



MassHealth
Eligibility Letter 239
June 29, 2021

TO: MassHealth Staff

FROM: Daniel Tsai, Assistant Secretary for MassHealth

RE: **Revisions to MassHealth Financial Requirements and Financial Eligibility Regulations: Cost Sharing Limits**

MassHealth is amending its regulations at 130 CMR 506.000: *MassHealth: Financial Requirements* and 520.000: *MassHealth: Financial Eligibility*, effective July 1, 2021. Specifically, sections 506.014 through 506.019 and 520.036 through 520.040 have been updated.

These amendments ensure that starting July 1, 2021, a member's cost sharing obligation, including copays and premiums, will not exceed 5% of the member's monthly income per month. MassHealth will replace the current \$250 annual pharmacy copay cap with a member-specific monthly copay cap not to exceed 2% of the member's monthly income per month. Please note that members will be subject to the new copay policy starting July 1, 2021. However, for the duration of the federal COVID-19 public health emergency, MassHealth will also ensure that members will not be charged more than \$250 in total copays annually. Members will be assigned their individual monthly copay cap based on the lowest individual income level within their household. MassHealth will notify members whenever their monthly copay cap changes or whenever they meet their current copay cap. Monthly copay caps will be established in \$10 increments, ranging from \$0 to \$60 per month, depending on income. Member premiums will not exceed 3% of monthly income per month except for those in CommonHealth, for whom there is federal authority to exceed that limit.

The amendments also expand the circumstances in which the agency can allow for a waiver or reduction of premiums as follows. The current regulation allows for a hardship waiver or reduction when a member has "outstanding" or "currently owed" medical or dental expenses totaling more than 7.5% of the family group's income. This revised regulation allows a member to seek a premium hardship waiver or reduction for medical or dental expenses totaling more than 7.5% of the family group's income if the expenses were "paid" within the twelve-month period before the member applied for a premium hardship waiver or reduction.

Additionally, the revised regulations expand the circumstances in which the agency can provide for a waiver or reduction of premiums when a member enrolled in CommonHealth has high premiums that may interfere with their ability to pay for other essential expenses, or when any member faces negative financial consequences due to a natural disaster or public health emergency.

For more information about MassHealth copays, please refer to 130 CMR 506.015 and 130 CMR 520.037 and www.mass.gov/copayment-information-for-members.

These regulations are effective July 1, 2021.

MANUAL UPKEEP

For 130 CMR 506.000

<u>Insert</u>	<u>Remove</u>	<u>Trans. By</u>
506.000	506.000	E.L. 228
506.011 (7 of 7)	506.011 (7 of 7)	E.L. 228
506.012 (1 of 10)	506.012 (1 of 11)	E.L. 228
506.012 (2 of 10)	506.012 (2 of 11)	E.L. 228
506.012 (3 of 10)	506.012 (3 of 11)	E.L. 228
506.012 (4 of 10)	506.012 (4 of 11)	E.L. 228
506.012 (5 of 10)	506.012 (5 of 11)	E.L. 228
506.012 (6 of 10)	506.012 (6 of 11)	E.L. 228
506.012 (7 of 10)	506.012 (7 of 11)	E.L. 228
506.012 (8 of 10)	506.012 (8 of 11)	E.L. 228
506.012 (9 of 10)	506.012 (9 of 11)	E.L. 228
506.012 (10 of 10)	506.012 (10 of 11)	E.L. 228
--	506.012 (11 of 11)	E.L. 228
506.013 (1 of 2)	506.013 (1 of 3)	E.L. 228
506.013 (2 of 2)	506.013 (2 of 3)	E.L. 228
--	506.013 (3 of 3)	E.L. 228
506.014	506.014	E.L. 237
506.015	506.015	E.L. 237
506.016	506.016	E.L. 237
506.018	--	
--	506.019	E.L. 228

For 130 CMR 520.000

<u>Insert</u>	<u>Remove</u>	<u>Trans. By</u>
520.000	520.000	E.L. 213
520.007 (2 of 9)	520.007 (2 of 9)	E.L. 213
520.007 (3 of 9)	520.007 (3 of 9)	E.L. 213
520.007 (4 of 9)	520.007 (4 of 9)	E.L. 213
520.007 (5 of 9)	520.007 (5 of 9)	E.L. 213
520.007 (6 of 9)	520.007 (6 of 9)	E.L. 213
520.007 (7 of 9)	520.007 (7 of 9)	E.L. 213
520.007 (8 of 9)	520.007 (8 of 9)	E.L. 213
520.007 (9 of 9)	520.007 (9 of 9)	E.L. 213
520.008 (1 of 2)	520.008 (1 of 2)	E.L. 213
520.008 (2 of 2)	520.008 (2 of 2)	E.L. 213
520.009 (1 of 3)	520.009 (1 of 3)	E.L. 213
520.009 (3 of 3)	520.009 (3 of 3)	E.L. 236
520.010	520.010	E.L. 236
520.011	520.012	E.L. 213
520.014	520.014	E.L. 213
520.016 (1 of 2)	520.016 (1 of 2)	E.L. 213
520.016 (2 of 2)	520.016 (2 of 2)	E.L. 213
520.017 (1 of 2)	520.017 (1 of 2)	E.L. 213
520.017 (2 of 2)	520.017 (2 of 2)	E.L. 213
520.018	520.018	E.L. 213
520.019 (3 of 8)	520.019 (3 of 8)	E.L. 213
520.019 (4 of 8)	520.019 (4 of 8)	E.L. 213
520.019 (5 of 8)	520.019 (5 of 8)	E.L. 213
520.019 (6 of 8)	520.019 (6 of 8)	E.L. 213
520.019 (7 of 8)	520.019 (7 of 8)	E.L. 213
520.023 (1 of 2)	520.023 (1 of 2)	E.L. 213
520.023 (2 of 2)	520.023 (2 of 2)	E.L. 213
520.024	520.024	E.L. 213
520.025	520.025	E.L. 213
520.026 (1 of 4)	520.026 (1 of 4)	E.L. 213
520.026 (2 of 4)	520.026 (2 of 4)	E.L. 213
520.026 (3 of 4)	520.026 (3 of 4)	E.L. 213
520.026 (4 of 4)	520.026 (4 of 4)	E.L. 213
520.027	520.027	E.L. 213
520.028	520.028	E.L. 213
520.034	520.034	E.L. 237
520.037	520.037	E.L. 237
520.038	520.038	E.L. 237

Trans. by E.L. 239
Rev. 07/01/21

MASSHEALTH: FINANCIAL REQUIREMENTS

Chapter 506
Page 506.000

TABLE OF CONTENTS

Section

- 506.001: Introduction
- 506.002: Household Composition
- 506.003: Countable Household Income
- 506.004: Noncountable Household Income
- 506.005: Verification of Income
- 506.006: Transfer of Income
- 506.007: Calculation of Financial Eligibility
- 506.008: Cost-of-living Adjustment (COLA) Protections
- 506.009: The One-time Deductible
- 506.010: Verification of Medical and Remedial-care Expenses
- 506.011: MassHealth Premiums and the Children's Medical Security Plan (CMSP) Premiums
- 506.012: Premium Assistance Payments
- 506.013: MassHealth Small Business Employee (SBE) Premium Assistance Program
- 506.014: Copayments Required by MassHealth
- 506.015: Copayment and Cost Sharing Requirement Exclusions
- 506.016: Services Subject to Copayments
- 506.017: Members Unable to Pay Copayment
- 506.018: Maximum Cost Sharing

MASSHEALTH: FINANCIAL REQUIREMENTS

(G) Waiver or Reduction of Premiums for Undue Financial Hardship.

(1) Undue financial hardship means that the member has shown to the satisfaction of the MassHealth agency that at the time the premium was or will be charged, or when the individual is seeking to reactivate benefits, the member:

(a) is homeless, or is more than 30 days in arrears in rent or mortgage payments, or has received a current eviction or foreclosure notice;

(b) has a current shut-off notice, or has been shut off, or has a current refusal to deliver essential utilities (gas, electric, oil, water, or telephone);

(c) has medical and/or dental expenses, totaling more than 7.5% of the family group's gross annual income, that are not subject to payment by the Health Safety Net, and have not been paid by a third-party insurance, including MassHealth (in this case "medical and dental expenses" means any outstanding medical or dental services debt that is currently owed by the family group or any medical or dental expenses paid by the family group within the 12 months prior to the date of application for a waiver, regardless of the date of service);

(d) has experienced a significant, unavoidable increase in essential expenses within the last six months;

(e) (1) is a CommonHealth member who has accessed available third-party insurance or has no third-party insurance, and (2) the total monthly premium charged for CommonHealth will cause extreme financial hardship the family, such that the paying of premiums could cause the family difficulty in paying for housing, food, utilities, transportation, other essential expenses, or would otherwise materially interfere MassHealth's goal of providing affordable health insurance to low-income persons; or

(f) has suffered within the six months prior to the date of application for a waiver, or is likely to suffer in the six months following such date, economic hardship because of a state or federally declared disaster or public health emergency.

(2) If the MassHealth agency determines that the requirement to pay a premium results in undue financial hardship for a member, the MassHealth agency may, in its sole discretion,

(a) waive payment of the premium or reduce the amount of the premiums assessed to a particular family; or

(b) grant a full or partial waiver of a past due balance. Past due balances include all or a portion of a premium accrued before the first day of the month of hardship; or

(c) both 130 CMR 506.011(H)(2)(a) and (b).

(3) Hardship waivers may be authorized for 12 months. At the end of the 12-month period, the member may submit another hardship application.

(a) The 12-month time period begins on the first day of the month in which the hardship application and supporting documentation is received by the MassHealth agency.

(b) The 12-month time period may be retroactive to the first day of the third calendar month before the month of hardship application.

(4) If a hardship waiver is granted and past-due balances are not waived, the MassHealth agency will automatically establish a payment plan for the member for any past-due balances.

(a) The duration of the payment plan will be determined by the MassHealth agency. The minimum monthly payment on the payment plan will be \$5.

(b) The member must make full monthly payments on the payment plan for the hardship waiver to stay in effect. Failure to comply with the established payment plan will terminate the hardship waiver.

Trans. by E.L. 239
Rev. 07/01/21

MASSHEALTH: FINANCIAL REQUIREMENTS

Chapter 506
Page 506.012 (1 of 10)

(H) Voluntary Withdrawal. If a member wishes to voluntarily withdraw from receiving MassHealth coverage, it is the member's responsibility to notify the MassHealth agency of his or her intention by telephone, in writing, or online. Coverage may continue through the end of the calendar month of withdrawal. The member is responsible for the payment of all premiums up to and including the calendar month of withdrawal, unless the request for voluntary withdrawal is made in accordance with 130 CMR 506.011(C)(5).

(I) Change in Premium Calculation. The premium amount is recalculated when the MassHealth agency is informed of changes in the household's MAGI, household composition, or health-insurance status, and whenever an adjustment is made to any of the MassHealth premium formula tables in 130 CMR 506.011(B) or in Federal Poverty Levels.

(J) Members Exempted from Premium Payment. The following members are exempt from premium payments:

- (1) MassHealth members who have verified that they are American Indians or Alaska Natives who have received or are eligible to receive an item or service furnished by the Indian Health Service, an Indian tribe, a tribal organization, or an urban Indian organization, or by a non-Indian health-care provider through referral, in accordance with federal law;
- (2) MassHealth members with MassHealth MAGI household income or MassHealth Disabled Adult household income at or below 150% of the federal poverty level;
- (3) pregnant women and children under age one receiving MassHealth Standard;
- (4) children when a parent or guardian in the PBF is eligible for a Qualified Health Plan (QHP) with Premium Tax Credits (PTC) who has enrolled in and has begun paying for a QHP;
- (5) children for whom child welfare services are made available under Part B of Title IV of the Social Security Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age;
- (6) individuals receiving hospice care;
- (7) independent former foster care children younger than 26 years old; and
- (8) members who have accumulated premium and copayment charges totaling an amount equal to five percent of the member's MAGI income of the MassHealth MAGI household or the MassHealth Disabled Adult household, as applicable, in a given calendar quarter do not have to pay further MassHealth premiums during the quarter in which the member reached the 5% cap.

506.012: Premium Assistance Payments

(A) Coverage Types. Premium assistance payments are available to MassHealth members who are eligible for the following coverage types:

- (1) MassHealth Standard, as described in 130 CMR 505.002: *MassHealth Standard*, with the exception of those individuals described in 130 CMR 505.002(F)(1)(d);
- (2) MassHealth Standard for Kaileigh Mulligan, as described in 130 CMR 519.007: *Individuals Who Would Be Institutionalized*;
- (3) MassHealth CommonHealth, as described in 130 CMR 505.004: *MassHealth CommonHealth*;
- (4) MassHealth CarePlus, as described in 130 CMR 505.008: *MassHealth CarePlus*;

Trans. by E.L. 239
Rev. 07/01/21

MASSHEALTH: FINANCIAL REQUIREMENTS

Chapter 506
Page 506.012 (2 of 10)

(5) MassHealth Family Assistance for HIV-positive adults and HIV-positive young adults, as described in 130 CMR 505.005(E): *Eligibility Requirements for HIV-Positive Individuals Who Are Citizens or Qualified Noncitizens with Modified Adjusted Gross Income of the MassHealth MAGI Household Greater than 133 and Less than or Equal to 200% of the Federal Poverty Level*;

(6) MassHealth Family Assistance for disabled adults whose Disabled Adult MassHealth household income is at or below 100% of the FPL and who are qualified noncitizens barred, nonqualified individuals lawfully present, and nonqualified PRUCOLs, as described in 130 CMR 505.005(C): *Eligibility Requirements for Children and Young Adults Who Are Nonqualified PRUCOLs with Modified Adjusted Gross Income of the MassHealth MAGI Household at or below 150% of the Federal Poverty Level*;

(7) MassHealth Family Assistance for children younger than 19 years old and young adults 19 and 20 years of age whose household MAGI is at or below 150% of the FPL and who are nonqualified PRUCOLs, as described in 130 CMR 505.005(C): *Eligibility Requirements for Children and Young Adults Who Are Nonqualified PRUCOLs with Modified Adjusted Gross Income of the MassHealth MAGI Household at or below 150% of the Federal Poverty Level*;

(8) MassHealth Family Assistance for children younger than 19 years old whose household MAGI is between 150% and 300% of the FPL and who are citizens, protected noncitizens, qualified noncitizens barred, nonqualified individuals lawfully present, and nonqualified PRUCOLs, as described in 130 CMR 505.005(C): *Eligibility Requirements for Children and Young Adults Who Are Nonqualified PRUCOLs with Modified Adjusted Gross Income of the MassHealth MAGI Household at or below 150% of the Federal Poverty Level*; and

(9) MassHealth Small Business Employee Premium Assistance Program, the rules and requirements of which are described at 130 CMR 506.013.

(B) Criteria. MassHealth may provide a premium assistance payment to an eligible member when all of the following criteria are met.

(1) The health insurance coverage meets the Basic Benefit Level (BBL) as defined in 130 CMR 501.001: *Definition of Terms*. Instruments including but not limited to Health Reimbursement Arrangements, Flexible Spending Arrangements, as described in IRS Pub. 969, or Health Savings Accounts, as described at IRC § 223(c)(2), cannot be used to reduce the health insurance deductible in order to meet the basic-benefit level requirement.

(2) The health insurance policy holder is either

(a) in the PBFG; or

(b) resides with the individual who is eligible for the premium assistance benefit and is related to the individual by blood, adoption, or marriage.

(3) At least one person covered by the health-insurance policy is eligible for MassHealth benefits as described in 130 CMR 506.012(A) and the health-insurance policy is a policy that meets the criteria of the MassHealth coverage type for premium assistance benefits as described in 130 CMR 506.012(C).

(C) Eligibility. Eligibility for MassHealth premium assistance is determined by the individual's coverage type and the type of private health insurance the individual has or has access to. MassHealth has three categories of health insurance for which it may provide premium assistance.

(1) Employer-Sponsored Insurance (ESI) 50% Plans are employer-sponsored health-insurance plans to which the employer contributes at least 50% towards the monthly premium amount. MassHealth provides premium assistance for individuals with ESI 50% Plans who are eligible for MassHealth coverage types as described in 130 CMR 506.012(A).

