Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth

MassHealth
Nursing Facility Bulletin 131
April 2010

TO: Nursing Facilities Participating in MassHealth

FROM: Terence G. Dougherty, Medicaid Director

RE: Administrative Annual Review Process for Certain MassHealth Members Residing in Nursing Facilities

Background

State and federal laws require that MassHealth perform a continuing eligibility review of every member on an annual basis.

The purpose of this bulletin is to describe a new administrative annual review process that will be used for certain MassHealth members residing in nursing facilities. This project will streamline the annual redetermination of MassHealth nursing facility residents by using data matching.

Eligible Population

The new administrative review process will be employed for a MassHealth nursing facility resident who meets the following criteria:

- is single with no dependents;
- has assets less than $2,000;
- has social security as the only source of income; and
- has Medicare only or Medicare and one other source of health insurance (not Medex).

Review Process

At the time of the annual review, a member who meets the criteria for the administrative review process will be sent the following:

- an administrative review cover letter (NF-AR-CL) (printed on yellow paper);
- a MassHealth Eligibility Review for Nursing Facility Services (NF-AR);
- an Eligibility Representative Designation (ERD) Form; and
- a UNIV-5 (Babel).

The cover letter advises the member that his or her eligibility has been reviewed electronically and, unless there are changes to report, no further action is needed.

(continued on next page)

Review Process
(cont.)

If there are changes in income, assets, health insurance, or an ERD, the cover letter instructs the member to complete the enclosed review form and return it to the MassHealth Enrollment Center (MEC) as soon as possible.

If there have been no changes in circumstances as described above, the member need not return the form and his or her eligibility will remain intact for another year, assuming no changes occur throughout the year.

Additional Information

The important difference between the administrative review form and other review forms is that this form does **not** need to be returned if there are no changes to report. All other review forms **must** be returned or the member's case will be closed.

Members must continue to report any change in circumstances to a MassHealth Enrollment Center (MEC) within 10 days of a change.

Attachments

Attached to this memo are

- a sample administrative review cover letter (NF-AR-CL); and
- a MassHealth Eligibility Review for Nursing Facility Services (NF-AR).

Questions

If you have any questions about the information in this bulletin, please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

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

MassHealth Enrollment Center
300 Ocean Avenue, Suite 4000
Revere, MA 02151
1-800-322-1448
1-877-668-4499 TTY (for people with partial or total hearing loss)
781-485-3400 (fax)

North Adams Commons
175 Franklin Street
City, State Zip

Date: 04/01/2010
Review for: John Doe
Review Date: 04/01/2010

Good News from MassHealth

A Notice about Your MassHealth Eligibility Review

for Nursing Facility Services

Federal and state laws require that MassHealth complete a review of your continuing eligibility every year. **We have reviewed your case electronically and determined you will continue to get MassHealth.** Unless there are changes you need to report to us, your next review will be scheduled for <month yyyy>.

Changes you need to report to us

- Your total assets have increased to over $2000.00.
  - Assets may include bank accounts (checking accounts, savings accounts, or credit union accounts), cash, or other assets.
- Your monthly income has changed over the last year, or you have received new types of income.
  - Do not send us changes to your social security income.
- You have added or dropped health insurance coverage like Blue Cross Medex or Medicare D.
- You would like to change or add an eligibility representative.

If you have any changes to report, complete the enclosed eligibility review form and send to the MassHealth Enrollment Center at the address above as soon as possible. Include any proof of changes, such as bank statements, pay stubs, health-insurance cards, life insurance policies, or burial account information to show the changes that took place during the last year.

If you **do not** have any changes to report, you **do not** need to send back the enclosed form.

If you have any questions, please call the telephone number above.

NF-AR-CL–R (04/10)

Reminder: Send this form back to us ONLY if you have changes.

Review for: <Member name> CAT: <#> SSN: <###-##-####>

MassHealth Eligibility Review for Nursing Facility Services

Review date: <mm/dd/yyyy> Date received:

Section I: Member information		
Name (Last, First, MI) <last name, first name, m.i.>	Social security number <###-##-####>	Are you a US citizen/national? ☐ yes ☐ no

Section II: Income information (Send proof of all income before taxes and deductions, except social security income.)	
Type of income	Monthly amount before deductions

