



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



MassHealth
Eligibility Letter 245
July 2023

TO: MassHealth Staff

FROM: Mike Levine, Assistant Secretary for MassHealth

RE: Updates to 130 CMR 501.000: MassHealth: General Policies, 130 CMR 505.000: MassHealth: Coverage Types, and 130 CMR 506.000: MassHealth: Financial Requirements

Regulations at 130 CMR 501.000 have been revised to update the Basic Benefit Level (BBL) definition, which governs which health insurance plans are eligible for MassHealth Premium Assistance payments. Updates include adjusting how the existing deductible and out of pocket maximum thresholds are set and clarifying the existing restriction on the use of Health Savings Accounts and similar instruments to reduce the deductible threshold.

Regulations at 130 CMR 505.000 have been revised to update the postpartum period to 12 months, plus an additional period extending to the end of the month in which the 12-month period ends. Updates were also made at 130 CMR 505.002(L) to comply with MassHealth's interpretation of federal law at 42 USC 1396r-6(a)(1), and at 130 CMR 505.002(A)(B)(3) to clarify the definition of "Young Adult." Throughout the regulation, updates were made to remove references to the Small Business Employee Premium Assistance program.

Regulations at 130 CMR 506.000 have been revised to clarify the existing Premium Assistance reimbursement adjustments process and introduce the new Premium Assistance reimbursement adjustments hardship waiver process. Updates were also made to comply with the Tax Cut and Jobs act of 2017, Public Law 115-97. Throughout the regulation, updates were also made to remove references to the Student Health Insurance Plan (SHIP) Premium Assistance and Small Business Employee Premium Assistance (SBEP) programs.

These regulations are effective as of July 21, 2023.

MANUAL UPKEEP

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501.001: Definition of Terms

The terms listed in 130 CMR 501.001 have the following meanings for the purposes of MassHealth, as described in 130 CMR 501.000 through 130 CMR 508.000: *Health Care Reform: MassHealth: Managed Care Requirements*. In the event that a definition conflicts with federal law, the federal law supersedes.

Accountable Care Organization (ACO) – an entity that enters into a population-based payment model contract with EOHHS as an accountable care organization, wherein the entity is held financially accountable for the cost and quality of care for an attributed or enrolled member population. ACOs include Accountable Care Partnership Plans, Primary Care ACOs, and MCO-administered ACOs.

Accountable Care Partnership Plan – a type of ACO with which the MassHealth agency contracts under its ACO program to provide, arrange for, and coordinate care and certain other medical services to members on a capitated basis and which is approved by the Massachusetts Division of Insurance as a health-maintenance organization (HMO) and which is organized primarily for the purpose of providing health care services.

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

American Indian or Alaska Native – a person who

- (1) is a member of a federally recognized tribe, band, or group as defined in Title 25 of U.S.C.;
- (2) is an Eskimo, Aleut, or other Alaska Native enrolled by the Secretary of the Interior, pursuant to the Alaska Native Claims Settlement Act at 43 U.S.C. 1601 *et seq.*; or
- (3) has been determined eligible to receive health care services from Indian Health Care Providers as an Indian pursuant to 42 CFR 136.12 or Title V of the Indian Health Care Improvement Act.

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

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

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

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

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Authorized Representative –

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

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

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

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

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

Basic-benefit Level (BBL) –

(1) benefits provided under a health insurance plan that include a broad range of medical benefits as defined in the minimum creditable coverage core services requirements in 956 CMR 5.03(1)(a); provided that the annual deductible and the annual maximum out-of-pocket costs under that plan do not exceed the maximum amounts the Massachusetts Health Connector sets for deductibles and out-of-pocket costs in order for a plan to be considered minimum creditable coverage, as set forth at 956 CMR 5.03(2)(b)2 and 3, and 956 CMR 5.03(2)(c), respectively, and as may be illustrated in administrative bulletins published by the Massachusetts Health Connector, and as are in effect on the first day coverage under that plan begins.

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(2) Exceptions.

(a) For the avoidance of doubt, 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.

(b) The MassHealth agency reserves the right to set its own annual deductible and maximum out-of-pocket limits. If the MassHealth agency deems it appropriate to set its own annual deductible and maximum out-of-pocket limits, a sub-regulatory bulletin will be issued.

Behavioral Health Contractor – the entity contracted with EOHHS to provide, arrange for, and coordinate behavioral health care and other services to members on a capitated basis.

Blindness – a visual impairment, as defined in Title XVI of the Social Security Act. Generally, Blindness means visual acuity with correction of 20/200 or less in the better eye, or a peripheral field of vision contracted to a 10° radius or less, regardless of the visual acuity.

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

Caretaker Relative – an adult who is the primary care giver for a child, is related to the child by blood, adoption, or marriage, or is a spouse or former spouse of one of those relatives, and lives in the same home as that child, provided that neither parent is living in the home.

Case File – the permanent written collection of documents and information required to determine eligibility and to provide benefits to applicants and members.

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

Child – a person younger than 19 years old.

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

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

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

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

Coverage Date – the date medical coverage begins.

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

Custodial Parent –

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

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

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

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

Disabled – having a permanent and total disability.

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

Disabled Working Adult – a person who is engaged in substantial gainful activity but otherwise meets the definition of disabled, as defined in Title XVI of the Social Security Act.

Disability Evaluation Services (DES) – a unit that consists of physicians and disability evaluators who determine permanent and total disability of an applicant or member seeking coverage under a MassHealth program for which disability is a criterion using criteria established by the Social Security Administration under Title XVI, and criteria established under state law. This unit may be a part of a state agency or under contract with a state agency.

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

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

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

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

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

Family Group – a family, couple, or individual.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Managed Care – a system of primary care and other medical services that are provided and coordinated by a MassHealth managed care provider, a SCO, an ICO, or the behavioral health contractor in accordance with the provisions of 130 CMR 450.117: *Managed Care* and 130 CMR 508.000: *MassHealth: Managed Care Requirements*.

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Managed Care Organization (MCO) – any entity with which the MassHealth agency contracts under its MCO program to provide, arrange for, and coordinate care and certain other medical services to members on a capitated basis, and is approved by the Massachusetts Division of Insurance as a health maintenance organization (HMO) and is organized primarily for the purpose of providing health care services.

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

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

MassHealth Managed Care Provider – an MCO, Accountable Care Partnership Plan, Primary Care ACO, or the Primary Care Clinician Plan.

MCO-administered ACO – a type of ACO with which the MassHealth agency contracts under its ACO program and is administered through an MCO.

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

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

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

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

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

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

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

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

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

Parent of a Child Younger than 19 Years Old – natural, adoptive, or stepmother or stepfather of a child.

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

(1) For Adults 18 Years of Age or Older.

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

1. can be expected to result in death; or
2. has lasted or can be expected to last for a continuous period of not less than 12 months.

(b) For purposes of 130 CMR 501.001: Permanent and Total Disability, an individual 18 years of age or older is determined to be disabled only if their physical or mental impairments are of such severity that the individual is not only unable to do their previous work, but cannot, considering age, education, and work experience, engage in any other kind of substantial gainful work that exists in the national economy, regardless of whether such work exists in the immediate area in which the individual lives, whether a specific job vacancy exists, or whether the individual would be hired if they applied for work.

"Work that exists in the national economy" means work that exists in significant numbers, either in the region where such an individual lives or in several regions of the country.

(2) For Children Younger than 18 Years Old. The condition of an individual younger than 18 years old who has any medically determinable physical or mental impairment, or combination of impairments, of comparable severity to an impairment or combination of impairments that disables an adult, or are of such severity that the child is unable to engage in age-appropriate activities, as defined in Title XVI of the Social Security Act as in effect on July 1, 1996.

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

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Person who is HIV Positive – a person who has submitted verification that they have tested positive for the human immunodeficiency virus (HIV).

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

Premium Assistance Payment – an amount contributed by the MassHealth agency toward the cost of health insurance coverage for certain MassHealth members who meet the criteria in 130 CMR 506.012: *Premium Assistance Payments*.

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

- (1) The group can be an individual, a couple who are two persons married to each other according to the rules of the Commonwealth of Massachusetts, or a family.
- (2) Two parents are members of the same premium billing family group if they are mutually responsible for one or more children who live with them.
- (3) A family making up a PBFG may consist of
 - (a) a child or children younger than 19 years old, any of their children, and their parents. A child who is absent from the home to attend school is considered as living in the home;
 - (b) siblings younger than 19 years old and any of their children who live together even if no adult parent or caretaker relative is living in the home; or
 - (c) a child or children younger than 19 years old, any of their children, and their caretaker relative when no parent is living in the home.

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

Primary Care ACO – a type of ACO with which the MassHealth agency contracts under its ACO program.

Primary Care Clinician (PCC) Plan – a managed care option administered by the MassHealth agency through which enrolled members receive primary care and other medical services. *See* 130 CMR 450.118: *Primary Care Clinician (PCC) Plan*.

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

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

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

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

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

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

Redetermination – a review of a member's circumstances to establish whether they remain eligible for benefits.

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

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

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

Substantial Gainful Activity – generally, employment that provides a set amount of gross earnings as determined by the Social Security Administration (SSA) under Title XVI of the Social Security Act.

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

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

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

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

Young Adult – an individual 19 or 20 years old.

501.002: Introduction to MassHealth

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

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

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

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

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501.003: MassHealth Coverage Types

(A) The MassHealth agency provides access to health care by determining eligibility for the coverage type that provides the most comprehensive benefits for an individual who may be eligible.

(B) MassHealth offers several coverage types: Standard, CommonHealth, CarePlus, Family Assistance, and Limited. The coverage type for which a person is eligible is determined based on the individual's income and circumstances, as described in 130 CMR 503.000: *Health Care Reform: MassHealth: Universal Eligibility Requirements* through 130 CMR 505.000: *Health Care Reform: MassHealth: Coverage Types*, and immigration status, as described in 130 CMR 504.000: *Health Care Reform: MassHealth: Citizenship and Immigration*.

(C) The MassHealth agency may limit the number of people who can be enrolled in MassHealth Family Assistance. When the MassHealth agency imposes such a limit, no new adult applicants (21 years of age or older) subject to these limitations will be added to MassHealth Family Assistance, and current adult members in these coverage types who have lost eligibility for more than 30 days for any reason will not be allowed to reenroll until the MassHealth agency is able to reopen enrollment for adults in MassHealth Family Assistance.

501.004: Administration of MassHealth

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

(B) Other Agencies.

(1) Department of Transitional Assistance (DTA).

(a) The Department of Transitional Assistance administers the Transitional Aid to Families with Dependent Children (TAFDC) Program. Persons who meet the requirements of section 1931 of Title XIX (42 U.S.C. § 1396u-1) are automatically eligible for MassHealth Standard coverage.

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

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

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3. MassHealth Family Assistance: children younger than 19 years old, young adults 19 and 20 years of age who are nonqualified persons living under color of law (PRUCOLs), parents and caretakers who are qualified noncitizens barred, nonqualified individuals lawfully present, nonqualified PRUCOLs, and adults 21 through 64 years of age who are qualified noncitizens barred, nonqualified individuals lawfully present, and nonqualified PRUCOLs.
- (2) Social Security Administration (SSA). The Social Security Administration administers the Supplemental Security Income (SSI) program and determines the eligibility of disabled individuals. Individuals receiving SSI are automatically eligible for MassHealth Standard coverage. Individuals without health insurance are provided choices of enrollment in a MassHealth managed care provider, SCO, or ICO in accordance with 130 CMR 508.000: *MassHealth: Managed Care Requirements*.
- (3) Health Connector. The Health Connector is Massachusetts's health insurance marketplace where individuals, families, and small businesses can shop among qualified health insurance carriers and choose a health insurance plan. The Health Connector administers Qualified Health Plans (QHP), premium tax credits (PTC), and the ConnectorCare program. The single, streamlined application is used to determine eligibility for both Health Connector and MassHealth programs as described in 130 CMR 502.000: *Health Care Reform: MassHealth: The Eligibility Process*. The Health Connector and MassHealth also coordinate eligibility notices and eligibility appeals.

501.005: Individuals and Families Eligible for or Receiving Medical Assistance on June 30, 1997

(A) Members Who Were Not Subject to a Deductible.

- (1) Individuals and families (including caretaker relatives) who were receiving Medical Assistance on June 30, 1997, and whose family group gross income on June 30, 1997, exceeded MassHealth eligibility standards will be provided MassHealth Standard coverage for one year after the date of MassHealth implementation, except in the following circumstances:
- (a) the individual or family no longer lives in Massachusetts;
 - (b) the individual enters an institution;
 - (c) the individual turns 65 years old;
 - (d) the individual or all members of the family are deceased; or
 - (e) the individual or family is no longer categorically eligible.
- (2) Eligibility for continuing coverage will be reviewed toward the end of this one-year period.

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501.009: Rights of Applicants and Members

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

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

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

(C) Right to Timely Provision of Benefits. Eligible applicants and members have the right to the timely provision of benefits, as defined in 130 CMR 502.000: *Health Care Reform: MassHealth: The Eligibility Process*.

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

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

(F) Right to Be Assisted by Others.

(1) The applicant or member has the right to be accompanied by any individual of their choice and the right to be represented by an appeal representative as defined in 130 CMR 610.004: *Definitions* during the appeal process.

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

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

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

(G) Right to Inspect the MassHealth Case File. The applicant or member has the right to inspect information in their MassHealth case file and contest the accuracy of the information. The case file may include electronic records used to determine eligibility.

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(H) Right to Appeal. The applicant or member has the right to appeal and request a fair hearing as the result of any adverse action or inaction taken by the MassHealth agency. The request will not be granted if the sole issue is a federal or state law requiring an automatic change adversely affecting members.

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

501.010: Responsibilities of Applicants and Members

(A) Responsibility to Cooperate. The applicant or member must cooperate with the MassHealth agency in providing information necessary to establish and maintain eligibility and must comply with all the rules and regulations of MassHealth, including recovery and obtaining or maintaining available health insurance. The MassHealth agency may request corroborative information necessary to maintain eligibility, including obtaining or maintaining available health insurance. The applicant or member must supply such information within 30 days of the receipt of the agency's request. If the member does not cooperate, MassHealth benefits may be terminated.

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

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

501.011: Referrals to Investigative Units

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

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501.012: Recovery of Overpayment of Medical Benefits

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

501.013: Estate Recovery

(A) Introduction.

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

(a) while the member was 65 years of age or older, except on or after October 1, 1993, while the member was 55 years of age or older; and

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

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

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

(3) Notwithstanding 130 CMR 501.013(A)(1) and in accordance with 42 U.S.C. 1396p(b)(B), the MassHealth agency will not recover Medicare cost-sharing benefits described at 42 U.S.C. 1396(a)(10)(E) with dates of payment on or after January 1, 2010, for persons who received such benefits under 130 CMR 505.002: *MassHealth Standard*, 130 CMR 505.007: *MassHealth Senior Buy-in and Buy-in*, 130 CMR 519.010: *MassHealth Senior Buy-in (for Qualified Medicare Beneficiaries (QMB))*, and 130 CMR 519.011: *MassHealth Buy-in*.