Trans. by E.L. 239
Rev. 07/01/21

MASSHEALTH: FINANCIAL REQUIREMENTS

Chapter 506
Page 506.012 (3 of 10)

(2) Other Group Insurance Plans are employer-sponsored health-insurance plans to which the employer contributes less than 50% towards the monthly premium amount, Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, and other group health insurance. MassHealth provides premium assistance for individuals with Other Group Health Insurance Plans who are eligible for MassHealth coverage types as described in 130 CMR 506.012(A), except for individuals described in 130 CMR 506.012(A)(8).

(3) Non-group unsubsidized Health Connector individual plans for children only, provided that such plans shall no longer be eligible for premium assistance as of January 1, 2019, and the last premium assistance payment for these plans shall be for coverage through December 31, 2018.

(4) Members enrolled in any of the following types of health-insurance coverage are not eligible for premium assistance payments from MassHealth:

- (a) Medicare supplemental coverage, including Medigap and Medex coverage;
- (b) Medicare Advantage coverage;
- (c) Medicare Part D coverage; and
- (d) Qualified Health Plans (QHP).

(5) The following MassHealth members are not eligible for premium assistance payments as described in 130 CMR 506.012(C) from MassHealth:

- (a) MassHealth members who have Medicare coverage. However, for those members who meet the eligibility requirements set forth in 130 CMR 505.002(O), Medicare buy-in benefits may be available;
- (b) all nondisabled nonqualified PRUCOL adults, as described in 130 CMR 505.005(D): *Eligibility Requirements for Adults and Young Adults 19 and 20 Years of Age Who Are Nonqualified PRUCOLs with Modified Adjusted Gross Income of the MassHealth MAGI Household at or below 300% of the Federal Poverty Level*; and
- (c) disabled nonqualified PRUCOL adults with MassHealth Disabled Adult household income above 100% of the FPL, as described in 130 CMR 505.005(F): *Eligibility Requirements for Disabled Adults Who Are Qualified Noncitizens Barred, Nonqualified Individuals Lawfully Present, and Nonqualified PRUCOLs with Modified Adjusted Gross Income of the MassHealth Disabled Adult Household at or below 100% of the Federal Poverty Level*.

(D) Required Member Contribution. The calculation of the MassHealth required member contribution is as follows.

(1) MassHealth may require that a member contribute towards the cost of their health-insurance coverage. MassHealth refers to this amount as the MassHealth required member contribution. The MassHealth required member contribution is based on MassHealth MAGI household income and size and/or the MassHealth Disabled Adult household income and size, as described in 130 CMR 506.002 and 506.003, as it relates to federal poverty guidelines and PBFG rules described at 130 CMR 506.011(A).

Trans. by E.L. 239
Rev. 07/01/21

MASSHEALTH: FINANCIAL REQUIREMENTS

Chapter 506
Page 506.012 (4 of 10)

- (2) The following members are responsible for a required member contribution.
- (a) MassHealth CommonHealth premium-assistance eligible members who have MassHealth MAGI household income or MassHealth Disabled Adult household income greater than 150% of the FPL have the following required member contribution amounts.
1. The required member contribution formula for children younger than 19 years old with household MAGI between 150 and 300% of the FPL is provided as follows.

CommonHealth Required Member Contribution Formula Children between 150% and 300% FPL	
<i>% of Federal Poverty Level (FPL)</i>	Estimated Member Share
Above 150% to 200%	\$12 per child (\$36 per PBFG maximum)
Above 200% to 250%	\$20 per child (\$60 per PBFG maximum)
Above 250% to 300%	\$28 per child (\$84 per PBFG maximum)

2. The required member contribution for adults with household MAGI above 150% of the FPL and children with household MAGI above 300% of the FPL is provided as follows.

CommonHealth Required Member Formula Adults above 150% FPL and Children above 300% FPL		
<i>Base Premium</i>	Additional Premium Cost	Range of Premium Cost
Above 150% FPL— start at \$15	Add \$5 for each additional 10% FPL until 200% FPL	\$15 — \$35
Above 200% FPL— start at \$40	Add \$8 for each additional 10% FPL until 400% FPL	\$40 — \$192
Above 400% FPL— start at \$202	Add \$10 for each additional 10% FPL until 600% FPL	\$202 — \$392
Above 600% FPL— start at \$404	Add \$12 for each additional 10% FPL until 800% FPL	\$404 — \$632
Above 800% FPL— start at \$646	Add \$14 for each additional 10% FPL until 1000%	\$646 — \$912
Above 1000% FPL— start at \$928	Add \$16 for each additional 10% FPL	\$928 + greater

3. CommonHealth members who are eligible to receive a premium assistance payment as described in 130 CMR 506.012 that is less than the CommonHealth required member contribution receive their premium assistance payment as an offset to the CommonHealth monthly premium bill and are responsible for the difference.

Trans. by E.L. 239
Rev. 07/01/21

MASSHEALTH: FINANCIAL REQUIREMENTS

Chapter 506
Page 506.012 (5 of 10)

(b) The required member contribution formula for MassHealth Family Assistance premium assistance eligible children, as described in 130 CMR 505.005 (B): *Eligibility Requirements for Children with Modified Adjusted Gross Income of the MassHealth MAGI Household Greater than 150% and Less than or Equal to 300% of the Federal Poverty Level*, whose household MAGI is between 150% and 300% of the FPL is as follows.

Family Assistance Member Contribution for Children Required Member Contribution Formula	
% of Federal Poverty Level (FPL)	Member Monthly Contribution Amount
Above 150% to 200%	\$12 per child (\$36 PBFM maximum)
Above 200% to 250%	\$20 per child (\$60 PBFM maximum)
Above 250% to 300%	\$28 per child (\$84 PBFM maximum)

(c) The required member contribution formula for MassHealth Family Assistance premium assistance for HIV-positive adults, as described in 130 CMR 505.005(E): *Eligibility Requirements for HIV-Positive Individuals Who Are Citizens or Qualified Noncitizens with Modified Adjusted Gross Income of the MassHealth MAGI Household Greater than 133 and Less than or Equal to 200% of the Federal Poverty Level* is as follows.

Family Assistance for HIV+ Adults Member Contribution Formula	
% of Federal Poverty Level (FPL)	Member Monthly Contribution Amount
Above 150% to 160%	\$15
Above 160% to 170%	\$20
Above 170% to 180%	\$25
Above 180% to 190%	\$30
Above 190% to 200%	\$35

- (3) The following members do not have a required member contribution:
- (a) MassHealth Standard premium assistance eligible members described at 130 CMR 505.002: *MassHealth Standard*;
 - (b) MassHealth CommonHealth premium assistance eligible members, as described in 130 CMR 505.004: *MassHealth CommonHealth*, who have household MAGI at or below 150% of the FPL;
 - (c) MassHealth CarePlus premium assistance eligible members, as described in 130 CMR 505.008: *MassHealth CarePlus*;

Trans. by E.L. 239
Rev. 07/01/21

MASSHEALTH: FINANCIAL REQUIREMENTS

Chapter 506
Page 506.012 (6 of 10)

(d) MassHealth Family Assistance premium assistance eligible members, as described in 130 CMR 505.005(C): *Eligibility Requirements for Children and Young Adults Who Are Nonqualified PRUCOLs with Modified Adjusted Gross Income of the MassHealth MAGI Household at or below 150% of the Federal Poverty Level*, who household MAGI is at or below 150% of the FPL; and

(e) MassHealth members who have verified that they are American Indians or Alaska Natives who have received or are eligible to receive an item or service furnished by the Indian Health Service, an Indian tribe, a tribal organization, or an urban Indian organization, or by a non-Indian health-care provider through referral, in accordance with federal law. These members receive premium assistance payments totaling the full employee share, to the extent that it is cost effective for the MassHealth agency. If it is not cost effective for the MassHealth agency, these members may choose to accept a premium assistance amount that is lower than the full-employee share or they may choose to enroll in direct coverage under MassHealth Family Assistance.

(E) MassHealth Premium Assistance Payment Amount Calculation.

(1) Formulas. MassHealth uses two formulas to calculate the premium assistance payments. The formulas are based on the category of assistance a member is enrolled in. In the event an individual is covered by more than one private health insurance policy, MassHealth will include that individual in the calculation of one premium assistance policy.

(a) The monthly premium assistance formula for ESI 50% Plans is described in 130 CMR 506.012(E)(2).

(b) The monthly premium assistance formula for Other Group Insurance Plans is described in 130 CMR 506.012(E)(3).

(2) MassHealth Premium Assistance Payment Amount Calculation — ESI 50% Plans.

(a) Determination of Actual Premium Assistance Payment Amount. In order to determine the actual premium assistance payment amount, MassHealth must review and compare the estimated premium assistance payment amount and the cost-effective amount. The estimated premium assistance payment amount and cost-effective amount are compared to calculate the actual premium assistance payment amount.

1. Estimated Premium Assistance Premium Payment Amount. The estimated premium assistance payment amount is calculated by subtracting the employer share of the policyholder's health-insurance premium and the MassHealth required member contribution of the health-insurance premium, as described in 130 CMR 506.012(D), from the total cost of the health-insurance premium.

2. Cost-Effective Amount. The ESI 50% Plans cost-effective amount is the MassHealth agency's cost of providing direct MassHealth benefits to the premium billing family group (PBF) who are beneficiaries of the ESI.

MASSHEALTH: FINANCIAL REQUIREMENTS

(b) Comparison of Payment Amounts. MassHealth compares the estimated premium assistance payment amount and cost-effective amount to determine the actual premium assistance payment amount.

1. If the estimated premium assistance payment amount is less than the cost-effective amount, the MassHealth agency sets the actual premium assistance payment amount at the estimated premium assistance payment amount.
2. If the estimated premium assistance payment amount is equal to or greater than the cost-effective amount, the MassHealth agency sets the actual premium assistance payment amount at the cost-effective amount. The policy holder is responsible for payment of the remainder of the health-insurance premium, if any.

(c) Example. A parent and two children apply for MassHealth. The two children are eligible for MassHealth, but the parent is not eligible. Their health insurance is an ESI 50% plan.

1. The total monthly cost of the health-insurance premium = S.
2. The employer's monthly share of the health-insurance premium = T.
3. The MassHealth estimated member share of the monthly health-insurance premium = U.
4. Calculating the estimated premium assistance payment amount:

$$\begin{aligned} S &= (\text{total cost of premium}) \\ - T &= (\text{employer's share of the cost}) \\ \hline V &= (\text{employee's share of the cost}) \\ - U &= (\text{the MassHealth estimated member share of the cost}) \\ \hline W &= (\text{estimated premium assistance payment amount}) \end{aligned}$$

ESI 50% Plans cost-effective amount: W is compared to the MassHealth cost of covering the three individuals (X).

If W is less than X, the MassHealth agency sets the actual premium assistance payment amount at W.

If W is equal to or greater than X, the MassHealth agency sets the actual premium assistance payment amount at X.

(3) MassHealth Premium Assistance Payment Amount Calculation — Other Group Insurance Plans and Individual Student Health Insurance Plans.

(a) Determination of Actual Premium Assistance Payment Amount. In order to determine the actual premium assistance payment amount, MassHealth must review and compare the estimated premium assistance payment amount and the cost-effective amount. The estimated premium assistance payment amount and cost-effective amount are compared to calculate the actual premium assistance payment amount.

1. Estimated Premium Assistance Payment Amount. The estimated premium assistance payment amount is calculated by subtracting both the MassHealth required member contribution, as described in 130 CMR 506.012(D) and any contribution amount from an employer a person covered by this plan is eligible for from the total cost of the health-insurance premium.

Trans. by E.L. 239
Rev. 07/01/21

MASSHEALTH: FINANCIAL REQUIREMENTS

Chapter 506
Page 506.012 (8 of 10)

2. Cost-Effective Amount. The Other Group Insurance Plans cost-effective amount is the MassHealth agency's cost of covering MassHealth-eligible premium billing family group (PBF) members who are beneficiaries of the Other Group Insurance Plan or the Individual Student Health Insurance Plan.
- (b) Comparison of Payment Amounts. MassHealth compares the estimated premium assistance payment amount and cost-effective amount to determine the actual premium assistance payment amount. MassHealth will use a monthly premium cost-equivalent in the calculation for an Individual Student Health Insurance Plan that charges premiums on an annual or semi-annual basis by dividing the premium by the number of months of coverage it provides.
1. If the estimated premium assistance payment amount is less than the cost-effective amount, the MassHealth agency sets the actual premium assistance payment amount at the estimated premium assistance payment amount.
 2. If the estimated premium assistance payment amount is equal to or greater than the cost-effective amount, the MassHealth agency sets the actual premium assistance payment amount at the cost-effective amount. The policy holder is responsible for payment of the remainder of the health-insurance premium, if any.
- (c) Example. A parent and two children apply for MassHealth. The two children are eligible for MassHealth, but the parent is not eligible. Their health insurance falls into Other Group Insurance Plans.
1. The total monthly cost of the health-insurance premium = S.
 2. The monthly contribution amount for an employer that a person covered by this plan is eligible for = T.
 3. The MassHealth required member contribution toward the monthly health-insurance premium = U.
 4. Calculating the estimated premium assistance payment amount:

$$\begin{array}{r} S = (\text{total cost of premium}) \\ - T = (\text{monthly contribution from an employer}) \\ \hline V = (\text{employee's share of the cost}) \\ - U = (\text{the MassHealth estimated member share of the cost}) \\ \hline W = (\text{estimated premium assistance payment amount}) \end{array}$$

Other Group Insurance Plans and Individual Student Health Insurance Plans cost-effective amount: W is compared to the cost of covering only those MassHealth eligible individuals = Z.

If W is less than Z, the MassHealth agency sets the actual premium assistance payment amount at W.

If W is equal to or greater than Z, the MassHealth agency sets the actual premium assistance payment amount at Z.

Trans. by E.L. 239
Rev. 07/01/21

MASSHEALTH: FINANCIAL REQUIREMENTS

Chapter 506
Page 506.012 (9 of 10)

(F) MassHealth Premium Payment Administration.

(1) Premium Assistance Payments.

- (a) The MassHealth agency makes only one premium assistance payment per policy.
- (b) Premium assistance payments are made directly each month to the policyholder with the exception of members receiving premium assistance for Individual Student Health Insurance Plans in accordance with 130 CMR 506.012(G).
- (c) Proof of health insurance premium payments may be required.
- (d) Premium assistance payments begin in the month of the MassHealth Premium Assistance eligibility determination or in the month that health insurance deductions begin, whichever is later.
- (e) Each monthly premium assistance payment is for health insurance coverage in the following month with the exception of members receiving premium assistance for Individual Student Health Insurance Plans in accordance with 130 CMR 506.012(G).
- (f) MassHealth reviews the cost effectiveness of the member's health insurance at least once every 12 months.

(2) Change in Premium Assistance Calculation.

- (a) The premium assistance amount is recalculated when the MassHealth agency is informed of changes in the federal poverty level, health insurance premium, employer contribution, and whenever an adjustment is made in the premium assistance payment formula.
- (b) Members whose premium assistance amount changes as the result of a reported change or any adjustment in the premium assistance payment formula receive the new premium assistance payment beginning with the calendar month following the reported change.

(3) Termination of Premium Assistance Payments.

- (a) If a member's health insurance terminates for any reason, the MassHealth premium assistance payments end.
- (b) If there is a change in the services covered under the policy that affects the Basic Benefit Level (BBL) requirements, the premium assistance payments end.
- (c) Members who become eligible for a different coverage type in which they are not eligible to receive a premium assistance benefit receive their final premium assistance payment in the calendar month in which the coverage type changes.
- (d) If a member voluntarily withdraws his or her MassHealth application for benefits, the MassHealth premium assistance payments end.

(G) Individual Student Health Insurance Plan (SHIP) Premium Assistance.

(1) MassHealth may provide premium assistance to members who have access to a cost-effective SHIP, as described in 956 CMR 8.00: *Student Health Insurance Program*, that is available through a participating school of higher education, and who are eligible for the following MassHealth coverage types:

- (a) MassHealth Standard, as described in 130 CMR 505.002: *MassHealth Standard*, with the exception of those described in 130 CMR 505.002(F)(1)(d) with MassHealth MAGI income over 133% of the federal poverty level (FPL);
- (b) MassHealth CommonHealth as described in 130 CMR 505.004: *MassHealth CommonHealth*;

Trans. by E.L. 239
Rev. 07/01/21

MASSHEALTH: FINANCIAL REQUIREMENTS

Chapter 506
Page 506.012 (10 of 10)

(c) MassHealth CarePlus as described in 130 CMR 505.008: *MassHealth CarePlus*; and
(d) MassHealth Family Assistance as described in 130 CMR 505.005: *MassHealth Family Assistance* with the exception of adults who are nonqualified PRUCOLs as defined at 130 CMR 504.003(C).