Section III: Asset information (Send proof of all assets you own.)			
Type	Bank/institution/company name	Account/Policy number	Current amount
Bank accounts (includes checking, savings, credit union, certificates of deposit, personal needs accounts, trust accounts, money market accounts, retirement accounts (IRAs, Keogh, 401K))			$
Life insurance			Face value $
Securities/other (includes stocks, bonds, savings bonds, mutual funds, cash)			$
Annuities			Date purchased: / /
Annuities purchased on or after February 8, 2006, may make you ineligible for payment of long-term-care services, unless certain conditions are met. To be eligible, you may be required to name the Commonwealth of Massachusetts as a remainder beneficiary.			
Real estate (home/other)	Description and address: _____ Type of ownership: ☐ sole ownership ☐ joint ownership ☐ tenants in common ☐ life estate ☐ other:_____		☐ Assessed value:_____ ☐ Other value: _____
If you applied for MassHealth on or after January 1, 2006, and the equity interest in your principle place of residence is over $750,000, you may be ineligible for payment of long-term-care services at home unless certain conditions are met.			
Vehicles	Year/make/model:	Amount owed $	Fair market value $
Burial-only accounts / burial contracts / burial trusts			$
Trusts	Revocable? ☐ yes ☐ no	Current trust principal $	
Have you transferred, gotten, sold, or closed any assets or income since your last eligibility review? ☐ yes ☐ no If **yes**, describe below. (If you transferred or changed your ownership in real estate, please **give us a copy** of the new deed showing the change.)			

Section IV: Spouse / Dependent information

Do you have a spouse or dependents living at home? ☐ yes ☐ no

Name(s): _____ Relationship: _____ Disabled? ☐ yes ☐ no

Section V: Health insurance Information (List all health-insurance policies you have, including Medex, BC/BS, AARP, HMO,TRICARE, or other policies. Do not list Medicare or MassHealth.)

Type	Policy number

- Have you stopped any health-insurance plans since your last eligibility review? ☐ yes ☐ no

If yes, list here.

_____

If you have long-term-care insurance, **send a copy** of the policy.

Section VI: Signature (you and/or your eligibility representative must read this page carefully, then sign and date it at the bottom.)

I understand that if I am eligible for MassHealth, I must tell MassHealth of any changes in my income or employment, assets, health-insurance coverage, health-insurance premiums, and immigration status, or of changes in any other information I gave on this review form and any supplements within 10 calendar days of learning of the change.

If I am found to be eligible for assistance through MassHealth, I give permission to MassHealth to get any records or data: (1) to prove any information given on this review form and any supplements, or other information I give while I am a member; (2) to document medical services claimed or provided; and (3) to support continued eligibility.

I also understand that if I applied for MassHealth on or after January 1, 2006, and the equity interest in my home is over $750,000, I may become ineligible for payment of long-term-care services, unless certain conditions are met.

I understand that in some cases, MassHealth may place a lien against any real estate that I have a legal interest in. If MassHealth puts a lien against my property and I sell it, I may need to use money I get from the sale of that property to repay MassHealth for medical services that I get.

I understand that if I am aged 55 or older, or I am any age and MassHealth helps pay for my care in a nursing home, MassHealth may be able to get back money from my estate after I die. Under current practice, this does not apply to Commonwealth Care.

I understand that annuity transactions, including purchases and selecting or changing payment plans, entered into on or after February 8, 2006, require that certain conditions are met and that I may not be eligible for payment of long-term-care services unless I provide proof that those conditions have been met. I also understand that the Commonwealth of Massachusetts may be required to be named as a remainder beneficiary of annuities for the total amount of medical assistance paid for the institutionalized individual. I further understand that the Commonwealth may not be removed as the beneficiary, and that eligibility may be ended and benefits recovered if the Commonwealth's position as a remainder beneficiary is not maintained.

I understand that if I am in an accident, or am injured in some other way, and get money from a third party because of that accident or injury, I will need to use that money to repay MassHealth for certain medical services provided (for MassHealth, these certain medical services are explained in the MassHealth and You guide). I also understand that I must tell MassHealth, in writing, within 10 calendar days, or as soon as possible, if I file any insurance claim or lawsuit because of an accident or injury to me.

I also understand that by signing below, I give permission to MassHealth to go after and collect third-party payments for medical care and medical support from my spouse (if applicable) who is living at home and refuses to cooperate or whose whereabouts is unknown.

I certify that I have read or have had read to me the information on this review form and the information in the MassHealth and You guide, and that I understand my rights and responsibilities. I further certify under penalty of perjury that the information on this review form and any supplements is correct and complete to the best of my knowledge.

If you are acting on behalf of someone in filling out this review form and any supplements, the enclosed MassHealth Eligibility Representative Designation (ERD) Form must also be filled out and sent back with this review form. Your signature on this review form and any supplements as an eligibility representative certifies that the information on this review form and any supplements is correct and complete to the best of your knowledge.

If you think MassHealth's decision about whether you are eligible is wrong, you have the right to appeal or file a grievance. If you are denied benefits or your benefits are stopped, you will get information about how to appeal a MassHealth decision and also how to file a grievance about any Health Safety Net decision.

_____ _____

Signature of member or eligibility representative Date