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

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

(B) Exceptions.

(1) Long-term Care Insurance Exception. No recovery for nursing facility or other long-term care services may be made from the estate of any person who meets the following requirements.

(a) The member was institutionalized; and

(b) The member notified the MassHealth agency that they had no intent of returning home; and

(c) On the date of admission to the long-term care institution, the member had long-term care insurance that, when purchased, or at any time thereafter, met 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.

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(2) Cost Effectiveness Exception. Effective for dates of death on or after May 14, 2021, in probate estates of members where the probate petition certifies under the penalties of perjury that the total assets in a member's estate are valued at \$25,000 or less, MassHealth has determined that it is not cost effective to pursue recovery. In such estates, MassHealth waives its right to recovery, and will not file a claim or otherwise pursue recovery. MassHealth reserves the right to file a claim and recover in such estates if probate filings do not sufficiently identify the value of the estate or if later probate filings or proceedings or investigation identify or establish that the total assets in the estate exceed \$25,000.00.

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

(D) Waiver of Estate Recovery Due to Undue Hardship. The MassHealth agency will waive its estate recovery claim if the agency determines that satisfaction of the claim would cause an undue hardship. An undue hardship does not exist solely because recovery will prevent any heir from receiving an anticipated inheritance. The duly court-appointed personal representative or public administrator of the deceased member's probate estate may apply for a waiver of estate recovery due to undue hardship. The application for a waiver and supporting documents must be received by the MassHealth agency within 60 days of the agency's notice of claim. The types of Waivers of Estate Recovery Due to Undue Hardship are

(1) Waiver of Estate Recovery Due to Residence and Financial Hardship.

(a) For notice of claims presented on or after November 15, 2003, but before May 14, 2021, recovery will be waived if MassHealth determines all of the following conditions have been met.

1. A sale of real property would be required to satisfy a claim against the member's probate estate; and
2. An individual who was using the property as a principal place of residence on the date of the member's death meets all of the following conditions:
 - a. the individual lived in the property on a continual basis for two years prior to the member's admission to an institution or death and continues to live in the property at the time the MassHealth agency first presented its claim for recovery against the deceased member's estate;
 - b. the individual has inherited or received an interest in the property from the deceased member's estate as defined in 130 CMR 501.013(A)(2) and 515.011(A)(2);
 - c. the individual is not being forced to sell the property by other devisees or heirs at law; and
 - d.. at the time the MassHealth agency first presented its claim for recovery against the deceased member's estate, the gross annual income of the individual's family group was less than or equal to 133 % of the applicable federal-poverty-level income standard for the appropriate family size.

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3. The waiver will be conditional for a period of two years from the date the MassHealth agency mails notice that the waiver requirements have been met, or from the date that a court of competent jurisdiction determines that the waiver requirements have been met. If at the end of that period, all circumstances and conditions that must exist for the MassHealth agency to waive recovery still exist, including meeting the same income standards under 130 CMR 501.013(D)(1)(a)2.d., and the real property has not been sold or transferred, the waiver will become permanent and binding. If at any time during the two-year period, the circumstances and conditions for the waiver no longer exist, including meeting the same income standards under 130 CMR 501.013(D)(1)(a)2.d, the property is sold or transferred, or the individual does not use the property as their primary residence, the MassHealth agency will be notified and its claim may be payable in full.
- (b) For claims presented on or after May 14, 2021, and upon application of a waiver of estate recovery due to residence and undue hardship by the personal representative or public administrator of the estate, MassHealth will waive recovery without a conditional two-year waiting period provided the personal representative or public administrator establishes to the satisfaction of the MassHealth agency that all the criteria for a residence and undue hardship waiver in 130 CMR 501.013(D)(1)(a)1. and 2. are currently met.
- (c) Any waivers arising out of notice of claims presented before May 14, 2021, which did not become permanent and binding pursuant to the two-year conditional requirements set forth in 130 CMR 501.013(D)(1)(a)3., and which had not been satisfied and were still subject to the two-year conditional requirements of that subsection as of May 14, 2021, will become permanent and binding.
- (2) Waiver of Estate Recovery Based on Care Provided. For claims presented on or after May 14, 2021, for an heir or devisee inheriting a legal interest in the deceased member's home, the MassHealth agency will waive estate recovery if MassHealth determines to its satisfaction all of the following conditions have been met:
 - (a) the heir or devisee resided in the member's home on a continual basis for two years prior to member's admission to an institution or death;
 - (b) during that time, the member needed and the heir or devisee provided a level of care that avoided the member's admission to a facility;
 - (c) the heir or devisee continues to live in the property at the time the notice of claim is filed;
 - (d) the heir or devisee was left an interest in the home under the member's will, or inherited the property under the laws of intestacy;
 - (e) the heir is not being forced to sell the property by other devisees or heirs; and
 - (f) the property would have to be sold to satisfy the claim.
- (3) Waiver of Estate Recovery Due to Financial Hardship Based on Income.
 - (a) For claims presented on or after May 14, 2021, the personal representative or public administrator of a member's estate may apply for a waiver of estate recovery due to financial hardship based on the income of an heir or heirs or devisee or devisees. If there are multiple heirs or devisees, the personal representative or public administrator must apply for an income-based waiver separately on behalf of each individual. To be considered a qualifying heir or devisee, the personal representative or public administrator of the estate must establish
 1. the qualifying heir or devisee is inheriting an interest in the member's estate under the member's probate estate; and,

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2. the family group of a qualifying heir or devisee has a Gross Income below 400% of the federal poverty level for the two-year period prior to the date the notice of claim is filed.

If MassHealth determines that both conditions have been met, the heir is considered a qualifying heir.

(b) MassHealth will waive recovery in an amount equal to the value of the qualifying heir's or devisee's interest in the estate up to a maximum of \$50,000 per qualifying heir or devisee. If there is more than one qualifying heir or devisee in an estate, the total amount of the agency's estate recovery claim waived for qualifying heirs or devisees shall be limited to a total of \$100,000.

(c) An estate with qualifying heirs or devisees, regardless of whether or not there are non-qualifying heirs, will be subject to estate recovery based on the lesser of

1. the value of the estate remaining after deducting the amount waived from the total value of the estate for qualifying heirs and devisees; or
2. the amount of the MassHealth claim remaining after deducting the amount waived from the total value of the MassHealth claim.

(d) Example 1. The value of the estate is \$400,000 and the MassHealth claim is \$60,000. There are two heirs who qualify for the waiver, each with an interest in the estate of \$50,000 or greater. There are also two heirs who do not qualify. In this example, the waived amount is \$100,000 ($50,000 + 50,000$). After deducting the \$100,000 waived amount from the estate there is \$300,000 left in the estate, but after deducting the \$100,000 waived amount from the \$60,000 MassHealth claim there is nothing left in the MassHealth claim. The result is no estate recovery.

(e) Example 2. The value of the estate is \$350,000 and the MassHealth claim is \$500,000. There are two qualifying heirs, each with an interest in the estate of \$50,000 or greater. There are also two non-qualifying heirs. In this example, the waived amount is \$100,000 ($50,000 + 50,000$). After deducting the \$100,000 waived amount from the estate there is \$250,000 left in the estate, and after deducting the \$100,000 waived amount from the \$500,000 MassHealth claim there is \$400,000 remaining in the MassHealth claim. In this example, MassHealth would recover \$250,000, since it is less than \$400,000.

(E) Outstanding Claims.

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

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

- (1) The personal representative or public administrator of the probate estate must verify the fair-market value by sending to the MassHealth agency a copy of the most recent tax bill or the property tax assessment that was most recently issued by the taxing jurisdiction, provided that this assessment is not one of the following:

- (a) a special-purpose tax assessment;

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- (b) based on a fixed-rate-per-acre method; or
 - (c) based on an assessment ratio or providing only a range.
 - (2) The personal representative or public administrator of the probate estate must also provide a comparable market analysis or a written appraisal of the property value from a knowledgeable source. A knowledgeable source includes one of the following: a licensed real-estate agent or broker, a real-estate appraiser, or an official of a bank, savings and loan association, or similar lending organization. The knowledgeable source must not have any real or apparent conflict-of-interest relationship with the estate.
 - (3) The MassHealth agency may also obtain an assessment from a knowledgeable source.
- (G) Exemption of Certain Assets from Estate Recovery for American Indians and Alaska Natives.
- (1) For notice of claims presented on or after July 1, 2009, and upon application for exemption of certain assets from estate recovery by the personal representative or public administrator of the member's estate, recovery from the following American Indian and Alaska Natives income, resources, and property will be waived:
 - (a) certain income and resources (such as interests in and income derived from tribal land and other resources currently held in trust status and judgment funds from the Indian Claims Commission and the U.S. Claims Court) that are exempt from Medicaid estate recovery by other laws and regulations;
 - (b) ownership interest in trust and non-trust property, including real property and improvements
 - 1. located on a reservation (any federally recognized Indian tribe's reservation, pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act at 43.U.S.C. chapter 33, and Indian allotments) or near a reservation as designated and approved by the Bureau of Indian Affairs of the U.S. Department of the Interior; or
 - 2. for any federally recognized tribe not described in 130 CMR 501.013(G)(1)(b)1., located within the most recent boundaries of a prior federal reservation;
 - (c) income left as a remainder in an estate derived from property protected in 130 CMR 501.013(G)(1)(b), that was either collected by an Indian or by a tribe or tribal organization and distributed to Indians, as long as the individual can clearly trace it as coming from protected property;
 - (d) ownership interests left as a remainder in an estate in rents, leases, royalties, or usage rights related to natural resources, including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, or fish products, resulting from the exercise of federally protected rights and income either collected by an Indian or by a tribe or tribal organization and distributed to Indians derived from these sources as long as the individual can clearly trace it as coming from protected sources; or
 - (e) ownership interests in or usage rights to items not covered by 130 CMR 501.013(G)(1)(a) through (d) that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional life style according to applicable tribal law or custom.

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(2) Protection of non-trust property described in 130 CMR 501.013(G)(1) is limited to circumstances when it passes from an Indian, as defined in § 4 of the Indian Health Care Improvement Act at 25 U.S.C. chapter 18, to one or more relatives (by blood, adoption, or marriage), including Indians not enrolled as members of a tribe and non-Indians, such as spouses or step-children, that their culture would nevertheless protect as family members, to a tribe or tribal organization, or to one or more Indians.

501.014: Voter Registration

- (A) Voter registration forms are available through the MassHealth agency to applicants and members who are
- (1) U.S. citizens; and
 - (2) 18 years of age or older, or who will be 18 years old on or before the date of the next election, in accordance with the National Voter Registration Act of 1993.
- (B) Applicants and members are
- (1) informed of the availability of voter registration forms at application, at the time of an eligibility review, and when there is an address change;
 - (2) offered assistance in completing the voter registration form unless such assistance is refused; and
 - (3) able to submit voter registration forms to the MassHealth agency for transmittal to the proper election offices.
- (C) MassHealth agency staff must not
- (1) seek to influence an applicant's or member's political preference or party registration;
 - (2) display any political preference or party allegiance to the applicant or member;
 - (3) make any statement to an applicant or member or take any action intended to influence the applicant's or member's decision regarding voter registration; or
 - (4) make any statement to an applicant or member or take any action intended to lead the applicant or member to believe that the decision to register or not has any bearing on the availability of services or benefits.
- (D) Completed voter registration forms that are submitted to the MassHealth agency are transmitted to the proper local election office for processing within five days of receipt.

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

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

- (1) A member who
 - (a) applied for SSI;
 - (b) was denied SSI benefits by the Social Security Administration; and
 - (c) had their initial Social Security Administration denial overturned through a reconsideration process, administrative hearing, appeals counsel review, federal court review, or reopening under the Social Security Administration rules on administrative finality.
- (2) A member who
 - (a) applied for TAFDC or MassHealth;
 - (b) was denied TAFDC by the Department of Transitional Assistance, or was denied MassHealth by the MassHealth agency; and
 - (c) had their initial denial overturned by a subsequent decision by DTA, the MassHealth agency, the fair hearing process, or the judicial review process.

(B) Limitations.

- (1) Reimbursement is limited to bills incurred on or after the coverage start date for the applicable coverage type as described in 130 CMR 505.000, and paid between the date of the erroneous eligibility decision and the date on which the member is notified of MassHealth eligibility. The bill must have been paid by the member, the member's spouse, the parent of a member, or a legal guardian.
- (2) Reimbursement is also limited to amounts actually paid for care or services that would have been covered under MassHealth had eligibility been determined correctly, even if these amounts exceed the MassHealth rate. Before reimbursing a member for care or services that would have required prior authorization, the MassHealth agency may require submission of medical evidence for consideration under the prior authorization standards. Reimbursement is available even though the medical care or services were furnished by a provider who does not participate in MassHealth.

(C) Verification.

- (1) Applicants or members seeking reimbursement must provide MassHealth with
 - (a) a bill for medical services that includes
 1. the provider's name;
 2. a description of the services provided; and
 3. the date the service was provided; and
 - (b) proof of payment of the bill presented, such as a canceled check or receipt.
- (2) Recipients of SSI must also provide documents from the Social Security Administration establishing the date of application and the date of application denial.

REGULATORY AUTHORITY

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

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505.001: Introduction

130 CMR 505.000 explains the categorical requirements and financial standards that must be met to qualify for a MassHealth coverage type. The rules of financial responsibility and calculation of financial eligibility are detailed in 130 CMR 506.000: *Health Care Reform: MassHealth: Financial Requirements*.

(A) The MassHealth coverage types are the following:

- (1) MassHealth Standard – for people who are pregnant, children, parents and caretaker relatives, young adults, disabled individuals, certain persons who are HIV positive, individuals with breast or cervical cancer, independent foster care adolescents, Department of Mental Health (DMH) members, and medically frail as such term is defined in 130 CMR 505.008(F);
- (2) MassHealth CommonHealth – for disabled adults, disabled young adults, and disabled children who are not eligible for MassHealth Standard;
- (3) MassHealth CarePlus – for adults 21 through 64 years of age who are not eligible for MassHealth Standard;
- (4) MassHealth Family Assistance – for children, young adults, certain noncitizens, and persons who are HIV positive who are not eligible for MassHealth Standard, MassHealth CommonHealth, or MassHealth CarePlus;
- (5) MassHealth Limited – for certain lawfully present immigrants as described in 130 CMR 504.003(A): *Lawfully Present Immigrants*, nonqualified PRUCOLs, and other noncitizens as described in 130 CMR 504.003: *Immigrants*; and
- (6) MassHealth Medicare Savings Programs – for certain Medicare beneficiaries.

(B) The financial standards referred to in 130 CMR 505.000 use MassHealth modified adjusted gross income (MAGI) household or MassHealth Disabled Adult household, as defined in 130 CMR 506.002: *Household Composition*.

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505.002: MassHealth Standard

(A) Overview.

(1) 130 CMR 505.002 contains the categorical requirements and financial standards for MassHealth Standard serving children, young adults, parents, caretaker relatives, people who are pregnant, disabled individuals, certain individuals with breast or cervical cancer, certain individuals who are HIV positive, independent foster-care adolescents, Department of Mental Health members, and medically frail as such term is defined in 130 CMR 505.008(F).