(2) Members with access to a cost effective SHIP must obtain and maintain the SHIP as a condition of MassHealth eligibility and cooperate by providing any information necessary to establish and maintain such coverage.

(3) The member must enroll through his or her participating school's SHIP enrollment process on at least an annual basis.

(4) SHIP Premium Assistance will not be provided to individuals who are already enrolled in a private health insurance plan, regardless if MassHealth is providing premium assistance for that plan.

(5) If MassHealth eligibility ends for a member for whom a SHIP premium assistance payment was made during a period for which a school would offer a prorated premium refund as described in 956 CMR 8.04(2)(d), MassHealth may seek such a refund.

(6) Members who are enrolled in SHIP Premium Assistance will be continuously eligible for MassHealth for a period of no longer than 12 months while enrolled in the SHIP plan, until the end of the SHIP policy. MassHealth will redetermine the individual's eligibility upon the completion of the SHIP policy. The individual's MassHealth eligibility will be terminated during the continuous eligibility period if the individual:

(a) cannot be located for a period of longer than one month;

(b) is no longer a Massachusetts resident; or

(c) fails to provide or cooperate in obtaining a social security number, if otherwise required, or provides an incorrect or fraudulent social security number.

(H) SHIP Premium Assistance Payments.

(1) The MassHealth agency makes only one premium assistance payment per policy.

(2) Premium assistance payments are made directly to the school or its designated third-party administrator.

(3) Premium assistance payments are made once annually to cover the cost of the plan year or bi-annually to cover the cost of the plan for the semester, depending on the process of the participating school's SHIP plan.

(4) Any prorated premium refunds, as described in 956 CMR 8.04: *Student Health Insurance Program Requirements*, or requested overpayments shall be reimbursed directly to the MassHealth agency and not to the member for whom MassHealth made the premium assistance payment.

(5) MassHealth reviews the cost effectiveness of the member's health insurance at least once every 12 months.

Trans. by E.L. 239
Rev. 07/01/21

MASSHEALTH: FINANCIAL REQUIREMENTS

Chapter 506
Page 506.013 (1 of 2)

506.013: MassHealth Small Business Employee (SBE) Premium Assistance Program

(A) Introduction. 130 CMR 506.013 describes the rules and requirements for the Small Business Employee (SBE) Premium Assistance Program eligibility and the payment calculation for individuals who are eligible for this program, as described at 130 CMR 505.009: *MassHealth Small Business Employee Premium Assistance*.

(B) Premium Assistance Eligibility Criteria. MassHealth provides a premium assistance payment to eligible individuals as described at 130 CMR 505.009: *MassHealth Small Business Employee Premium Assistance* if such individuals have access to an employer-sponsored health insurance (ESI) that meets all of the following criteria.

(1) The ESI meets the Basic Benefit Level (BBL), as described at 130 CMR 501.001: *Definition of Terms*.

(2) The ESI policy holder is in the premium billing family group (PBFPG).

(3) At least one person covered by the ESI policy is eligible for MassHealth SBE Premium Assistance benefits, as described in 130 CMR 505.009: *MassHealth Small Business Employee Premium Assistance*.

(4) The ESI is from an employer that offers an individual health insurance plan to the employee for which the employee contribution costs more than the Health Connector affordability schedule as defined at 956 CMR 6.05: *Determining Affordability* but less than 9.5% of the MassHealth MAGI income.

(5) The ESI does not cover any individuals who are eligible for or receiving a MassHealth premium assistance payment as described in 130 CMR 506.012.

(6) Effective January 1, 2015, the ESI is a small group health insurance plan purchased by the individual's employer through the Health Connector.

(C) Required Member Contribution. For individuals eligible for the MassHealth SBE Premium Assistance Program, as described in 130 CMR 505.009: *MassHealth Small Business Employee Premium Assistance*, whose household MassHealth MAGI income is between 133% and 300% of the federal poverty level (FPL) the required member contribution can be found at 956 CMR 12.00: *Eligibility, Enrollment and Hearing Process for Connector Care*.

(D) MassHealth SBE Premium Assistance Payment Amount Calculations.

(1) Calculation of Estimated Premium. MassHealth compares the estimated premium assistance payment amount and the maximum premium assistance amount to calculate the actual premium assistance amount.

(a) The estimated premium assistance payment amount is calculated by subtracting the employer share of the policyholder's health-insurance premium and the MassHealth required member contribution of the health-insurance premium, as described in 130 CMR 506.013(C), from the total cost of the health-insurance premium.

(b) The SBE maximum premium assistance amount is \$150 per adult covered by the employer-sponsored plan in the PBFPG and cannot exceed two adults.

Trans. by E.L. 239
Rev. 07/01/21

MASSHEALTH: FINANCIAL REQUIREMENTS

Chapter 506
Page 506.013 (2 of 2)

(2) Comparison of Payment Amounts. MassHealth compares the estimated premium assistance payment amount and the SBE maximum premium assistance amount and uses the following formula to determine the actual premium assistance payment amount.

(a) If the estimated premium assistance payment amount is less than the SBE maximum premium assistance amount, the MassHealth agency sets the actual premium assistance payment amount at the estimated premium assistance payment amount.

(b) If the estimated premium assistance payment amount is equal to or greater than the SBE maximum premium assistance amount, the MassHealth agency sets the actual premium assistance payment amount at the SBE maximum premium assistance amount. The policy holder is responsible for payment of the remainder of the health-insurance premium, if any.

(3) Example. An adult applies for MassHealth and is determined eligible for SBE premium assistance. The adult has access to employer-sponsored insurance (ESI) that meets the requirements set out in 130 CMR 506.013(B). The adult has enrolled in ESI coverage from the employer.

(a) The total monthly cost of the health-insurance premium = S.

(b) The monthly contribution amount for an employer that a person covered by this plan is eligible for = T.

(c) The MassHealth required member contribution toward the monthly health-insurance premium = U.

(d) Calculating the estimated premium assistance payment amount:

$$\begin{aligned} S &= (\text{total cost of premium}) \\ - T &= (\text{employer's share of the cost}) \\ V &= (\text{employee's share of the cost}) \\ - U &= (\text{the MassHealth SBE required member contribution}) \\ \hline W &= (\text{estimated premium assistance payment amount}) \end{aligned}$$

SBE premium assistance maximum contribution amount: X = \$150 times the number of adults covered by the employer-sponsored plan in the PBF, not to exceed two adults.

Actual SBE premium assistance amount: W is compared to X.

If W is less than X, the MassHealth agency sets the actual premium assistance payment amount at W.

If W is equal to or greater than X, the MassHealth agency sets the actual premium assistance payment amount at X.

MASSHEALTH: FINANCIAL REQUIREMENTS

- (E) MassHealth SBE Premium Payment Administration.
- (1) SBE Premium Assistance Payments.
- (a) The MassHealth agency makes only one SBE premium assistance payment per policy.
 - (b) SBE premium assistance payments are made directly each month to the policyholder.
 - (c) Proof of health insurance premium payments may be required.
 - (d) SBE premium assistance payments begin in the month of the MassHealth Premium Assistance eligibility determination or in the month that health insurance deductions begin, whichever is later.
 - (e) Each monthly SBE premium assistance payment is for health-insurance coverage in the following month.
 - (f) MassHealth reviews the SBE maximum contribution amount and the cost of the member's health insurance at least once every 12 months.
- (2) Change in SBE Premium Assistance Calculation.
- (a) The SBE premium assistance amount is recalculated when the MassHealth agency is informed of changes in the federal poverty level, health-insurance premium, employer contribution, and whenever an adjustment is made in the premium assistance payment formula.
 - (b) Members whose SBE premium assistance amount changes as the result of a reported change or any adjustment in the SBE premium assistance payment formula receive the new SBE premium assistance payment beginning with the calendar month following the reported change.
- (3) Termination of Premium Assistance Payments.
- (a) If a member's health insurance terminates for any reason, the MassHealth SBE premium assistance payments end.
 - (b) If there is a change in the services covered under the policy such that the policy no longer meets the BBL requirements, the SBE premium assistance payments end.
 - (c) Members who become eligible for a different coverage type in which they are not eligible to receive an SBE premium assistance benefit receive their final SBE premium assistance payment in the calendar month in which the coverage type changes.
 - (d) If a member voluntarily withdraws his or her MassHealth application for benefits, the MassHealth SBE premium assistance payments end.

506.014: Copayments Required by MassHealth

The MassHealth agency requires its members to make the copayments described in 130 CMR 506.016, up to the maximum described in 130 CMR 506.018, except as excluded in 130 CMR 506.015, and provided that if the payment rate for the service is equal to or less than the copayment amount, the member must pay the payment rate for the service minus one cent.

130 CMR: DIVISION OF MEDICAL ASSISTANCE

Trans. by E.L. 239
Rev. 07/01/21

MASSHEALTH: FINANCIAL REQUIREMENTS

Chapter 506
Page 506.015

506.015: Copayment and Cost Sharing Requirement Exclusions

(A) Excluded Individuals.

(1) The following individuals do not have to pay the copayments described in 130 CMR 506.016:

- (a) members younger than 21 years old;
- (b) members who are pregnant or in the postpartum period that extends through the last day of the second calendar month following the month in which their pregnancy ends (for example, if the woman gave birth May 15th, she is exempt from the copayment requirement until August 1st);
- (c) MassHealth Limited members;
- (d) MassHealth Senior Buy-In members or MassHealth Standard members for drugs covered under Medicare Parts A and B only, when provided by a Medicare-certified provider;
- (e) members who are inpatients in nursing facilities, chronic-disease or rehabilitation hospitals, or intermediate-care facilities for individuals with intellectual disabilities or who are admitted to a hospital from such a facility or hospital;
- (f) members receiving hospice services;
- (g) persons receiving medical services through the Emergency Aid to the Elderly, Disabled and Children Program pursuant to 130 CMR 450.106: *Emergency Aid to the Elderly, Disabled and Children Program*, if they do not receive MassHealth Standard, MassHealth CarePlus, or MassHealth Family Assistance;
- (h) members who are former foster care individuals and who are eligible for MassHealth Standard until they reach the age of 21 or the age of 26, as specified in 130 CMR 505.002(H): *Eligibility Requirements for Former Foster-Care Individuals*;
- (i) members who are American Indians or Alaska Natives who are currently receiving or have ever received an item or service furnished by the Indian Health Service, an Indian tribe, a tribal organization, or an urban Indian organization, or through referral, in accordance with federal law;
- (j) “referred eligible” members, who are:
 1. persons who receive Supplemental Security Income (SSI) benefits from the Social Security Administration (SSA) and who receive MassHealth Standard under 130 CMR 505.002(A)(2) or 130 CMR 519.002(B);
 2. persons who receive Transitional Aid to Families with Dependent Children (TAFDC) cash assistance from the Department of Transitional Assistance (DTA) and who receive MassHealth Standard under 130 CMR 505.002(A)(3);
 3. children, young adults, and parents and caretaker relatives who receive Emergency Aid to the Elderly, Disabled and Children (EAEDC) cash assistance and who receive MassHealth Standard under 130 CMR 505.002(K) or 130 CMR 519.002(D), MassHealth Family Assistance under 130 CMR 505.005(G) or 130 CMR 519.013(C), or MassHealth CarePlus under 130 CMR 505.008(B);
 4. children receiving medical assistance under 130 CMR 522.003: *Adoption Assistance and Foster Care Maintenance*, because they are receiving Title IV-E or state-subsidized adoption or foster-care assistance;

Trans. by E.L. 239
Rev. 07/01/21

MASSHEALTH: FINANCIAL REQUIREMENTS

Chapter 506
Page 506.016

5. persons who receive extended eligibility for MassHealth Standard under 130 CMR 505.002(L)(1) and (2) or 130 CMR 519.002(C); and
 6. persons who receive MassHealth Standard or CarePlus because they are eligible for Refugee Medical Assistance (RMA) under 130 CMR 522.002: *Refugee Resettlement Program*; and
- (k) members whose applicable income for the purposes of calculating copayments is at or below 50% of the FPL.
- (2) Members who are inpatients in a hospital do not have to pay a copayment for pharmacy services provided as part of the hospital stay.
- (3) Members who are inpatients in a hospital do not have to pay a copayment for pharmacy services provided as part of the hospital stay.

(B) Excluded Services. The following services are excluded from the copayment requirement described in 130 CMR 506.016:

- (1) family planning services and supplies such as oral contraceptives, contraceptive devices, such as diaphragms and condoms, and contraceptive jellies, creams, foams, and suppositories;
- (2) detoxification and maintenance treatment of an individual for substance use disorders using FDA approved medications (including methadone, buprenorphine, buprenorphine/naloxone, and naltrexone);
- (3) preventive services assigned a grade of 'A' or 'B' by the United States Preventive Services Task Force (USPSTF), or such broader exclusion as specified by MassHealth;
- (4) all approved vaccines and their administration, recommended by the Advisory Committee on Immunization Practices (ACIP);
- (5) smoking cessation products and drugs;
- (6) emergency services; and
- (7) provider-preventable services as defined in 42 CFR 447.26(b).

506.016: Services Subject to Copayments

MassHealth members are responsible for making the following copayments for pharmacy services unless excluded in 130 CMR 506.015.

(A) \$1 for each prescription and refill for each generic drug and over-the-counter drug covered by the MassHealth agency in the following drug classes: antihyperglycemics, antihypertensives, and antihyperlipidemics; and

(B) \$3.65 for each prescription and refill for all other generic and over-the-counter drugs, and all brand-name drugs covered by the MassHealth agency.

506.017: Members Unable to Pay Copayment

Providers may not refuse services to a member who is unable to pay at the time the service is provided. However, the member remains liable to the provider for the copayment amount.

Trans. by E.L. 239
Rev. 07/01/21

MASSHEALTH: FINANCIAL REQUIREMENTS

Chapter 506
Page 506.018

506.018: Maximum Cost Sharing

(A) Members are responsible for the MassHealth copayments described in 130 CMR 506.016 up to a monthly maximum of 2% of applicable monthly income. Each member's monthly copayment cap will be calculated using 2% of the lowest income in the MassHealth MAGI household or the MassHealth Disabled Adult household, as applicable, and assigning the member a monthly cap of the nearest \$10 increment that corresponds to 2% of the applicable income without exceeding 2%. A further explanation of this calculation is publicly available on MassHealth's website.

(B) Members are responsible for the MassHealth premiums described in 130 CMR 506.012 up to a monthly maximum of 3% of applicable monthly income, except no such limit applies to CommonHealth members. Each member's monthly premium cap will be calculated using 3% of the lowest income in the MassHealth MAGI household or the MassHealth Disabled Adult household, as applicable. A further explanation of this calculation is publicly available on MassHealth's website.

REGULATORY AUTHORITY

130 CMR 506.000: M.G.L. c. 118E, §§ 7 and 12.

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

**Chapter 520
Page 520.000**

TABLE OF CONTENTS

Section

520.001:	Introduction to General Financial Requirements
520.002:	Financial Responsibility
520.003:	Asset Limit
520.004:	Asset Reduction
520.005:	Ownership of Assets
520.006:	Inaccessible Assets
520.007:	Countable Assets
520.008:	Noncountable Assets
520.009:	Countable-income Amount
520.010:	Business Expenses
520.011:	Standard Income Deductions
520.012:	Community Earned-income Deductions
520.013:	Community Unearned-income Deductions
520.014:	Long-term-care Earned-income Deductions
520.015:	Noncountable Income
520.016:	Long-term Care: Treatment of Assets
520.017:	Right to Appeal the Asset Allowance or Minimum-monthly-maintenance-needs Allowance
520.018:	Transfer of Resources Regardless of Date of Transfer
520.019:	Transfer of Resources Occurring on or after August 11, 1993 (130 CMR 520.020 Reserved)
520.021:	Treatment of Trusts
520.022:	Trusts or Similar Legal Devices Created before August 11, 1993
520.023:	Trusts or Similar Legal Devices Created on or after August 11, 1993
520.024:	General Trust Rules
520.025:	Long-term-care Income Standard
520.026:	Long-term-care General Income Deductions
520.027:	Long-term-care Deductible
520.028:	Eligibility for a Deductible
520.029:	The Deductible Period
520.030:	Calculating the Deductible
520.031:	Notification of Potential Eligibility
520.032:	Submission of Bills to Meet the Deductible
520.033:	Verification of Medical Expenses
520.034:	Interim Changes
520.035:	Conclusion of the Deductible Process
520.036:	Copayments Required by the MassHealth Agency
520.037:	Copayment and Cost Sharing Requirement Exclusions
520.038:	Services Subject to Copayments
520.039:	Members Unable to Pay Copayment
520.040:	Maximum Cost Sharing

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

**Chapter 520
Page 520.007 (2 of 9)**

(c) If during an eligibility review the member states either orally or in writing that an account other than a checking account contains a balance of \$25 or less, the MassHealth agency does not require verification provided that, in combination with other countable assets, it would not affect continued eligibility.

