finality.

(2) A member who
  (a) applied for TAFDC or MassHealth;
  (b) was denied TAFDC by the Department of Transitional Assistance, or was denied MassHealth by the MassHealth agency; and
  (c) had his or her initial denial overturned by a subsequent decision by DTA, the MassHealth agency, the fair hearing process, or the judicial review process.

(B) Limitations.

(1) Reimbursement is limited to bills incurred on or after the coverage start date for the applicable coverage type as described in 130 CMR 505.001: *Introduction* through 505.009: *MassHealth Small Business Employee Premium Assistance* , and paid between the date of the erroneous eligibility decision and the date on which the member is notified of MassHealth eligibility. The bill must have been paid by the member, the member's spouse, the parent of a member, or a legal guardian.

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

(C) Verification.

(1) Applicants or members seeking reimbursement must provide MassHealth with
  (a) a bill for medical services that includes
    1. the provider's name;
    2. a description of the services provided; and
    3. the date the service was provided; and
  (b) proof of payment of the bill presented, such as a canceled check or receipt.

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

REGULATORY AUTHORITY

130 CMR 501.000: M.G.L. c. 118E, §§ 7 and 12.