(2) Persons who receive Supplemental Security Income (SSI) benefits from the Social Security Administration (SSA) are eligible for MassHealth Standard.

(3) Persons who receive Transitional Aid to Families with Dependent Children (TAFDC) cash assistance from the Department of Transitional Assistance (DTA) are eligible for MassHealth Standard.

(4) Children, young adults, and parents and caretaker relatives who receive Emergency Aid to the Elderly, Disabled and Children (EAEDC) cash assistance are eligible for MassHealth Standard if they meet the citizenship and immigration requirements described at 130 CMR 504.002: *U.S. Citizens* and 130 CMR 504.003(A)(1): *Qualified Noncitizens*, (2): *Qualified Noncitizens Barred*, and (3): *Nonqualified Individuals Lawfully Present*.

(5) Persons who do not otherwise meet the requirements of 130 CMR 505.002, but who meet the AFDC rules that were in effect on July 16, 1996, are eligible for MassHealth Standard.

(6) Persons eligible for MassHealth Standard coverage are eligible for medical benefits as described at 130 CMR 450.105(A): *MassHealth Standard* and 130 CMR 508.000: *MassHealth: Managed Care Requirements*.

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(B) Eligibility Requirements for Children and Young Adults. Children and young adults may establish eligibility for MassHealth Standard coverage subject to the requirements described in 130 CMR 505.002(B).

(1) Children Younger than One Year Old.

(a) A child younger than one year old born to an individual who was not receiving MassHealth Standard on the date of the child's birth is eligible if

1. the modified adjusted gross income of the MassHealth MAGI household is less than or equal to 200% of the federal poverty level (FPL); and
2. the child is a citizen as described in 130 CMR 504.002: *U.S. Citizens* or a lawfully present immigrant as described in 130 CMR 504.003(A): *Lawfully Present Immigrants*.

(b) A child born to an individual who was receiving MassHealth on the date of the child's birth is automatically eligible for one year and is exempt from the requirement to provide verification of citizenship and identity.

(c) A child receiving MassHealth Standard who receives inpatient services on the date of their first birthday remains eligible until the end of the stay for which the inpatient services are furnished.

(2) Children One through 18 Years Old.

(a) A child one through 18 years old is eligible if

1. the modified adjusted gross income of the MassHealth MAGI household is less than or equal to 150% of the federal poverty level; and
2. the child is a citizen as described in 130 CMR 504.002: *U.S. Citizens* or a lawfully present immigrant as described in 130 CMR 504.003(A): *Lawfully Present Immigrants*.

(b) Eligibility for a child who is pregnant is determined under 130 CMR 505.002(D).

(3) Young Adults 19 through 20 Years Old.

(a) A young adult is eligible if

1. the modified adjusted gross income of the MassHealth MAGI household is less than or equal to 150% of the federal poverty level (FPL); and
2. the young adult is a citizen as described in 130 CMR 504.002: *U.S. Citizens* or a lawfully present immigrant as described in 130 CMR 504.003(A): *Lawfully Present Immigrants*.

(b) A young adult receiving MassHealth Standard who receives inpatient services on the date of their 21st birthday remains eligible until the end of the stay for which the inpatient services are furnished.

(c) Eligibility for a young adult who is pregnant is determined under 130 CMR 505.002(D).

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(C) Eligibility Requirements for Parents and Caretaker Relatives.

(1) A parent or caretaker relative of a child younger than 19 years old is eligible for MassHealth Standard coverage if

- (a) the modified adjusted gross income of the MassHealth MAGI household is less than or equal to 133% of the federal poverty level (FPL);
- (b) the individual is a citizen as described at 130 CMR 504.002: *U.S. Citizens* or a qualified noncitizen as described in 130 CMR 504.003(A)(1): *Qualified Noncitizens*; and
- (c) 1. the parent lives with their children, and assumes primary responsibility for the child's care, in the case of a parent who is separated or divorced, has custody of their children, or has children who are absent from home to attend school; or
2. the caretaker relative lives with children to whom they are related by blood, adoption, or marriage (including stepsiblings), or is a spouse or former spouse of one of those relatives, and assumes primary responsibility for the child's care if neither parent lives in the home.

(2) The parent or caretaker relative complies with 130 CMR 505.002(M).

(D) Eligibility Requirements for People who are Pregnant.

(1) A person who is pregnant is eligible if

- (a) the modified adjusted gross income of the MassHealth MAGI household is less than or equal to 200% of the federal poverty level (FPL); and
- (b) the individual is a citizen as described in 130 CMR 504.002: *U.S. Citizens*, lawfully present immigrant, nonqualified PRUCOL, or other noncitizen as described in 130 CMR 504.003: *Immigrants*.

(2) In determining the MassHealth MAGI household size, the unborn child or children are counted as if born and living with the mother.

(3) Eligibility, once established, continues for the duration of the pregnancy.

(4) Eligibility for postpartum care for pregnant individuals who meet the requirements of 130 505.002(B)(2) and (3), (C) through (H), and (L) continues for 12 months following the termination of the pregnancy plus an additional period extending to the end of the month in which the 12-month period ends.

(E) Disabled Individuals.

(1) Disabled Adults. A disabled adult 21 through 64 years old or a disabled young adult 19 through 20 years old who does not meet the requirements described at 130 CMR 505.002(B)(3)(a)1. is eligible for MassHealth Standard coverage if they meet the following requirements:

- (a) the individual is permanently and totally disabled as defined in 130 CMR 501.001: *Definition of Terms*;
- (b) the modified adjusted gross income of the MassHealth Disabled Adult household as described in 130 CMR 506.002(C): *MassHealth Disabled Adult Household* is less than or equal to 133% of the federal poverty level (FPL), or the individual is eligible under section 1634 of the Social Security Act (42 U.S.C. § 1383c) as a disabled adult child or as a disabled widow or widower, or is eligible under the provisions of the Pickle Amendment as described at 130 CMR 519.003: *Pickle Amendment Cases*;

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- (c) the individual is a citizen as described in 130 CMR 504.002: *U.S. Citizens* or a qualified noncitizen as described in 130 CMR 504.003(A)(1): *Qualified Noncitizens*; and
 - (d) the individual complies with 130 CMR 505.002(M).
 - (2) Determination of Disability. Disability is established by
 - (a) certification of legal blindness by the Massachusetts Commission for the Blind (MCB);
 - (b) a determination of disability by the SSA; or
 - (c) a determination of disability by the Disability Evaluation Services (DES).
 - (3) Extended MassHealth Eligibility. Disabled persons whose SSI disability assistance has been terminated and who are determined to be potentially eligible for MassHealth continue to receive MassHealth Standard until the MassHealth agency makes a determination of ineligibility.
- (F) Individuals with Breast or Cervical Cancer.
- (1) Eligibility Requirements. An individual with breast or cervical cancer is eligible for MassHealth Standard coverage if they meet all of the following requirements:
 - (a) the individual is younger than 65 years old;
 - (b) the individual has been certified by a physician to be in need of treatment for breast or cervical cancer, including precancerous conditions;
 - (c) the modified adjusted gross income of the MassHealth MAGI household is less than or equal to 250% of the federal poverty level (FPL);
 - (d) for individuals with breast or cervical cancer whose MassHealth MAGI household modified adjusted gross income is greater than 133% of the FPL, but does not exceed 250% of the FPL, the individual must
 - 1. be uninsured; or
 - 2. have insurance that does not provide creditable coverage. An individual is not considered to have creditable coverage when the individual is in a period of exclusion for treatment of breast or cervical cancer, has exhausted the lifetime limit on all benefits under the plan, including treatment of breast or cervical cancer, or has limited scope coverage or coverage only for specified illness; or
 - 3. be an American Indian or Alaska Native who is provided care through a medical care program of the Indian Health Service or of a tribal organization;
 - (e) the individual is a citizen as described in 130 CMR 504.002: *U.S. Citizens* or a qualified noncitizen as described in 130 CMR 504.003(A)(1): *Qualified Noncitizens*; and
 - (f) the individual does not otherwise meet the requirements for MassHealth Standard described at 130 CMR 505.002(B) through (E).

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(2) Premiums. Individuals who meet the requirements of 130 CMR 505.002(F) are assessed a monthly premium in accordance with 130 CMR 506.011: *MassHealth and the Children's Medical Security Plan (CMSP) Premiums*.

(3) Duration of Eligibility. Individuals meeting the requirements of 130 CMR 505.002(F) are eligible for MassHealth Standard for the duration of their cancer treatment.

(G) Eligibility Requirements for Individuals Who Are HIV Positive. An individual who is HIV positive is eligible for MassHealth Standard coverage if

- (1) the individual is younger than 65 years old;
- (2) the individual has verified their HIV positive status by providing a letter from doctor, qualifying health clinic, laboratory, or AIDS service provider or organization. The letter must indicate the individual's name and their HIV-positive status;
- (3) the modified adjusted gross income of the MassHealth MAGI household is less than or equal to 133% of the federal poverty level (FPL);
- (4) the individual is a citizen as described in 130 CMR 504.002: *U.S. Citizens* or a qualified noncitizen as described in 130 CMR 504.003(A)(1): *Qualified Noncitizens*; and
- (5) the individual does not meet the requirements for MassHealth Standard described at 130 CMR 505.002(B) through (E).

(H) Eligibility Requirements for Former Foster-care Individuals.

- (1) An individual who was in foster care under the responsibility of a state or tribe and enrolled in Medicaid coverage on their 18th birthday, or later date of aging out, receives MassHealth Standard coverage until
 - (a) their 26th birthday if the individual is a citizen, as described at 130 CMR 504.002: *U.S. Citizens*, or qualified noncitizen, as described at 130 CMR 504.003(A)(1): *Qualified Noncitizens*; or
 - (b) their 21st birthday if the individual is a qualified noncitizen barred, as described at 130 CMR 504.003(A)(2): *Qualified Noncitizens Barred*, or a nonqualified individual lawfully present, as described at 130 CMR 504.003(A)(3): *Nonqualified Individuals Lawfully Present*.
- (2) An individual who was in foster care under the responsibility of a state or tribe on their 18th birthday and not enrolled in Medicaid coverage receives MassHealth Standard coverage until their 21st birthday if the individual is a citizen, as described at 130 CMR 504.002: *U.S. Citizens*, a qualified noncitizen as described at 130 CMR 504.003(A)(1): *Qualified Noncitizens*, a qualified noncitizen barred, as described at 130 CMR 504.003(A)(2): *Qualified Noncitizens Barred*, or a nonqualified individual lawfully present, as described at 130 CMR 504.003(A)(3): *Nonqualified Individuals Lawfully Present*.

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(I) Eligibility Requirements for Department of Mental Health (DMH) Members. An individual who receives services from the Department of Mental Health, or has been determined eligible for such services and is on a waiting list, is eligible for MassHealth Standard if the individual

- (1) is younger than 65 years old;
- (2) has modified adjusted gross income of the MassHealth MAGI household of less than or equal to 133% of the federal poverty level;
- (3) is a citizen as described at CMR 504.002: *U.S. Citizens* or qualified noncitizen as described at 130 CMR 504.003(A)(1): *Qualified Noncitizens*; and
- (4) is not otherwise eligible for MassHealth Standard.

(J) Eligibility Requirements for Individuals Who Are Medically Frail. An individual who is medically frail is eligible for MassHealth Standard if the individual

- (1) is younger than 65 years old;
- (2) is medically frail as defined at 130 CMR 505.008(F);
- (3) has modified adjusted gross income of the MassHealth MAGI household of less than or equal to 133% of the federal poverty level;
- (4) is a citizen as described at 130 CMR 504.002: *U.S. Citizens* or qualified noncitizen as described at 130 CMR 504.003(A)(1): *Qualified Noncitizens*; and
- (5) has been determined to meet the eligibility criteria for MassHealth CarePlus and has elected to receive MassHealth Standard benefits.

(K) Eligibility Requirements for Certain EAEDC Recipients.

(1) Eligibility Requirements. Certain EAEDC recipients are eligible for MassHealth Standard if

(a) the individual is

1. a child and is a citizen as defined in 130 CMR 504.002: *U.S. Citizens* or a lawfully present immigrant as defined in 130 CMR 504.003(A): *Lawfully Present Immigrants*;
2. the individual is a young adult and is a citizen as defined in 130 CMR 504.002: *U.S. Citizens* or a lawfully present immigrant as defined in 130 CMR 504.003(A): *Lawfully Present Immigrants*;
3. the individual is a parent or caretaker relative and is a citizen as defined in 130 CMR 504.002: *U.S. Citizens* or a qualified noncitizen as defined in 130 CMR 504.003(A)(1): *Qualified Noncitizens*; and

(b) the individual receives EAEDC cash assistance.

(2) Eligibility End Date. Individuals whose EAEDC cash assistance terminates and who are determined to be potentially eligible for MassHealth continue to receive medical benefits under MassHealth Standard until a determination of ineligibility is made by MassHealth.

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(L) Extended Eligibility.

(1) Members of an EAEDC or TAFDC household whose cash assistance terminates continue to receive four months of MassHealth Standard coverage beginning in the month the household became ineligible if they are

- (a) terminated from EAEDC or TAFDC and are determined to be potentially eligible for MassHealth; or
- (b) terminated from TAFDC because of receipt of or an increase in spousal or child support payments.

(2) Members of a TAFDC household who become ineligible for TAFDC for employment-related reasons continue to receive MassHealth Standard for a full 12-calendar-month period beginning with the date on which they became ineligible for TAFDC if

- (a) the household continues to include a child;
- (b) a parent or caretaker relative continues to be employed; and
- (c) the parent or caretaker relative complies with 130 CMR 505.002(M).

(3) Members of a MassHealth MAGI household who receive MassHealth Standard (whether or not they receive TAFDC) and have earnings that raise the MassHealth MAGI household's modified adjusted gross income above 133% of the federal poverty level (FPL) continue to receive MassHealth Standard for a full 12-calendar-month period that begins with the date on which the members MAGI exceeds 133% of the federal poverty level (FPL) if

- (a) the MassHealth household continues to include a child younger than 19 years old living with the parent or caretaker;
- (b) a parent or caretaker relative continues to be employed;
- (c) the parent or caretaker relative complies with 130 CMR 505.002(M); and
- (d) the member is a citizen or a qualified noncitizen.

(4) MassHealth independently reviews the continued eligibility of the TAFDC, EAEDC, and MassHealth MAGI households at the end of the extended period described in 130 CMR 505.002(L)(1) through (3).

(5) If an individual in a MassHealth MAGI household who receives MassHealth under 130 CMR 505.002(L)(1) or (2) had income at or below 133% of the FPL during their extended period, and now has income including earnings that raise the MassHealth MAGI modified adjusted gross income above that limit, the MassHealth MAGI household is eligible for another full 12-calendar-month period that begins with the date on which the member's MAGI exceeds 133% of the federal poverty level (FPL) if

- (a) the MassHealth household continues to include a child younger than 19 years old living with the parent or caretaker;
- (b) a parent or caretaker relative continues to be employed; and
- (c) the parent or caretaker relative complies with 130 CMR 505.002(M).