(d) If lack of either access to or ownership of funds in an account is verified, the MassHealth agency will not consider the funds a countable asset.

(C) Individual Retirement Accounts, Keogh Plans, and Pension Funds.

(1) Individual Retirement Accounts. An Individual Retirement Account (IRA) is a tax-deductible savings account that sets aside money for retirement. Funds in an IRA are counted as an asset in their entirety less the amount of penalty for early withdrawal.

(2) Keogh Plans. A Keogh Plan is a retirement plan established by a self-employed individual. A Keogh Plan may be established for the self-employed individual alone or for the self-employed individual and his or her employees. If the Keogh Plan was established for the self-employed individual alone, the funds in the Plan are counted as an asset in their entirety less the amount of penalty for early withdrawal. If the Keogh Plan was established for employees other than the spouse of the applicant or member, the MassHealth agency does not count the funds as an asset.

(3) Pension Funds. A pension fund is a retirement plan established by an employer to provide benefit payments to employees upon retirement or disability. Pension funds that are being set aside by an individual's current employer are not countable as an asset. Pension funds from an individual's former employer are countable in their entirety less any penalties for withdrawal provided such funds are accessible. (See 130 CMR 520.006.)

(D) Securities. Securities include, but are not limited to, stocks, bonds, options, futures contracts, debentures, mutual funds including money-market mutual funds, and other financial instruments. Tradable securities are valued at the most recent closing-bid price, and nontradable securities are valued at current equity value. A security for which there is no market value or that is inaccessible in accordance with 130 CMR 520.006 is noncountable.

(E) Cash-surrender Value of Life-insurance Policies.

(1) The cash-surrender value of a life-insurance policy is the amount of money, if any, that the issuing company has agreed to pay the owner of the policy upon its cancellation. An individual may adjust the cash-surrender value of life insurance to meet the asset limit. The MassHealth agency will consider the cash-surrender-value amount an inaccessible asset during the adjustment period.

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

**Chapter 520
Page 520.007 (3 of 9)**

(2) If the total face value of all countable life-insurance policies owned by the applicant, member, or spouse exceeds \$1,500, the total cash-surrender value of all policies held by that individual is countable. The MassHealth agency does not count the face value of burial insurance and the face value of life-insurance policies not having cash-surrender value (for instance, term insurance) in determining the total face value of life-insurance policies. Burial insurance is insurance whose terms specifically provide that the proceeds can be used only to pay the burial expenses, funeral expenses, or both of the insured.

(F) Vehicles as Countable Assets.

(1) Requirements. In determining the assets of an individual (and the spouse, if any), the countability of a vehicle is determined as follows.

(a) One vehicle per household is noncountable regardless of its value if it is for the use of the eligible individual or couple or a member of the eligible individual's or couple's household.

(b) The equity value of all other vehicles is a countable asset.

(2) Exemption.

(a) Three-month Exemption. The MassHealth agency does not count the value of nonexempt vehicles exceeding the asset limit for three calendar months provided the applicant or member signs an agreement with the MassHealth agency to dispose of the vehicles at fair-market value.

(b) Additional Exemption for Good Cause. The MassHealth agency may grant an additional three-month extension if the disposition was prevented by an event beyond the control of the individual who was making a good-faith effort to dispose of the property during the initial three-month period.

(c) Proceeds. The proceeds from the sale of the vehicle after payment of loans or other encumbrances and expenses of sale such as taxes, fees, and advertising costs are a countable asset in the month received and in subsequent months. The equity value of a vehicle that has not been sold three calendar months after the date of the written agreement (or six calendar months after the date of the written agreement if an extension has been granted) is a countable asset.

(d) Equity Value. Equity value is determined by subtracting the balance of any loans, liens, encumbrances, and expenses of sale, such as taxes, fees, and advertising costs, from the fair-market value of the vehicle.

(e) Fair-market Value. Fair-market value is the price for which the vehicle will sell on the open market.

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

**Chapter 520
Page 520.007 (4 of 9)**

(f) Verification. The applicant or member must verify the fair-market value and equity value of all vehicles. Verification must be a written document providing reasonable evidence of value. Acceptable verification includes, but is not limited to, the following:

1. the wholesale value (for cars and trucks) and finance value (for recreational vehicles) tables in the most recent vehicle valuation book that is used by the MassHealth agency;
2. the low value in an older car valuation book (for cars and trucks). If the car or truck is too old to be listed in an older car valuation book, the MassHealth agency will assign a value of \$250;
3. the written appraisal of a licensed automobile dealer who deals with classic, custom-made, or antique vehicles, if the vehicle is considered a classic, custom-made, or antique; or
4. for recreational vehicles, the projected loan value as quoted by a bank or other lending institution; documents showing the value of the vehicle for insurance purposes; or a written estimate of the cash value of the vehicle from a licensed recreational vehicle dealer.

(g) Specially Equipped Vehicles. Special equipment for the handicapped, other optional equipment, or low mileage do not increase the value of the vehicle.

(G) Real Estate.

(1) Real Estate As a Countable Asset. All real estate owned by the individual and the spouse, with the exception of the principal place of residence as described in 130 CMR 520.008(A), is a countable asset. The principal place of residence is subject to allowable limits as described in 130 CMR 520.007(G)(3). Business or nonbusiness property as described in 130 CMR 520.008(D) is a noncountable asset.

(2) Nine-month Exemption. The value of such real estate is exempt for nine calendar months after the date of notice by the MassHealth agency, provided that the individual signs an agreement with the MassHealth agency within 30 days after the date of notice to dispose of the property at fair-market value. The MassHealth agency will extend the nine-month period as long as the individual or the spouse continues to make a good-faith effort to sell, as verified in accordance with 130 CMR 520.007(G)(4).

(3) Fair-market Value and Equity Value. The fair-market value and equity value of all countable real estate owned by the individual and the spouse must be verified at the time of application and when it affects or may affect eligibility. For applications received on or after January 1, 2006, equity interest in the principal place of residence exceeding \$750,000 renders an individual ineligible for payment of nursing facility and other long-term-care services, unless the spouse of such individual or the individual's child who is younger than 21 years old or who is blind or permanently and totally disabled resides in the individual's home. The allowable equity interest amount will be adjusted annually, beginning in January 2011. The adjustment will be based year-to-year on the percentage increase in the Consumer Price Index.

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

Chapter 520
Page 520.007 (5 of 9)

(a) The applicant or member must verify the fair-market value by 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:

1. a special purpose assessment;
2. based on a fixed-rate-per-acre method; or
3. based on an assessment ration or providing only a range.

(b) In the event that a current property-tax assessment is not available or the applicant or member wishes to rebut the fair-market value determined by the MassHealth agency, a comparable market analysis or a written appraisal of the value of the property from a knowledgeable source will establish the fair-market value. A knowledgeable source is a licensed real-estate agent or broker, a real-estate appraiser, an official of a bank, a savings-and-loan association, or a similar lending organization, or an official of the local real-estate tax jurisdiction.

(c) A copy of the loan instruments or other binding documents that show evidence of the payment schedule and the outstanding balance of the loan will verify the equity value of the property.

(d) The MassHealth agency may waive the period of ineligibility due to excess equity value in real estate if the individual meets the conditions described at 130 CMR 520.007(G)(13).

(4) Good-faith Effort to Sell Real Estate. The individual or the spouse must verify his or her good-faith effort to dispose of countable real estate by evidence such as advertisements or documentation of the listing of the real estate with licensed real-estate agents or brokers, including a report of any offer from prospective buyers. The MassHealth agency will terminate eligibility if, at any time, the individual rejects a reasonable offer to buy the real estate. An offer to buy real estate is considered reasonable if it is at least two-thirds of the fair-market value, unless the individual proves otherwise to the MassHealth agency's satisfaction.

(5) Proceeds from the Sale of Real Estate. The proceeds from the sale of the real estate, after the payment of loans, liens, or other encumbrances, and expenses of sale such as taxes, fees, and advertising costs, are a countable asset in the month received and in subsequent months.

(6) Right to Recovery. If a member fails to report the acquisition of real estate within 10 days after taking title to the real estate and the equity value of the real estate, when added to all other countable assets, exceeds the MassHealth asset standard, the MassHealth agency has the right to recover overpayment in accordance with 130 CMR 515.010: *Recovery of Overpayment of Medical Benefits* and to initiate any and all other legal remedies available.

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

**Chapter 520
Page 520.007 (6 of 9)**

(7) Former Home of a Community-based Individual. If an applicant or member (or spouse, if any) moves out of his or her home for reasons other than institutionalization without the intent to return, the home, whether or not held in trust, becomes a countable asset because it is no longer used as the individual's principal place of residence. The former home is subject to the requirements described in 130 CMR 520.007(G)(2).

(8) Former Home of an Institutionalized Individual. If an applicant or member moves out of his or her home to enter a medical institution, the MassHealth agency considers the former home a countable asset that is subject to 130 CMR 520.007(G)(2), provided all of the following conditions are met. If the former home of a nursing-facility resident as defined in 130 CMR 515.001: *Definition of Terms* is placed in a trust, the MassHealth agency will apply the trust rules in accordance with 130 CMR 520.021 through 520.024.

(a) The individual is institutionalized as defined in 130 CMR 515.001: *Definition of Terms*.

(b) None of the following relatives of the individual is living in the property:

1. a spouse;
2. a child who is younger than 21 years old or who is blind or permanently and totally disabled;
3. a sibling who has a legal interest in the home and who was living there for a period of at least one year immediately before the applicant's or member's admission to the medical institution;
4. a son or daughter who was living in the applicant's or member's home for a period of at least two years immediately before the date of the applicant's or member's admission to the medical institution, and who establishes to the satisfaction of the MassHealth agency that he or she provided care to the applicant or member that permitted him or her to live in the home rather than in a medical institution; or
5. a dependent relative. A dependent relative is any of the following who has any kind of medical, financial, or other dependency: a child, stepchild, or grandchild; a parent, stepparent, or grandparent; an aunt, uncle, niece, or nephew; a brother, sister, stepbrother, or stepsister; a half brother or half sister; a cousin; or an in-law.

(c) The applicant or member (and spouse, if any) moves out of his or her home without the intent to return.

(d) The applicant or member does not own long-term-care insurance with coverage that meets the requirements of 130 CMR 515.014: *Long-term-care Insurance Minimum Coverage Requirements for MassHealth Exemptions* and the Division of Insurance regulations at 211 CMR 65.09(1)(e)(2).

**MASSHEALTH
FINANCIAL ELIGIBILITY**

- (9) Verification of Dependency and Residence of Relative Living in the Former Home.
- (a) Relationship. The institutionalized individual must verify his or her relationship to the relative living in the former home by birth certificates, marriage licenses, or any other documents necessary to establish the relationship.
- (b) Dependency. The institutionalized individual must verify the relative's dependency on the institutionalized individual by a signed statement from the relative attesting to the existence and duration of the dependency. The MassHealth agency may require additional evidence if the relative's claim of dependency is questionable or self-contradictory.
- (c) Residence. The institutionalized individual must verify the relative's residence in his or her former home only if there is conflicting or contradictory evidence regarding the relative's residence.
- (10) Option to Liquidate to Pay for Medical Care. Instead of selling the countable former home, the individual may liquidate its equity value to pay for his or her medical care. If the individual chooses this option, the home will be noncountable until the equity value is liquidated, but not longer than nine calendar months after the date of the MassHealth agency's notice.
- (11) Undue Hardship: Jointly Owned Assets.
- (a) The MassHealth agency will continue to exclude otherwise countable property, including a former home, when it is jointly owned and the sale of the property by an individual would cause the other owners to lose housing.
- (b) Loss of housing would result when the property serves as the principal place of residence for one (or more) of the other owners, and sale of the property would result in loss of that residence, and no other housing would be readily available for the displaced other owner. If undue hardship as defined in 130 CMR 520.007(G)(11) ceases to exist, the property becomes a countable asset.
- (12) Lien. The MassHealth agency will place a lien before the death of a member against any real estate in which the member has a legal interest. This lien will be placed only if all of the conditions of 130 CMR 515.012: *Real Estate Liens* are met.
- (13) Waiver of the Period of Ineligibility Due to Excess Equity Value in the Principal Place of Residence Causing Undue Hardship.
- (a) The MassHealth agency may waive the denial of payment of long-term-care services for excess equity value in the principal place of residence if ineligibility would cause the individual undue hardship when the following conditions exist:
1. the denial of long-term-care services would deprive the nursing-facility resident of medical care such that his or her health or life would be endangered, or the nursing-facility resident would be deprived of food, shelter, clothing, or other necessities such that he or she would be at risk of serious deprivation; and
 2. the institution has notified the nursing-facility resident of its intent to initiate discharge the resident because the resident has not paid for his or her institutionalization; and
 3. there is no less costly noninstitutional alternative available to meet the nursing-facility resident's needs.

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

**Chapter 520
Page 520.007 (8 of 9)**

(b) Undue hardship does not exist when imposition of the period of ineligibility would merely inconvenience or restrict the nursing-facility resident without putting the nursing-facility resident at risk of serious deprivation.

(c) Where the MassHealth agency has issued a denial notice based on the equity value in the principal place of residence, the individual may request a hardship waiver.

1. The individual must submit a written request for consideration of undue hardship and supporting documentation to the MassHealth Enrollment Center listed on the notice of denial within 15 days after the date on the notice.

2. Within 30 days after the date of the request, the MassHealth agency informs the individual in writing of the decision and of the right to a fair hearing. The MassHealth agency extends this 30-day period if the MassHealth agency requests additional documentation or if extenuating circumstances, as determined by the MassHealth agency, require additional time.

(d) The nursing-facility resident may appeal the MassHealth agency undue-hardship decision and denial of payment of long-term-care services by submitting a request for a fair hearing to the Office of Medicaid Board of Hearings within 30 days after the receipt of the MassHealth agency written undue-hardship notice, in accordance with 130 CMR 610.000: *MassHealth: Fair Hearing Rules*. If the denial occurs pursuant to 130 CMR 520.007(G)(13)(c)1., the nursing-facility resident may instead appeal the denial of eligibility for long-term-care services by submitting a request for a fair hearing to the Office of Medicaid Board of Hearings, in accordance with 130 CMR 610.000: *MassHealth: Fair Hearing Rules*, while the resident also submits a written request for consideration of undue hardship. If the request for the hardship waiver is later denied, the nursing-facility resident may appeal the MassHealth agency's undue hardship decision by submitting a request for a fair hearing to the Office of Medicaid Board of Hearings within 30 days after the receipt of the MassHealth agency written undue hardship decision notice, in accordance with 130 CMR 610.000: *MassHealth: Fair Hearing Rules*.

(H) Retroactive SSI and RSDI Benefit Payments.

(1) Requirements. Retroactive SSI and RSDI benefit payments are noncountable in the month of receipt and for six months after the month of receipt. Such payments must be readily identifiable as retroactive SSI or RSDI payments, and should be deposited in a separately identifiable account. If commingled with other funds, and not separately identifiable according to the MassHealth agency, the MassHealth agency considers the total amount on deposit a countable asset. Any amount of the benefit payment still retained on the first day following the excluded periods described in 130 CMR 520.007(H)(1) is a countable asset.

(2) Verification. The applicant or member must verify the amount of the benefit and the date of receipt. The preferred source of verification is the notification letter from the Social Security Administration. The amount on deposit may be verified by a bank book or bank statement that shows that the benefit payment is not commingled with other funds.

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

Chapter 520
Page 520.007 (9 of 9)

(I) Trusts. The MassHealth agency counts the value of the principal and income of a revocable or irrevocable trust in accordance with 130 CMR 520.021 through 520.024.

(J) Annuities, Promissory Notes, Loans, Mortgages, and Similar Transactions.

(1) Treatment of Annuities Established Before February 8, 2006. Payments from an annuity are countable income in accordance with 130 CMR 520.009. If the annuity can be converted to a lump sum, the lump sum, less any penalties or costs of converting to a lump sum, is a countable asset. Purchase of an annuity is a disqualifying transfer of assets for nursing-facility residents as defined at 130 CMR 515.001: *Definition of Terms* in the following situations:

- (a) when the beneficiary is other than the applicant, member, or spouse;
- (b) when the beneficiary is the applicant, member, or spouse and when the total present value of projected payments from the annuity is less than the value of the transferred asset (purchase price). In this case, the MassHealth agency determines the amount of the disqualifying transfer based on the actuarial value of the annuity compared to the beneficiary's life expectancy using the life-expectancy tables as determined by the MassHealth agency, giving due weight to the life-expectancy tables of institutions in the business of providing annuities;
- (c) when the terms of the annuity postpone payment beyond 60 days, the MassHealth agency will treat the annuity as a disqualifying transfer of assets until the payment start date; or
- (d) when the terms of the annuity provide for unequal payments, the MassHealth agency may treat the annuity as a disqualifying transfer of assets. Commercial annuity payments that vary solely as a result of a variable rate of interest are not considered unequal payments under 130 CMR 520.007(J)(1)(d).

(2) Treatment of Annuities Established on or after February 8, 2006. In addition to the requirements in 130 CMR 520.007(J)(1), the following conditions must be met.

- (a) The purchase of an annuity will be considered a disqualifying transfer of assets unless
 1. the Commonwealth of Massachusetts is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual;
 2. the Commonwealth of Massachusetts is named as such a remainder beneficiary in the second position after the community spouse, or minor or disabled children; or
 3. the Commonwealth of Massachusetts is named as such a remainder beneficiary in the first position if the community spouse or the representative of any minor or disabled children in 130 CMR 520.007(J)(2)(a)2. disposes of any such remainder for less than fair-market value.
- (b) The purchase of an annuity is considered a disqualifying transfer of assets unless the annuity satisfies 130 CMR 520.007(J)(1) and (J)(2)(a) and is irrevocable and nonassignable, or unless the annuity satisfies 130 CMR 520.007(J)(2)(c).

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

**Chapter 520
Page 520.008 (1 of 2)**

(c) The purchase of an annuity is considered a disqualifying transfer of assets unless the annuity satisfies 130 CMR 520.007(J)(2)(b), or unless the annuity names the Commonwealth of Massachusetts as a beneficiary as required under 130 CMR 520.007(J)(2)(a) and the annuity is

1. described in section 408(b) or (q) of the Internal Revenue Code of 1986;
2. purchased with the proceeds from an account or trust described in section 408(a), (c), or (p) of the Internal Revenue Code of 1986;
3. purchased with the proceeds from a simplified employee pension described in section 408(k) of the Internal Revenue Code of 1986; or
4. purchased with the proceeds from a Roth IRA described in section 408A of the Internal Revenue Code of 1986.

(3) Promissory Notes, Loans, or Mortgages. The value of any outstanding balance due on a promissory note, loan, or mortgage is considered a disqualifying transfer of assets, unless all of the following conditions are met:

- (a) the repayment terms of the promissory note, loan, or mortgage are actuarially sound, based on actuarial tables as determined by the MassHealth agency;
- (b) the promissory note, loan, or mortgage provides for equal payment amounts during the life of the loan, with no deferral and no balloon payments; and
- (c) the promissory note, loan, or mortgage prohibits cancellation of the balance upon the death of the lender.

(4) Transactions Involving Future Performance. Any transaction that involves a promise to provide future payments or services to an applicant, member, or spouse, including but not limited to transactions purporting to be annuities, promissory notes, contracts, loans, or mortgages, is considered to be a disqualifying transfer of assets to the extent that the transaction does not have an ascertainable fair-market value or if the transaction is not embodied in a valid contract that is legally and reasonably enforceable by the applicant, member, or spouse. This provision applies to all future performance whether or not some payments have been made or services performed.

(5) Additional Regulations About Transfers of Assets. Transfers of assets are further governed by 130 CMR 520.018 and 520.019.

520.008: Noncountable Assets

Noncountable assets are those assets exempt from consideration when determining the value of assets. In addition to the noncountable assets described in 130 CMR 520.006 and 520.007, the following assets are noncountable.

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

**Chapter 520
Page 520.008 (2 of 2)**

(A) The Home. The home of the applicant or member and the spouse and any land appertaining to the home, as determined by the MassHealth agency, if located in Massachusetts and used as the principal place of residence, are considered noncountable assets, except when the equity interest in the home exceeds the amount described in 130 CMR 520.007(G)(3). The home is subject to the lien rules at 130 CMR 515.012: *Real Estate Liens*. If the home is placed in a trust or in an arrangement similar to a trust, the MassHealth agency will apply the trust rules at 130 CMR 520.021 through 520.024.

(B) Assets of an SSI Recipient. The assets of an SSI recipient are exempt from consideration as countable assets.

(C) Proceeds from the Sale of a Home. The proceeds from the sale of a home used by the applicant or member as the principal place of residence, provided the proceeds are used to purchase another home to be used as the principal place of residence, are considered noncountable assets. Such proceeds are exempt from consideration as countable assets for the three calendar months following the month of receipt. The MassHealth agency places a lien before the death of the member against any real estate in which the member has a legal interest in accordance with 130 CMR 515.012: *Real Estate Liens*.

(D) Business and Nonbusiness Property. Business and nonbusiness property essential to self-support and property excluded under an SSA-approved plan for self-support are considered noncountable assets.

(E) Any Loan or Grant. Any loan or grant including, but not limited to, scholarships, the terms of which preclude their use for current maintenance, is considered a noncountable asset.

(F) Funeral or Burial Arrangements.

(1) The following funeral or burial arrangements for the applicant, member, or spouse are considered noncountable assets:

- (a) any burial space, including any burial space for any immediate family member;
- (b) one of the following:
 - 1. a separately identifiable amount not to exceed \$1,500 expressly reserved for funeral and burial expenses; or
 - 2. life-insurance policies designated exclusively for funeral and burial expenses with a total face value not to exceed \$1,500;
- (c) the cash-surrender value of burial insurance; and
- (d) prepaid irrevocable burial contracts or irrevocable trust accounts designated for funeral and burial expense.

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

**Chapter 520
Page 520.009 (1 of 3)**

(2) Appreciated value or interest earned or accrued and left to accumulate on any contracts, accounts, or life insurance is also noncountable. If the applicant, member, or spouse uses any of these assets, including the interest accrued, for other than funeral or burial arrangements of the applicant, member, or spouse, the MassHealth agency considers the asset available and countable under the provisions of 130 CMR 520.007, 520.018, and 520.019.

(3) The applicant, member, or spouse has the right to establish a burial arrangement or change the designation of his or her funds to a burial arrangement described in 130 CMR 520.008(F). If such arrangement is made within 60 days after the date that the applicant or member was notified of his or her right to do so, then the MassHealth agency considers the arrangement to have been in existence on the first day of the third month before the application.

(G) Veterans' Payments. Veterans' payments for aid and attendance, unreimbursed medical expenses, housebound benefits, and enhanced benefits retained after the month of receipt, provided these payments are separately identifiable, are considered noncountable assets. Appreciated value and earned interest are also noncountable.

(H) Special-needs Trust. A special-needs trust in accordance with the trust rules at 130 CMR 520.021 through 520.024 is considered a noncountable asset.

(I) Pooled Trust. A pooled trust in accordance with the trust rules at 130 CMR 520.021 through 520.024 is considered a noncountable asset.

(J) ICF/MR Trust. A trust established before April 7, 1986, solely for the benefit of a resident of an intermediate-care facility for the mentally retarded (ICF/MR) is considered a noncountable asset.

(K) Other Assets. Any other assets considered noncountable for Title XIX eligibility purposes is considered a noncountable asset.

520.009: Countable-income Amount

(A) Overview.

(1) An individual's and the spouse's gross earned and unearned income less certain business expenses and standard income deductions is referred to as the countable-income amount. In determining gross monthly income, the MassHealth agency multiplies the average weekly income by 4.333 unless the income is monthly.

(2) For community residents, the countable-income amount is compared to the applicable income standard to determine the individual's financial eligibility.

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

**Chapter 520
Page 520.009 (3 of 3)**

(3) Verification of Earned Income. The applicant or member must verify gross earned income. However, if he or she is applying solely for MassHealth Senior Buy-In for Qualified Medicare Beneficiaries (QMB) as described in 130 CMR 519.010: *MassHealth Buy-In (for Qualified Medicare Beneficiaries (QMB))* or MassHealth Buy-In for Specified Low Income Medicare Beneficiaries (SLMB), or MassHealth Buy-In for Qualifying Individuals (QI), both as described in 130 CMR 519.011: *MassHealth Buy-In*, verification is required only upon the request of the MassHealth agency. Verifications include

- (a) two recent pay stubs;
- (b) a signed statement from the employer;
- (c) the most recent U.S. tax return or self-employment income records;
- (d) for room and board: a statement signed by both parties stating the amount and frequency of payments; or
- (e) other reliable evidence.

(D) Unearned Income. Income that does not directly result from an individual's own labor or services is unearned. Unearned income includes, but is not limited to, social security benefits, railroad retirement benefits, pensions, annuities, federal veterans' benefits, rental income, interest, and dividend income. Gross rental income is the countable rental-income amount received less business expenses as described at 130 CMR 520.010(C). The applicant or member must verify gross unearned income. However, if he or she is applying solely for MassHealth Senior Buy-In for Qualified Medicare Beneficiaries (QMB) as described in 130 CMR 519.010: *MassHealth Senior Buy-in (for Qualified Medicare Beneficiaries (QMB))* or MassHealth Buy-In for Specified Low Income Medicare Beneficiaries (SLMB) or MassHealth Buy-In for Qualifying Individuals (QI) or both as described in 130 CMR 519.011: *MassHealth Buy-In*, verification is required only upon MassHealth agency request. Verifications include

- (1) a recent check stub showing gross income;
- (2) a statement from the income source when matching is not available;
- (3) for rental income: a written statement from the tenant or a copy of the lease; or
- (4) other reliable evidence.

(E) Lump-sum Payments. A lump-sum payment is a one-time-only payment that represents either windfall payments such as inheritances or legacies, or the accumulation of recurring countable income such as retroactive unemployment compensation or federal veterans' retirement benefits. Generally, lump-sum payments are counted as unearned income in the calendar month received and as an asset in subsequent months, except as provided in 130 CMR 520.009(E)(1).

- (1) Exceptions. The following lump-sum payments are noncountable:
 - (a) a retroactive RSDI and/or SSI benefit payment, subject to the provisions of 130 CMR 520.007(H)(1);
 - (b) proceeds reserved for the replacement or repair of an asset that is lost, damaged, or stolen and any interest earned on such proceeds are exempt from consideration as assets for nine calendar months after the month of receipt and may be exempt for an additional nine calendar months where good cause exists;

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

**Chapter 520
Page 520.010**

(c) proceeds from the sale of a home used as the principal place of residence provided the proceeds are used to purchase another home to be used as the principal place of residence. Such proceeds are exempt from considerations as assets for three calendar months after the month of receipt;

(d) proceeds from the sale of real estate other than a home subject to the provisions of 130 CMR 520.007(G); and

(e) proceeds from the sale of nonexempt vehicles subject to the provisions of 130 CMR 520.007(F).

(2) Verifications. The applicant or member must verify a lump-sum payment. However, if he or she is applying solely for MassHealth Senior Buy-In for Qualified Medicare Beneficiaries (QMB) as described in 130 CMR 519.010: *MassHealth Senior Buy-In (for Qualified Medicare Beneficiaries (QMB))* or MassHealth Buy-In for Specified Low Income Medicare Beneficiaries (SLMB) or MassHealth Buy-in for Qualifying Individuals (QI) both as described in 130 CMR 519.011: *MassHealth Buy-In*, verification is required only at MassHealth agency request. Verifications include

(a) a benefit or settlement award letter;

(b) a retirement-fund document indicating the amount of the lump-sum payment;

(c) a written statement from the agency, company, or institution making the payment;

(d) a copy of the payment document; or

(e) other reliable evidence.

520.010: Business Expenses

(A) Self-employment. Allowable business expenses from self-employment are those listed on Schedule C of the U.S. Tax Return form.

(B) Room and Board. For the rental of a room only, the MassHealth agency allows 25% of the income to be deducted as business expenses. For income from both room and meals, the MassHealth agency allows 75% of the income to be deducted as business expenses. The MassHealth agency allows actual expenses only if the provider can document that they exceed these standard deductions.

(C) Rental Income.

(1) Allowable business expenses from rental income include carrying charges, cost of fuel and utilities provided to tenants, and any maintenance and repair costs.

(2) If the individual occupies an apartment in the same building from which he or she receives rental income, carrying charges are prorated per unit. The cost of fuel and utilities are prorated if they are paid through a single heating unit or meter.

(3) The MassHealth agency may deduct actual maintenance and repair costs, other than cosmetic changes, from the amount of rental income if the individual verifies such expenses.

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

**Chapter 520
Page 520.011**

520.011: Standard Income Deductions

For community and institutionalized individuals, the MassHealth agency allows certain standard earned- and unearned-income deductions from gross income. These deductions are described in 130 CMR 520.012 through 520.014.

520.012: Community Earned-income Deductions

In addition to business expenses described at 130 CMR 520.010(A) and (B), the MassHealth agency allows the following deductions from the gross earned income of each employed individual or married couple living in the community. These deductions do not apply to the income of a community spouse, as described at 130 CMR 520.026(B). Standard earned-income deductions are applied in the following order:

- (A) \$20, if there is no unearned income or, if there is unearned income that is less than \$20, the balance of the \$20 is disregarded from earned income;
- (B) the next \$65 a month of earned income; and
- (C) one-half of the remaining earned income.

520.013: Community Unearned-income Deductions

In addition to business expenses described at 130 CMR 520.010, the MassHealth agency allows the deductions listed below from the total gross unearned income. These deductions do not apply to the income of a community spouse described at 130 CMR 520.026(B). The deductions allowed from the total gross unearned income are the following:

- (A) a deduction of \$20 per individual or married couple; or
- (B) in determining eligibility for MassHealth Standard, a deduction that is equivalent to the difference between the applicable MassHealth deductible-income standard at 130 CMR 520.030 and 133 % of the federal poverty level. This deduction includes, and is not in addition to, the \$20 disregard.
 - (1) This deduction from gross unearned income is allowed only for persons who
 - (a) are 65 years of age and older;
 - (b) are receiving personal-care attendant services paid for by the MassHealth agency, or have been determined by the MassHealth agency, through initial screening or by prior authorization, to be in need of personal-care attendant services; and
 - (c) prior to applying the deduction at 130 CMR 520.013(B), have countable income that is over 100 % of the federal poverty level.

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

**Chapter 520
Page 520.014**

- (2) The MassHealth agency will redetermine eligibility without this deduction if
 - (a) after 90 days from the date of the MassHealth agency eligibility approval notice, the person is not receiving personal-care attendant services paid for by the MassHealth agency or has not submitted, upon request from the MassHealth agency, proof of efforts to obtain personal-care attendant services paid for by the MassHealth agency; or
 - (b) the MassHealth agency denies the prior-authorization request for personal-care attendant services.
- (3) If countable income, prior to applying the deduction at 130 CMR 520.013(B), is greater than 133 percent of the federal poverty level, eligibility is determined under 130 CMR 519.005(B): *Financial Standards Not Met*.

520.014: Long-term-care Earned-income Deductions

(A) The following expenses may be deducted from the earnings of a long-term-care-facility resident:

- (1) a standard deduction of \$11; and
- (2) any of the following work-related expenses deducted from salary:
 - (a) social security taxes (FICA);
 - (b) federal and state income taxes;
 - (c) retirement and employee benefit plans;
 - (d) health or medical insurance premiums; and
 - (e) union dues.

(B) Deductions that may be used to determine the amount owed to the long-term-care facility (patient-paid amount) are described at 130 CMR 520.026.