(6) If a MassHealth MAGI household's modified adjusted gross income decreases to 133% of the FPL or below during its extended eligibility period, and the decrease is timely reported to MassHealth, the MassHealth MAGI household's eligibility for MassHealth Standard may be redetermined. If the MassHealth MAGI household's gross income later increases above 133% of the FPL, the MassHealth MAGI household is eligible for a new extended eligibility period.

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(M) Use of Potential Health Insurance Benefits. Applicants and members must use potential health insurance benefits in accordance with 130 CMR 503.007: *Potential Sources of Health Care*, and must enroll in health insurance, including Medicare, if available at no greater cost to the applicant or member than they would pay without access to health insurance, or if purchased by MassHealth in accordance with 130 CMR 505.002(O) or 130 CMR 506.012: *Premium Assistance Payments*. Members must access other health insurance benefits and must show their private health insurance card and their MassHealth card to providers at the time services are provided.

(N) Access to Employer-sponsored Insurance and Premium Assistance Investigations for Individuals Who Are Eligible for MassHealth Standard.

(1) MassHealth may perform an investigation to determine if individuals receiving MassHealth Standard

- (a) have health insurance that MassHealth may help pay for; or
- (b) have access to employer-sponsored health insurance in which MassHealth wants the individual to enroll and for which MassHealth will help pay.

(2) The individual receives MassHealth Standard while MassHealth investigates the insurance.

(a) Investigations for Individuals Who Are Enrolled in Health Insurance.

- 1. If MassHealth determines that the health insurance the individual is enrolled in meets the criteria at 130 CMR 506.012: *Premium Assistance Payments*, the individual is notified in writing that MassHealth will provide MassHealth Standard Premium Assistance Payments as described at 130 CMR 506.012: *Premium Assistance Payments*.
- 2. If MassHealth determines that the health insurance the individual is enrolled in does not meet the criteria at 130 CMR 506.012: *Premium Assistance Payments*, the individual is eligible for MassHealth Standard Direct Coverage.
- 3. Individuals described at 130 CMR 505.002(F)(1)(d) will not undergo an investigation.

(b) Investigations for Individuals Who Have Potential Access to Employer-sponsored Health Insurance.

- 1. If MassHealth determines the individual has access to employer-sponsored health insurance and the employer is contributing at least 50% of the premium cost and the insurance meets all other criteria described at 130 CMR 506.012: *Premium Assistance Payments*, the individual is notified in writing that they must enroll in this employer-sponsored coverage. MassHealth allows the individual up to 60 days to enroll in this coverage. Once enrolled in this health insurance plan, MassHealth provides MassHealth Standard Premium Assistance Payments as described in 130 CMR 506.012: *Premium Assistance Payments*. Failure to enroll in the employer-sponsored health insurance plan at the request of MassHealth will result in the loss or denial of eligibility for all individuals unless the individual is younger than 21 years old or is pregnant.
- 2. If MassHealth determines the individual does not have access to employer-sponsored health insurance, the individual is eligible for MassHealth Standard Direct Coverage.
- 3. Individuals described at 130 CMR 505.002(F) and (G) will not undergo an investigation.

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(O) Medicare Premium Payment.

(1) MassHealth also pays the following on behalf of members who meet the requirements of 130 CMR 505.002(E) and 519.005(C): *Parents and Caretaker Relatives of Children Younger than 19 Years Old*:

- (a) the cost of the monthly Medicare Part B premiums;
- (b) where applicable, the cost of hospital insurance under Medicare Part A for members who are entitled to Medicare Part A; and
- (c) where applicable, for the deductibles and coinsurance under Medicare Parts A and B.

(2) The coverage described in 130 CMR 505.002(O)(1) begins on the first day of the month following the date of the MassHealth eligibility determination.

(P) Medical Coverage Date.

- (1) The medical coverage date for Mass Health Standard is described at 130 CMR 502.006: *Coverage Dates*, except as described at 130 CMR 505.002(P)(2).
- (2) Provisional eligibility is described in 130 CMR 502.003(E): *Provisional Eligibility*.

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505.004: MassHealth CommonHealth

(A) Overview.

- (1) 130 CMR 505.004 contains the categorical requirements and financial standards for CommonHealth coverage available to both disabled children and disabled adults, and to disabled working adults.
- (2) Persons eligible for MassHealth CommonHealth coverage are eligible for medical benefits as described in 130 CMR 450.105(E): *MassHealth CommonHealth*.

(B) Disabled Working Adults. Disabled working adults must meet the following requirements:

- (1) be 21 through 64 years of age (for those 65 years of age or older, see 130 CMR 519.012: *MassHealth CommonHealth*);
- (2) be employed at least 40 hours per month, or if employed less than 40 hours per month, have been employed at least 240 hours in the six-month period immediately preceding the month of receipt of the application or MassHealth's eligibility review;
- (3) be permanently and totally disabled (except for engagement in substantial gainful activity) as defined in 130 CMR 501.001: *Definition of Terms*;
- (4) be a citizen as described in 130 CMR 504.002: *U.S. Citizens* or a qualified noncitizen as described in 130 CMR 504.003(A)(1): *Qualified Noncitizens*;
- (5) be ineligible for MassHealth Standard; and
- (6) comply with 130 CMR 505.004(J).

(C) Disabled Adults. Disabled adults must meet the following requirements:

- (1) be 21 through 64 years old;
- (2) be permanently and totally disabled, as defined in 130 CMR 501.001: *Definition of Terms*;
- (3) be ineligible for MassHealth Standard;
- (4) be a citizen as described in 130 CMR 504.002: *U.S. Citizens* or a qualified noncitizen as described in 130 CMR 504.003(A)(1): *Qualified Noncitizens*;
- (5) (a) meet a one-time-only deductible in accordance with 130 CMR 506.009: *The One-time Deductible*; or
(b) have modified adjusted gross income of the MassHealth Disabled Adult household that is less than or equal to 200% of the federal poverty level (FPL) and provide verification that they are HIV positive; and
- (6) comply with 130 CMR 505.004(J).

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(D) Disabled Working Young Adults. Disabled working young adults are eligible for MassHealth CommonHealth if they meet the following requirements:

- (1) be permanently and totally disabled (except for engagement in substantial gainful activity), as defined in 130 CMR 501.001: *Definition of Terms*;
- (2) be ineligible for MassHealth Standard;
- (3) (a) be a citizen as described at 130 CMR 504.002: *U.S. Citizens* or qualified noncitizen as described in 130 CMR 504.003(A)(1): *Qualified Noncitizens* and be employed at least 40 hours per month, or if employed less than 40 hours per month, have been employed at least 240 hours in the six-month period immediately preceding the month of receipt of the application or MassHealth eligibility review; or
(b) be a nonqualified PRUCOL as described in 130 CMR 504.003(C): *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs)* with a modified adjusted gross income of the MassHealth Disabled Adult household income that is less than or equal to 150% of the FPL; and
- (4) comply with 130 CMR 505.004(J).

(E) Disabled Young Adults. Disabled young adults are eligible for MassHealth CommonHealth if they meet the following requirements:

- (1) be permanently and totally disabled, as defined in 130 CMR 501.001: *Definition of Terms*;
- (2) be ineligible for MassHealth Standard;
- (3) (a) be a citizen as described at 130 CMR 504.002: *U.S. Citizens* or qualified noncitizen as described in 130 CMR 504.003(A)(1): *Qualified Noncitizens*, and either
 1. meet a one-time-only deductible in accordance with 130 CMR 506.009: *The One-time Deductible*; or
 2. have modified adjusted gross income of the MassHealth Disabled Adult household that is less than or equal to 200% of the FPL and provide verification that they are HIV positive; or
(b) be a nonqualified PRUCOL as described in 130 CMR 504.003(C): *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs)* with a modified adjusted gross income of the MassHealth Disabled Adult household income that is less than or equal to 150% of the FPL; and
- (4) comply with 130 CMR 505.004(J).

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(F) Disabled 18-year-olds. Disabled 18-year-olds must meet the following requirements:

- (1) be ineligible for MassHealth Standard;
- (2) be a citizen as described at 130 CMR 504.002: *U.S. Citizens* or lawfully present immigrant or a nonqualified PRUCOL, as described in 130 CMR 504.003: *Immigrants*, and either
 - (a) if not working, be permanently and totally disabled, as defined in 130 CMR 501.001: *Definition of Terms*; or
 - (b) if working, be permanently and totally disabled (except for engagement in substantial gainful activity), as defined in 130 CMR 501.001: *Definition of Terms*.

(G) Disabled Children Younger than 18 Years Old. Disabled children younger than 18 years old must meet the following requirements:

- (1) be permanently and totally disabled, as defined in 130 CMR 501.001: *Definition of Terms*;
- (2) be ineligible for MassHealth Standard; and
- (3) be a citizen as described at 130 CMR 504.002: *U.S. Citizens*, lawfully present immigrant, or a nonqualified PRUCOL, as described in 130 CMR 504.003: *Immigrants*.

(H) Determination of Disability. Disability is established by

- (1) certification of legal blindness by the Massachusetts Commission for the Blind (MCB);
- (2) a determination of disability by the SSA; or
- (3) a determination of disability by the Disability Evaluation Services (DES).

(I) MassHealth CommonHealth Premium. Disabled adults, disabled working adults, disabled young adults, and disabled children who meet the requirements of 130 CMR 505.004 may be assessed a premium in accordance with the premium schedule provided in 130 CMR 506.011(B)(2). No premium is assessed during a deductible period.

(J) Use of Potential Health Insurance Benefits. Applicants and members must use potential health insurance benefits, in accordance with 130 CMR 503.007: *Potential Sources of Health Care*, and must enroll in health insurance, including Medicare, if available at no greater cost to the applicant or member than they would pay without access to health insurance, or if purchased by the MassHealth agency in accordance with 130 CMR 505.002(O) and 130 CMR 506.012: *Premium Assistance Payments*. Members must access those other health insurance benefits and must show their private health insurance card and their MassHealth card to providers at the time services are provided.

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(K) Access to Employer-sponsored Health Insurance and Premium-assistance Investigations for Individuals Who Are Eligible for MassHealth CommonHealth.

(1) MassHealth may perform an investigation to determine if individuals receiving MassHealth CommonHealth

- (a) have health insurance that MassHealth may help pay for; or
- (b) have access to employer-sponsored health insurance in which MassHealth wants the individual to enroll and for which MassHealth will help pay.

(2) The individual receives MassHealth CommonHealth while MassHealth investigates the insurance.

(a) Investigations for Individuals Who Are Enrolled in Health Insurance.

1. If MassHealth determines that the health insurance that the individual is enrolled in meets the criteria at 130 CMR 506.012: *Premium Assistance Payments*, the individual is notified in writing that MassHealth will provide MassHealth CommonHealth Premium Assistance as described at 130 CMR 506.012: *Premium Assistance Payments*.

2. If MassHealth determines that the health insurance that the individual is enrolled in does not meet the criteria at 130 CMR 506.012: *Premium Assistance Payments*, the individual continues to be eligible for MassHealth CommonHealth.

(b) Investigations for Individuals Who Have Potential Access to Employer-sponsored Health Insurance.

1. If MassHealth determines that the individual has access to employer-sponsored health insurance, the employer is contributing at least 50% of the premium cost, and the insurance meets all other criteria described in 130 CMR 506.012: *Premium Assistance Payments*, the individual is notified in writing that they must enroll in this employer-sponsored coverage. MassHealth allows the individual up to 60 days to enroll in this coverage. Once enrolled in this health insurance plan, MassHealth provides premium assistance payments as described in 130 CMR 506.012: *Premium Assistance Payments*. Failure to enroll in the employer-sponsored health insurance plan at the request of MassHealth will result in the loss or denial of eligibility for all individuals unless the individual is younger than 19 years old, the individual is 19 or 20 years old, and has household income less than or equal to 150% of the federal poverty level, or is pregnant.

2. If MassHealth determines the individual does not have access to employer-sponsored health insurance, the individual continues to be eligible for MassHealth CommonHealth.

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(L) Medicare Premium Payment.

- (1) MassHealth also pays the cost of the monthly Medicare Part B premium on behalf of members who meet the requirements of 130 CMR 505.004 and who have modified adjusted gross income of the MassHealth Disabled Adult household that is less than 135% of the FPL.
- (2) The coverage described in 130 CMR 505.004(L)(1) begins on the first day of the month following the date of the MassHealth eligibility determination and may be retroactive up to three months prior to the date the application was received by MassHealth.

(M) Medical Coverage Date.

- (1) The medical coverage date for MassHealth CommonHealth is described at 130 CMR 502.006: *Coverage Dates*, except as described at 130 CMR 505.004(M)(2) and (3).
- (2) Persons described in 130 CMR 505.004(C) who have been notified by the MassHealth agency that they must meet a one-time deductible have their medical coverage date established in accordance with 130 CMR 506.009(E): *Notification of the Deductible*.
- (3) Provisional eligibility is described in 130 CMR 502.003(E): *Provisional Eligibility*.

(N) Extended CommonHealth Coverage. MassHealth CommonHealth members (described in 130 CMR 505.004(B)) who terminate their employment, continue to be eligible for MassHealth CommonHealth for up to three calendar months after termination of employment provided they continue to make timely payments of monthly premiums.

(O) Postpartum Coverage. For people who are pregnant, MassHealth will provide postpartum care for 12 months following the termination of a pregnancy plus an additional period extending to the end of the month in which the 12-month period ends.

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505.005: MassHealth Family Assistance

(A) Overview. 130 CMR 505.005 contains the categorical requirements and financial standards for MassHealth Family Assistance.

(1) Children who are citizens, as defined in 130 CMR 504.002: *U.S. Citizens*, lawfully present immigrants, as defined in 130 CMR 504.003(A): *Lawfully Present Immigrants*, or nonqualified PRUCOLs, as defined in 130 CMR 504.003(C): *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs)*, whose modified adjusted gross income of the MassHealth MAGI household is greater than 150 and less than or equal to 300% of the federal poverty level (FPL) are eligible for MassHealth Family Assistance.

(2) Children and young adults who are nonqualified PRUCOLs, as defined in 130 CMR 504.003(C): *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs)*, whose modified adjusted gross income of the MassHealth MAGI household is at or below 150% of the FPL are eligible for MassHealth Family Assistance. Children under age one who are nonqualified PRUCOLs, as defined in 130 CMR 504.003(C): *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs)*, whose modified adjusted gross income of the MassHealth MAGI household is at or below 200% of the FPL are eligible for MassHealth Family Assistance. Young adults who are nonqualified PRUCOLs, as defined in 130 CMR 504.003(C): *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs)*, whose modified adjusted gross income of the MassHealth MAGI household is greater than 150 and less than or equal to 300% of the FPL are eligible for MassHealth Family Assistance.

(3) Adults who are nonqualified PRUCOLs, as defined in 130 CMR 504.003(C): *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs)*, whose modified adjusted gross income of the MassHealth MAGI household is at or below 300% of the FPL are eligible for MassHealth Family Assistance.

(4) HIV-positive individuals who are citizens as defined in 130 CMR 504.002: *U.S. Citizens* and qualified noncitizens as defined in 130 CMR 504.003(A)(1): *Qualified Noncitizens*, whose modified adjusted gross income of the MassHealth MAGI household is greater than 133 and less than or equal to 200% of the FPL are eligible for MassHealth Family Assistance.

(5) Disabled adults who are qualified noncitizens barred, as defined in 130 CMR 504.003(A)(2): *Qualified Noncitizens Barred*, nonqualified individuals lawfully present, as defined in 130 CMR 504.003(A)(3): *Nonqualified Individuals Lawfully Present*, or nonqualified PRUCOLs, as defined in 130 CMR 504.003(C): *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs)*, whose modified adjusted gross income of the MassHealth Disabled Adult household is at or below 100% of the FPL are eligible for MassHealth Family Assistance.

(6) Certain Emergency Aid to the Elderly, Disabled and Children (EAEDC) recipients are eligible for MassHealth Family Assistance.

(7) Persons eligible for MassHealth Family Assistance must obtain and maintain all available health insurance as described in 130 CMR 503.007: *Potential Sources of Health Care*.

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(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. Children younger than 19 years old are eligible for MassHealth Family Assistance coverage described in 130 CMR 505.005(B) if they meet the following criteria.

(1) Eligibility Requirements. A child is eligible if

- (a) the child is younger than 19 years old;
- (b) the child's modified adjusted gross income of the MassHealth MAGI household is greater than 150 and less than or equal to 300% of the federal poverty level (FPL);
- (c) the child is ineligible for MassHealth Standard or CommonHealth;
- (d) the child is a citizen as defined in 130 CMR 504.002: *U.S. Citizens* or a lawfully present immigrant as defined in 130 CMR 504.003(A), or a nonqualified PRUCOL, as defined in 130 CMR 504.003(C): *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs)*;
- (e) the child complies with 130 CMR 505.005(B)(2) and meets one of the following criteria:

- 1. the child is uninsured; or
- 2. the child has health insurance that meets the criteria at 130 CMR 506.012: *Premium Assistance Payments*.

(2) Access to Employer-sponsored Insurance and Premium Assistance Investigations for Individuals Who Are Eligible for MassHealth Family Assistance. MassHealth may perform an investigation to determine if individuals potentially eligible for MassHealth Family Assistance

- (a) have health insurance that MassHealth can help pay for; or
- (b) have access to employer-sponsored insurance in which MassHealth wants the individual to enroll and for which MassHealth will help pay.

1. Investigations for Individuals Who Are Enrolled in Health Insurance.

- a. If MassHealth determines that the health insurance the individual is enrolled in meets the criteria at 130 CMR 506.012: *Premium Assistance Payments*, the individual is notified in writing that MassHealth will provide MassHealth Family Assistance Premium Assistance Payments as described at 130 CMR 450.105(G)(1): *Premium Assistance* and 130 CMR 506.012: *Premium Assistance Payments*.
- b. If MassHealth determines that the health insurance the individual is enrolled in does not meet the criteria at 130 CMR 506.012: *Premium Assistance Payments*, the individual continues to be eligible for MassHealth Family Assistance.

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2. Investigations for Individuals Who Have Potential Access to Employer-sponsored Health Insurance (ESI).

- a. If MassHealth determines the individual has access to employer-sponsored health insurance, the employer is contributing at least 50% of the premium cost, and the insurance meets all other criteria described at 130 CMR 506.012: *Premium Assistance Payments*, the individual is notified in writing that they must enroll in this employer-sponsored coverage that meets the criteria described in 130 CMR 506.012: *Premium Assistance Payments*. MassHealth allows the individual up to 60 days to enroll in this coverage. Once enrolled in this health insurance plan, MassHealth provides MassHealth Family Assistance Premium Assistance Payments as described in 130 CMR 450.105(G)(1): *Premium Assistance* and 130 CMR 506.012: *Premium Assistance Payments*. Failure to enroll in the employer-sponsored health insurance plan at the request of MassHealth will result in the loss or denial of eligibility.
- b. If MassHealth determines the individual does not have access to employer-sponsored health insurance, the individual continues to be eligible for MassHealth Family Assistance.

(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. Children and young adults who are nonqualified PRUCOLs, as defined in 130 CMR 504.003(C): *Nonqualified Persons Residing under Color of Law* (*Nonqualified PRUCOLs*), are eligible for MassHealth Family Assistance coverage described in 130 CMR 505.005(C) if they meet the following criteria.

- (1) Eligibility Requirements. The individual is eligible if
 - (a) the individual is younger than 19 years old and the individual's modified adjusted gross income of the MassHealth MAGI household is at or below 300% of the federal poverty level (FPL);
 - (b) the individual is a young adult and individual's modified adjusted gross income of the MassHealth MAGI household is at or below 150% of the FPL;
 - (c) the individual is ineligible for MassHealth Standard or MassHealth CommonHealth;
 - (d) the individual is a nonqualified PRUCOL, as defined in 130 CMR 504.003(C): *Nonqualified Persons Residing under Color of Law* (*Nonqualified PRUCOLs*); and
 - (e) the individual complies with 130 CMR 505.005(C)(2).
- (2) Investigations for Individuals Who Have Potential Access to Employer-sponsored Insurance. MassHealth may perform an investigation to determine if individuals potentially eligible for MassHealth Family Assistance
 - (a) have health insurance that MassHealth can help pay for; or
 - (b) have access to employer-sponsored insurance in which MassHealth wants the individual to enroll and for which MassHealth will help pay.

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1. Investigations for Individuals Who Are Enrolled in Health Insurance.
 - a. If MassHealth determines that the health insurance the individual is enrolled in meets the criteria at 130 CMR 506.012: *Premium Assistance Payments*, the individual is notified in writing that MassHealth will provide MassHealth Family Assistance Premium Assistance Payments as described at 130 CMR 450.105(G)(1): *Premium Assistance* and (2): *Payment of Copayments, Coinsurance, and Deductibles for Certain Children Who Receive Premium Assistance* and 130 CMR 506.012: *Premium Assistance Payments*.
 - b. If MassHealth determines that the health insurance the individual is enrolled in does not meet the criteria at 130 CMR 506.012: *Premium Assistance Payments*, the individual continues to be eligible for MassHealth Family Assistance.
2. Investigations for Individuals Who Have Potential Access to Employer-sponsored Health Insurance (ESI).
 - a. If MassHealth determines the individual has access to employer-sponsored health insurance, the employer is contributing at least 50% of the premium cost, and the insurance meets all other criteria described at 130 CMR 506.012: *Premium Assistance Payments*, the individual is notified in writing that they must enroll in this employer-sponsored coverage that meets the criteria described in 130 CMR 506.012: *Premium Assistance Payments*. MassHealth allows the individual up to 60 days to enroll in this coverage. Once enrolled in this health insurance plan, MassHealth provides MassHealth Family Assistance Premium Assistance Payments as described in 130 CMR 450.105(G)(1): *Premium Assistance* and (2): *Payment of Copayments, Coinsurance, and Deductibles for Certain Children Who Receive Premium Assistance* and 130 CMR 506.012: *Premium Assistance Payments*. Failure to enroll in the employer-sponsored health insurance plan at the request of MassHealth may result in the loss or denial of eligibility.
 - b. If MassHealth determines the individual does not have access to employer-sponsored health insurance, the individual continues to be eligible for MassHealth Family Assistance.

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(D) Eligibility Requirement for Adults and Young Adults Who Are Nonqualified PRUCOLs with Modified Adjusted Gross Income of the MassHealth MAGI Household at or below 300% of the Federal Poverty Level. Individuals who are nonqualified PRUCOLs, as defined in 130 CMR 504.003(C): *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs)*, are eligible for MassHealth Family Assistance coverage described in 130 CMR 505.005(D) if they meet the following criteria.

- (1) The individual is eligible if
 - (a) the individual is a nonqualified PRUCOL, as defined in 130 CMR 504.003(C): *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs)*;
 - (b) the individual is ineligible for MassHealth Standard or MassHealth CommonHealth;
 - (c) the individual is uninsured;
 - (d) the individual does not have access to affordable Minimum Essential Coverage as defined in section 1401 of the Patient Protection and Affordable Care Act; and
 - (e) the individual is either
 1. a young adult 19 or 20 years old 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 (FPL); or
 2. 21 through 64 years old with modified adjusted gross income of the MassHealth MAGI household at or below 300% of the FPL.
- (2) Members eligible for benefits described in 130 CMR 505.005(D) receive MassHealth Family Assistance benefits described in 130 CMR 450.105(G)(4): *Managed Care Participation* and 130 CMR 508.000: *MassHealth: Managed Care Requirements*.

(E) Eligibility Requirement 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. Individuals who are HIV positive are eligible for MassHealth Family Assistance coverage described in 130 CMR 505.005(E) if they meet the following criteria.

- (1) The individual is eligible if
 - (a) the individual is younger than 65 years old;
 - (b) the individual is ineligible for MassHealth Standard or MassHealth CommonHealth;
 - (c) the individual's modified adjusted gross income of the MassHealth MAGI household is greater than 133 and less than or equal to 200% of the FPL;
 - (d) the individual is a citizen as defined in 130 CMR 504.002: *U.S. Citizens* or qualified noncitizen, as defined in 130 CMR 504.003(A)(1): *Qualified Noncitizens*; and
 - (e) the individual has verified their HIV-positive status by providing a letter from a doctor, qualifying health clinic, laboratory, or AIDS service provider or organization. The letter must indicate the individual's name and their HIV-positive status.
- (2) Health Insurance Investigation. MassHealth may perform an investigation to determine if individuals receiving MassHealth Family Assistance have health insurance that MassHealth may help pay for, as described at 130 CMR 506.012: *Premium Assistance Payments*.

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- (a) If MassHealth determines that the health insurance the individual is enrolled in meets the criteria at 130 CMR 506.012: *Premium Assistance Payments*, the individual is notified in writing that MassHealth will provide MassHealth Family Assistance Premium Assistance Payments as described at 130 CMR 450.105(G)(1): *Premium Assistance* and (2): *Payment of Copayments, Coinsurance, and Deductibles for Certain Children Who Receive Premium Assistance* and 130 CMR 506.012: *Premium Assistance Payments*.
- (b) If MassHealth determines that the health insurance the individual is enrolled in does not meet the criteria at 130 CMR 506.012: *Premium Assistance Payments*, the individual is eligible for MassHealth Family Assistance Direct Coverage.
- (3) Unless otherwise indicated in 130 CMR 505.005(E)(2), individuals determined eligible for MassHealth Family Assistance as described in 130 CMR 505.005(E) will receive benefits as described in 130 CMR 450.105(G)(4): *Managed Care Participation*.

(F) Eligibility Requirement 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. Individuals who are disabled adults are eligible for MassHealth Family Assistance coverage described in 130 CMR 505.005(F) if they meet the following criteria.

- (1) Eligibility Requirements. The individual is eligible if
 - (a) the individual is totally and permanently disabled as defined in 130 CMR 501.001: *Definition of Terms*;
 - (b) the individual is younger than 65 years old;
 - (c) the individual is ineligible for MassHealth Standard or MassHealth CommonHealth;
 - (d) the individual's modified adjusted gross income of the MassHealth Disabled Adult household is at or below 100% of the FPL; and
 - (e) the individual is a qualified noncitizen barred as described in 130 CMR 504.003(A)(2): *Qualified Noncitizens Barred*, nonqualified individual lawfully present, as defined in 130 CMR 504.003(A)(3): *Nonqualified Individuals Lawfully Present*, or a nonqualified PRUCOL, as defined in 130 CMR 504.003(C): *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs)*.
- (2) Determination of Disability. Disability is established by
 - (a) certification of legal blindness by the Massachusetts Commission of the Blind (MCB);
 - (b) a determination of disability by the Social Security Administration (SSA); or
 - (c) a determination of disability by the Disability Evaluation Services (DES).
- (3) Access to Employer-sponsored Insurance and Premium Assistance Investigations for Individuals Who Are Eligible for MassHealth Family Assistance. MassHealth may perform an investigation to determine if individuals potentially eligible for MassHealth Family Assistance
 - (a) are enrolled in health insurance that MassHealth can help pay for; or
 - (b) have access to employer-sponsored insurance in which MassHealth wants the individual to enroll and for which MassHealth will help pay.

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1. Investigations for Individuals Who Are Enrolled in Health Insurance.
 - a. If MassHealth determines that the health insurance the individual is enrolled in meets the criteria at 130 CMR 506.012: *Premium Assistance Payments*, the individual is notified in writing that MassHealth will provide MassHealth Family Assistance Premium Assistance Payments as described at 130 CMR 450.105(G)(1): *Premium Assistance* and (2): *Payment of Copayments, Coinsurance, and Deductibles for Certain Children Who Receive Premium Assistance* and 130 CMR 506.012: *Premium Assistance Payments*.
 - b. If MassHealth determines that the health insurance the individual is enrolled in does not meet the criteria at 130 CMR 506.012: *Premium Assistance Payments*, the individual continues to be eligible for MassHealth Family Assistance Direct Coverage.
2. Investigations for Individuals Who Have Potential Access to Employer-sponsored Health Insurance (ESI).
 - a. If MassHealth determines the individual has access to employer-sponsored health insurance and the employer is contributing at least 50% of the premium cost and the insurance meets all other criteria described at 130 CMR 506.012: *Premium Assistance Payments*, the individual is notified in writing that they must enroll in this employer-sponsored coverage that meets the criteria described in 130 CMR 506.012: *Premium Assistance Payments*. MassHealth allows the individual up to 60 days to enroll in this coverage. Once enrolled in this health insurance plan, MassHealth provides MassHealth Family Assistance Premium Assistance Payments as described in 130 CMR 450.105(G)(1): *Premium Assistance* and (2): *Payment of Copayments, Coinsurance, and Deductibles for Certain Children Who Receive Premium Assistance* and 130 CMR 506.012: *Premium Assistance Payments*. Failure to enroll in the employer-sponsored health insurance plan at the request of MassHealth may result in the loss or denial of eligibility.
 - b. If MassHealth determines the individual does not have access to employer-sponsored health insurance, the individual continues to be eligible for MassHealth Family Assistance.

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(G) Eligibility Requirements for Certain Emergency Aid for Elderly, Disabled and Children (EAEDC) Recipients.

(1) Eligibility Requirements. Certain EAEDC recipients are eligible for MassHealth Family Assistance if

(a) the individual is

1. a child or a young adult and is a nonqualified PRUCOL as described at 130 CMR 504.003(C): *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs)*; or
2. a parent, caretaker relative, or adult 21 through 64 years of age who is a qualified noncitizen barred, as described in 130 CMR 504.003(A)(2): *Qualified Noncitizens Barred*, nonqualified individual lawfully present, as defined in 130 CMR 504.003(A)(3): *Nonqualified Individuals Lawfully Present*, or a nonqualified PRUCOL, as defined in 130 CMR 504.003(C): *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs)*; and

(b) the individual receives EAEDC cash assistance.