520.015: Noncountable Income

The following types of income are not considered in determining the financial eligibility of the applicant or member:

- (A) the income of any individual who is a recipient of EAEDC or SSI;
- (B) the portion of the income that is disregarded
 - (1) for disabled adult children according to 130 CMR 519.004: *Disabled Adult Children*; and
 - (2) under the Pickle Amendment according to 130 CMR 519.003: *Pickle Amendment Cases*;
- (C) income-in-kind;
- (D) money received from a loan secured by the equity in the home of an individual who is aged 60 or older (reverse mortgage);

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

**Chapter 520
Page 520.016 (1 of 2)**

520.016: Long-term Care: Treatment of Assets

130 CMR 520.016 describes the treatment of countable assets when one member of a couple is institutionalized, the post-eligibility transfer of assets, and the allowable income deductions for applicants and members who are residents of a long-term-care facility.

- (A) Institutionalized Individuals. The total value of assets owned by an institutionalized single individual or by a member of an institutionalized couple must not exceed \$2,000.
- (B) Treatment of a Married Couple's Assets When One Spouse Is Institutionalized.
- (1) Assessment.
- (a) Requirement. The MassHealth agency completes an assessment of the total value of a couple's combined countable assets and computes the community spouse's asset allowance as of the date of the beginning of the most recent continuous period of institutionalization of one spouse.
- (b) Right to Request an Assessment. When one spouse has entered a medical institution and is expected to remain institutionalized for at least 30 days, either spouse may request the MassHealth agency to make this assessment, even if the institutionalized spouse is not applying for MassHealth Standard at that time. The period of institutionalization must be continuous and expected to last for at least 30 days.
- (c) Right to Appeal. The MassHealth agency must give each spouse a copy of the assessment and the documentation used to make such assessment. Each spouse must be notified that he or she has the right to appeal the determination of countable assets and the community spouse's asset allowance when the institutionalized spouse (or authorized representative) applies for MassHealth Standard.
- (2) Determination of Eligibility for the Institutionalized Spouse. At the time that the institutionalized spouse applies for MassHealth Standard, the MassHealth agency must determine the couple's current total countable assets, regardless of the form of ownership between the couple, and the amount of assets allowed for the community spouse as follows. The community spouse's asset allowance is not considered available to the institutionalized spouse when determining the institutionalized spouse's eligibility for MassHealth Standard.
- (a) Deduct the community spouse's asset allowance, based on countable assets as of the date of the beginning of the most recent continuous period of institutionalization of the institutionalized spouse, from the remaining assets. The community spouse's asset allowance is the greatest of the following amounts:
1. the combined total countable assets of the institutionalized spouse and the community spouse, not to exceed \$109,560;
 2. a court-ordered amount; or
 3. an amount determined after a fair hearing in accordance with 130 CMR 520.017.

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

**Chapter 520
Page 520.016 (2 of 2)**

- (b) Compare the amount of the remaining assets to the MassHealth asset standard for one person, which is \$2,000. When the amount of the remaining assets is equal to or below \$2,000, the institutionalized spouse has met the asset test of eligibility.
- (3) Post-eligibility Transfer of Assets.
- (a) To meet the needs of the community spouse and to allow the continuing eligibility of the institutionalized spouse, the MassHealth agency allows the institutionalized spouse, after he or she has been determined eligible for MassHealth Standard, to transfer assets to or for the sole benefit of the community spouse in accordance with 130 CMR 520.016(B)(1) and (2).
- (b) The institutionalized spouse must transfer any of his or her assets that are part of the community spouse's asset allowance no later than 90 days immediately after the date of the notice of approval for MassHealth Standard. During this 90-day period, the MassHealth agency
1. will continue to exclude these assets in the determination of continuing eligibility; and
 2. will not apply the transfer rules in 130 CMR 520.018 and 520.019 to the assets transferred to the community spouse.
- (c) The MassHealth agency may extend the 90-day period if any of the following conditions exist:
1. the court is involved in assigning the couple's property through support actions;
 2. an appeal of the asset allowance has been filed with the Office of Medicaid Board of Hearings; or
 3. the condition of the institutionalized spouse requires the appointment of a conservator or guardian to act on his or her behalf.
- (d) The amount of the transferred assets added to the assets owned by the community spouse cannot exceed the community spouse's asset allowance as defined in 130 CMR 520.016(B)(2).
- (e) After the initial 90-day period or the extension is over, the MassHealth agency counts all assets that remain in the institutionalized spouse's name in determining his or her eligibility.
- (4) Retroactive Eligibility. In determining the eligibility of the institutionalized spouse for the three-month retroactive period before application in a continuous period of institutionalization, the MassHealth agency deducts the amount defined in 130 CMR 520.016(B)(2) from the couple's total countable assets.
- (5) Eligibility of the Community Spouse. The amount defined in 130 CMR 520.016(B)(2) must be counted in determining the community spouse's eligibility for MassHealth.

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

**Chapter 520
Page 520.017 (1 of 2)**

520.017: Right to Appeal the Asset Allowance or Minimum-monthly-maintenance-needs Allowance

(A) Request for an Adjustment to the Community Spouse's Asset Allowance. After the institutionalized spouse has applied for MassHealth Standard and has received a notice of approval or denial for MassHealth Standard, either spouse may appeal to the Office of Medicaid Board of Hearings to request an adjustment to the asset allowance. The purpose of the adjustment is to generate sufficient income, as determined by the MassHealth agency, for the community spouse to remain in the community.

(B) Minimum-monthly-maintenance-needs Allowance. The minimum-monthly-maintenance-needs allowance is the amount needed by the community spouse to remain in the community. This amount is based on a calculation that includes the community spouse's shelter and utility costs in addition to certain federal standards, in accordance with 130 CMR 520.026(B)(1).

(C) Adjustment of the Amount of Asset Allowance. If either spouse claims at a fair hearing that the amount of income generated by the community spouse's asset allowance as determined by the MassHealth agency is inadequate to raise the community spouse's income to the minimum-monthly-maintenance-needs allowance, the fair-hearing officer determines the gross income available to the community spouse as follows.

(1) The fair-hearing officer determines the gross amount of income available to the community spouse. The fair-hearing officer includes the amount of the income that would be generated by the spouse's asset allowance if \$10,000 of the asset allowance were generating income at an interest rate equal to the deposit yield quoted in the Bank Rate Monitor Index as of the hearing date for money market accounts, and if the remainder of the spouse's asset allowance were generating income at an interest rate equal to the highest deposit yield quoted in the Bank Rate Monitor Index as of the hearing date for any term not to exceed two and one-half years.

(2) If the community spouse's gross income under 130 CMR 520.017(C)(1) is less than the minimum-monthly-maintenance-needs allowance (MMMNA), then the fair-hearing officer allows an amount of income from the institutionalized spouse (after the personal-needs deduction described in 130 CMR 520.026(A)) that would increase the community spouse's total income to equal, but not to exceed, the MMMNA. 130 CMR 520.017(C)(2) applies to all hearings held on or after September 1, 2003, regardless of the date of application.

(3) If after the fair-hearing officer has increased the community spouse's gross income under 130 CMR 520.017(C)(1) and (2), the community spouse's gross income is still less than the MMMNA, then the fair-hearing officer increases the community spouse's asset allowance by the amount of additional assets that, if generating income at an interest rate equal to the highest deposit yield in the Bank Rate Monitor Index as of the hearing date for any term not to exceed two and one-half years, would generate sufficient income to raise the income total to the MMMNA.

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

**Chapter 520
Page 520.017 (2 of 2)**

(D) Adjustment to the Minimum-monthly-maintenance-needs Allowance Due to Exceptional Circumstances. After the institutionalized spouse has received notice of either approval or denial for MassHealth Standard, either spouse may appeal to the Office of Medicaid Board of Hearings the calculation of income available to the community spouse and request an increase in the MMMNA, based on exceptional circumstances, as defined in 130 CMR 520.017(D)(1).

(1) Exceptional Circumstances. Exceptional circumstances exist when there are circumstances other than those already taken into account in establishing the maintenance standards for the community spouse under 130 CMR 520.026(B) and these circumstances result in significant financial duress. Since the federal standards used in calculating the MMMNA cover such necessities as food, shelter, clothing, and utilities, exceptional circumstances are limited to those necessities that arise from the medical condition, frailty, or similar special needs of the community spouse. Such necessities include, but are not limited to, special remedial and support services and extraordinary uncovered medical expenses. Such expenses generally do not include car payments, even if the car is used for transportation to medical appointments, or home-maintenance expenses such as security systems and lawn care.

(a) In determining an increased MMMNA, the fair-hearing officer ensures that no expense (for example, for food or utilities) is counted more than once in the calculation.

(b) If the community spouse lives in an assisted-living facility or similar facility and requests an increase in his or her minimum-monthly-maintenance-needs allowance, the fair-hearing officer reviews the housing agreement, service plan, fee schedule, and other pertinent documents to determine whether exceptional circumstances exist. Additional amounts are allowed only for specific expenses necessitated by exceptional circumstances of the community spouse and not for maintaining any pre-set standard of living.

(2) Determination of Increase for Exceptional Circumstances. If the fair-hearing officer determines that exceptional circumstances exist, the fair-hearing officer may increase the community spouse's MMMNA to meet the expenses caused by the exceptional circumstances as follows.

(a) The fair-hearing officer first verifies that the calculation of the gross income of the community spouse in determining the existing spousal-maintenance-needs deduction includes the income generated by the community spouse's asset allowance. If the community spouse has no assets remaining from the allowance, he or she must verify the dollar amount of the remaining assets, if any, and how the money was spent. The fair-hearing officer considers how the assets were spent in determining whether or not significant financial duress exists.

(b) The fair-hearing officer determines the revised MMMNA by including in the calculation the amount needed to meet the exceptional circumstances.

(c) The fair-hearing officer compares the revised MMMNA to the community spouse's total income. If the community spouse's total income is less than the amount of the revised MMMNA, the fair-hearing officer first deducts the personal-needs allowance from the institutionalized spouse's countable-income amount and then a spousal-maintenance-needs deduction needed to reach the revised MMMNA.

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

**Chapter 520
Page 520.018**

520.018: Transfer of Resources Regardless of Date of Transfer

- (A) The provisions of 42 U.S.C. 1396p apply to all transfers of resources. In the event that any portion of 130 CMR 520.018 and 520.019 conflicts with federal law, the federal law supersedes.
- (B) The MassHealth agency denies payment for nursing-facility services to an otherwise eligible nursing-facility resident as defined in 130 CMR 515.001: *Definition of Terms* who transfers or whose spouse transfers countable resources for less than fair-market value during or after the period of time referred to as the look-back period.
- (C) The denial of payment for nursing-facility services does not affect the individual's eligibility for other MassHealth benefits.
- (D) Circumstances giving rise to disqualifying transfers of resources are also described at 130 CMR 520.007(J).

520.019: Transfer of Resources Occurring on or after August 11, 1993

- (A) Payment of Nursing-facility Services. The MassHealth agency applies the provisions of 130 CMR 520.018 and 520.019 to nursing-facility residents as defined at 130 CMR 515.001: *Definition of Terms* requesting MassHealth agency payment for nursing-facility services provided in a nursing facility or in any institution for a level of care equivalent to that received in a nursing facility or for home- and community-based services provided in accordance with 130 CMR 519.007(B): *Home- and Community-based Services Waiver-Frail Elder*.
- (B) Look-back Period. Transfers of resources are subject to a look-back period, beginning on the first date the individual is both a nursing-facility resident and has applied for or is receiving MassHealth Standard.
- (1) For transfers occurring before February 8, 2006, this period generally extends back in time for 36 months.
 - (2) For transfers of resources occurring on or after February 8, 2006, the period generally extends back in time for 60 months. The 60-month look-back period will begin to be phased in on February 8, 2009. Beginning on March 8, 2009, applicants will be asked to provide verifications of their assets for the 37 months prior to the application. As each month passes, the look-back period will increase by one month until the full 60 months is reached on February 8, 2011.
 - (3) For transfers of resources from or into trusts, the look-back period is described in 130 CMR 520.023(A).

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

Chapter 520
Page 520.019 (3 of 8)

(G) Period of Ineligibility Due to a Disqualifying Transfer.

(1) Duration of Ineligibility. If the MassHealth agency has determined that a disqualifying transfer of resources has occurred, the MassHealth agency will calculate a period of ineligibility. The number of months in the period of ineligibility is equal to the total, cumulative, uncompensated value as defined in 130 CMR 515.001: *Definition of Terms* of all resources transferred by the nursing-facility resident or the spouse, divided by the average monthly cost to a private patient receiving nursing-facility services in the Commonwealth of Massachusetts at the time of application, as determined by the MassHealth agency.

(2) Determination of the Period of Ineligibility in Special Circumstances. The MassHealth agency determines the periods of ineligibility in the following situations.

(a) Transfers in the Same Month. When a number of resources have been transferred in the same month, the MassHealth agency calculates the period of ineligibility by dividing the total value of the transferred resources by the average monthly cost to a private patient receiving nursing-facility services in the Commonwealth of Massachusetts at the time of application, as determined by the MassHealth agency. The period of ineligibility begins on the first day of the month in which the resources were transferred.

(b) Periods of Ineligibility That Overlap. When transfers of resources result in periods of ineligibility that overlap, the MassHealth agency adds the value of all the transferred resources and divides the total by the average monthly cost to a private patient receiving nursing-facility services in the Commonwealth of Massachusetts at the time of application, as determined by the MassHealth agency. The result is a single period of ineligibility beginning on the first day of the month in which the first transfer was made.

(c) Periods of Ineligibility That Do Not Overlap. In the case of multiple transfers where the periods of ineligibility for each transfer do not overlap, the MassHealth agency considers each transfer as a separate event with its own period of ineligibility. For non-overlapping multiple transfers occurring on or after February 8, 2006, see 130 CMR 520.019(G)(2)1.

(d) Periods of Ineligibility of Less Than One Month. If the calculated period of ineligibility is less than one month, the MassHealth agency imposes a partial-month period of ineligibility and does not round down or disregard any fractional period of ineligibility.

(e) Transfer of Lump-sum Income. When income has been transferred as a lump sum, the MassHealth agency calculates the period of ineligibility on the lump-sum value.

(f) Transfer of Stream of Income. When a stream of income has been transferred, the MassHealth agency calculates the period of ineligibility for each income payment that is periodically transferred. The MassHealth agency may impose partial-month periods of ineligibility.

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

Chapter 520
Page 520.019 (4 of 8)

(g) Transfer of the Right to a Stream of Income. When the right to a stream of income has been transferred, the MassHealth agency calculates the period of ineligibility based on the total amount of income expected to be transferred during the nursing-facility resident's life, according to the life-expectancy tables as determined by the MassHealth agency.

(h) Transfer by the Spouse. When a transfer by the spouse results in a period of ineligibility for the nursing-facility resident, and the spouse later becomes institutionalized and applies for MassHealth agency payment of nursing-facility services, the MassHealth agency apportions the remaining period of ineligibility equally between the spouses. If both spouses become nursing-facility residents in the same month, the MassHealth agency divides the period of ineligibility equally between them. When one spouse is no longer subject to a penalty, any remaining penalty must then be imposed on the remaining nursing-facility-resident spouse.

(i) Multiple Transfers Occurring on or after February 8, 2006. For transfers occurring on or after February 8, 2006, the MassHealth agency adds the value of all the resources transferred during the look-back period and divides the total by the average monthly cost to a private patient receiving long-term-care services in the Commonwealth of Massachusetts at the time of application, as determined by the MassHealth agency. The result will be a single period of ineligibility beginning on the first day of the month in which the first transfer was made or the date on which the individual is otherwise eligible for long-term-care services, whichever is later.

(3) Begin Date. For transfers occurring before February 8, 2006, the period of ineligibility begins on the first day of the month in which resources have been transferred for less than fair-market value. For transfers occurring on or after February 8, 2006, the period of ineligibility begins on the first day of the month in which resources were transferred for less than fair-market value or the date on which the individual is otherwise eligible for MassHealth agency payment of long-term-care services, whichever is later. For transfers involving revocable trusts, the date of transfer is the date the payment to someone other than the nursing-facility resident or the spouse is made. For transfers involving irrevocable trusts, the date of transfer is

- (a) the date that the countable trust resources are transferred to someone other than the nursing-facility resident or spouse; or
- (b) the latest of the following:
 1. the date that payment to the nursing-facility resident or the spouse was foreclosed under the terms of the trust;
 2. the date that the trust was established; or
 3. the date that any resource was placed in the trust.