(2) Extended Eligibility. Individuals whose EAEDC cash assistance ends and who are determined to be potentially eligible for MassHealth continue to receive medical benefits under MassHealth Family Assistance until a determination of ineligibility is made by MassHealth.

(H) MassHealth Family Assistance Premiums. Individuals who meet the requirements of 130 CMR 505.005 may be assessed a premium in accordance with the premium schedule provided at 130 CMR 506.011(B)(3) through (5).

(I) MassHealth Family Assistance Coverage Begin Date.

(1) The medical coverage date for MassHealth Family Assistance is described at 130 CMR 502.006: *Coverage Dates*, except as described at 130 CMR 505.005(B) and 130 CMR 505.005(I)(2) and (3).

(2) Provisional eligibility is described in 130 CMR 502.003(E): *Provisional Eligibility*.

(3) For those individuals eligible for MassHealth Family Assistance as described at 130 CMR 505.005(B), the begin date of the Premium Assistance is in accordance with 130 CMR 506.012(F)(1)(d).

(J) Postpartum Coverage. For people who are pregnant, MassHealth will provide postpartum care for 12 months following the termination of a pregnancy plus an additional period extending to the end of the month in which the 12-month period ends.

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505.006: MassHealth Limited

(A) Overview. 130 CMR 505.006 contains the categorical requirements and financial standards for MassHealth Limited coverage for children, young adults, and adults 21 through 64 years old who are parents, caretakers, adults, and disabled adults.

(B) Eligibility Requirements.

(1) MassHealth Limited is available to the following:

(a) other noncitizens as described in 130 CMR 504.003(D): *Other Noncitizens* who are

1. children younger than one year old with modified adjusted gross income of the MassHealth MAGI household that is less than or equal to 200% of the federal poverty level (FPL);
2. children one through 18 years old with modified adjusted gross income of the MassHealth MAGI household that is less than or equal to 150% of the FPL;
3. young adults 19 and 20 years old with modified adjusted gross income of the MassHealth MAGI household that is less than or equal to 150% of the FPL;
4. adults 21 through 64 years old who are parents, caretakers, or adults with modified adjusted gross income of the MassHealth MAGI household that is less than or equal to 133% of the FPL; and
5. disabled adults 21 through 64 years old with modified adjusted gross income of the MassHealth Disabled Adult household that is less than or equal to 133% of the FPL;

(b) nonqualified PRUCOLs as described in 130 CMR 504.003(C): *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs)* who are

1. children younger than one year old with modified adjusted gross income of the MassHealth MAGI household that is less than or equal to 200% of the federal poverty level (FPL);
2. children one through 18 years old with modified adjusted gross income of the MassHealth MAGI household that is less than or equal to 150% of the FPL;
3. young adults 19 and 20 years old with modified adjusted gross income of the MassHealth MAGI household that is less than or equal to 150% of the FPL;
4. adults 21 through 64 years old who are parents, caretakers, or adults with modified adjusted gross income of the MassHealth MAGI household that is less than or equal to 133% of the FPL; and
5. disabled adults 21 through 64 years old with modified adjusted gross income of the MassHealth Disabled Adult household that is less than or equal to 133% of the FPL;

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(c) qualified noncitizens barred, as described in 130 CMR 504.003(A)(2): *Qualified Noncitizens Barred*, and nonqualified individuals lawfully present, as described in 130 CMR 504.003(A)(3): *Nonqualified Individuals Lawfully Present* who are

1. adults, including parents and caretaker relatives, 21 through 64 years old with modified adjusted gross income of the MassHealth MAGI household that is less than or equal to 133% of the FPL;
2. disabled adults 21 through 64 years old with modified adjusted gross income of the MassHealth Disabled Adult household that is less than or equal to 133% of the FPL;
3. parents and caretakers who are 21 through 64 years old who are receiving EAEDC; and
4. adults 21 through 64 years old who are receiving EAEDC.

(2) Nonqualified PRUCOLs eligible for MassHealth Limited in 130 CMR 505.006(B)(1)(b) and qualified noncitizens barred and nonqualified individuals lawfully present eligible for MassHealth Limited in 130 CMR 505.006(B)(1)(c) may also be eligible for MassHealth CommonHealth if they meet the categorical and financial requirements in 130 CMR 505.004 or MassHealth Family Assistance if they meet the categorical and financial requirements in 130 CMR 505.005.

(3) Persons eligible for MassHealth Limited coverage are eligible for medical benefits as described in 130 CMR 450.105(F): *MassHealth Limited*. These individuals are eligible for medical benefits under MassHealth Limited only to the extent that such benefits are not covered by their health insurance.

(C) Use of Potential Health Insurance Benefits. All individuals who meet the requirements of 130 CMR 505.006 must use potential health insurance benefits in accordance with 130 CMR 503.007: *Potential Sources of Health Care*, and must enroll in health insurance, including Medicare, if available at no greater cost to the applicant or member than they would pay without access to health insurance. Members must access those other health insurance benefits and must show both their private health insurance card and their MassHealth card to providers at the time services are provided.

(D) Medical Coverage Date.

- (1) The medical coverage date for MassHealth Limited is described at 130 CMR 502.006: *Coverage Dates*, except as described at 130 CMR 505.006(D)(2).
- (2) Provisional eligibility is described in 130 CMR 502.003(E): *Provisional Eligibility*.

(E) Referral to Children's Medical Security Plan. MassHealth submits the names of children who are eligible for MassHealth Limited coverage to the Children's Medical Security Plan.

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505.007: MassHealth Senior Buy-In and Buy-In

(A) MassHealth Senior Buy-In and Buy-In coverage are available to Medicare beneficiaries who are not eligible for MassHealth Standard, in accordance with 130 CMR 519.010: *MassHealth Senior Buy-In* and 519.011: *MassHealth Buy-In*. MassHealth Standard members receive this benefit under 130 CMR 505.002(O). MassHealth CommonHealth members receive this benefit in accordance with 130 CMR 505.004(L).

(B) Income and assets for benefits provided under 130 CMR 519.010: *MassHealth Senior Buy-In* and 519.011: *MassHealth Buy-In* are determined in accordance with 130 CMR 520.000: *Health Care Reform: MassHealth: Financial Eligibility*.

505.008: MassHealth CarePlus

(A) Overview.

(1) 130 CMR 505.008 contains the categorical requirements and financial standards for MassHealth CarePlus. This coverage type provides coverage to adults 21 through 64 years old.

(2) Persons eligible for MassHealth CarePlus Direct Coverage are eligible for medical benefits, as described in 130 CMR 450.105(B): *MassHealth CarePlus* and 130 CMR 508.000: *MassHealth: Managed Care Requirements* and must meet the following conditions.

(a) The individual is an adult 21 through 64 years old.

(b) The individual is a citizen, as described in 130 CMR 504.002: *U.S. Citizens*, or a qualified noncitizen, as described in 130 CMR 504.003(A)(1): *Qualified Noncitizens*.

(c) The individual's modified adjusted gross income of the MassHealth MAGI household is less than or equal to 133% of the federal poverty level.

(d) The individual is ineligible for MassHealth Standard.

(e) The adult complies with 130 CMR 505.008(C).

(f) The individual is not enrolled in or eligible for Medicare Parts A or B.

(B) Eligibility Requirements for Certain EAEDC Recipients.

(1) Eligibility Requirements. Certain EAEDC recipients are eligible for MassHealth CarePlus if

(a) the individual is an adult 21 through 64 years old;

(b) the individual receives EAEDC cash assistance; and

(c) the individual is a citizen, as described in 130 CMR 504.002: *U.S. Citizens*, or a qualified noncitizen, as described in 130 CMR 504.003(A)(1): *Qualified Noncitizens*.

(2) Eligibility End Date. Individuals whose EAEDC cash assistance ends and who are determined to be potentially eligible for MassHealth continue to receive medical benefits under MassHealth CarePlus until a determination of ineligibility is made by the MassHealth agency.

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(C) Use of Potential Health Insurance Benefits. All applicants and members must use potential health insurance benefits in accordance with 130 CMR 503.007: *Potential Sources of Health Care* and must enroll in health insurance, if available at no greater cost to the applicant or member than they would pay without access to health insurance, or if purchased by MassHealth in accordance with 130 CMR 505.008(D) or 130 CMR 506.012: *Premium Assistance Payments*. Members must access those other health insurance benefits and must show both their private health insurance card and their MassHealth card to providers at the time services are provided.

(D) Access to Employer-sponsored Insurance and Premium Assistance Investigations for Individuals Who Are Eligible for MassHealth CarePlus.

(1) MassHealth may perform an investigation to determine if individuals receiving MassHealth CarePlus have

- (a) health insurance that MassHealth can help pay for; or
- (b) access to employer-sponsored insurance that MassHealth wants the individual to enroll and for which MassHealth will help pay.

1. Investigations for Individuals Who Are Enrolled in Health Insurance. If MassHealth determines that the health insurance the individual is enrolled in meets the criteria at 130 CMR 506.012: *Premium Assistance Payments*, the individual is notified in writing that MassHealth will provide MassHealth CarePlus Premium Assistance Payments as described at 130 CMR 506.012: *Premium Assistance Payments*. If MassHealth determines that the health insurance the individual is enrolled in does not meet the criteria at 130 CMR 506.012: *Premium Assistance Payments*, the individual is eligible for MassHealth CarePlus Direct Coverage.

2. Investigations for Individuals Who Have Potential Access to Employer-sponsored Health Insurance. If MassHealth determines the individual has access to employer-sponsored insurance and the employer is contributing at least 50% of the premium cost and the insurance meets all other criteria described in 130 CMR 506.012: *Premium Assistance Payments*, the individual is notified in writing that they must enroll in this employer-sponsored coverage. MassHealth will allow the individual up to 60 days to enroll in this coverage. Once enrolled in the health insurance plan, MassHealth will provide MassHealth CarePlus Premium Assistance Payments as described at 130 CMR 506.012: *Premium Assistance Payments*. Failure to enroll in the employer-sponsored health insurance plan at the request of MassHealth will result in loss or denial of eligibility for all individuals.

(2) If MassHealth determines the individual does not have access to employer-sponsored insurance, the individual continues to be eligible for MassHealth CarePlus.

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(E) MassHealth CarePlus Coverage Begin Date.

- (1) The MassHealth CarePlus coverage start date is described at 130 CMR 502.006: *Coverage Dates*, except as described at 130 CMR 505.008(E)(2).
- (2) Provisional eligibility is described in 130 CMR 502.003(E): *Provisional Eligibility*.

(F) Medically Frail. If an individual is determined medically frail or is an individual with special medical needs and has been determined to meet the eligibility criteria for MassHealth CarePlus as described in 130 CMR 505.008, the individual may elect at any time to receive MassHealth Standard benefits, as described in 130 CMR 505.002(J). If at any time after enrolling in MassHealth CarePlus an individual becomes medically frail or is determined to be medically frail, the individual may elect to receive MassHealth Standard benefits. The effective date of MassHealth Standard is the date of the reported change. To be considered medically frail or a person with special medical needs, an individual must be

- (1) an individual with a disabling mental disorder (including children with serious emotional disturbances and adults with serious mental illness);
- (2) an individual with a chronic substance use disorder;
- (3) an individual with a serious and complex medical condition;
- (4) an individual with a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or
- (5) an individual with a disability determination based on Social Security criteria.

(130 CMR 505.009 Reserved)

REGULATORY AUTHORITY

130 CMR 505.000: M.G.L. c. 118E, §§ 7 and 12.

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506.001: Introduction

(A) 130 CMR 506.000 describes the rules governing financial eligibility for MassHealth. Financial eligibility includes household composition, countable income, deductibles, calculation of premiums, and copayments for all coverage types described in 130 CMR 505.000: *Coverage Types*.

(B) Financial eligibility for MassHealth Medicare Savings Programs is determined in accordance with 130 CMR 519.010: *MassHealth Senior Buy-in*, 130 CMR 519.011: *MassHealth Buy-in*, and 130 CMR 520.000: *Financial Eligibility*.

506.002: Household Composition

(A) Determination of Household Composition. MassHealth determines household size at the individual member level. MassHealth determines household composition in two ways.

(1) MassHealth Modified Adjusted Gross Income (MAGI) Household Composition.

MassHealth uses the MassHealth MAGI household composition rules to determine member eligibility for the following benefits:

- (a) MassHealth Standard, as described in 130 CMR 505.002(B), (C), (D), (F), and (G);
- (b) MassHealth CommonHealth, as described in 130 CMR 505.004(F) and (G);
- (c) MassHealth CarePlus, as described in 130 CMR 505.008: *MassHealth CarePlus*;
- (d) MassHealth Family Assistance, as described in 130 CMR 505.005(B) through (E);
- (e) MassHealth Limited, as described at 130 CMR 505.006: *MassHealth Limited*; and
- (f) Children's Medical Security Plan (CMSP), as described in 130 CMR 522.004: *Children's Medical Security Plan (CMSP)*.

(2) MassHealth Disabled Adult Household. MassHealth uses the MassHealth Disabled Adult household composition rules to determine member eligibility for the following benefits:

- (a) MassHealth Standard, as described in 130 CMR 505.002(E): *Disabled Adults*;
- (b) MassHealth CommonHealth, as described in 130 CMR 505.004(B) through (E); and
- (c) MassHealth Family Assistance, as described in 130 CMR 505.005(F): *Eligibility Requirement 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*.

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(B) MassHealth MAGI Household Composition.

(1) Taxpayers Not Claimed as a Tax Dependent on Their Federal Income Taxes. For an individual who expects to file a tax return for the taxable year in which the initial determination or renewal of eligibility is being made and who is not claimed as a tax dependent by another taxpayer, the household consists of

- (a) the taxpayer, including their spouse, if the taxpayers are married and filing jointly regardless of whether they are living together;
- (b) the taxpayer's spouse, if living with them regardless of filing status;
- (c) all persons the taxpayer expects to claim as tax dependents; and
- (d) if any individual described in 130 CMR 506.002(B)(1)(a) through (c) is pregnant, the number of expected children.

(2) Individuals Claimed as a Tax Dependent on Federal Income Taxes.

(a) For an individual who expects to be claimed as a tax dependent by another taxpayer for the taxable year in which the initial determination or renewal of eligibility is being made and who does not otherwise meet the Medicaid exception rules as described in 130 CMR 506.002(B)(2)(b)1., 2., or 3., the household consists of

1. the individual;
2. the individual's spouse, if living with them;
3. the taxpayer claiming the individual as a tax dependent;
4. any of the taxpayer's tax dependents; and
5. if any individual described in 130 CMR 506.002(B)(2)(a)1. through 4. is pregnant, the number of expected children.

(b) Medicaid Exceptions. Household size must be determined in accordance with non-tax filer rules for any of the following individuals:

1. individuals other than the spouse or natural, adopted, or stepchild who expect to be claimed as a tax dependent by the taxpayer;
2. individuals younger than 19 years old who expect to be claimed by one parent as a tax dependent and are living with both natural, adopted or stepparents, but whose natural, adopted, or stepparents do not expect to file a joint tax return;
3. individuals younger than 19 years old who expect to be claimed as a tax dependent by a noncustodial parent. For the purpose of determining custody, MassHealth uses a court order or binding separation, divorce, or custody agreement establishing physical custody controls or, if there is no such order or agreement or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights.