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

**Chapter 520
Page 520.019 (5 of 8)**

(H) Transfers of Jointly Held Resources. The MassHealth agency will determine the amount of the nursing-facility resident's ownership interest of jointly held resources as defined in 130 CMR 515.001: *Definition of Terms* in accordance with the ownership rules at 130 CMR 520.005. The MassHealth agency will consider as a transfer any action taken by any person that reduces or eliminates the nursing-facility resident's ownership or control of the resource. The MassHealth agency then will determine whether the transfer was made at less than fair-market value in accordance with the transfer rules.

(I) Transfer of Life-estate and Remainder Interest. The rules pertaining to transfer of life-estate and remainder interest apply in instances involving remainder interest of property including life estates, annuities, wills, and trusts.

(1) The MassHealth agency considers a transfer of property with the retention of a life estate, as defined in 130 CMR 515.001: *Definition of Terms*, to be a transfer of resources. The difference between the fair-market value of the entire asset and the value of the life estate is called the remainder interest. The remainder interest is the amount considered to be transferred at less than fair-market value. The MassHealth agency will calculate the values of the remainder interest and the life estate in accordance with the life-estate tables, as determined by the MassHealth agency. If the language of the document creating the life estate explicitly states that the owner of the life estate has the power to sell the entire property (not simply the life estate), then the creation of this type of life estate will be treated as a trust.

(2) If the nursing-facility resident's or the spouse's life-estate interest or property including the life-estate interest is sold or transferred, the value of the life-estate interest at the time of the sale or transfer is calculated in accordance with the life-estate tables, as determined by the MassHealth agency. The MassHealth agency will attribute the value of the life-estate interest at the time of the sale or transfer to the person selling or transferring the life estate.

(3) The MassHealth agency considers the purchase of a life estate in another individual's home made on or after April 1, 2006, a disqualifying transfer, unless the purchaser resides in the home for a period of at least one year after the date of the purchase.

(J) Home Equity Loans and Reverse Mortgages. Proceeds from a home equity loan or a reverse mortgage that are transferred in the month of receipt will be considered a disqualifying transfer of resources if transferred for less than fair-market value.

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

Chapter 520
Page 520.019 (6 of 8)

(K) Exempting Transfers from the Period of Ineligibility.

(1) During the Eligibility Process. To avoid the imposition of a period of ineligibility, the nursing-facility resident may take action during the determination of eligibility before the issuance of a notice of a period of ineligibility as follows.

(a) Revising a Trust. During the eligibility process, the nursing-facility resident may revise a trust to comply with the criteria of a special-needs trust or a pooled trust, as defined in 130 CMR 515.001: *Definition of Terms*. The use of resources to create these trusts are permissible transfers, in accordance with 130 CMR 520.019(D). The MassHealth agency will use the original application date if during the eligibility process the nursing-facility resident provides proof that the trust has been revised accordingly.

(b) Curing a Transfer. During the eligibility process, the full value or a portion of the full value of the transferred resources may be returned to the nursing-facility resident. The MassHealth agency will use the original application date and consider the transfer to have been eliminated or adjusted. The MassHealth agency will apply the countable assets rules at 130 CMR 520.007 and the countable income rules at 130 CMR 520.009 to the returned resources in determining eligibility.

(2) After Issuance of the Notice of the Period of Ineligibility. After the issuance of the notice of the period of ineligibility, the nursing-facility resident may avoid imposition of the period of ineligibility in the following instances.

(a) Revising a Trust. If the nursing-facility resident revises a trust to comply with the criteria of a special-needs trust or a pooled trust as defined in 130 CMR 515.001: *Definition of Terms* and exempted in 130 CMR 520.019(D), the MassHealth agency will rescind the period of ineligibility as follows.

1. The MassHealth agency will use the original application date if within 60 days after the date of the notice of the period of ineligibility, the nursing-facility resident provides proof that the trust has been revised to comply with the criteria of a special-needs trust or a pooled trust. The MassHealth agency may extend the original 60-day period for an additional 120 days, if court action is required to revise the trust, as long as the court action is filed within the 60-day period after the date of the notice of the period of ineligibility.

2. If after the 60th day after the date of the notice of the period of ineligibility, the nursing-facility resident provides proof that the trust has been revised to comply with the criteria of a special-needs trust or a pooled trust, the MassHealth agency will consider the trust revised as of the date the trust has been both revised and notarized.

(b) Curing a Transfer. If the full value or a portion of the full value of the transferred resources is returned to the nursing-facility resident, the MassHealth agency will rescind or adjust the period of ineligibility and will apply the countable-assets rules at 130 CMR 520.007 and the countable-income rules at 130 CMR 520.009 to the returned resources in the determination of eligibility. The MassHealth agency will rescind or adjust the period of ineligibility as follows.

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

**Chapter 520
Page 520.019 (7 of 8)**

1. The MassHealth agency uses the original application date if the nursing-facility resident provides proof within 60 days after the date of the notice of the period of ineligibility that the transfer has been fully or partially cured. In the case of a partial cure, the MassHealth agency recalculates the period of ineligibility based on the transferred amount remaining after deducting the cured portion, beginning with the date of transfer or, for cures of transfers occurring on or after February 8, 2006, the later of the date of transfer or the date on which the individual would have otherwise been eligible.
2. If the nursing-facility resident provides proof later than the 60th day after the date of the notice of a period of ineligibility that the transfer has been fully or partially cured, the nursing-facility resident must reapply. The MassHealth agency recalculates the period of ineligibility based on the amount of the transfer remaining after the cure, beginning with the date of transfer or, for cures of transfers occurring on or after February 8, 2006, the later of the date of transfer or the date on which the individual would have otherwise been eligible.

(L) Waiver of the Period of Ineligibility Due to Undue Hardship. In addition to revising a trust and curing a transfer, the nursing-facility resident may claim undue hardship in order to eliminate the period of ineligibility.

- (1) The MassHealth agency may waive a period of ineligibility due to a disqualifying transfer of resources if ineligibility would cause the nursing-facility resident undue hardship. The MassHealth agency may waive the entire period of ineligibility or only a portion when all of the following circumstances exist.
 - (a) The denial of MassHealth would deprive the nursing-facility resident of medical care such that his or her health or life would be endangered, or the nursing-facility resident would be deprived of food, shelter, clothing, or other necessities such that he or she would be at risk of serious deprivation.
 - (b) Documentary evidence has been provided that demonstrates to the satisfaction of the MassHealth agency that all appropriate attempts to retrieve the transferred resource have been exhausted and that the resource or other adequate compensation cannot be obtained to provide payment, in whole or part, to the nursing-facility resident or the nursing facility.
 - (c) The institution has notified the nursing-facility resident of its intent to initiate a discharge of the resident because the resident has not paid for his or her institutionalization.
 - (d) There is no less costly noninstitutional alternative available to meet the nursing-facility resident's needs.
- (2) Undue hardship does not exist when imposition of the period of ineligibility would merely inconvenience or restrict the nursing-facility resident without putting the nursing-facility resident at risk of serious deprivation.

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

**Chapter 520
Page 520.023 (1 of 2)**

520.023: Trusts or Similar Legal Devices Created on or after August 11, 1993

The trust and transfer rules at 42 U.S.C. 1396p apply to trusts or similar legal devices created on or after August 11, 1993, that are created or funded other than by a will. Generally, resources held in a trust are considered available if under any circumstances described in the terms of the trust, any of the resources can be made available to the individual.

(A) Look-back Period for Transfers into or from Trusts.

(1) Look-back Period.

(a) For transfers made before February 8, 2006, the look-back period is 36 months for trusts where all or any portion of the income or principal of an irrevocable trust can be paid to or for the benefit of the nursing-facility resident, but is paid instead to someone else.

(b) The look-back period is 60 months

1. for transfers made on or after February 8, 2006, subject to the phase-in described in 130 CMR 520.019(B)(2), if all or any portion of the income or principal of a trust can be paid to or for the benefit of the nursing-facility resident, but is instead paid to someone else;

2. if payments are made from a revocable trust to other than the nursing-facility resident and are not for the benefit of the nursing-facility resident; or

3. if payments are made into an irrevocable trust where all or a portion of the trust income or principal cannot under any circumstances be paid to or for the benefit of the nursing-facility resident.

(2) Period of Ineligibility Due to a Disqualifying Transfer. The MassHealth agency determines the amount of the transfer and the period of ineligibility for payment of nursing-facility services in accordance with the rules at 130 CMR 520.019(G).

(B) Revocable Trusts.

(1) The entire principal in a revocable trust is a countable asset.

(2) Payments from a revocable trust made to or for the benefit of the individual are countable income.

(3) Payments from a revocable trust made other than to or for the benefit of the nursing-facility resident are considered transfers for less than fair-market value and are treated in accordance with the transfer rules at 130 CMR 520.019(G).

(4) The home or former home of a nursing-facility resident or spouse held in a revocable trust is a countable asset. Where the home or former home is an asset of the trust, it is not subject to the exemptions of 130 CMR 520.007(G)(2) or 520.007(G)(8).

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

Chapter 520
Page 520.023 (2 of 2)

(C) Irrevocable Trusts.

(1) Portion Payable.

(a) Any portion of the principal or income from the principal (such as interest) of an irrevocable trust that could be paid under any circumstances to or for the benefit of the individual is a countable asset.

(b) Payments from the income or from the principal of an irrevocable trust made to or for the benefit of the individual are countable income.

(c) Payments from the income or from the principal of an irrevocable trust made to another and not to or for the benefit of the nursing-facility resident are considered transfers of resources for less than fair-market value and are treated in accordance with the transfer rules at 130 CMR 520.019(G).

(d) The home or former home of a nursing-facility resident or spouse held in an irrevocable trust that is available according to the terms of the trust is a countable asset. Where the home or former home is an asset of the trust, it is not subject to the exemptions of 130 CMR 520.007(G)(2) or 520.007(G)(8).

(2) Portion Not Payable. Any portion of the principal or income from the principal (such as interest) of an irrevocable trust that could not be paid under any circumstances to or for the benefit of the nursing-facility resident will be considered a transfer for less than fair-market value and treated in accordance with the transfer rules at 130 CMR 520.019(G).

(D) Exemptions to the Trust Rules.

(1) Special-needs Trusts and Pooled Trusts. Under federal trust exemption regulations at 42 U.S.C. 1396(p)(d)(4) special-needs trusts and pooled trusts as defined in 130 CMR 515.001: *Definition of Terms* are not subject to the income and asset countability rules at 130 CMR 520.023(B) and (C).

(2) Revision of a Trust to Comply with the Criteria of a Special-needs or Pooled Trust. The MassHealth agency will not deny or terminate MassHealth due to excess assets if a trust is revised to comply with the criteria of a special-needs trust or a pooled trust in accordance with the rules at 130 CMR 520.019(J).

(3) Burial Trust. A burial trust is a trust established to pay solely for various funeral and burial expenses of the individual or the spouse. An irrevocable burial trust meeting the criteria of 130 CMR 520.008(F) is not a countable asset.

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

**Chapter 520
Page 520.024**

520.024: General Trust Rules

130 CMR 520.024 applies to trusts whether or not established by will and whether or not established by the individual or spouse.

(A) Irrevocable Trust.

- (1) The assets and income held in an irrevocable trust established by the individual or spouse that the trustee is required to distribute to or for the benefit of the individual are countable.
- (2) Payments from the income or principal of an irrevocable trust established by the individual or spouse to or for the benefit of the individual are countable.
- (3) The assets and income held in an irrevocable trust established by other than the individual or spouse that the trustee is required to distribute to the individual are countable.
- (4) Payments from the income or the principal of an irrevocable trust established by other than the individual or spouse to the individual are countable.

(B) Home in Trust: Community-based Individuals. For an applicant or member who is not a nursing-facility resident, the principal place of residence held in a revocable or irrevocable trust is a noncountable asset. A home that is not the principal place of residence is countable and not subject to the exemptions of 130 CMR 520.007(G)(2) while an asset of the trust.

(C) Home in Trust: Cure.

- (1) If the MassHealth agency has denied or terminated MassHealth because the home or former home in trust is considered an excess asset, the MassHealth agency will rescind that action if the home or former home has been removed from the trust and returned to the nursing-facility resident in accordance with the full cure rules at 130 CMR 520.019(K).
- (2) When the home or former home is removed from a trust, as determined by the MassHealth agency, the MassHealth agency will redetermine eligibility using the rules at 130 CMR 520.007(G)(8) and the full cure rules at 130 CMR 520.019(K).
- (3) When the home or former home has been removed from the trust, the MassHealth agency may place a lien in accordance with 130 CMR 515.012: *Real Estate Liens*.

(D) Repayment of Financial and Medical Assistance. An individual who has received or will be receiving payments from a third party as a result of an accident, injury, or other loss must first repay the MassHealth agency for medical assistance under M.G.L. c. 118E, § 22 and 42 U.S.C. 1396a(a)(25)(A) and (B) and the Department of Transitional Assistance for financial assistance under M.G.L. c. 18, § 5G, even if such third-party payments have been or will be placed in a special-needs or pooled trust in accordance with 42 U.S.C. 1396p(d)(4).

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

**Chapter 520
Page 520.025**

(E) Waiver of the Trust Rules: Undue Hardship. When the MassHealth agency denies or terminates MassHealth due to excess assets, the individual may request, in accordance with 130 CMR 520.019(L), that the MassHealth agency rescind the denial or termination because such action would result in undue hardship.

(F) Verification of a Trust. The individual must provide the MassHealth agency with a copy of the trust or similar legal device or, when appropriate, a will and any information detailing investments, holdings, and distributions, as determined by the MassHealth agency.

(G) No Double Penalty. The MassHealth agency will apply the rules at 130 CMR 520.019(N) to prevent double penalty.

520.025: Long-term-care Income Standard

The MassHealth income standard for long-term-care residents is \$72.80 per month.

520.026: Long-term-care General Income Deductions

General income deductions must be taken in the following order: a personal-needs allowance; a spousal-maintenance-needs allowance; a family-maintenance-needs allowance for qualified family members; a home-maintenance allowance; and health-care coverage and incurred medical and remedial-care expenses. These deductions are used in determining the monthly patient-paid amount.

(A) Personal-needs Allowance.

- (1) The MassHealth agency deducts \$72.80 for a long-term-care resident's personal-needs allowance (PNA).
- (2) If an individual does not have income totaling the standard, the MassHealth agency will pay the individual an amount up to that standard on a monthly basis.
- (3) The PNA for SSI recipients is \$72.80.

(B) Spousal-maintenance-needs-deduction. If the community spouse's gross income is less than the amount he or she needs to live in the community (minimum-monthly-maintenance-needs allowance, MMMNA) as determined by the MassHealth agency, the MassHealth agency may deduct an amount from the institutionalized spouse's countable-income amount to meet this need. This amount is the spousal-maintenance-needs deduction. 130 CMR 520.026(B) applies to the first month of eligibility in an institution and terminates the first full calendar month in which the spouse is no longer in an institution or no longer has a spouse in the community. This deduction is the amount by which the minimum-monthly-maintenance-needs allowance exceeds the community spouse's gross income.

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

**Chapter 520
Page 520.026 (1 of 4)**

- (1) The MassHealth agency determines the MMMNA by adding the following amounts:
 - (a) \$1,822 (the federal standard maintenance allowance); and
 - (b) an excess shelter allowance determined by calculating the difference between the standard shelter expense of \$547 and the shelter expenses for the community spouse's principal residence, including
 1. the actual expenses for rent, mortgage (including interest and principal), property taxes and insurance, and any required maintenance charge for a condominium or cooperative; and
 2. the applicable standard deduction under the Supplemental Nutrition Assistance Program for utility expenses. If heat is included in the rent or condominium fee, this amount is \$375. If heat is not included in the rent or condominium fee, this amount is \$611.
 - (2) The maximum-monthly-maintenance-needs allowance is \$2,739.00 per month, unless it has been increased as the result of a fair-hearing decision based on exceptional circumstances in accordance with 130 CMR 520.017(D).
 - (3) If the institutionalized individual is subject to a court order for the support of the community spouse, the court-ordered amount of support must be used as the spousal-maintenance-needs deduction when it exceeds the spousal-maintenance-needs deduction calculated according to 130 CMR 520.026(B) or resulting from a fair hearing.
- (C) Deductions for Family-maintenance Needs.
- (1) The MassHealth agency allows a deduction from the income of a long-term-care resident to provide for the maintenance needs of the following family members if they live with the community spouse:
 - (a) a minor child — a child younger than 21 years old of either member of the couple;
 - (b) a dependent child — a child 21 years of age and older who is claimed as a dependent by either spouse for income-tax purposes under the Internal Revenue Code;
 - (c) a dependent parent — a parent of either spouse who lives with the community spouse and who is claimed as a dependent by either spouse for income-tax purposes under the Internal Revenue Code; and
 - (d) a dependent sibling — a brother or sister of either spouse (including a half-brother or half-sister) who lives with the community spouse and who is claimed as a dependent by either spouse for income-tax purposes under the Internal Revenue Code.
 - (2) The deduction for family-maintenance needs is $\frac{1}{3}$ of the amount by which the federal standard maintenance allowance exceeds the monthly gross income of the family member. The federal standard maintenance allowance is \$1,822.

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

Chapter 520
Page 520.026 (2 of 4)

- (D) Deductions for Maintenance of a Former Home.
- (1) The MassHealth agency allows a deduction for maintenance of a home when a competent medical authority certifies in writing that a single individual, with no eligible dependents in the home, is likely to return home within six months after the month of admission. This income deduction terminates at the end of the sixth month after the month of admission regardless of the prognosis to return home at that time.
 - (2) The amount deducted is the 100 % federal-poverty-level income standard for one person.
- (E) Deductions for Health-care Coverage and Other Incurred Expenses.
- (1) Health-insurance Premiums or Membership Costs. The MassHealth agency allows a deduction for current health-insurance premiums or membership costs when payments are made directly to an insurer or a managed-care organization.
 - (2) Incurred Expenses.
 - (a) After the applicant is approved for MassHealth, the MassHealth agency will allow deductions for the applicant's necessary medical and remedial-care expenses. These expenses must not be payable by a third party. These expenses must be for medical or remedial-care services recognized under state law but not covered by MassHealth.
 - (b) These expenses must be within reasonable limits as established by the MassHealth agency. The MassHealth agency considers expenses to be within reasonable limits provided they are
 1. not covered by the MassHealth per diem rate paid to the long-term-care facility; and
 2. certified by a treating physician or other medical provider as being medically necessary.
 - (3) Guardianship Fees and Related Expenses. The MassHealth agency allows deductions from a member's income for guardianship fees and related expenses when a guardian is essential to enable an incompetent applicant or member to gain access to or consent to medical treatment, as provided below.
 - (a) Expenses Related to the Appointment of a Guardian.
 1. The MassHealth agency allows a deduction for fees and expenses related to the appointment of a guardian if the guardian's appointment is made for the purpose of
 - a. assisting an incompetent applicant to gain access to medical treatment through MassHealth; or
 - b. consenting to medical treatment on behalf of a MassHealth member.

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

Chapter 520
Page 520.026 (3 of 4)

2. The MassHealth agency allows a deduction for reasonable costs, including attorney fees, as approved by the probate court, not to exceed \$500 for the appointment, except as provided in 130 CMR 520.026(E)(3)(a)3.
 3. The MassHealth agency may allow a deduction, as approved by the probate court, of up to \$750 for the appointment when the medical issues before the court are more complex. An example of such complexities includes providing evidence of the need for anti-psychotic medications.
 4. The deduction is made from the member's monthly patient-paid amount over a 12-month period.
- (b) Guardianship Services Related to the Application Process.
1. The MassHealth agency allows a deduction for fees for guardianship services related to the MassHealth application process when the guardian has been appointed by the probate court to assist an incompetent person with the MassHealth application when the securing of MassHealth benefits is essential for the member to gain access to medical treatment.
 2. The MassHealth agency allows a deduction for reasonable costs related to the MassHealth application process, as approved by the probate court, not to exceed \$500. In cases where an administrative hearing is held, the total deduction may not exceed \$750 for the costs related to the application process and hearing.
 3. The deduction is made from the member's monthly patient-paid amount over a 12-month period.
- (c) Guardianship Services Related to the Redetermination Process.
1. The MassHealth agency allows a deduction for fees for guardianship services related to the MassHealth redetermination process when the guardian has been appointed by the probate court to assist an incompetent person with securing continued access to medical treatment.
 2. The MassHealth agency allows a deduction for reasonable costs related to the MassHealth redetermination process, as approved by the probate court, not to exceed \$250. In cases where an administrative hearing is held, the total deduction may not exceed \$375 for the costs related to the redetermination process and hearing.
 3. The deduction is made from the member's monthly patient-paid amount over a 12-month period.
- (d) Monthly Guardianship Services.
1. The MassHealth agency allows a deduction for monthly fees for a guardian to the extent the guardian's services are essential to consent to medical treatment on behalf of the member.
 2. The MassHealth agency allows a deduction, as approved by the probate court, for up to 24 hours per year at a maximum of \$50 per hour for guardianship services.

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

**Chapter 520
Page 520.026 (4 of 4)**

3. The MassHealth agency allows the deduction only if the guardianship services provided include the attendance and participation of the guardian in quarterly care meetings held by the nursing facility where the member lives.
4. The MassHealth agency allows this deduction only if each year the guardian submits to the MassHealth agency a copy of the affidavit that describes the guardianship services provided to the member.
5. The deduction is made from the member's monthly patient-paid amount over a 12-month period.

(e) Expenses Incurred by the Guardian in Connection with Monthly Guardianship Services.

1. The MassHealth agency allows a deduction up to, but not exceeding, the member's monthly patient-paid amount for filing and court fees incurred by the guardian in connection with monthly guardianship services that are essential to consent to medical treatment for the member.
2. If monthly guardianship services are provided, these expenses are included in the affidavit of services required under 130 CMR 520.026(E)(3)(d)4.
3. The deduction is made from the member's monthly patient-paid amount in the month following receipt of the affidavit of services.

(f) Hardship.

1. If exceptional circumstances exist that make the deductions allowed under 130 CMR 520.026(E) insufficient to cover the expenses required for a guardian to provide essential guardianship services needed to gain access to or consent to medical treatment, the guardian, on behalf of the member, may appeal to the Office of Medicaid Board of Hearings for an increased deduction.
2. A hearing officer may allow for an increased deduction for guardianship expenses only in circumstances where the issues surrounding the member's need to gain access to or consent to medical treatment are extraordinary.
3. Extraordinary circumstances may exist when
 - a. there is a need for a guardian to consistently spend more than 24 hours per year providing guardianship services to appropriately consent to medical treatment needed by the member; or
 - b. the circumstances of a MassHealth member cause the guardian appointment or application process to be particularly complex and significantly more costly than the deduction allowed at 130 CMR 520.026(E)(3)(a) or (b).

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

**Chapter 520
Page 520.027**

- (g) Guardianship Services and Expenses That are not Deductible. The following fees and costs are not allowed as a deduction under 130 CMR 520.026(E):
1. amounts that are also used to reduce a member's assets under 130 CMR 520.004;
 2. amounts that are also used to meet a deductible or any other deduction allowed under MassHealth regulations;
 3. expenses related to the appointment of a guardian for an applicant when the appointment is made more than six months before submission of a MassHealth application;
 4. expenses related to the appointment of a guardian for an applicant or member when the applicant or member does not request a deduction for the appointment within six months of the date of application or date of appointment, whichever is later. However, these expenses may be used as allowed pursuant to 130 CMR 506.009: *The One-time Deductible* or 520.032 to meet a deductible;
 5. expenses, fees, or costs for expenses that are not essential to obtain medical treatment for the ward including financial management, except when the management is necessary to accurately complete a MassHealth application or redetermination form;
 6. expenses, fees, or costs for transportation or travel time.
 7. attorney fees, except when payment of the fees is required for the appointment of the guardian; and
 8. fees for guardianship services provided by a parent, spouse, sibling, or child, even if appointed by the probate court. However, the MassHealth agency allows a deduction for guardianship expenses in accordance with 130 CMR 520.026(E)(3)(a) and (e).

520.027: Long-term-care Deductible

If after applying the deductions in 130 CMR 520.026(A) through (E) the long-term-care-facility resident's monthly income exceeds the public rate at the long-term-care facility, the MassHealth agency will establish a six-month deductible in accordance with 130 CMR 520.028 through 520.035 and use an income standard of \$72.80.

**Trans. by E.L. 239
Rev. 07/01/21**

**MASSHEALTH
FINANCIAL ELIGIBILITY**

**Chapter 520
Page 520.028**

520.028: Eligibility for a Deductible

The following individuals may establish eligibility by meeting a deductible:

- (A) former SSI recipients who are not eligible under the Pickle Amendment;
- (B) community-based individuals whose countable-income amount exceeds the 100 percent federal poverty level income standards;
- (C) long-term-care-facility residents whose income, after general deductions described in 130 CMR 520.026, exceeds the public rate in a long-term-care facility;
- (D) disabled adult children whose incomes exceed the standards set forth in 130 CMR 519.004(A): *Eligibility Requirements*; and
- (E) persons who are eligible for an increased disregard as described at 130 CMR 520.013(B).

520.029: The Deductible Period

The deductible period is a six-month period that starts on the first day of the month of application or may begin up to three months before the first day of the month of application. The applicant is eligible for this period of retroactivity only if the applicant incurred medical expenses covered by MassHealth and was otherwise eligible.

520.030: Calculating the Deductible

The deductible is determined by multiplying the excess monthly income by six. Excess monthly income is the amount by which the applicant's countable-income amount as described in 130 CMR 520.009 exceeds the MassHealth deductible-income standard.

MASSHEALTH DEDUCTIBLE-INCOME STANDARDS		
<u>Number of Persons</u>	<u>Monthly-Income Standard for Community Residents</u>	<u>Monthly-Income Standard for Long-term-care-facility Residents</u>
1	\$522	\$72.80
2	650	

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

**Chapter 520
Page 520.034**

520.034: Interim Changes

The applicant or member must notify the MassHealth agency of any changes occurring before meeting the deductible or during the deductible period. These changes include an increase or decrease in income or an increase in assets.

520.035: Conclusion of the Deductible Process

When the total of submitted bills is equal to or greater than the deductible and all other eligibility requirements continue to be met, the MassHealth agency notifies the applicant that he or she is eligible. The member is eligible for payment of all covered medical expenses incurred during that deductible period, other than those submitted to meet the deductible, as long as the member continues to meet all other eligibility requirements during the balance of the deductible period.

520.036: Copayments Required by the MassHealth Agency

The MassHealth agency requires its members to make the copayments described in 130 CMR 520.038, up to the maximum described in 130 CMR 520.040, except as excluded in 130 CMR 520.037, and provided that if the payment rate for the service is equal to or less than the copayment amount, the member must pay the payment rate for the service minus one cent.

520.037: Copayment and Cost Sharing Requirement Exclusions

(A) Excluded Individuals.

(1) The following individuals do not have to pay the copayments described in 130 CMR 520.038:

- (a) members younger than 21 years old;
- (b) members who are pregnant or in the postpartum period that extends through the last day of the second calendar month following the month in which their pregnancy ends (for example, if the woman gave birth May 15th, she is exempt from the copayment requirement until August 1st);
- (c) MassHealth Limited members;
- (d) MassHealth Senior Buy-In members or MassHealth Standard members for drugs covered under Medicare Parts A and B only, when provided by a Medicare-certified provider;
- (e) members who are inpatients in nursing facilities, chronic-disease or rehabilitation hospitals, or intermediate-care facilities for individuals with intellectual disabilities or who are admitted to a hospital from such a facility or hospital;
- (f) members receiving hospice services;
- (g) persons receiving medical services through the Emergency Aid to the Elderly, Disabled and Children Program pursuant to 130 CMR 450.106: *Emergency Aid to the Elderly, Disabled and Children Program*, if they do not receive MassHealth Standard, or MassHealth Family Assistance;

**MASSHEALTH
FINANCIAL ELIGIBILITY**

(h) members who are former foster care individuals and who are eligible for MassHealth Standard until they reach the age of 21 or the age of 26, as specified in 130 CMR 505.002(H): *Eligibility Requirements for Former Foster-care Individuals*;

(i) members who are American Indians or Alaska Natives who are currently receiving or have ever received an item or service furnished by the Indian Health Service, an Indian tribe, a tribal organization or an urban Indian organization, or through referral, in accordance with federal law.

(j) “referred eligible” members, who are:

1. persons who receive Supplemental Security Income (SSI) benefits from the Social Security Administration (SSA) and who receive MassHealth Standard under 130 CMR 505.002(A)(2) or 130 CMR 519.002(B);
2. persons who receive Transitional Aid to Families with Dependent Children (TAFDC) cash assistance from the Department of Transitional Assistance (DTA) and who receive MassHealth Standard under 130 CMR 505.002(A)(3);
3. children, young adults, and parents and caretaker relatives who receive Emergency Aid to the Elderly, Disabled and Children (EAEDC) cash assistance and who receive MassHealth Standard under 130 CMR 505.002(K) or 130 CMR 519.002(D), MassHealth Family Assistance under 130 CMR 505.005(G) or 130 CMR 519.013(C), or MassHealth CarePlus under 130 CMR 505.008(B);
4. children receiving medical assistance under 130 CMR 522.003: *Adoption Assistance and Foster Care Maintenance*, because they are receiving Title IV-E or state-subsidized adoption or foster-care assistance
5. persons who receive extended eligibility for MassHealth Standard under 130 CMR 505.002(L)(1) and (2) or 130 CMR 519.002(C); and
6. persons who receive MassHealth Standard or CarePlus because they are eligible for Refugee Medical Assistance (RMA) under 130 CMR 522.002: *Refugee Resettlement Program*; and

(k) members whose applicable income for the purposes of calculating copayments is at or below 50% of the FPL when adjusted for family size.

(2) Members who are inpatients in a hospital do not have to pay a copayment for pharmacy services provided as part of the hospital stay.

(B) Excluded Services. The following services are excluded from the copayment requirement described in 130 CMR 520.038:

- (1) family-planning services and supplies such as oral contraceptives, contraceptive devices such as diaphragms and condoms, and contraceptive jellies, creams, foams, and suppositories;
- (2) detoxification and maintenance treatment of an individual for substance use disorders using FDA approved medications (including methadone, buprenorphine, buprenorphine/naloxone, and naltrexone);
- (3) preventive services assigned a grade of ‘A’ or ‘B’ by the United States Preventive Services Task Force (USPSTF), or such broader exclusion as specified by MassHealth;
- (4) all approved vaccines and their administration, recommended by the Advisory Committee on Immunization Practices (ACIP);

Trans. by E.L. 239
Rev. 07/01/21

**MASSHEALTH
FINANCIAL ELIGIBILITY**

**Chapter 520
Page 520.038**

- (5) smoking cessation products and drugs;
- (6) emergency services; and
- (7) provider-preventable services as defined in 42 CFR 447.26(b).

520.038: Services Subject to Copayments

MassHealth members are responsible for making the following copayments for pharmacy services unless excluded in 130 CMR 520.037.

- (A) \$1 for each prescription and refill for each generic drug and over-the-counter drug covered by MassHealth in the following drug classes: antihyperglycemics, antihypertensives, and antihyperlipidemics; and
- (B) \$3.65 for each prescription and refill for all other generic and over-the-counter drugs, and all brand-name drugs covered by MassHealth.

520.039: Members Unable to Pay Copayment

Providers may not refuse services to a member who is unable to pay at the time the service is provided. However, the member remains liable to the provider for the copayment amount.

520.040: Maximum Cost Sharing

- (A) Members are responsible for the MassHealth copayments described in 130 CMR 520.038 up to a monthly maximum of 2% of applicable monthly income. Each member's monthly copayment cap will be calculated using 2% of the lowest income in the MassHealth MAGI household or the MassHealth Disabled Adult household, as applicable, and assigning the member a monthly cap of the nearest \$10 increment that corresponds to 2% of the applicable income without exceeding 2%. A more detailed explanation of this calculation is publicly available on MassHealth's website.
- (B) Members are responsible for MassHealth premiums described in 130 CMR 506.012 up to a monthly maximum of 3% of applicable monthly income, except no such limit applies to CommonHealth members. Each member's monthly premium cap will be calculated using 3% of the lowest income in the MassHealth MAGI household or the MassHealth Disabled Adult household, as applicable. A further explanation of this calculation is publicly available on MassHealth's website.

REGULATORY AUTHORITY

130 CMR 520.000: M.G.L. c. 118E, §§ 7 and 12.