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(3) Individuals Who Do Not File a Federal Tax Return and Are Not Claimed as a Tax Dependent on a Federal Tax Return. For an individual who does not expect to file a federal tax return and who does not expect to be claimed as a tax dependent on a federal tax return or when any of the exceptions described at 130 CMR 506.002(B)(2)(b)1., 2., or 3. apply, the household consists of

- (a) the individual;
- (b) the individual's spouse if living with them;
- (c) the individual's natural, adopted, and stepchildren younger than 19 years old if living with them;
- (d) for individuals younger than 19 years old, the individual's natural, adoptive, or stepparents and natural, adoptive, or stepsiblings younger than 19 years old if living with them; and
- (e) if any individual described in 130 CMR 506.002(B)(3)(a) through (d) is pregnant, the number of expected children.

(C) MassHealth Disabled Adult Household. The household consists of

- (1) the individual;
- (2) the individual's spouse if living with them;
- (3) the individual's natural, adopted, and stepchildren younger than 19 years old if living with them; and
- (4) if any individual described in 130 CMR 506.002(C)(1), (2), or (3) is pregnant, the number of expected children.

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(D) Deductions. Under federal law, the following deductions are allowed when calculating MAGI countable income. Changes to federal law may impact the availability of these deductions:

- (1) educator expenses;
- (2) reservist/performance artist/fee-based government official expenses;
- (3) health savings account;
- (4) moving expenses, for the amount and populations allowed under federal law;
- (5) one-half self-employment tax;
- (6) self-employment retirement account;
- (7) penalty on early withdrawal of savings;
- (8) alimony paid to a former spouse for individuals with alimony agreements finalized on or before December 31, 2018. Alimony payments under separation or divorce agreements finalized after December 31, 2018, or pre-existing agreements modified after December 31, 2018, are not deductible;
- (9) individual retirement account (IRA);
- (10) student loan interest;
- (11) scholarships, awards, or fellowships used solely for educational purposes; and
- (12) other deductions described in the Tax Cut and Jobs Act of 2017, Public Law 115-97 for as long as those deductions are in effect under federal law.

506.004: Noncountable Household Income

Because of state or federal law the following types of income are noncountable in the determination of eligibility for individuals described at 130 CMR 506.002. Changes to state or federal law may affect whether the following remains noncountable:

- (A) TAFDC, EAEDC, or SSI income;
- (B) federal veteran benefits that are not taxable in accordance with IRS rules;
- (C) income-in-kind;
- (D) roomer and boarder income derived from persons residing in the applicant's or member's principal place of residence;
- (E) most workers' compensation income;
- (F) pretax contributions to salary reduction plans for payment of dependent care, transportation, and certain health expenses within allowable limits;
- (G) child support received;
- (H) alimony payments under separation or divorce agreements finalized after December 31, 2018, or pre-existing agreements modified after December 31, 2018. For individuals with alimony agreements finalized on or before December 31, 2018, alimony continues to be included in the income of the recipient for the duration of the agreement unless or until the agreement is modified;

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(I) taxable amounts received as a lump sum, except those sums that are counted in the month received; in the case of lottery or gambling winnings, those sums that are counted in the month or months required under federal law, including the Tax Cut and Jobs Act of 2017, Public Law 115-97;

(J) money received for acting as a Parent Mentor as defined under section 1397 mm(f)(5) of chapter 42 of the United States Code of the Social Security Act;

(K) income received by independent foster-care adolescents described at 130 CMR 505.002(H): *Eligibility Requirements for Former Foster-care Individuals*;

(L) income from children and tax dependents who are not expected to be required to file a tax return under *Internal Revenue Code*, U.S.C. Title 26, § 6012(a)(1) for the taxable year in which eligibility for MassHealth is being determined, whether or not the children or the tax dependents files a tax return; and

(M) any other income that is excluded by federal laws other than the Social Security Act.

506.005: Verification of Income

Verification of income is mandatory. Income may be verified either through electronic data matches or paper verification.

(A) Electronic Data Matches.

(1) Data Matches. MassHealth electronically matches with federal and state data sources described at 130 CMR 502.004: *Matching Information* to verify attested income.

(2) Reasonable Compatibility. The income data received through an electronic data match is compared to the attested income amount to determine if the attested amount and the data source amount are reasonably compatible. If these amounts are reasonably compatible, the attested income is considered verified for purposes of an eligibility determination. To be considered reasonably compatible

(a) both the attested income and the income from the data sources must be above the applicable income standard for the individual; or

(b) both the attested income and the income from the data sources must be at or below the applicable income standard for the individual; or

(c) the attested income is at or below the applicable standard and the income from the data sources is above the applicable standard but their difference is 10% or less; or

(d) the attested income is above the applicable standard and the income from the data sources is at or below the applicable standard.

(3) Self-attested Income. When self-attested income is reasonably compatible with the electronic data, the income amount used to determine eligibility is the self-attested amount.

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(B) Paper Verification. If the attested income and the income from the electronic data source are not reasonably compatible, or if the electronic data match is unavailable, paper verification of income is required.

- (1) Paper verification of monthly earned income includes, but is not limited to
 - (a) recent paystubs;
 - (b) a signed statement from the employer; or
 - (c) the most recent U.S. Individual Tax Return.
- (2) Verification of monthly unearned income is mandatory and includes, but is not limited to
 - (a) a copy of a recent check or paystub showing gross income from the source;
 - (b) a statement from the income source, where matching is not available; or
 - (c) the most recent U.S. Individual Tax Return.
- (3) Verification of gross monthly income may also include any other reliable evidence of the applicant's or member's earned or unearned income.
- (4) For reasonably predictable fluctuating income, as described at 130 CMR 506.003(A)(4), verification may also include documentation of a contract for employment or clear history of predictable fluctuations in income.

506.006: Transfer of Income

All household members are required to avail themselves of all potential income.

(A) If the MassHealth agency determines that income has been transferred for the primary purpose of establishing eligibility for MassHealth, the income is counted as if it were received.

(B) If the MassHealth agency is unable to determine the amount of available income, the family group remains ineligible until such information is made available.

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506.007: Calculation of Financial Eligibility

The rules at 130 CMR 506.003 and 506.004 describing countable income and noncountable income apply to both MassHealth MAGI households and MassHealth Disabled Adult households.

(A) Financial eligibility for coverage types that are determined using the MassHealth MAGI household rules and the MassHealth Disabled Adult household rules is determined by comparing the sum of all countable income less deductions for the individual's household as described at 130 CMR 506.002 with the applicable income standard for the specific coverage type.

(1) The MassHealth agency will construct a household as described in 130 CMR 506.002 for each individual who is applying for or renewing coverage. Different households may exist within a single family, depending on the family members' familial and tax relationships to each other.

(2) Once the individual's household is established, financial eligibility is determined by using the total of all countable monthly income for each person in that individual's MassHealth MAGI or Disabled Adult household. Income of all the household members forms the basis for establishing an individual's eligibility.

(a) A household's countable income is the sum of the MAGI-based income of every individual included in the individual's household with the exception of children and tax dependents who are not expected to be required to file a return as described in 42 CFR 435.603 and 130 CMR 506.004(M).

(b) Countable income includes earned income described in 130 CMR 506.003(A) and unearned income described in 130 CMR 506.003(B) less deductions described in 130 CMR 506.003(D).

(c) In determining monthly income, the MassHealth agency multiplies average weekly income by 4.333.

(3) Five percentage points of the current federal poverty level (FPL) is subtracted from the applicable household total countable income to determine eligibility of the individual under the coverage type with the highest income standard.

(B) The financial eligibility standards for each coverage type may be found in 130 CMR 505.000: *Health Care Reform: MassHealth: Coverage Types*.

(C) The monthly federal-poverty-level income standards are determined according to annual standards published in the *Federal Register* using the following formula. The MassHealth agency adjusts these standards annually.

(1) Multiply the annual 100% figure posted in the *Federal Register* by the applicable federal poverty level income standard.

(2) Round these annual figures up to the nearest hundredth.

(3) Divide by 12 to arrive at the monthly income standards.

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(D) Safe Harbor Rule. The MassHealth agency will provide a safe harbor for individuals whose household income determined through MassHealth MAGI income rules results in financial ineligibility for MassHealth but whose household income determined through Health Connector income rules as described at 26 CFR 1.36B-1(e) is below 100% of the FPL. In such case, the individual's financial eligibility will be determined in accordance with Health Connector income rules.

(1) MassHealth uses current monthly income and the Health Connector uses projected annual income amounts.

(2) MassHealth MAGI household uses exceptions to tax household rules and the Health Connector uses the pure tax filing household.

(E) MAGI Protection for Individuals Receiving MassHealth Coverage on December 31, 2013. Notwithstanding 130 CMR 506.007(A) through (D), in the case of determining ongoing eligibility for individuals determined eligible for MassHealth coverage to begin on or before December 31, 2013, application of the MassHealth MAGI Household Income Calculation methodologies as set forth in 130 CMR 506.007 will not be applied until March 31, 2014, or the next regularly scheduled annual renewal of eligibility for such individual under 130 CMR 502.007: *Continuing Eligibility*, whichever is later, if the application of such methodologies would result in a downgrade of benefits.

506.008: Cost-of-living Adjustment (COLA) Protections

Applicants and members whose income increases each January as the result of a cost-of-living adjustment (COLA) will have their eligibility determined using their social security income just before the COLA, if such income can be verified, until the subsequent federal poverty level adjustment.

506.009: The One-time Deductible

(A) Eligibility Requirements. Disabled adults described in 130 CMR 505.004(C)(5)(a) and disabled young adults described in 130 CMR 505.004(E)(3)(a) 1. may establish eligibility for MassHealth CommonHealth by meeting a one-time-only deductible. Once a deductible has been met, the person may be assessed a premium in accordance with the premium schedule in 130 CMR 506.011(B)(2). Once the deductible has been met, the person is not required to meet another deductible if there is a lapse in CommonHealth coverage.

(B) Definition of the Deductible. The deductible is the total dollar amount of incurred medical expenses that an applicant, whose MassHealth Disabled Adult household income, as described in 130 CMR 506.003, exceeds 133% of the federal poverty level (FPL), must be responsible for before MassHealth eligibility is established.

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(C) The Deductible Period. The deductible period is a six-month period beginning on the date established in accordance with 130 CMR 505.004(M): *Medical Coverage Date*.

(D) Calculating the Deductible. The amount of the deductible is determined by comparing the MassHealth Disabled Adult household income as described in 130 CMR 506.003 to the MassHealth CommonHealth Monthly Deductible Income Standards provided in the following chart and multiplying the difference by six.

THE MASSHEALTH COMMONHEALTH MONTHLY DEDUCTIBLE INCOME STANDARDS	
<u>MassHealth Disabled Adult Household Size</u>	<u>Income Standards</u>
1	542
2	670
3	795
4	911
5	1036
6	1161
7	1286
8	1403
9	1528
10	1653
	+ 133 for each additional person

(E) Notification of the Deductible.

(1) The applicant who has excess monthly income will be informed that they are currently ineligible for MassHealth, but may establish eligibility by meeting the deductible. The applicant will be informed in writing of the following:

- (a) the deductible amount; and
- (b) the start and end dates of the deductible period.

(2) A person who meets a deductible will be eligible for MassHealth CommonHealth effective with the begin date of the deductible period.

(F) Persons Deemed to Have Met a Deductible. The following disabled adults will be considered to have met a deductible:

- (1) those who were receiving MassHealth on July 1, 1997, as the result of meeting a deductible; and
- (2) those who were denied eligibility with a deductible before July 1, 1997, but who submit medical bills on or after July 1, 1997, to meet the deductible.

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(G) Submission of Bills to Meet the Deductible.

(1) Criteria. To establish eligibility, the applicant must submit verification of medical or remedial bills whose total equals or exceeds the deductible and that meets the following criteria.

- (a) The bill must not be subject to further payment by health insurance or other liable third-party coverage, including the Health Safety Net.
- (b) The bill must be for an allowable medical or remedial expense as provided in 130 CMR 506.009(G)(2). A remedial expense is a nonmedical support service made necessary by the medical condition of any individual in the family group.
- (c) The bill must be unpaid and a current liability, or, if paid, was paid during the six-month deductible period.
- (d) The bill may not be for one of the following services:
 1. cosmetic surgery;
 2. rest-home care;
 3. weight-training equipment;
 4. massage therapy;
 5. special diets; and
 6. room and board charges for individuals in residential programs.

(2) Meeting the Deductible.

- (a) Bills to meet the deductible are applied in the following order:
 1. Medicare and other health insurance premiums credited prospectively for the cost of six months' coverage;
 2. expenses incurred by any member of the MassHealth Disabled Adult household for necessary medical and remedial-care services that are recognized under state law but are not covered by MassHealth, including guardianship fees and related expenses as defined at 130 CMR 515.001: *Definition of Terms*, and described in and allowed under 130 CMR 520.026(E)(3): *Guardianship Fees and Related Expenses*; and
 3. expenses incurred by any member of the MassHealth Disabled Adult household for necessary medical and remedial-care services that are covered by MassHealth.
- (b) Premiums for Qualified Health Plans can be applied to meet the deductible as they are incurred.
- (c) Any bills or portions of bills that are used to meet the deductible are not paid by the MassHealth agency and remain the responsibility of the applicant.

506.010: Verification of Medical and Remedial-care Expenses

(A) Medical or remedial-care expenses must be verified by a bill or written statement from a health care provider with the exception of expenses for nonprescription drugs, which must be verified by a receipt from the provider of the drug.

(B) Verifications must include all of the following information:

- (1) the type of service provided;
- (2) the name of the person for whom the service was provided;
- (3) the amount charged for the service including the current balance; and
- (4) the date of service.

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506.011: MassHealth Premiums and the Children's Medical Security Plan (CMSP) Premiums

The MassHealth agency may charge a monthly premium to MassHealth Standard, CommonHealth, or Family Assistance members who have income above 150% of the federal poverty level (FPL), as provided in 130 CMR 506.011. The MassHealth agency may charge a monthly premium to members of the Children's Medical Security Plan (CMSP) who have incomes at or above 200% of the FPL. MassHealth and CMSP premiums amounts are calculated based on a member's household modified adjusted gross income (MAGI) and their household size as described in 130 CMR 506.002 and 130 CMR 506.003 and the premium billing family group (PBFG) rules as described in 130 CMR 506.011(A). Certain members are exempt from paying premiums, in accordance with 130 CMR 506.011(J).

(A) Premium Billing Family Groups.

- (1) Premium formula calculations for MassHealth and CMSP premiums are based on premium billing family groups (PBFG). A PBFG is comprised of
 - (a) an individual;
 - (b) a couple who are two persons married to each other according to the rules of the Commonwealth of Massachusetts and are living together; or
 - (c) a family who live together and consist of
 1. a child or children younger than 19 years old, any of their children, and their parents;
 2. siblings younger than 19 years old and any of their children who live together, even if no adult parent or caretaker is living in the home; or
 3. a child or children younger than 19 years old, any of their children, and their caretaker relative when no parent is living in the home.
- (2) A child who is absent from the home to attend school is considered as living in the home.
- (3) A parent may be natural, adoptive, or a stepparent. Two parents are members of the same PBFG as long as they are mutually responsible for one or more children who live with them.
- (4) In a family with more than one child, any child with a MAGI household income that does not exceed 300% FPL will have its premium liability determined based on the MAGI household income of the child in the family PBFG with the lowest percentage of the FPL. If a child in the PBFG has an income percentage of the FPL at or below 150% of the FPL, premiums for all children in the PBFG are waived.
- (5) MassHealth and CMSP premiums for children with a MassHealth MAGI household income greater than 300% of the FPL and all premiums for young adults and adults are calculated using the individual's FPL and the corresponding premium amount as described in 130 CMR 506.011.
- (6) For individuals within a PBFG that is approved for more than one premium billing coverage type, except where application of 130 CMR 506.011(A)(4) will result in a lower premium for children in the PBFG, the following apply.
 - (a) When the PBFG contains members in more than one coverage type or program, including CMSP, and who are responsible for a premium or required member contribution, the PBFG is responsible for only the higher premium or required member contribution.

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(b) When the PBFG includes a parent or caretaker relative who is paying a premium for and is receiving Qualified Health Plan (QHP) with Premium Tax Credits, the premiums for children in the PBFG are waived once the parent or caretaker relative enrolls in and pays for a QHP.

(B) MassHealth and Children's Medical Security Plan (CMSP) Premium Formulas.

(1) The premium formula for MassHealth Standard members with breast or cervical cancer (BCC) whose eligibility is described at 130 CMR 505.002(F): *Individuals with Breast or Cervical Cancer* is as follows.

Standard Breast and Cervical Cancer Premium Formula	
% of Federal Poverty Level (FPL)	Monthly Premium Cost
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
Above 200% to 210%	\$40
Above 210% to 220%	\$48
Above 220% to 230%	\$56
Above 230% to 240%	\$64
Above 240% to 250%	\$72

(2) The premium formulas for MassHealth CommonHealth members whose eligibility is described in 130 CMR 505.004(B): *Disabled Working Adults* through (G): *Disabled Children Younger than 18 Years Old* are as follows.

(a) The premium formula for children with MassHealth MAGI household income between 150 and 300% of the FPL is provided as follows.

CommonHealth Full Premium Formula Children between 150% and 300%	
% of Federal Poverty Level (FPL)	Monthly Premium Cost
Above 150% to 200%	\$12 per child (\$36 PBFG maximum)
Above 200% to 250%	\$20 per child (\$60 PBFG maximum)
Above 250% to 300%	\$28 per child (\$84 PBFG maximum)

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(b) The full premium formula for young adults with household income above 150% of the FPL, adults with household income above 150% of the FPL, and children with household income above 300% of the FPL is provided as follows. The full premium is charged to members who have no health insurance and to members for whom the MassHealth agency is paying a portion of their health insurance premium.

CommonHealth Full Premium Formula Young Adults and Adults above 150% of the FPL and Children above 300% of the FPL		
<i>Base Premium</i>	<i>Additional Premium Cost</i>	<i>Range of Monthly Premium Cost</i>
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

(c) The supplemental premium formula for young adults, adults, and children with household income above 300% of the FPL is provided as follows. A lower supplemental premium is charged to members who have health insurance to which the MassHealth agency does not contribute. Members receiving a premium assistance payment from the MassHealth agency are not eligible for the supplemental premium rate.

CommonHealth Supplemental Premium Formula	
<i>% of Federal Poverty Level (FPL)</i>	<i>Monthly Premium Cost</i>
Above 150% to 200%	60% of full premium
Above 200% to 400%	65% of full premium
Above 400% to 600%	70% of full premium
Above 600% to 800%	75% of full premium
Above 800% to 1000%	80% of full premium
Above 1000%	85% of full premium

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(d) CommonHealth members who are eligible to receive a premium assistance payment, as described in 130 CMR 506.012, that is less than the full CommonHealth premium receive their premium assistance payment as an offset to the CommonHealth premium assistance bill and are responsible for the difference.

(3) The premium formula for MassHealth Family Assistance children whose eligibility is described at 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* and (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 Children Premium Formula	
% of Federal Poverty Level (FPL)	Monthly Premium Cost
Above 150% to 200%	\$12 per child (\$36 PBFG maximum)
Above 200% to 250%	\$20 per child (\$60 PBFG maximum)
Above 250% to 300%	\$28 per child (\$84 PBFG maximum)

(4) The premium formulas for MassHealth Family Assistance HIV-positive adults whose eligibility is described at 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* are as follows.

(a) The full premium formula for MassHealth Family Assistance HIV-positive adults between 150 and 200% of the FPL is charged to members who have no other health insurance and to members for whom the MassHealth agency is paying a portion of their health insurance premium. The full premium formula is provided as follows.

Family Assistance for HIV+ Adults Premium Formula	
% of Federal Poverty Level (FPL)	Monthly Premium Cost
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

(b) The supplemental premium formula for MassHealth Family Assistance HIV-positive adults is charged to members who have other health insurance to which the MassHealth agency does not contribute. A lower supplemental premium is charged to these members. Members receiving a premium assistance payment from the MassHealth agency are not eligible for the supplemental premium rate. The supplemental formula is provided as follows.

Family Assistance for HIV+ Adults Premium Formula Supplemental Premium Formula	
% of Federal Poverty Level (FPL)	Monthly Premium Cost
Above 150% to 200%	60% of full premium

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(5) The premium formula for MassHealth Family Assistance for nonqualified PRUCOL (NQP) adults, as described in 130 CMR 505.005(D): *Eligibility Requirements for Adults and Young Adults Aged 19 and 20 Who Are Nonqualified PRUCOLs with Modified Adjusted Gross Income of the MassHealth MAGI Household at or below 300% of the Federal Poverty Level* is based on MassHealth MAGI household income and MassHealth MAGI household size as it relates to the FPL income guidelines and PBFG rules, as described at 130 CMR 506.011(B). The premium formula can be found at 956 CMR 12.00: *Eligibility, Enrollment and Hearing Process for Connector Care*.

(6) The premium formula for Children's Medical Security Plan (CMSP) members, as described in 130 CMR 522.004: *Children's Medical Security Plan (CMSP)* is as follows.

CMSP Premium Schedule	
% of Federal Poverty Level (FPL)	Monthly Premium Cost
<i>Greater than or equal to 200%, but less than or equal to 300%</i>	<i>\$7.80 per child per month; PBFG maximum \$23.40 per month</i>
<i>Greater than or equal to 300.1%, but less than or equal to 400.0%</i>	<i>\$33.14 per PBFG per month</i>
<i>Greater than or equal to 400.1%</i>	<i>\$64.00 per child per month</i>

(C) Premium Payment Billing.

(1) With the exception of persons described in 130 CMR 505.004(C): *Disabled Adults*, MassHealth members who are assessed a premium are responsible for monthly premium payments beginning with the calendar month following the date of the MassHealth agency's eligibility determination.

(2) Persons described in 130 CMR 505.004(C): *Disabled Adults* who are assessed a premium, are responsible for monthly premium payments beginning with the calendar month following the date the deductible period ends, or the calendar month following the month in which the member has verified that the deductible has been met, whichever is later.

(3) Members who are assessed a revised premium as the result of a reported change, or any adjustment in the premium schedule, are responsible for the new premium payment beginning

- with the calendar month following the reported change if the premium is increased; or
- with the calendar month of the reported change if the premium is decreased or no longer assessed.

(4) Members who have been assessed premiums but who are subsequently determined eligible for MassHealth benefits that do not require a premium will not be charged a premium for the calendar month in which the coverage type changes or thereafter.

(5) If the member contacts the MassHealth agency by telephone, in writing, or online and requests a voluntary withdrawal within 60 calendar days from the date of the eligibility notice and premium notification, MassHealth premiums are waived.

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(D) Delinquent Premium Payments.

(1) Termination for Delinquent Premium Payments. If the MassHealth agency has billed a member for a premium payment, and the member does not pay the entire amount billed within 60 days of the date on the bill, the member's eligibility for benefits is terminated. The member will be sent a notice of termination before the date of termination. The member's eligibility will not be terminated if, before the date of termination, the member

- (a) pays all delinquent amounts that have been billed;
- (b) establishes a payment plan and agrees to pay the current premium being assessed and the payment-plan-arrangement amount;
- (c) is eligible for a nonpremium coverage type;
- (d) is eligible for a MassHealth coverage type that requires a premium payment and the delinquent balance is from a CMSP benefit; or
- (e) requests a waiver of past-due premiums as described in 130 CMR 506.011(G).

(2) Default on a Payment Plan.

- (a) If the member does not make payments in accordance with the payment plan within 30 days of the date on the bill, the member's payment plan is terminated and the past due balance is due in full.
- (b) If the member is in a premium-paying coverage type and does not pay the past due amount within 60 days of the date on the bill, the member's eligibility is terminated.
- (c) If a member has defaulted on a payment plan twice within a 24-month period, the member must pay in full any past due balances before they can be determined eligible for a coverage type that requires a premium payment.
- (d) A member may be granted additional payment plans if the member has been approved for a hardship waiver as described at 130 CMR 506.011(F).

(3) Referral to State Intercept Program for Collection of Delinquent Payment. The MassHealth agency may refer a member who is 150 days or more in arrears to the State Intercept Program (SIP) in compliance with 815 CMR 9.00: *Collection of Debts*. Members will not be referred to SIP for collection of a past due balance if they have and are currently paying on the payment-plan arrangement that was approved by the MassHealth agency.

(E) Reactivating Coverage Following Termination When a Member Has a Past Due Balance.

- (1) Except as provided in 130 CMR 506.011(E)(2), after the member has paid in full all payments due, has established a payment plan with MassHealth, or has been granted a waiver of past-due balance as described in 130 CMR 506.011(G), the MassHealth agency will reactivate coverage.
- (2) For children younger than 19 years old, coverage may be reactivated after 90 days from the date termination upon request, regardless of any outstanding payments due.

(F) Waiver of Outstanding Premium Payments. Outstanding premium balances that are older than 24 months are waived.

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(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 MassHealth CommonHealth member who has accessed available third-party insurance or has no third-party insurance; and

2. the total monthly premium charged for MassHealth 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 with 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(G)(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.

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(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 their 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 individuals and children younger than one year old;
- (4) children when a parent or guardian in the PBFG 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 5% 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*;

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(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 old 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*; and

(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*.

(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).

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(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 Savings Program 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 130 CMR 506.003, as it relates to federal poverty guidelines and PBFG rules described at 130 CMR 506.011(A).

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(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 (PBFG) who are beneficiaries of the ESI.

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(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:

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

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.

(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.

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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 (PBFG) members who are beneficiaries of the Other Group 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.

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:

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

Other Group 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.

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(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.
- (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.
- (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 their MassHealth application for benefits, the MassHealth premium assistance payments end.

(4) Premium Assistance Reimbursement Adjustments.

- (a) As stated in 130 CMR 501.012, the MassHealth agency has the right to recover payment for medical benefits to which the member was not entitled at the time the benefit was received, regardless of who was responsible and whether or not there was fraudulent intent.
- (b) If a member receives a premium assistance payment and is not entitled to receive all or part of the payment, regardless of who was responsible and whether or not there was fraudulent intent, the MassHealth agency will notify the member of the premium assistance reimbursement adjustment in writing and inform the member to repay the difference between the premium assistance reimbursement they received and the corrected premium assistance reimbursement amount within 30 days of the date of the reimbursement adjustment notice.
- (c) At the discretion of the MassHealth agency, policyholders may apply for a monthly payment plan agreement to govern the repayment of their reimbursement adjustment.
- (d) A member may not be required to repay a Premium Assistance Reimbursement Adjustment where the reimbursement adjustment

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1. was identified as an error on the part of the MassHealth agency when the agency knew or should have known at the time the Premium Assistance reimbursement was made based on the information available to it that the Premium Assistance reimbursement amount was incorrect;
 2. has a total value of no more than \$100;
 3. is associated with a former Premium Assistance policyholder who is identified as deceased; or
 4. occurred prior to April 1st, 2023.
- (e) Where a Premium Assistance Reimbursement Adjustment is identified by the MassHealth agency to be greater than four times the monthly Premium Assistance amount, a member may not be required to repay any amount exceeding four times the monthly Premium Assistance amount. Example: If a member had a monthly Premium Assistance amount of \$500, they may not be required to repay the portion of the Premium Assistance Reimbursement Adjustment amount exceeding \$2000.
- (5) Referral to State Intercept Program for Collection of Delinquent Premium Assistance Reimbursement Adjustments. The MassHealth agency may refer a member who is 150 days or more in arrears to the State Intercept Program (SIP) in compliance with 815 CMR 9.00: *Collection of Debts*. Members will not be referred to SIP for collection of a past due balance if they have and are currently paying on the payment-plan arrangement that was approved by the MassHealth agency.
- (6) Temporary Deferral or Reduction of Premium Assistance Reimbursement Adjustments for Undue Financial Hardship.
- (a) Policyholders with an active Premium Assistance Reimbursement Adjustment may be eligible for a temporary deferral or reduction of their monthly reimbursement adjustment repayments if they are experiencing an undue financial hardship.
 - (b) Policyholders must first set up a monthly payment plan to repay the Premium Assistance Reimbursement Adjustment before they may apply for the temporary deferral or reduction.
 - (c) The MassHealth agency may determine that a policyholder is experiencing an undue financial hardship and is eligible for a temporary deferral or reduction of their reimbursement adjustment if they meet one or more of the following criteria, at the discretion of the agency:
 1. are homeless, or are more than 30 days in arrears in rent or mortgage payments, or have received a current eviction or foreclosure notice;
 2. have a current shut-off notice, or have been shut off, or have a current refusal to deliver essential utilities (gas, electric, oil, water, or telephone);
 3. have a very high student loan bill or are delinquent in their student loan repayments, and there is no forgiveness, forbearance, or deferment available;
 4. have 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 deferral, regardless of the date of service);
 5. have experienced a significant, unavoidable increase in essential expenses within the last six months;

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- 6. have suffered within the six months prior to the date of application for a deferral, or are likely to suffer in the six months following such date, economic hardship because of a state or federally declared disaster or public health emergency; or
- 7. have an annual household income of no more than 150% of the Federal Poverty Level.

(d) Policyholders who are denied their request for a temporary deferral or reduction of their Premium Assistance Reimbursement Adjustment may appeal that decision.

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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.

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 twelfth 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 June 1st the following year);
- (c) MassHealth Limited members;
- (d) MassHealth Medicare Savings Programs 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 21 years old or 26 years old, 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);

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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.

(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.

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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.

506.019: Copayment Waiver During Federal Public Health Emergency Unwind.

Notwithstanding 130 CMR 506.015 through 506.018, the MassHealth agency will require no copayments by its members during the period May 1, 2023, through March 31, 2024.

REGULATORY AUTHORITY

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